NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, NOVEMBER 3, 2016
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Todd Spitzer, Alternate

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

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

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

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

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
    a. Strategic Planning Session
    b. Information Security Matter
    c. Real Estate Development Rights
    d. California Association of Health Plans
    e. Coordinated Care Initiative
    f. Whole Person Care Pilot
    g. Board of Supervisors Recognition
    h. Legislative Luncheon
    i. Joint Medical Audit
    j. Key Meetings

PUBLIC COMMENTS

At this time, members of the public may address the Board of Directors on matters not appearing on the agenda, but within the subject matter jurisdiction of the Board of Directors. Speakers will be limited to three (3) minutes.

CONSENT CALENDAR

2. Minutes
    a. Approve Minutes of the October 6, 2016 Regular Meeting of the CalOptima Board of Directors
    b. Receive and File Minutes of the September 8, 2016 Meeting of the CalOptima Board of Directors' Provider Advisory Committee

REPORTS

3. Consider Amendment of the AMVI Care Health Network, CHOC Health Alliance, CHOC Hospital, Family Choice Health Network, OC Advantage and Fountain Valley Hospital Medi-Cal Physician Hospital Consortium Health Network Contracts to Extend These Agreements, and Consider Rates of Payment for Medi-Cal Expansion Members Assigned to These Health Networks During the Extension Period

4. Consider Amendment of the Alta Med Health Services, AMVI/Prospect Medical Group, Arta Western Medical Group, Family Choice Medical Group, Monarch HealthCare, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Group OneCare Shared Risk Health Network Contracts to Extend These Agreements for the Period January 1, 2017 – December 31, 2017, and Add Other Provisions

5. Consider Authorizing Extension Amendment of Contract with Liberty Dental Plan of California, Inc., for Dental Services Provided to OneCare Members for the 2017 Calendar Year

6. Consider Authorizing Increased Medi-Cal Payments for Specific Services to Qualifying Primary Care Providers Who Submitted Attestations Between January 1 and June 15, 2015

7. Consider Adoption of Resolution Approving Updated Human Resources Policies

8. Consider Authorizing Expenditures in Support of CalOptima's Participation in the Family Voices of California's 2017 Annual Health Summit, in Preparation for the Upcoming Transition of the California Children's Services Benefit to CalOptima

9. Consider Ratification and Approval of Expenditures Related to Health Insurance Portability and Accountability Act (HIPAA) Security Breach Response; Authorize Contract(s) and Contract Amendment(s) with Vendors Providing HIPAA Security Breach Response Services

ADVISORY COMMITTEE UPDATES

10. OneCare Connect Cal MediConnect (Medicare and Medicaid Plan) Member Advisory Committee Update

11. Member Advisory Committee Update

12. Provider Advisory Committee Update

INFORMATION ITEMS

13. September 2016 Financial Summary

14. Compliance Report

15. Federal and State Legislative Advocates Reports

16. CalOptima Community Outreach and Program Summary

17. Strategic Planning Session

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

CS 1 CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION: Significant exposure to litigation pursuant to Government Code section 54956.9, subdivision (d)(2): (One case)

CS 2 CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. Government Code Section54956.9, subdivision (d)(1) Two Cases: 1) Saddleback Memorial Medical Center v. CalOptima. Orange County Superior Court (OCSC) Case No. 30-2015-00808448-CU-CO-CJC; and 2) Orange Coast Memorial Medical Center v. CalOptima, OCSC Case No. 30-2016-00847325-CU-BC-CJC

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, December 1, 2016 at 2:00 p.m.

MEMORANDUM

DATE:	November 3, 2016
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee

Strategic Planning Session
As previously announced, CalOptima's November Board meeting will be abbreviated to allow time for your Board to participate in a session dedicated to the agency's next three-year strategic plan. Facilitator Bobbie Wunsch has asked that each Board member prepare for the discussion by bringing answers to the following questions:

- How can CalOptima be best prepared to respond to the evolving health care environment and strengthen our position as a valued asset in our community?
- What big ideas do you have that staff should consider as they move toward implementation of the new CalOptima strategic plan and priorities?

Thank you in advance for your insight and guidance on the 2016–19 Strategic Plan.

Information Security Matter
On October 14, CalOptima notified approximately 56,000 current and former members about a security matter involving their protected health information (PHI). In August, a departing employee downloaded data, including PHI, to an unencrypted USB flash drive. Shortly after leaving the agency, the former employee returned the drive. CalOptima is cooperating with local law enforcement and health plan regulators on the investigation of this matter. While we are still investigating, CalOptima does not believe the information was shared. The downloaded PHI included member names, demographic information and other health-plan related information. Social Security numbers were also included for some of the affected members. CalOptima established a toll-free number to respond to questions. In addition, CalOptima is offering no-cost, triple-bureau credit monitoring services to affected adult members and a separate free service for affected child members, so parents can monitor whether a fraudulent credit file exists in the child's name. To help protect against this type of incident in the future, CalOptima has implemented several additional safeguards and security standards. CalOptima was also required to inform the media, and four publications wrote articles. At this time, members are beginning to respond by calling Customer Service or enrolling in credit monitoring. I will keep your Board informed as we work to resolve the matter and strengthen our member protections even further.

Real Estate Development Rights
On November 17, your Board's Finance and Audit Committee (FAC) will receive an informational update about CalOptima's real estate development rights. A consultant engaged via Request for Proposal, Glen Allen, president of Newport Real Estate Services Inc., will make

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a detailed presentation regarding the options available to CalOptima with regard to developing the land currently in use as a parking lot for 505 City Parkway West. After the FAC vets the information, the next step will be for the full Board to hear the presentation in December.

California Association of Health Plans (CAHP)
In October, CAHP held its annual conference in Palm Desert to bring together nearly 50 public and private health plans that operate in California. The conference featured more than a dozen sessions covering key industry topics. I spoke as part of a three-person panel addressing the future of Medi-Cal. Inland Empire Health Plan CEO Brad Gilbert, M.D., discussed integrating behavioral and physical health and his plan's effort to administer behavioral health directly. Toby Douglas, the former director of the Department of Health Care Services (DHCS) and now the senior vice president of Medicaid solutions for Centene, spoke about Medicaid activities in other states. I shared my vision of where Medi-Cal is going by focusing on seniors. In the past, Medi-Cal was built for moms and babies. Currently, Medi-Cal is addressing high-acuity populations with multiple chronic conditions and behavioral health issues. But the future is seniors, and I emphasized that serving seniors may require moving beyond Medi-Cal. Because everyone ages differently and most people prefer to continue living at home, seniors need to have many options before long-term care, options such as Community-Based Adult Services, In-Home Supportive Services, Program for All-Inclusive Care for the Elderly and others.

Coordinated Care Initiative (CCI)
CalOptima continues to participate in the CCI Sustainability Workgroup, a collaborative effort among CCI health plans organized by CAHP. The workgroup remains focused on demonstrating the value of the CCI and its associated Cal MediConnect plans, including CalOptima's OneCare Connect. This is of particular importance now, given that the FY 2017–18 state budget is being formulated for January, and there is attention on whether the CCI has delivered the anticipated financial savings. By statute, the CCI can be terminated if it doesn't realize cost savings. The workgroup recently launched a statewide advocacy campaign, and I will be meeting with state officials in the coming weeks to share OneCare Connect success stories. In addition, to demonstrate to the governor that broad interest in maintaining the CCI exists, the advocacy campaign also engaged stakeholders to send letters of support. In less than a week, CalOptima stakeholders generated nearly 30 letters to the governor from key influencers, such as elected officials, provider groups, community-based organizations and associations.

Whole Person Care (WPC) Pilot
In late October, DHCS approved Orange County's application to participate in the WPC pilot program, which aims to better coordinate health care and social services for the local homeless population. The program will be funded by the county, with matching federal dollars, for a total of $23.5 million in spending over the five-year pilot. The Orange County Health Care Agency (HCA) will be the lead entity on the program, and CalOptima will be a participating entity. HCA plans to convene a WPC Collaborative to begin implementation work after the county's agreement with the state is finalized.

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Board of Supervisors Recognition
On October 25, CalOptima was honored by the Orange County Board of Supervisors for our National Committee for Quality Assurance (NCQA) rating as the top Medi-Cal plan in California for the third year in a row. I was pleased to accept a resolution that highlights our agency's achievement on behalf of the Orange County residents who are our members.

Legislative Luncheon
On October 28, CalOptima welcomed nearly 50 representatives from elected offices and other stakeholder groups to a Legislative Luncheon. At the luncheon, I was presented with a special joint State Senate and State Assembly Resolution in recognition of CalOptima's NCQA rating as the top Medi-Cal plan in California. During the program, I shared information that explained the background and significance of the NCQA honor. Further, since this was the first luncheon since your new Board was installed in August, I provided details about the structure of your new Board. The program concluded with Director of Government Affairs Arif Shaikh reviewing federal and state legislation that will impact CalOptima in the near future.

Joint Medical Audit
CalOptima received notice that DHCS and Department of Managed Health Care (DMHC) will audit Medi-Cal and OneCare Connect in February 2017. The regulators intend to audit Medi-Cal for Seniors and Persons with Disabilities services and OneCare Connect for Medicaid-based services. Both audits are triannual and will be conducted by DMHC on behalf of DHCS. DMHC also stated that its audit will coincide with DHCS' annual medical audit of Medi-Cal.

Key Meetings
- CAHP Board Meeting and Dinner: The CAHP Board of Directors gathered October 11 for a meeting with featured guests Sen. Ed Hernandez, chair of the Senate Health Committee, and Assemblyman Jim Wood, chair of the Assembly Health Committee. After the meeting at dinner, I interacted further with both elected officials who are likely to play important roles in future health policy-making. While I had met with them on other occasions, the CAHP dinner provided an opportunity to reinforce that CalOptima is a leader in the state's primary health plan association.
- Hospital Association of Southern California (HASC): On October 19 at the final meeting of the HASC-sponsored Medi-Cal Task Force, the group narrowed down the priority issues to pursue at the local level. From among a list of 14 recommendations, five areas emerged as most important, including physical/behavioral health integration, workforce development, care coordination for high-acuity populations, data exchange/technology, and ongoing collaboration among hospitals, clinics, physician groups and health plans. As the next step, local HASC organizations will bring together community partners to identify areas of action, so we can expect to continue this valuable work through the Orange County HASC office.
- Department of Managed Health Care (DMHC): DMHC Director Shelley Rouillard and her team visited CalOptima on October 21. The meeting was part of DMHC's effort to engage with health plans across the state to discuss its mission to protect consumers' health care rights and ensure a stable delivery system, and highlight regulatory priorities now and in the future. One main topic was DMHC's goal to better understand risk-sharing arrangements and improve oversight of risk-bearing organizations. My general presentation about CalOptima

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included discussion of our delegated model and contracting methods. I suggested that DMHC staff were welcome to learn more about our risk-sharing arrangements and oversight through on-site training, and Director Rouillard expressed interest in this opportunity. Further, she expressed appreciation for other elements of my presentation, including the discussion of the diverse backgrounds of our chief executives in areas ranging from commercial insurance and county government to regulatory agencies. In all, it was a positive meeting that positioned CalOptima as a strongly managed agency that puts quality care for members first.

- UCI Health: On October 24, as part of a continuing series of meetings, Chet Uma, Ladan Khamseh, Richard Bock, M.D., and I met with the leadership team from UCI Health, including CEO Howard Federoff, CFO Jay Sial and others. UCI leaders are interested in collaborating with CalOptima to explore ideas that address the hospital's reimbursement and capacity for Medi-Cal members.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

October 6, 2016

A Regular Meeting of the CalOptima Board of Directors was held on October 6, 2016, at CalOptima, 505 City Parkway West, Orange, California. Chair Mark Refowitz called the meeting to order at 2:01 p.m. Director Khatibi led the Invocation, and Supervisor Do led the Pledge of Allegiance.

ROLL CALL

Members Present: Mark Refowitz, Chair (non-voting); Lee Penrose, Vice Chair; Supervisor Lisa Bartlett, Ron DiLuigi, Supervisor Andrew Do, Dr. Nikan Khatibi, Alexander Nguyen, M.D., Scott Schoeffel, Paul Yost, M.D.

Members Absent: Ria Berger

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

Chair Refowitz announced the following change to the agenda: Item 23, Consider Options for Managed Behavioral Health Organization (MBHO) benefit and Contract(s) Effective January 1, 2017, was pulled from the agenda.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader provided a brief update on the transition of California Children's Services (CCS) Program in certain counties to the Whole Child Model, which aims to deliver coordinated care for children with chronic conditions. The responsibility for CCS services will shift from counties to managed care plans no earlier than July 1, 2017. Many of the CCS services currently administered by the Orange County Health Care Agency will transition to CalOptima, such as care coordination, case management, service authorizations, and provider referrals. CalOptima has been actively collaborating with state regulators and county officials to prepare for the change.

Mr. Schrader noted that work on CalOptima's next three-year strategic plan will continue at the Board meeting on Thursday, November 3, 2016, with the goal to present a final strategic plan for approval at the December Board meeting. It was also reported that CalOptima is California's top Medi-Cal plan for the third year in a row, according to the National Committee for Quality Assurance (NCQA) 2016–2017 Medicaid Health Insurance Plan Ratings.

PUBLIC COMMENTS

Joe Diaz, California Association of Health Facilities – Oral re: Support of Agenda Item 13, Consider Authorizing Modifications to CalOptima's Payment Process to Long-Term Care (LTC) Facilities and Hospice Agencies for LTC Services; Amend Contracts with LTC Facilities to Allow CalOptima to

Offset Overpayments from Future Payments and to Establish Repayment Plans Should Recoupment of Overpayment Result in Financial Burden to LTC Facilities

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the September 1, 2016 Regular Meeting of the CalOptima Board of Directors; and
   b. Receive and File Minutes of the May 18, 2016 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee, May 19, 2016 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, August 11, 2016 Meeting of the CalOptima Board of Directors' Provider Advisory Committee, August 25, 2016 and June 23, 2016 Meetings of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee

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

4. Consider Authorizing Contract to Conduct a Medical Loss Ratio Audit of CalOptima's Contracted Health Networks Participating in the Medi-Cal and OneCare Connect Programs and Approve Budget Allocation

5. Consider Revisions to the FY 2016-17 Board of Directors' Quality Assurance Committee Meeting Schedule

6. Consider Approval of Amendment to the 2016 Quality Improvement Program Description Regarding Culturally Competent Access and Delivery of Services

7. Consider Approval of Amendment to the Measurement Year 2016 Pay for Value Program Payment Methodology for Medi-Cal

8. Consider Approval to Distribute Provider Payments that Support Initiatives to Reduce 30-Day All Clause (Non Maternity Related) Avoidable Hospital Readmissions for Medi-Cal

9. Consider Authorization to Expend Intergovernmental Transfer (IGT) 1 Funds to Expand the Child and Adolescent Components of the Shape Your Life Weight Management Program for CalOptima Medi-Cal Members and Contracts with Vendor(s) to Provide Weight Management Program Interventions

With regard to Consent Calendar Item 9, Supervisor Do directed staff to include remote visits (e.g., school or community center) in addition to provider office visits.

Supervisor Bartlett pulled Consent Calendar Item 8 for discussion.

8. Consider Approval to Distribute Provider Payments that Support Initiatives to Reduce 30-Day All Clause (Non Maternity Related) Avoidable Hospital Readmissions for Medi-Cal
Director Schoeffel did not participate in the discussion and vote on this item due to potential conflicts of interest.

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Supervisor Bartlett inquired about the proposed facilities payments totaling $180,000; however, the amount proposed is $200,000. Dr. Helmer responded that any remaining facilities payment balance would be returned to the IGT program.

Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors approved the distribution of 30-day all cause (non maternity related) avoidable readmission reduction program for Medi-Cal incentive payments to the highest performing health networks and hospitals, and approved discontinuing the Readmission Program. (Motion carried 7-0-0; Director Berger absent)***

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

REPORTS

Chair Refowitz noted the following for the record: 1) Supervisors Bartlett and Do did not participate in the discussion and vote on Agenda Items 10, 11 and 13 due to potential conflicts of interest based on campaign contributions under the Levine Act; and 2) Director Schoeffel did not participate on Agenda Items 10, 11 and 13 due to potential conflicts of interest based on campaign contributions under the Levine Act and other potential conflicts of interest, and left the room during the discussion and vote on these items.

Before Board consideration of Agenda Items 10, 11, and 13, Director Khatibi provided a brief report on behalf of the Health Network Contract – Expansion Population Ad Hoc. The ad hoc, composed of Directors Berger, Khatibi and Chair Refowitz, reviewed the health network rates for the Medi-Cal Expansion population and discussed extending the terms of the health network contracts through June 30, 2017. Based on the review of Medi-Cal member utilization data, Medi-Cal Expansion (MCE) revenue adjustments from the state, the historical MCE provider rates, and additional reimbursements such as shared risk pools, the ad hoc recommended that the Board extend the health network contracts at the current rates as proposed through the end of Fiscal Year (FY) 2016-17, and recommended that MCE rates remain at their current levels through the end of FY 2016-17.

10. Consider Amendment of Heritage Provider Network (Heritage) Medi-Cal Full-Risk Health Network Contract to Extend Agreement, and Consider Rates of Payment for Medi-Cal Expansion Members Assigned to Heritage During the Extension Period

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors approved maintaining the current rates paid to Full Risk Health Network(s) for Medi-Cal Expansion Members through June 30, 2017, and authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into an amendment to extend the Heritage Provider Network Medi-Cal Full-Risk Health Network Contract through June 30, 2017 on the same terms and conditions. (Motion carried 5-0-0; Supervisors Bartlett and Do recused; Directors Berger and Schoeffel absent)***

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11. Consider Amendment of the Arta Western Health Network, Monarch Family HealthCare, Noble Mid-Orange County, Prospect Medical Group, Talbert Medical Group, United Care Medical Network and AltaMed Health Services Medi-Cal Shared Risk Health Network Contracts to Extend These Agreements, and Consider Rates of Payment for Medi-Cal Expansion Members Assigned to These Health Networks During the Extension Period

Action: ***On motion of Director Yost, seconded and carried, the Board of Directors approved maintaining the current rates paid to contracted Shared Risk Health Networks for Medi-Cal Expansion Members through June 30, 2017, and authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into amendments to extend the Arta Western Health Network, Monarch Family HealthCare, Noble Mid-Orange County, Prospect Medical Group, Talbert Medical Group, United Care Medical Network, and AltaMed Health Services Medi-Cal Shared-Risk Health Network Contracts through June 30, 2017 on the same terms and conditions. (Motion carried 5-0-0; Supervisors Bartlett and Do recused; Directors Berger and Schoeffel absent)***

12. Consider Amendment of the AMVI Care Health Network, CHOC Health Alliance, CHOC Hospital, Family Choice Health Network, OC Advantage and Fountain Valley Hospital Medi-Cal Physician Hospital Consortium Health Network Contracts to Extend These Agreements, and Consider Rates of Payment for Medi-Cal Expansion Members Assigned to These Health Networks During the Extension Period

Due to a lack of quorum, this item was continued to the November 3, 2016 Board meeting.

13. Consider Authorizing Modifications to CalOptima's Payment Process to Long-Term Care (LTC) Facilities and Hospice Agencies for LTC Services; Amend Contracts with LTC Facilities to Allow CalOptima to Offset Overpayments from Future Payments and to Establish Repayment Plans Should Recoupment of Overpayment Result in Financial Burden to LTC Facilities

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized and directed the Chief Executive Officer (CEO) to implement a process to ensure that rates for Long-Term Care (LTC) facilities and Hospice agencies are paid in accordance with both interim and final annual changes to the California Department of Health Care Services (DHCS) rates within 90 days of notification from DHCS, subject to reconciliation of interim payments to final rates and retroactive adjustments, as appropriate; and authorized the CEO, with the assistance of legal counsel, to amend LTC contracts to allow CalOptima to offset overpayments from future payments to LTC facilities should the retroactive adjustments result in overpayments, or allow the CEO to establish a repayment plan for up to six months should recoupment of the overpayment result in a financial burden to the LTC facility. (Motion carried 5-0-0; Supervisors Bartlett and Do recused; Directors Berger and Schoeffel absent)***

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14. Consider Authorizing Extension of Existing Transportation Contract for CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO), with the assistance of legal counsel, to extend the existing CalOptima Program of All-Inclusive Care for the Elderly (PACE) transportation contract with vendor Secure Transportation for six months, with an option for the CEO to extend the contract for an additional six months. (Motion carried 8-0-0; Director Berger absent)***

15. Consider Authorizing Contract with Risk Adjusted Factor (RAF) Vendor for CalOptima's Program of All-Inclusive Care for the Elderly (PACE) and Related Expenditures

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to contract with a Risk Adjusted Factor vendor selected in accordance with CalOptima's Board-approved purchasing policy for the purpose of assisting staff in appropriately capturing PACE member medical information, and authorized expenditures of up to $75,000 of unbudgeted dollars to pay the consultant for work performed under the contract. (Motion carried 8-0-0; Director Berger absent)***

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

Action: ***On motion of Director Yost, seconded and carried, the Board of Directors adopted Resolution No. 16-1006, Approving CalOptima's Updated Human Resources Policy GA.8058: Salary Schedule, and approved proposed market adjustments for various positions as presented. (Motion carried 8-0-0; Director Berger absent)***

17. Consider Authorizing Employee and Retiree Group Health Insurance and Updated Employer Contribution Level

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors: 1) Authorized the CEO to enter into contracts and/or amendments to provide group health insurance policies, including medical, dental, and vision, for CalOptima employees and retirees, and basic employee life insurance and accidental death and dismemberment, short-term and long-term disability, employee assistance program, and flexible spending accounts, for CalOptima employees, effective January 1, 2017, for a total amount for calendar year 2017 not to exceed $14,523,005; 2) Authorized an increase to employer contributions (based on % of premium, employer pays for each plan) to absorb the entire increase to premium rates, thereby maintaining employee contributions at current levels and increasing costs to CalOptima for calendar year 2017 of an amount not to exceed $321,608 for the increase to premium***

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rates for the benefits package, as well as an additional amount of up to $11,512 for the cost of realigning Medicare-eligible retiree contributions to be consistent with Policy GA. 8055: Retiree Health Benefit for calendar year 2017; and 3) Directed staff to revise Policy GA.8055: Retiree Health Benefit to allow for the payment of a stipend in lieu of dependent insurance coverage in situations in which CalOptima is unable to obtain reasonable medical coverage for a Medicare-eligible retiree's spouse and/or dependents who are not Medicare eligible, and return to the Board with the revised policy at the November 2016 Board Meeting. (Motion carried 8-0-0; Director Berger absent)

18. Consider Chairperson and Vice Chair Person Appointments to the CalOptima Board of Directors' OneCare Connect Cal MediConnect Member Advisory Committee (OCC MAC) and the Provider Advisory Committee (PAC)

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors appointed Patty Mouton to serve as OCC MAC Chair for the remainder of Fiscal Year (FY) 2016-17; appointed Gio Corzo to serve as OCC MAC Vice Chair for the remainder of FY 2016-17; Teri Miranti to serve as PAC Chair for the remainder of FY 2016-17; and Suzanne Richards to serve as PAC Vice Chair for the remainder of FY 2016-17. (Motion carried 8-0-0; Director Berger absent)***

19. Consider Authorization of Expenditures in Support of CalOptima's Participation in the Vietnamese Physician Association of Southern California (VPASC) Foundation's Free Health Fair

Action: ***On motion of Director Yost, seconded and carried, the Board of Directors authorized the expenditure of up to $2,000 for CalOptima's participation in the VPASC Foundation's Free Health Fair on October 23, 2016 in Westminster, CA; made a finding that such expenditure is for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and authorized the Chief Executive Officer to execute agreements as necessary for the event and expenditure. (Motion carried 8-0-0; Director Berger absent)***

20. Consider Approval of Reforecasted CalOptima Fiscal Year 2016-17 Operating Budget

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors approved the reforecasted CalOptima FY 2016-17 Operating Budget, as detailed on the attachments; and authorized the expenditures and appropriated the funds for items listed in the revised Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy. (Motion carried 8-0-0; Director Berger absent)***

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21. Receive and File the Fiscal Year 2016 CalOptima Audited Financial Statements

As Chair of the Board of Directors' Finance and Audit Committee, Vice Chair Penrose reported that the Committee reviewed the audit of CalOptima's FY 2016 financial statements at the September 15, 2016 meeting, and received a detailed presentation of the audit results by John Blakey of Moss Adams, CalOptima's independent financial auditor. Mr. Blakey provided an overview of the FY 2016 audit results for Board discussion, and reported that Moss Adams will issue an unmodified opinion on the financial statements indicating that the FY 2016 financial statements fairly state the financial condition of CalOptima in all material respects.

On behalf of the Board of Directors' Finance and Audit Committee, Mr. Penrose recommended Board acceptance of the CalOptima FY 2016 audited financials as presented.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors received and filed the FY 2016 CalOptima consolidated audited financial statements as submitted by Moss-Adams LLP. (Motion carried 8-0-0; Director Berger absent)***

22. **Acting as the CalOptima Foundation:** Receive and File CalOptima Foundation FY 2016 Audited Financial Statements

As Chair of the CalOptima Foundation Audit Committee, Vice Chair Penrose reported that the Foundation Audit Committee met on September 15, 2016 to review the CalOptima Foundation FY 2016 audited financial statements presented by Mr. Blakey of Moss Adams. Mr. Blakey provided a brief overview of the CalOptima Foundation FY 2016 audit results for discussion and reported that Moss Adams will issue an unmodified opinion on the FY 2016 CalOptima Foundation financial statements.

On behalf of the Foundation Audit Committee, Mr. Penrose recommended Foundation Board of Directors acceptance of the CalOptima Foundation FY 2016 audited financials as presented.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Foundation Board of Directors received and filed the FY 2016 CalOptima Foundation consolidated audited financial statements as submitted by Moss-Adams LLP. (Motion carried 8-0-0; Director Berger absent)***

23. Consider Options for Managed Behavioral Health Organization (MBHO) Benefit and Contract(s) Effective January 1, 2017

This item was pulled from the agenda.

ADVISORY COMMITTEE UPDATES

25. Provider Advisory Committee (PAC) Update

PAC Chair Jenna Jensen provided a brief update on the activities at the September 8, 2016 PAC meeting, including an update on CalOptima's Pay for Value program and the Whole Person Care pilot program. It was reported that the PAC CAHPS Ad Hoc has met several times with the focus on improving the member experience for adults and children while attempting to improve the NCQA rating on consumer satisfaction by 2018.

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

Christine Chow, OCC MAC Member Advocate Representative, presented a brief review of activities at the August 25, 2016 OCC MAC meeting. The Committee received updates on OCC member enrollment, and a presentation from the SCAN Foundation on the Coordinated Care Initiative evaluation survey.

27. Member Advisory Committee (MAC) Update

Mallory Vega, MAC Chair, reported that a quorum was not reached at the Committee's scheduled September 8, 2016 meeting.

INFORMATION ITEMS

The following Information Items were accepted as presented:
28. August 2016 Financial Summary
29. Compliance Report
30. Federal and State Legislative Advocates Report
31. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Members of the Board congratulated staff and CalOptima's provider partners on achieving NCQA Commendable status, and as California's top Medi-Cal plan for the third year in a row. The Board also thanked Jenna Jensen for her service as Provider Advisory Committee Chair.

Vice Chair Penrose commented on the strategic planning discussion at the November 3, 2016 Board meeting, and on the importance of reviewing CalOptima's Mission, Vision and Values that will shape the agency over the next three years.

Chair Refowitz announced the formation of an ad hoc to review the Federal Lobbyist Request for Proposal, and appointed Supervisors Bartlett and Do, and Directors DiLuigi and Khatibi to serve on this ad hoc. Mr. Refowitz also thanked CHOC, CHOC Health Alliance, and community providers for their collaboration and support with members affected by the recent public health issue at a pediatric dental practice.

ADJOURN TO CLOSED SESSION

The Board adjourned to closed session at 3:36 p.m. pursuant to: 1) Government Code Section 54956.9, subdivision (d)(2), Conference with Legal Counsel – Anticipated Litigation: Significant exposure to litigation (one case); 2) Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer); 3) Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS: Agency Designated Representatives: (Mark Refowitz and Lee Penrose), Unrepresented Employee: (Chief Executive Officer); 4) Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Counsel); and 5) Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS: Agency Designated Representatives: (Mark Refowitz and Lee Penrose), Unrepresented Employee: (Chief Counsel).

The Board reconvened to open session at 5:20 p.m. with no reportable actions taken.

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The Board considered Agenda Item 24.

24. Consider Chief Executive Officer and Chief Counsel Performance Evaluation and Compensation

Chair Refowitz reported that the Board met to consider Chief Executive Officer Michael Schrader's performance evaluation, and stated that the Board gave him an overall rating of "Exceeds Expectations" for the period ending June 30, 2016, and compensation will be awarded consistent with the CEO's contract.

The Board also considered the performance of Chief Counsel Gary Crockett. Based on the input provided by the Board, and the overall rating of "Exceeds Expectations" for the period ending June 30, 2016, it was recommended that the Chief Counsel be awarded a merit increase consistent with CalOptima's merit matrix. The recommended merit is calculated as a function of both the evaluation score and the base salary and range, and is the same merit matrix that is used for all CalOptima employees.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors awarded Chief Counsel an overall rating of "Exceeds Expectations" based on the input provided by the Board for the period ending June 30, 2016, and a merit increase consistent with CalOptima's merit matrix. (Motion carried 7-0-0; Supervisor Do and Director Berger and absent)***

ADJOURNMENT
Hearing no further business, the meeting was adjourned at 5:23 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: November 3, 2016

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MINUTES

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

September 8, 2016

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, September 8, 2016 at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Jena Jensen, PAC Chair, called the meeting to order at 8:05 a.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Anjan Batra, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Alan Edwards, M.D.; Stephen N. Flood; Jena Jensen; Pamela Kahn, R.N.; Teri Miranti; John Nishimoto, O.D.; George Orras, Ph.D.; FAAP; Mary Pham, Pharm.D, CHC; Pamela Pimentel, R.N.; Suzanne Richards, RN, MBA, FACHE; Barry Ross, R.N., MPH, MBA
Members Absent:	Jacob Sweidan, M.D.
Others Present:	Michael Schrader, Chief Executive Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Ladan Khamseh, Chief Operating Officer; Chet Uma, Chief Financial Officer; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Caryn Ireland, Executive Director, Quality Analytics; Cheryl Meronk, Director, Strategic Development; Cheryl Simmons, Staff to the PAC

MINUTES

Approve the Minutes of the August 11, 2016 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Ross seconded and carried, the Committee approved the minutes of the August 11, 2016 meeting. (Motion carried 14-0-0; Member Sweidan absent)***

PUBLIC COMMENTS

No requests for public comment were received.

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On behalf of the PAC, Chair Jensen welcomed new PAC members Anjan Batra, M.D. as the Physician Representative and John Nishimoto, O.D. as the Non-Physician Medical Practitioner Representative.

REPORTS

Consider Recommendation of 2016 PAC Chairperson and PAC ViceChairperson

The PAC recommended that Teri Miranti be appointed as PAC Chair and Suzanne Richards as Vice-Chair for the FY 2016-2017 term. Members Miranti and Richards were the only candidates who applied for the positions and the nominations ad hoc committee was not reconvened.

Action: ***On motion of Member Pimentel, seconded and carried, the Committee approved the recommendation to appoint Teri Miranti to PAC Chair position and Suzanne Richards to Vice-Chair position for the FY 2016-2017 term.***

Term for both positions will run through June 30, 2017. (Motion carried 14-0-2; Members Miranti and Richards abstained; Member Sweidan absent).

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, updated the PAC on Board actions from the September 1, 2016 Board Meeting. Mr. Schrader informed the PAC that the National Committee for Quality Assurance (NCQA) awarded CalOptima a Commendable rating and that CalOptima's lower Healthcare Effectiveness Data and Information Set (HEDIS) scores could affect CalOptima's number one ranking in California. He noted that the focus would be on raising the HEDIS scores.

Chief Financial Officer Update

Chet Uma, Chief Financial Officer, presented CalOptima's Financial Report for July 2016. Mr. Uma reviewed the enrollment summary with the members and noted that the Temporary Assistance for Needy Families (TANF) for adult and children was below budget but Medi-Cal expansion (MCE) membership continued to exceed budgeted enrollment. Membership in the OneCare Connect product line is lower than budget by 15.2% which causes a budget variance. Mr. Uma also reviewed the administrative expenses that were also tracking under budget by 3.2%, which is largely attributable to open positions. He also noted that the medical loss ratio was tracking to budget at 96.3%.

Mr. Uma also reviewed the Health Network Enrollment Summary.

Chief Medical Officer Update

Dr. Richard Bock, Deputy Chief Medical Officer, provided an update on the Pay for Value program and discussed the goals of the current program and methodology.

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Dr. Bock noted that the "commendable" status achieved from the NCQA was largely due to improvement in the member experience/satisfaction scores. He noted that the results also showed declining scores in clinical quality.

After an extended discussion, PAC members indicated their willingness to form a HEDIS Ad Hoc Committee and work with CalOptima staff to help address the lower HEDIS scores. Member Caliendo requested that staff continue to inform the PAC of upcoming CalOptima Quality Forums and Quality Assurance Committee meetings to allow interested PAC members to attend.

Dr. Bock also provided a presentation on the hazards of nicotine and the use of e-cigarettes among minors and young adults.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, noted that 20 additional physicians have completed the Developmental Evaluation for Autism Training, and reported that the Health Home Program implementation date has been delayed, and the anticipated start date for the program is now January 1, 2018.

INFORMATION ITEMS

Federal and State Budget Update

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, provided a brief review of the Legislative Tracking Matrix that follows healthcare bills currently pending in the State Legislature. He noted that the deadline for the Governor to sign or veto was September 30, 2016.

Whole Person Care

Cheryl Meronk, Director of Strategic Development, presented information on the Whole Person Care (WPC) pilot program. The WPC pilot is part of Medi-Cal 2020, California's latest 1115 waiver. Ms. Meronk noted that the county-led pilot aims to improve health and well-being of individuals that frequently use multiple systems of care/support and to increase data and service coordination between health, behavioral health and social services.

CalOptima is working on this initiative in conjunction with the Orange County Health Care Agency, which is the lead agency in this endeavor.

PAC Member Comments

Member Ross provided an update on the progress of the CAHPS Ad Hoc subcommittee. He noted that the committee had met three times since June, and the goal of the committee was to improve the member experience for adults and children while attempting to achieve an NCQA rating of three (3) on consumer satisfaction by 2018.

Another goal of the committee is to help raise physician satisfaction scores among CalOptima members. The CAHPS Ad Hoc subcommittee will reconvene once the reports are created using data from CalOptima's supplemental survey.

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Chair Jensen reminded the members that their annual compliance training is due by November 4, 2016.

ADJOURNMENT
There being no further business before the Committee, the PAC Chair adjourned the meeting at 9:36 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: October 13, 2016

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Amendment of the AMVI Care Health Network, CHOC Health Alliance, CHOC Hospital, Family Choice Health Network, OC Advantage and Fountain Valley Hospital Medi-Cal Physician Hospital Consortium Health Network Contracts to Extend These Agreements, and Consider Rates of Payment for Medi-Cal Expansion Members Assigned to These Health Networks During the Extension Period

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions

1. Maintain current rates paid to contracted Medi-Cal Physician Hospital Consortium (PHC) Health Networks for Medi-Cal Expansion Members through June 30, 2017; and
2. Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into amendments to extend the AMVI Care Health Network, CHOC Health Alliance, CHOC Hospital, Family Choice Health Network, OC Advantage and Fountain Valley Hospital Medi-Cal Physician Hospital Consortium Health Network Contracts through June 30, 2017 on the same terms and conditions.

Background

At its May 5, 2016 meeting, the CalOptima Board of Director authorized extension of CalOptima's contracts with the PHC health networks from July 1, 2016 to December 31, 2016. All PHC health network contracts were extended.

At the May 5, 2016 meeting, staff had recommended extension of all health network contracts through June 30, 2017. Due to lower than anticipated utilization (and corresponding rate reductions from the state), staff also had recommended reducing the capitation rates paid to the health networks for the Medi-Cal Expansion (MCE) members by 15% for the 2016-17 fiscal year. However, based in part on stakeholder input, the Board of Directors approved the rate reduction, but only for a six-month period – effective July 1, 2016 through December 31, 2016 – for the health networks. The Board Chair established an ad hoc committee to evaluate the financial impact of the rate reduction for the MCE members to CalOptima and the health networks and make a recommendation regarding the second half of the fiscal year.

Discussion

Following appointment by the Board Chair, the members of the ad hoc met to review member utilization and discuss and evaluate the financial impact of the reduction in rates on CalOptima and the health networks, with the final recommendation to: 1) maintain the current capitation rates to the PHC health networks; and 2) extend the health network contracts through June 30, 2017.

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Fiscal Impact
Based on direction provided by the Board, the CalOptima Fiscal Year 2016-17 Operating Budget reflects the continuation of capitation rate reductions enacted at the May 5, 2016, meeting for the full fiscal year. In the event further capitation rate adjustments are necessary, Staff will make the appropriate budget revisions and return to the Board for approval.

If the Ad Hoc Committee's recommendations are approved, CalOptima staff plans to maintain the current health network rates for the Medi-Cal Expansion population through the end of the 2016-17 fiscal year. The recommended action to extend Medi-Cal health network contracts through June 30, 2017, and extend the MCE rates for the same time period is a budgeted item. No additional budget revisions are required for this proposed extension.

Rationale for Recommendation
The health network rates have been determined to be in line with the rates provided by the Department of Health Care Services. Therefore no modification to the MCE rate reduction is warranted. The recommendation is that the Health Network contracts be extended through the end of the fiscal year at the current rates, which will support the stability of CalOptima's delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *9/28/2016*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Amendment of the AltaMed Health Services, AMVI/Prospect Medical Group, Arta Western Medical Group, Family Choice Medical Group, Monarch HealthCare, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Group OneCare Shared Risk Health Network Contracts to Extend These Agreements for the period January 1, 2017 – December 31, 2017, and Add Other Provisions

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into amendments to extend the AltaMed Health Services, AMVI/Prospect Medical Group, Arta Western Medical Group, Family Choice Medical Group, Monarch HealthCare, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Group OneCare Shared Risk Health Network Contracts for the period January 1, 2017 through December 31, 2017, and add provisions related to Personal Care Coordinators and Health Network sanctions and update policies as applicable.

Background/Discussion

CalOptima is required to submit an annual bid to Centers for Medicare and Medicaid Services ("CMS") for the OneCare program. At the May 2016 meeting, the CalOptima Board of Directors authorized submission of the OneCare Bid for calendar year 2017. The bid has been submitted and accepted by CMS. Staff now seeks authority to extend contracts through December 31, 2017.

CalOptima contracts with eight Health Networks for OneCare. Each of these contracts currently expires on December 31, 2016. Staff is seeking Board authorization to extend these contracts through December 31, 2017. CalOptima staff is also seeking authority to amend the Contracts to add additional contractual language that elaborates on the process of imposing sanctions on Health Networks based on monetary sanctions from CalOptima's regulators that arise out of Health Network non-compliance.

In addition, the Personal Care Coordinator (PCC) program currently has an approved date range in the contract, which was subsequently extended by Board action. Staff is seeking authorization to amend the Contract to delete the specific date range, and provide that the PCC program will continue during those periods for which the CalOptima Board provides funding for the program. CalOptima funding for the Personal Care Coordinators included in the current contract, will expire on December 31, 2016. Funding through December 31, 2016 was extended at the March 3, 2016 Board meeting. Staff plans to request approval of additional funding for this program at the Board's December 1, 2016 meeting. Other than the effective dates of the program, pending approval of continued funding, the terms and conditions associated with the PCC program will continue in 2017.

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Fiscal Impact
The CalOptima Fiscal Year (FY) 2016-17 Operating Budget approved by the Board on June 2, 2016, includes OneCare health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $4.3 million annually in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts from January 1, 2017, through June 30, 2017, is a budgeted item with no additional fiscal impact

Management will include expenses for the period of July 1, 2017, through December 31, 2017, related to the contract renewals in the CalOptima FY 2017-18 Operating Budget.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the Provider Network and to address issues regarding Personal Care Coordinators and Health Network sanctions.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Board Action dated March 3, 2016, Authorize Extension of Expenditures of Fiscal Year 2010-11 Intergovernmental Transfer Funds for OneCare Personal Care Coordinators (PCC) through December 31, 2016; and Authorize the Reallocation of OneCare Connect PCC Funding to Cover the Cost of the OneCare PCC Program through Calendar Year 2016

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

9/28/2016 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Authorize Extension of Expenditures of Fiscal Year 2010-11 Intergovernmental Transfer Funds for OneCare Personal Care Coordinators (PCC) through December 31, 2016; and Authorize the Reallocation of OneCare Connect PCC Funding to Cover the Cost of the OneCare PCC Program through Calendar Year 2016

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Phil Tsunoda, Executive Director Public Policy and Public Affairs (714) 246-8400

Recommended Actions

1. Extend the authorization of expenditures of Fiscal Year (FY) 2010-11 Intergovernmental Transfer (IGT) Funds (IGT 1) for OneCare Personal Care Coordinators (PCC) from April 1, 2016 through December 31, 2016; and

2. Authorize the reallocation of $50,000 in OneCare Connect PCC funds from IGT 1 to OneCare PCC in order to compensate delegated OneCare health networks for the period of April 1, 2016, through December 31, 2016.

Background

At the March 6, 2014, meeting, CalOptima's Board of Directors approved the final expenditure plan for $12.4 million for IGT 1. The expenditure plan included an initiative, Complex Case Management – Part 1, to provide case management for high-risk members across various care settings. As part of this initiative, CalOptima and health networks would hire PCCs for up to two years. At the health network level, the PCC serves as a single point of contact for OneCare members and assist members in navigating the healthcare delivery system, facilitating access to care and services.

On April 3, 2014, the Board authorized the CEO, with the assistance of legal counsel, to execute OneCare health network PMG contract amendments to provide funding to health networks to hire and retain PCCs. The Board authorized the expenditure of IGT 1 funds over a two-year period, with a total of up to $1.85 million expended in Year 1, and up to $1.95 million expended in Year 2 as authorized by the Board in March 2014. The end date of the two-year authorization is March 31, 2016.

At the April 2, 2015, meeting, the Board authorized reallocation of $200,000 from the $1.95 million budget allocation in Year 2 to make the March 2015 OneCare PCC capitation payment.

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Discussion

On January 1, 2016, the majority of OneCare members were passively enrolled into the OneCare Connect program. However, not all OneCare members were eligible for this transition, and these members still remain in OneCare. As of January 2016, there were approximately 1,238 active OneCare members. In order to maintain similar practices for OneCare and OneCare Connect, so that OneCare members receive the same quality of care as OneCare Connect members, staff proposes to continue the PCC program for the remaining OneCare members through December 31, 2016.

Staff estimates the monthly expenditures for OneCare PCCs is approximately $20,000. As of January 31, 2016, $175,401 remains in IGT 1 funds for the OneCare PCC program. Assuming the same level of funding through the rest of the calendar year, the projected shortfall for the OneCare PCC capitation payments by December 31, 2016, will be approximately is $44,599. To cover this shortfall, Management recommends that the Board approve a budget reallocation of $50,000 from OneCare Connect PCC funds from IGT 1 to OneCare PCC in order to compensate delegated OneCare health networks for the period of April 1, 2016 through December 31, 2016.

Fiscal Impact

The recommended actions to extend authorization of expenditures for the OneCare PCC program through December 31, 2016 and to reallocate $50,000 from the OneCare Connect PCC program to the OneCare PCC program is expected to have a neutral fiscal impact to CalOptima. Expenditure of IGT funds is limited to providing enhanced benefits to CalOptima Medi-Cal beneficiaries, and has been restricted to one-time purposes, and does not commit CalOptima to future funding or budget allocations.

Rationale for Recommendation

CalOptima staff recommends this action in support of the OneCare PCC program, which is an integral component of the enhanced Model of Care that has been developed for the OneCare program and expands our ability to apply best practices in care coordination for CalOptima's Medicare members.

Concurrence

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

Attachments

None

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

02/26/2016 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Authorizing Extension Amendment of Contract with Liberty Dental Plan of California, Inc., for Dental Services Provided to OneCare Members for the 2017 Calendar Year

Contact
Chet Uma, Chief Financial Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to exercise an option to extend the Liberty Dental Plan of California, Inc. contract for OneCare members for calendar year 2017 under the existing terms and conditions.

Background/Discussion
The OneCare program includes a supplemental dental benefit for its members. In actions taken on December 3, 2015 the CalOptima Board of Directors authorized a contract amendment to the Liberty Dental OneCare Connect contract to provide the supplemental dental benefit for OneCare members. The contract period with Liberty Dental for OneCare was granted from January 1, 2016 through December 31, 2016, with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

At its May 2016 meeting, the Board authorized submission of the OneCare Bid for calendar year 2017. The bid has been submitted and was accepted by the Centers for Medicare & Medicaid Services (CMS), and includes the supplemental dental benefit. Staff now seeks authority to exercise an option to extend the contract with Liberty Dental through December 31, 2017.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2016-17 Operating Budget approved by the Board on June 2, 2016 includes OneCare dental service expenses that were consistent with forecasted enrollment. Staff included approximately $100,000 in the FY2016-17 budget for this purpose. Since the rates and terms of the contract will not change, the recommended action to renew the contract with Liberty Dental for dental services from January 1, 2017, through June 30, 2017, is a budgeted item with no additional fiscal impact

Management will include expenses for the period of July 1, 2017, through December 31, 2017, related to the contract renewal in the CalOptima FY 2017-18 Operating Budget.

Rationale for Recommendation
CalOptima staff recommends Board approval of this action to ensure that OneCare members continue to have access to dental services.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
Board Action dated December 3, 2015, Authorize Contract Amendments with Liberty Dental for a Supplemental Dental Benefit for OneCare; Extend the Supplemental Dental Benefit for OneCare Connect; and Authorize Deemed Eligibility for Member Receiving Denti-Cal

/s/ Michael Schrader — *9/28/2016*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 3, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Authorize Contract Amendments with Liberty Dental for a Supplemental Dental Benefit for OneCare; Extend the Supplemental Dental Benefit for OneCare Connect; and Authorize Deemed Eligibility for Members Receiving Denti-Cal

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into contract amendments with Liberty Dental for supplemental dental benefits for:
    a. OneCare from January 1, 2016 through December 31, 2016, with two additional one year extension options, each exercisable at CalOptima's sole discretion
    b. OneCare Connect from January 1, 2016 through December 31, 2017; and
2. Authorize one month of deemed eligibility for OneCare Connect members receiving Denti-Cal services provided by Liberty Dental.

Background/ Discussion

In actions taken on April 2, 2015, the CalOptima Board of Directors authorized a supplemental dental benefit for the OneCare Connect program as well as funding and contracting with Liberty Dental. Voluntary enrollment into OneCare Connect has increased based on the additional supplemental dental benefits being offered by CalOptima in the program. The supplemental dental benefit provides services not covered by the Denti-Cal benefit. Staff believes the supplemental dental benefit has increased member retention in the program.

In order to keep the benefits similar to OneCare Connect, OneCare added the same supplemental dental benefit to the 2016 Centers for Medicare &Medicaid Services (CMS) approved OneCare bid.

At its August 6, 2015 meeting, the CalOptima Board of Directors authorized a one month deeming period for OneCare Connect Members who no longer met Cal MediConnect eligibility requirements due to loss of Medi-Cal eligibility with CalOptima. This benefit was added to mitigate breaks in coverage and maintain continuity of care for members. Management proposes a similar one month deeming period for Denti-Cal benefits for OneCare Connect members. Should a member fail to regain eligibility for the Medi-Cal program during the one month period of deemed eligibility, CalOptima would be financially responsible for the cost of the month of deemed eligibility. Based on the proposed action, eligibility for the one month of deemed dental benefits through Liberty Dental would be available through December 31, 2017 for OneCare Connect members.

Fiscal Impact

Based on the forecasted OneCare enrollment for Fiscal Year (FY) 2015-16, the fiscal impact of the recommended action to issue a contract amendment for the supplemental dental benefit for the OneCare Program from January 1, 2016, through June 30, 2016, is approximately $55,000. Costs associated with the recommended action were incorporated into Calendar Year 2016 OneCare capitation rate. Funding

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for the recommended action for the period July 1, 2016 through December 31, 2016, will be included in the FY 2016-17 CalOptima Consolidated Operating Budget.

Based on the forecasted OneCare Connect enrollment for FY 2015-16, the fiscal impact of the recommended action to issue a contract amendment for supplemental dental benefit for the OneCare Connect Program from January 1, 2016 through June 30, 2016, is approximately $445,000. This is a budgeted item under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015. Funding for the recommended action for the period July 1, 2016 through December 31, 2017, will be budgeted in subsequent operating budgets.

Projected expenses related to the provision of the deeming benefit are approximately $3,500 per month.

Rationale for Recommendation

CalOptima staff recommends supplemental dental services to OneCare Connect members to strengthen the programs ability to minimize pre-enrollment opt out, maximize post enrollment retention and strong provider participation in the program. OneCare members will continue to have the same CMS approved supplemental benefit as OneCare Connect members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Previous Board actions referenced in this Report Item:

- August 6, 2015, Agenda Item VIII. J., Authorize Actions Related to OneCare Connect Enrollment
- April 2, 2015, Agenda Item VIII. B., Authorize Modifications to Member Assignment Process for the OneCare Connect Program; Authorize Supplemental Dental Benefit for the OneCare Connect Program, as well as Funding and Contracting with a Vendor as Necessary to Implement

/s/ Michael Schrader *11/25/2015*

Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. B. Authorize Modifications to Member Assignment Process for the OneCare Connect Program; Authorize Supplemental Dental Benefit for the OneCare Connect Program, as well as Funding and Contracting with a Vendor as Necessary to Implement

Contact

Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions

1. Authorize modifications to the Board approved OneCare Connect (Cal MediConnect) Program member enrollment process to allow for enrollment by Long Term Care (LTC) Facility, subject to approval by the Department of Health Care Services (DHCS); and
2. Authorize the Chief Executive Officer (CEO) to contract with dental benefits administrator to provide a supplemental benefit to the Medi-Cal dental benefit subject to approval by the DHCS and the Centers for Medicare & Medicaid Services (CMS), and upon the successful negotiation of contract terms with Liberty Dental from July 1, 2015 to December 31, 2015.

Background

In actions taken on January 3, 2013, February 7, 2013 and December 5, 2013, the Board authorized the CEO to develop a provider delivery system for implementation of the Duals Demonstration, a program for beneficiaries eligible for Medi-Cal and Medicare or "Duals", also known as Cal MediConnect Program and branded by CalOptima as OneCare Connect.

On December 5, 2013 the Board approved the Member enrollment process in order to ensure a seamless passive enrollment of OneCare Connect members who will be allowed the opportunity to make a voluntary choice to disenroll (opt-out). The enrollment process, previously approved, is based on the DHCS requirements to passively enroll eligible members on their birthday month. Approximately 3,900 members in Orange County are expected to be eligible for passive enrollment monthly.

The Cal MediConnect program launched state wide on April 1, 2014 and has been implemented in six counties. Passive enrollment start dates have been staggered throughout the state and the opt-out rates have varied by county with an overall statewide average of 49%. Concerned about the high opt-out rate, CalOptima staff has developed strategies to mitigate opt-out. The member strategies include increasing member outreach efforts and outreach to our community stakeholders informed as they are considered our member's "trusted advisors". Provider strategies, as approved by your Board, include increased provider participation through the implementation of the Community Network and increasing primary care and specialist reimbursement from 80% to 100% of Medicare fee-for-service. Based on the experience of the other Cal MediConnect plans, staff proposes two additional strategies related to the member enrollment process and dental services.

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Discussion

As CalOptima prepares to launch the Cal MediConnect or OneCare Connect program, CalOptima staff has explored strategies intended to reduce the pre-enrollment opt-out and strengthening retention of members who are passively enrolled in the program. The strategies CalOptima staff considered are both from the member and provider perspective so as to ensure that both stakeholder groups are motivated to remain in OneCare Connect.

Long Term Care Facility Based Enrollment. From the member impact perspective, CalOptima is proposing to modify the previously approved passive enrollment strategy for individuals who are residing in Long-Term Care (LTC) Facilities. Among the approximately 80,000 Dual eligible individuals in Orange County, approximately 3,500 reside in 56 LTC facilities. These 3,500 individuals are among the most vulnerable members, have complex health care needs, and would greatly benefit from increased integration and coordination of care, which will be available with OneCare Connect. For this reason, CalOptima staff is proposing that it would be a better approach to passively enroll these Duals by LTC facility rather than by birth month based on DHCS approval and on a mutually agreed upon schedule with DHCS. This would allow CalOptima to communicate one-on-one with members and their families regarding care options available to them through OneCare Connect. CalOptima staff would also be able to personally educate providers and coordinate member care. Providing the opportunity to work closely with the LTC facilities, to educate and answer questions and provide the additional care coordination component will help improve the OneCare Connect retention rate.

Dental Benefit. Another proposal to improve the retention rate is by providing supplemental dental services not covered by Medi-Cal to CalOptima OneCare Connect members. While OneCare Connect members are eligible for Denti-Cal, in certain situations, access remains an issue. Management believes that improving access to dental services facilitates a positive member experience, thereby motivating members to stay in OneCare Connect. The CalOptima OneCare program previously offered a supplemental dental benefit that was very popular in attracting Duals to enroll in OneCare. Based on member input, CalOptima staff views the availability of dental services as a key component of a successful OneCare Connect program. Subject to approval by both DHCS and the Centers for Medicare & Medicaid Services (CMS), CalOptima management proposes to utilize funding from the DHCS for the Medi-Cal component of the Cal MediConnect capitation payment to implement this option.

If approved, staff recommends contracting with Liberty Dental Plan to administer and coordinate the proposed supplemental dental benefits for OneCare Connect members on a per member per month (PMPM) payment basis. Liberty Dental has been the dental benefit administrator that administered the OneCare benefit on behalf of CalOptima. Management believes that Liberty Dental Plan is the only potential subcontractor qualified to provide the appropriate supplement to the Medi-Cal benefit. Liberty Dental Plan will ensure timely access to a comprehensive, contracted network of primary and specialty Denti-Cal providers. Unlike in Denti-Cal where certain members may face delays or difficulty in accessing care, the proposed benefit would allow OneCare Connect members to have an

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assigned primary care dentist through which to obtain dental services to guarantee a straightforward and seamless path to dental coverage. Through this arrangement, CalOptima intends to:

- Increase CMC members' awareness of the dental benefit through education and outreach;
- Improve utilization of preventive dental services;
- Improve coordination between dental and physical health care providers;
- Provide limited supplemental benefits not covered under Denti-Cal; and
- Improve access to dental providers.

Both the LTC member enrollment and dental strategies require Board and regulator approval. Staff will return to the Board for additional authority, as necessary, to implement these and potentially other retention strategies.

Fiscal Impact

The recommended action to execute a contract with Liberty Dental Plan to provide supplemental dental benefits will have a total fiscal impact between $1.7 million and $2.0 million at capitation rates from $7.00 per member per month (PMPM) to $8.00 PMPM for Fiscal Year 2015-16. Under this capitated arrangement, Liberty Dental Plan will assume full risk for dental services, and will coordinate dental benefits with Denti-Cal. As such, the capitation payment will cover supplemental dental benefits only, including enhanced access to their dental network, with no additional payments made to Liberty Dental Plan. Denti-Cal will remain the primary payor and provider of dental services to OneCare Connect members.

Rationale for Recommendation

CalOptima staff recommends these actions to strengthen the OneCare Connect program's ability to minimize pre enrollment opt-out, maximize post enrollment retention and strong provider participation in the OneCare Connect program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *3/27/2015*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 6, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. J. Authorize Actions Related to OneCare Connect Enrollment

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions
1. Authorize implementation of transition plan of OneCare members to OneCare Connect effective January 1, 2016;
2. Authorize a one-month deeming period effective no sooner than September 1, 2015 for OneCare Connect members who no longer meet Cal MediConnect eligibility requirements due to loss of Medi-Cal eligibility with CalOptima;
3. Authorize enhancement of the delivery model for OneCare Connect members who reside in a long-term care facility that is exclusive to CalOptima Direct, subject to approval by the Department of Health Care Services and the Centers for Medicare & Medicaid Services; and
4. Authorize updates to policies as necessary for implementation.

Background
On December 5, 2013, the CalOptima Board of Directors authorized execution of the Three-Way Agreement between the California Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS) and CalOptima for implementation of Cal MediConnect (CMC), branded CalOptima OneCare Connect Plan (Medicare-Medicaid Plan) (OCC) in Orange County. OCC is a managed care plan that combines Medicare and Medi-Cal, including long-term services and supports (such as In-Home Supportive Services, Multipurpose Senior Services Program, Community-Based Adult Services, and long-term care). Both the DHCS and CMS have continued to issue guidance regarding the implementation of CMC. Two topics of recent regulatory discussion include the enrollment of Medicare Dual-Eligible Special Needs Plans (D-SNPs) and a period of deemed continued eligibility for CMC. Additionally, CalOptima is involved in ongoing communications with CMS and DHCS regarding initiatives specific to members residing in long-term care facilities.

Enrollment into D-SNPs
DHCS issued guidance through an All Plan Letter *(APL) 14-014: Enrollment Requirements for Dual-Eligible Special Needs Plan in Alameda and Orange Counties,* which delineates D-SNP enrollment criteria once CMC is implemented in a county. Specific to CalOptima, the APL states that if a D-SNP is also a CMC plan, the following will apply: "No earlier than January 1, 2016, DHCS will crosswalk all Duals who are eligible for CMC into the corresponding CMC plan once CMC is implemented in Orange County. These Duals will not be permitted to re-enroll in the CMC D-SNP; and the CMC D-SNP may serve any existing or new beneficiaries who are not eligible for CMC (Excluded Beneficiaries) only."

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Based on this guidance, CalOptima is required to transition its OCC-eligible OneCare Members into OCC effective January 1, 2016. OneCare can no longer enroll Members eligible for CMC. However, OneCare can continue to enroll dual eligible Members not eligible for CMC into the OneCare plan. These include, for example, Members under 21 years of age, Members receiving services through Regional Center or Members participating in Section 1115(c) waiver programs, such as Assisted Living, In Home Operations, and Nursing Facility/Acute Hospital Waivers. During this transition to OCC, Members are subject to the same noticing requirements as apply to Members being passively enrolled into OCC, and CalOptima staff is in the process of obtain approval of modifications to the existing notice templates so that they can be used in conjunction with this transition.

Deeming Process for CMC

Current OCC policy provides that Members, who lose Medi-Cal eligibility, as determined by the State, are disenrolled from the plan. DHCS, in compliance with CMS policy, issued guidance on June 15, 2015 encouraging plans such as CalOptima to offer an optional one or two-month period of deemed continued eligibility in the Medicare-Medi-Cal Plan (MMP) due to loss of Medi-Cal eligibility. For OCC members who lose eligibility with the plan due to 1) loss of Medi-Cal eligibility or 2) change of circumstance impacting eligibility (such as a change in Medi-Cal eligibility aid code or a move out of the service area), DHCS will allow plans to choose to provide a one or two month period of deemed continued eligibility. Deeming guidance became effective July 1, 2015.

Long-Term Care

CalOptima has been responsible for the Medi-Cal long-term care benefit since January 1996. The Medi-Cal long-term care benefit includes room and board for Members who are no longer able to live safely at home or in the community, require round-the-clock custodial care prescribed by a physician, and meet DHCS level of care requirements. These members receive medical, social, and personal care services in a nursing facility. Only care in sub-acute, skilled nursing facilities and intermediate care facilities apply; assisted living and board and care facilities are not eligible.

Traditionally, for Dual eligible members, physician and hospital services are provided through the Medicare fee-for-service program, a Medicare Advantage Plan, or a Special-Needs Plan. CalOptima has managed and paid for long-term care services for these members directly and has not delegated this responsibility. Through OCC, Dual eligible members can now receive all of their services through one coordinated plan.

Since 2009, CalOptima Medi-Cal members in long-term care have received physician, hospital, and long-term care services through the CalOptima Direct network, which includes the CalOptima Community Network. OCC now affords CalOptima the opportunity to provide the full scope of services covered under both Medicare and Medi-Cal through the CalOptima Community Network.

Discussion

Enrollment into D-SNPs

As indicated, effective January 1, 2016, CalOptima is required to transition eligible OneCare Members into OCC. CalOptima intends to make the transition as seamless as possible for Members

and ensure that disruption is kept to a minimum. For this reason, staff intends to assign the Member to the same OneCare primary care provider (PCP) and health network, unless otherwise requested by Member. If the PCP participates in a different OCC health network at the time of transition, the Member will be assigned to the same PCP and the PCP's new health network. This is in alignment with the DHCS March 27, 2015 Dual Plan Letter (DPL) 15-003 requirements for continuity of care which states "if the MMP contracts with delegated entities, the MMP must assign the beneficiary to a delegated entity that has the beneficiary's preferred PCP in its network."

If the member's OneCare PCP does not participate in the same OCC health network but does participate in two or more OCC health networks or none, the Member will be assigned according to the OCC auto-assignment policy initially approved during the December 2013 Board meeting and amended in May 2015, unless otherwise requested by Member.

CalOptima will modify its OCC policies related to primary care selection, network assignment, and member notification to the extent necessary to reflect the above.

Deeming Process for CMC

DHCS issued guidance allowing CMC plans to offer up to two months of deeming eligibility due to loss of Medi-Cal eligibility. The deeming period would apply to OCC members who no longer qualify for OCC due to loss of Medi-Cal eligibility or change of circumstance impacting Medi-Cal eligibility. Plans already participating in CMC have reported that many members who have been involuntarily disenrolled from CMC due to loss of Medi-Cal eligibility regain their Medi-Cal eligibility within one to two months after disenrollment.

For example, a Member may lose Medi-Cal eligibility as a result of late submission of annual Medi-Cal redetermination documentation, delays in redetermination processing, a report of having an out of county residence, or other health coverage information. In many instances, the situation is quickly remediated either by submission of required redetermination documentation or correcting erroneous records, and Medi-Cal eligibility is reinstated. Without a deeming period, these members will be disenrolled from OCC and cannot be automatically enrolled back to the plan. Instead, these members would have to voluntarily re-enroll with OCC to continue coverage.

In order to mitigate breaks in coverage and maintain continuity of care for members, staff proposes to allow a one-month deeming period for OCC Members. A one month deeming period is recommended at this time to limit CalOptima's financial exposure. Based on the proposed action, during the deeming period, CalOptima would continue providing OCC benefits to the Member. CalOptima will continue to receive member premium payments from Medicare; however, Medi-Cal capitation payments will be suspended during this time. Medi-Cal capitation payments from DHCS will be retroactively paid for the deeming month if the member regains Medi-Cal eligibility. However, if the Member does not regain Medi-Cal eligibility during the deeming period, the member would be disenrolled from OCC at the end of the deeming period month, and CalOptima would not be reimbursed for Medi-Cal expenses incurred on behalf of this member during the one-month period.

All regulatory notice requirements to Members will be followed for this process. While DHCS permits plans to implement deeming effective July 1, 2015, due to the time required for regulatory

approval of member materials, CalOptima staff proposes to implement the one month deeming process no earlier than September 1, 2015. As proposed, deeming will continue through the duration of the CMC, currently authorized by the DHCS and CMS through December 31, 2017.

CalOptima will modify its OCC policies related to member enrollment and disenrollment, to the extent necessary to implement the above.

Long-Term Care

On April 2, 2015, the CalOptima Board of Directors authorized staff to modify the OCC enrollment process to allow for enrollment by long-term care facility. Regulatory approval was received in July 2015 and the enrollment of members by facility will begin in November 2015. In order to enhance the care for OCC members residing in a long-term care facility, staff proposes to implement a delivery model specific for these members. By enhancing the delivery model, staff expects to:

- Improve coordination of Medicare and Medi-Cal services, consistent with the goals of Cal MediConnect
- Improve member, family and facility satisfaction
- Promote member enrollment in OCC
- Utilize emergency department (ED) and inpatient resources appropriately with subsequent reduction in ED visits, hospital admissions, days and readmissions rates
- Adhere to regulatory requirements for OCC
- Improve communication and discuss expectations with member, facility, providers, and family
- Measure and report benefits of integrated care

A key component of this delivery model is to contract with providers who provide services in skilled nursing and long-term care facilities. These providers are referred to as skilled nursing facility (SNF) physicians. Because these members permanently reside in the facility, it is important for the members' care to be rendered by physicians who go directly to the facility to provide services on a regular and frequent basis in order to identify and treat acute or deteriorating conditions. These physicians will also be available around-the-clock to provide urgent care services at the facility in order to avoid unnecessary emergency department admissions. As such, new contracts requiring the SNF physician to provide around-the-clock care and minimum thresholds of visits in addition to traditional primary care services will be developed. These contracts will be offered exclusively through CalOptima Direct to individual providers and physician groups and may be based on fee-for-service or capitated with a risk sharing agreement.

The other key component of enhancing the deliver model is to designate the managed CalOptima Community Network, a part of CalOptima Direct, as the assigned network for OCC members residing in a long-term care facility, similar to CalOptima's current policy for Medi-Cal members. The CalOptima Community Network is designed to provide physician, hospital, and long-term care services to all Medi-Cal members residing in a long-term care facility. For Dual eligible members, while physician and hospital services are provided through the Medicare fee-for-service program, a Medicare Advantage Plan, or a Special-Needs Plan, CalOptima has always managed and paid for long-term care services for these members directly. Assigning OCC members to CalOptima

Community Network, therefore, promotes continuity with their CalOptima Medi-Cal network. Additionally, this allows a single entity to be responsible for the members entire covered services.

Subject to approval by both the DHCS and CMS, CalOptima will modify and/or develop OCC policies related to health network selection, primary care selection, auto-assignment, and services provided to a member residing in a long-term care facility to the extent necessary to reflect the above.

Fiscal Impact
The recommended actions are budget neutral. Transition of OneCare members into OneCare Connect, expenses due to deeming, and direct costs related to the reimbursement to long-term care facilities are accounted for in the FY16 budget.

Rationale for Recommendation
In order to comply with the DHCS guidelines for OCC enrollment and to maintain maximum membership and minimize disruption of member's health care services, CalOptima staff proposes to implement the above recommended actions.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/31/2015*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing Increased Medi-Cal Payments for Specific Services to Qualifying Primary Care Providers Who Submitted Attestations Between January 1 and June 15, 2015

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO) to make increased Medi-Cal payments for specific services to qualifying primary care providers (PCPs) who submitted attestations between January 1 and June 15, 2015.

Background

Under the Patient Protection and Affordable Care Act (ACA), Section 1202 requires states to provide an incremental rate increase to qualifying PCPs for specific services from 2009 Medi-Cal levels to the same level as Medicare rates for the same services. The PCP increase was effective for dates of services from January 1, 2013, through December 31, 2014.

Following is a brief summary of actions taken by the CalOptima Board of Directors related to implementation of the PCP increase in CalOptima's contract with the California Department of Health Care Services (DHCS):

- At its November 7, 2013 meeting, the Board approved revised capitation rates for Fiscal Year (FY) 2012-13 that included funding for the PCP increase for the period of January 1, 2013, through June 30, 2013;
- At its December 5, 2013 meeting, the Board approved revised capitation rates for FY 2013-14 that included funding for the PCP increase for the period of July 1, 2013, through June 30, 2014; and
- At its December 4, 2014 meeting, the Board approved base capitation rates for FY 2014-15 that included funding for the PCP increase for the period of July 1, 2014, through December 31, 2014.

On August 21, 2015, DHCS approved CalOptima's ACA Managed Care Compliance Plan (MCCP) for passing through the PCP increase to qualifying PCPs. As part of the MCCP, CalOptima opted to use DHCS's online registry for the mandatory provider attestation process, and to adhere to the state's attestation submission deadline of December 31, 2014. The MCCP provides that PCPs who failed to submit their attestations by the deadline are not eligible for the PCP increase.

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Discussion

In February 2016, a routine audit of CalOptima found that the DHCS online registry included PCPs who had submitted attestations after the December 31, 2014, deadline. Specifically, the DHCS online registry included PCPs who submitted their attestations between January 1 and June 15, 2015. The impact of this finding is twofold:

1. CalOptima made PCP increase payments to 16 PCPs who had submitted their attestation after the deadline. The total amount of PCP increase payments made to the affected PCPs is $292,853. In June 2016, CalOptima took corrective actions by sending letters to these affected PCPs requesting that they return the amounts overpaid. To date, CalOptima has not yet received repayment from any of the affected PCPs.

2. Pursuant to CalOptima's ACA MCCP, other PCPs who submitted late attestations and were included in the DHCS online registry did not receive increased payments from CalOptima. However, since these PCPs were included in the online registry, DHCS provided the increased payments for their Medi-Cal fee-for-service claims. In line with DHCS's practice, PCPs are requesting that CalOptima provide increased payments for their Medi-Cal managed care claims. As of October 14, 2016, Staff has identified 14 PCPs who would need their managed care claims adjusted to reflect the PCP increase. The fiscal impact for this change is $761,424.

On October 19, 2016, DHCS gave written approval to CalOptima to provide the PCP increase to qualifying PCPs who attested after the December 31, 2014, deadline. Therefore, Management recommends that the Board re-categorize qualifying PCPs who submitted attestations between January 1 and June 15, 2015, and are listed on the DHCS online registry as eligible to receive the PCP increase payments for specific services with dates of services from January 1, 2013, through December 31, 2014. Specifically, Management proposes that CalOptima will:

- Forego the recoupment of PCP increase payments made to such PCPs on the basis of submitting the attestation after the December 31, 2014, deadline; and

- Adjust CalOptima health network and direct network managed care claims for affected PCPs to reflect the PCP increase.

Fiscal Impact

The total fiscal impact is estimated at $1,054,277, and is budget neutral. Funding for the recommended action will come from the remaining PCP ACA funds received by CalOptima.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Board Action dated November 7, 2013, Authorize and Direct the Chairman of the Board of Directors to Execute Amendments to the Primary Agreement with the California Department of Health Care Services (DHCS)
2. Board Action dated December 5, 2013, Authorize and Direct the Chairman of the Board of Directors to Execute Amendments to the Primary Agreement with the California Department of Health Care Services (DHCS)
3. Board Action dated December 4, 2014, Authorize and Direct the Chairman of the Board of Directors to Execute Amendments to the Primary and Secondary Agreements with the California Department of Health Care Services (DHCS)

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

9/28/2016 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

V. A. Authorize and Direct the Chairman of the Board of Directors to Execute Amendments to the Primary Agreement with the California Department of Health Care Services (DHCS)

Contact

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

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute Amendments to the Primary Agreement between the DHCS and CalOptima related to:

a. Expansion of the Medi-Cal Program;
b. Implementation of mental health and substance use benefits in the Medi-Cal program; and
c. Revised capitation rates for Fiscal Year (FY) 2012-13 and revised capitation rates for the period January 1, 2013 through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services. The Primary and Secondary Agreements expire December 31, 2014.

The following is a summary of amendments to the Primary Agreement approved by the Board to date:

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments	November 4, 2010

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Amendments to Primary Agreement	Board Approval
for maximum allowable cost pharmacy pricing.	
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012
A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013

Discussion

Expansion of the Medi-Cal Program

The Affordable Care Act (ACA) provides the opportunity for states to expand Medicaid coverage for single adults without children, ages 19-64, with incomes of up to 138% of the Federal Poverty Level (FPL) based on modified adjusted gross income. California will proceed with the expansion and will also transition eligible Low Income Health Program (LIHP) beneficiaries, known locally as the Medical Services Initiative (MSI) program, into Medi-Cal, effective January 1, 2014.

CalOptima staff anticipate the benefit structure for the Medi-Cal expansion population will be the same as the current Medi-Cal population, with the possible exception of managed long term services and supports (MLTSS), which includes In-Home Supportive Services (IHSS), Community Based

Adult Services (CBAS), Multipurpose Senior Services Program (MSSP) and Long Term Care (LTC). DHCS will request approval from the Centers for Medicare & Medicaid Services (CMS) to apply an asset test for the expansion population for the MLTSS benefits. Staff continues to work with DHCS to clarify whether the asset test, if approved by CMS, will apply to all MTLSS or will be limited to select benefits.

Mental Health and Substance Use Disorder Benefits

The FY13-14 California state budget enhances Medi-Cal mental health and substance use disorder services. Medi-Cal managed care plans will cover the following expanded benefits:

- Individual/group mental health evaluation and treatment (psychotherapy);
- Psychological testing when clinically indicated to evaluate a mental health condition;
- Psychiatric consultation for medication management;
- Outpatient laboratory, supplies and supplements;
- Screening and Brief Intervention (SBI); and
- Drugs, excluding anti-psychotic drugs (which are covered by Medi-Cal FFS).

County mental health plans will continue to be responsible for coverage of Medi-Cal Specialty mental health services. DHCS convened a workgroup to refine the criteria for individuals that will receive mental health care under Medi-Cal managed care plans and expects to issue guidance shortly.

DHCS submitted a State Plan Amendment (SPA) at the end of September and will now need to submit waivers to CMS to complete the new benefit integration into Medi-Cal managed care. CMS must approve the waivers prior to the implementation date, currently scheduled for January 1, 2014. DHCS and plans continue discussions regarding readiness for the January 1, 2014 implementation date.

Contract Amendment

CalOptima anticipates receiving the draft amendment to our Primary Agreement for Medi-Cal expansion and integration of the mental health benefit and the corresponding rates by the November 7, 2013 Board of Directors meeting. Pursuant to discussions with DHCS, the amendment will include aid code and benefit changes, continuity of care obligations, policy and procedure requirements, and deliverables to DHCS regarding readiness and reporting requirements.

Rate Revisions

CalOptima staff recently received draft revised capitation rates for FY 2012-13 and draft revised capitation rates for the period January 1, 2013 through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program.

Fiscal Year 2012-13 Revised Rates

Rate changes for the period July 1, 2012, through June 30, 2013 reflect the following:

1. Funding for the Primary Care Physician rate increase as provided under section 1202 of ACA.

2. Funding for the gross premium tax for the period July 1, 2012, through June 30, 2013. The rate increases attributable to the MCO gross premiums tax reflect an increase equal to 2.35%

of CalOptima's estimated revenues for taxable programs for the period July 1, 2012, through June 30, 2013. Taxable programs for the purposes of the gross premiums tax include Medi-Cal, HFP, and Multipurpose Senior Services Program (MSSP). Medicare is not taxable under the gross premiums tax.

3. Final adjustment for the elimination of retroactive eligibility in COHS plans.

HFP Transition Revised Rates
At the April 4, 2013 meeting, the Board of Directors approved rates related to the transition of HFP members into Medi-Cal. The draft rates CalOptima recently received impact rates for Phases 1-3 and includes the following changes by Phase:

- Phase 1:
  - Funding for the Primary Care Physician as provided under section 1202 of ACA; and
  - Funding for the gross premium tax for the period January 1, 2013, through March 31, 2013 at a rate of 2.35%.

- Phase 2:
  - Funding for the Primary Care Physician rate increase as noted above for the period April 1, 2013, through June 30, 2013;
  - Funding for the gross premium tax for the period April 1, 2013, through June 30, 2013 at a rate of 2.35%; and
  - Funding for the sales tax as authorized under Senate Bill (SB) 78 for the period July 1, 2013 through July 31, 2013. The rate increase attributable to the sales tax reflect an increase equal to 3.9375% of CalOptima's estimated revenues for taxable programs for the period July 1, 2013, through June 30, 2013. As with the gross premiums tax, taxable programs for the purposes of the tax include Medi-Cal, HFP, and MSSP.

- Phase 3:
  - Funding for the Primary Care Physician rate increase as noted above for the period August 1, 2013, through December 31, 2013; and
  - Funding for the sales tax as noted above for the period August 1, 2013, through December 31, 2013; and
  - An adjustment for the implementation of the Assembly Bill (AB) 97 provider payment reductions.

Fiscal Impact
The costs for Medi-Cal expansion and the integration of mental health and substance use benefits are expected to be covered by new rates established by DHCS for the initiatives. The revision to the FY 12-13 rates to include the final adjustment for the elimination of retroactive eligibility in COHS plans results in a reduction of $9,859,039 in revenue.

Rationale for Recommendation
The Amendments will make language changes that are consistent with statutory language and California's 1115 waiver, as well as revised rates to pay for services for the new initiatives and ensure CalOptima is held harmless for the PCP rate increase, gross premium and sales taxes.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/1/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

V. D. Authorize and Direct the Chairman of the Board of Directors to Execute Amendments to the Primary Agreement with the California Department of Health Care Services (DHCS)

Contact

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

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute Amendments to the Primary Agreement between DHCS and CalOptima related to:

1. Revised capitation rates for Fiscal Year (FY) 2013-14.
2. Implementation of the Affordable Care Act (ACA) including:
    - Primary Care Provider Payment Increase;
    - Incentives for meeting performance standards for encounter data for the Medi-Cal Expansion (MCE) population; and
    - Medical Loss Ratio requirements for medical services provided to the MCE population.
3. Language revisions to clarify existing program requirements for health plan operations and provision of services to Members as included in the Primary Agreement with DHCS.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services. The Primary and Secondary Agreements expire December 31, 2014.

The following is a summary of amendments to the Primary Agreement approved by the CalOptima Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010

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Amendments to Primary Agreement	Board Approval
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012
A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013

Discussion

Rate Revisions

On September 17, 2013, CalOptima received draft rates for the period July 1, 2013 – June 30, 2014. Since that time, staff from managed care plans has worked with DHCS to develop rates related to Medi-Cal expansion and the integration of mental health and substance use benefits, effective January

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1, 2014. DHCS will provide managed care plans with a rate amendment to incorporate all program changes effective fiscal year 2013-14.

Rate changes for the period July 1, 2013, through June 30, 2014 reflect the following:

1. Revised capitation rates.

2. Funding for the Primary Care Physician rate increase as provided under section 1202 of Affordable Care Act (ACA).

3. Funding for the sales tax as authorized under Senate Bill (SB) 78 for the period July 1, 2013 through June 30, 2014. The rate increase attributable to the sales tax reflect an increase equal to 3.9375% of CalOptima's estimated revenues for taxable programs for the period July 1, 2013 through June 30, 2014. Taxable programs for the purposes of the sales tax include Medi-Cal, HFP, and Multipurpose Senior Services Program (MSSP). Medicare is not taxable under the gross premiums tax.

4. Funding for Medi-Cal expansion.

5. Funding for mental health and substance use benefits.

6. Adjustments for Medi-Cal program changes.

7. Adjustments for the following:

    a. Implementation of the Assembly Bill (AB) 97 provider payment reductions, effective October 1, 2013.
    b. Maximum allowable cost (MAC) pharmacy pricing. In FY 2010-11, DHCS began applying the MAC pricing adjustment to managed care plans' rates. With the adjustment, plans rates are "adjusted" for failing to meet pharmacy pricing benchmarks.
    c. Potentially preventable admissions (PPA). In FY 2012-13, DHCS began applying the PPA adjustment to managed care plans' rates. With the adjustment, plan rates are "adjusted" for occurrences where an inpatient admission was potentially preventable.

<u>Contract Amendment</u>
On November 22, 2013, DHCS shared the draft contract amendment that will be effective January 1, 2014. In addition to the expected revisions related to implementation of the ACA and the integration of the managed care mental health and substance use benefits (approved by the Board at its November 7, 2013 meeting), this amendment provides language revisions related to existing contractual requirements and program guidance from DHCS regarding the following:

Requirement	Impact
Encounter Data	• Clarifies existing encounter data reporting requirements.
Financial Reporting and Incentives	• Requires managed care plans to track and

Requirement	Impact
	include financial data for Medi-Cal Expansion (MCE) population in regular filings and meet Medical Loss Ratio (MLR) standards for medical services provided to the MCE population. • Provides an opportunity to receive increased capitation rates (up to 5%) for the MCE aid codes for meeting performance standards for encounter data submissions.
Subcontractor Monitoring	• Clarifies plan subcontractors shall comply with monitoring requests by are subject to monitoring requests by DHCS.
Group Needs Assessment (GNA)	• Clarifies existing requirements for the GNA as provided in Policy letters issued by DHCS.
Individual Health Education Behavioral Assessment/Staying Healthy Assessment	• Clarifies existing requirements for the Individual health education behavioral assessment/Staying Healthy Assessment as provided in All Plan and Policy letters issued by DHCS.
Health Education	• Clarifies existing requirements related to health education initiatives.
Third Party Liability	• Clarifies requirements related to reporting other health coverage sources.

The amendment also makes other minor language revisions as well as formatting and grammatical edits.

Fiscal Impact
The FY 2013-14 Medi-Cal rates result in a 4.7% increase over the FY 2012-13 rates, net of MCO tax and the ACA 1202 provision for increased PCP payments. The rates are consistent with the FY 2013-14 operating budget and are expected to fully fund the Medi-Cal program.

Rationale for Recommendation
CalOptima's 2013-14 operating budget was based on the anticipated rates for FY 2013-14. Therefore, execution of the rate amendment will ensure revenues and cash payment consistent with the approved budget.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 4, 2014
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

VI. B. Authorize and Direct the Chairman of the Board of Directors to Execute Amendments to the Primary and Secondary Agreements with the California Department of Health Care Services (DHCS)

Contact

Michael Ruane, Chief of Strategy and Public Affairs, (714) 246-8400
Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to:
   a. Revised section 1202 of the Affordable Care Act (ACA) capitation rates for the Medi-Cal expansion and former Healthy Families Program (HFP) populations for the period of January 1, 2014, through June 30, 2014;
   b. Base capitation rates for FY 2014-15;
   c. Addition of an aid code related to the Optional Targeted Low-Income Children (OTLIC) Program for Access for Infants and Mothers (AIM) program; and
   d. Language revisions related to supplemental payments for coverage of Hepatitis C medications.
2. Authorize and direct the Chairman of the Board of Directors to execute Amendment A-05 to the Secondary Agreement between DHCS and CalOptima.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 19, which extends the agreement through December 31, 2015. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services

Discussion

Primary Agreement

On November 12, 2014, DHCS notified plans that it will submit to the Centers for Medicare & Medicaid Services (CMS) an amendment that will revise rates for FY 13-14, incorporate base rates for FY 14-15, add an aid code and incorporate language changes as detailed below. DHCS stated that it will provide the amendment to plans in mid-December for signature by the end of the year. If the amendment is not consistent with this understanding or includes significant

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language changes or other requirements, staff will return to the Board of Directors for consideration.

Rate Revisions

FY 13-14

In September 2013 and February 2014, CalOptima received draft rates for the period July 1, 2013, through June 30, 2014. Since that time, DHCS revised rates to incorporate revisions related to program changes, funding for the Primary Care Physician (PCP) rate increase as provided under section 1202 of ACA as well as expansion of the Medi-Cal program.

The rates in this amendment will reflect funding for the Medi-Cal expansion and former HFP populations to include PCP rate increase for the period January 1, 2014 through June 30, 2014.

FY 14-15

In July and October 2014, CalOptima received draft rates for the period July 1, 2014, through June 30, 2015.

Rate changes for the period July 1, 2014, through June 30, 2015 reflect the following:

1. Revised capitation rates.

2. Funding for the PCP rate increase as provided under section 1202 of ACA.

3. Blending of the Adult & Family (18 and under) and Healthy Families Program (HFP) rates to create a "Child" rate.

4. Adjustments for the removal of Blood Factor medications from plan responsibility.

5. Adjustments for supplemental payments for coverage of Hepatitis C medications.

6. Funding for the sales tax as authorized under Senate Bill (SB) 78 for the period July 1, 2014 through June 30, 2015. The rate increase attributable to the sales tax reflect an increase equal to 3.9375% of CalOptima's estimated revenues for taxable programs for the period July 1, 2013 through June 30, 2014. Taxable programs for the purposes of the sales tax include Medi-Cal, and Multipurpose Senior Services Program (MSSP). DHCS reimburses CalOptima for the full amount of the sales tax paid on all taxable lines of business.

7. Funding for Medi-Cal expansion.

8. Adjustments for Medi-Cal program changes.

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9. Adjustments for the following:

    a. Implementation of the Assembly Bill (AB) 97 provider payment reductions, effective October 1, 2013.

    b. Maximum allowable cost (MAC) pharmacy pricing. In FY 2010-11, DHCS began applying the MAC pricing adjustment to managed care plans' rates. With the adjustment, plans rates are "adjusted" for failing to meet pharmacy pricing benchmarks.

    c. Potentially preventable admissions (PPA). In FY 2012-13, DHCS began applying the PPA adjustment to managed care plans' rates. With the adjustment, plan rates are "adjusted" for occurrences where an inpatient admission was potentially preventable.

Aid Code Addition

The AIM program provides low cost health insurance coverage to uninsured, middle income pregnant women. Pursuant to the Budget Act of 2014, the AIM program transitioned from the Managed Risk Medical Insurance Board (MRMIB) to DHCS. Commencing November 1, 2014, DHCS will add aid code, E6, for infants and children ages 0 up to 2 years in the Medi-Cal OTLIC Program. This aid code provides full-scope, no-cost Medi-Cal coverage to AIM-linked infants and children 0 up to 2 years of age whose family income is above 213 percent up to and including 266 percent of the Federal Poverty Level (FPL).

Supplemental Payments for coverage of Hepatitis C Medications

Over the last year, the Food and Drug Administration (FDA) has approved effective, high-cost medications for the treatment of Hepatitis C. In response to plans' concern regarding the significant increase in pharmacy costs due to the utilization of high-cost Hepatitis C drugs, DHCS issued policy criteria on the use of the drugs and developed a revised the capitation structure to implement a Hepatitis C supplemental payment to ensure plans are not financially harmed when covering the medications for its members. On November 19, 2014, DHCS provided draft language to plans to detail the Hepatitis C supplemental payment methodology and process.

Secondary Agreement

Amendment A-05
The Secondary Agreement provides funding for Sensitive Services, which do not qualify for federal financial participation. These rates are based on statewide average costs, and determined as an allocation of CalOptima's Primary Agreement rates for the Family and Adult aid categories

Amendment A-05 to the Secondary Agreement incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014

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through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.

Fiscal Impact

Primary Agreement

At this time, the fiscal impact of the inclusion of ACA PCP rate increases for the Medi-Cal expansion and former HFP populations for the period of January 1, 2014, through June 30, 2014, is not known.

The recommended action to execute updated Medi-Cal capitation rates for the period of July 1, 2014, through June 30, 2015, results in a 5.2% increase from the FY 2013-14 rates, based on prior guidance from DHCS. The rate change will result in a net increase of approximately $71 million in "Classic" Medi-Cal revenue.

The recommended action to add aid code E6 to the Medi-Cal OTLIC program does not have an adverse fiscal impact to CalOptima.

The recommended action to execute language revisions related to supplemental payments for coverage of Hepatitis C medications is revenue neutral to CalOptima. The rates are expected to fully fund anticipated costs for currently approved Hepatitis C medications.

Secondary Agreement

Amendment A-05 result in revenues of approximately $324,000 for FY 2013-14 and $1.56 million in FY 2014-15. Upon review, the amended capitation rates remain actuarially sound based on our cost experience in providing these covered services under the Secondary Agreement. Therefore, the adjustments in the Secondary Agreement rates are expected to have no negative impact on our future financial performance for the Medi-Cal line of business.

Rationale for Recommendation

CalOptima's 2014-15 operating budget was based on the anticipated rates for FY 2014-15. Therefore, execution of the rate amendment will ensure revenues and cash payment consistent with the approved budget. Additionally, the Amendment will add a covered aid code that is consistent with statutory language.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Appendix summary of amendments to Primary and Secondary Agreements with DHCS

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

11/26/2014 — **Date**

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APPENDIX TO AGENDA ITEM VI. B.

The following is a summary of amendments to the Primary Agreement approved by the CalOptima Board of Directors (Board) to date:

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014

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Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
7. Consider Adoption of Resolution Approving Updated Human Resources Policies

Contact
Michael Schrader, Chief Executive Officer, (714) 246-8400
Katia Taylor, Interim Director Human Resources, (714) 246-8400

Recommended Action
1. Adopt Resolution Approving CalOptima's Updated Human Resources Policies; and
2. Approve proposed market adjustments for various positions.

Background
On November 1, 1994, the Board of Directors delegated authority to the Chief Executive Officer to promulgate employee policies and procedures, and to amend these policies from time to time, subject to annual presentation of the policies and procedures, with specific emphasis on any changes thereto, to the Board of Directors or a committee appointed by the Board of Directors for that purpose. On December 6, 1994, the Board adopted CalOptima's Bylaws, which requires, pursuant to section 13.1, that the Board of Directors adopt by resolution, and from time to time amend, procedures, practices and policies for, among other things, hiring employees and managing personnel.

Pursuant to the California Code of Regulations, Title 2, Section 570.5, CalOptima is required to adopt a publicly available pay schedule that meets the requirements set forth by the California Public Employees' Retirement System (CalPERS) to reflect recent changes, including the addition or deletion of positions and revisions to wage grades for certain positions.

The following table lists existing Human Resources policies that have been updated and are being presented for review and approval.

	Policy No./Name	Summary of Changes	Reason for Change
1.	GA.8016 Unusual Occurrence	• Minor language and formatting change. • Recommend that this become an Environmental Health and Safety (EHS) Department Policy.	-Annual review with minor updates and formatting changes. - Revise responsibility from HR to EHS to have jurisdiction.
2.	GA.8027 Unlawful Harassment	• Purpose of policy was revised and new terms added. • Added language to reflect requirements consistent with recent revisions to FEHA,	-Update to be consistent with recent revisions to the State Fair Employment and Housing Act law effective April 1, 2016.

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	Policy No./Name	Summary of Changes	Reason for Change
		including, but not limited to, inclusion of all protected groups under FEHA to be listed in policy, and add requirement that policy is disseminated to entire workforce via electronic attestation.	
3.	GA.8032 Employee Dress Code	• Minor language and formatting change.	-Annual review with minor updates and formatting changes.
4.	GA.8034 Service of Summons	• Revised policy title to reflect service of other legal documents • Make changes consistent with Policy AA. 1215: Public Records Requests and Subpoenas • Expanded descriptions	- Expand scope of policy to address service of different types of legal documents and to more closely reflect what the policy encompasses. - Changes necessitated by CalOptima Policy AA. 1215: Public Records Requests and Subpoenas
5.	GA.8055 Retiree Health Benefit	• Minor language and formatting change. • Added language to allow for a stipend to be provided in lieu of insurance coverage to Eligible Dependent(s) in the event CalOptima is unable to reasonably obtain coverage.	- To update policy consistent with the Board of Directors' direction from the October 6, 2016, Board meeting. - To address situations where CalOptima cannot obtain coverage for the retiree's dependents.
6.	GA. 8058: Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment 1 – Salary Schedule, has been revised in order to reflect recent changes to the Salary Schedule, including changes to, and the addition and deletion of positions. A summary of the changes to the Salary Schedule is included for reference.	- Pursuant to CalPERS requirement, 2 CCR §570.5, CalOptima periodically updates the salary schedule to reflect current job titles and pay rates for each job position. - There are changes to 9 positions indicated on the attached revised Salary Schedule. New Position: Creation of a new Job Title typically due to a change in the scope of a current position or the

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	Policy No./Name	Summary of Changes	Reason for Change
			addition of a new level in a job family. (5 positions) Remove Position: Elimination of a Job Title typically due to a change in the scope of a current position or the elimination of position in a job family. (2 positions) Change Job Title: Revision of a Job Title typically due to a change in the scope of a current position. (2 positions)

Market Adjustments
Staff recommends salary adjustments for 1 position effective on or after the pay period ending November 12, 2016. This impacts an employee in the following department: one (1) in Community Relations. The recommended increase is to meet the updated salary and compensation levels under the Fair Labor Standards Act (FLSA) requirements needed for executive, administrative, and professional employees to be exempt, which takes effect December 1st, and to attract and retain qualified staff. Pursuant to the Compensation Administration Guidelines adopted as part of CalOptima Policy GA. 8057: Compensation Program, approval by the Board of Directors is required as part of the process for market adjustments, which are not part of the regular merit process. Recommendations are made based on extensive research by the Human Resources Department and review by CalOptima's Resources Workgroup consistent with the market adjustment process to ensure that CalOptima remains competitive with market trends and meets its ongoing obligation to provide structure and clarity on employment matters, consistent with applicable federal, state, and local laws and regulations.

Fiscal Impact
The fiscal impact of this recommended action is budget neutral. Unspent budgeted funds for salaries and benefits approved in the CalOptima Fiscal Year 2016-2017 Operating Budget on June 2, 2016, will fund the market adjustment. The total cost for the market adjustment effective on or after the pay period ending November 12, 2016, through June 30, 2017, is $3,394.56. The estimated annual cost is $5,191.68. Projected expenses related to the other recommended policy changes were included in the CalOptima Fiscal Year 2016-2017 Operating Budget approved on June 2, 2016.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. Resolution No. 16-1103, Approve Updated Human Resources Policies
2. Revised CalOptima Policies:
    a. GA. 8016: Unusual Occurrence (redlined and clean versions) – with Attachment
    b. GA. 8027: Unlawful Harassment (redlined and clean versions)
    c. GA. 8032: Employee Dress Code (redlined and clean versions) – with Attachment
    d. GA. 8034: Service of Summons, Subpoenas, and Other Legal Documents (redlined and clean versions)
    e. GA. 8055: Retiree Health Benefit (redlined and clean versions)
    f. GA.8058: Salary Schedule (redlined and clean versions) – with revised Attachment
3. Summary of Changes to the Salary Schedule and Market Adjustments

/s/ Michael Schrader *9/28/2016*

Authorized Signature **Date**

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RESOLUTION NO. 16-1103

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY
d.b.a. CalOptima

APPROVE UPDATED HUMAN RESOURCES POLICIES

WHEREAS, section 13.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provide that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, among other things, hiring employees, and managing personnel; and,

WHEREAS, in 1994, the Board of Directors designated the Chief Executive Officer as the Appointing Authority with full power to hire and terminate CalOptima employees at will, to set compensation within the boundaries of the budget limits set by the Board, to promulgate employee policies and procedures, and to amend said policies and procedures from time to time, subject to annual review by the Board of Directors, or a committee appointed by the Board for that purpose; and

WHEREAS, California Code of Regulations, Title 2, Section 570.5, requires CalOptima to adopt a publicly available pay schedule that identifies the position title and pay rate for every employee position, and CalOptima regularly reviews CalOptima's salary schedule accordingly.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policies.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 3rd day of November, 2016.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Vice Chair, Board of Directors
Printed Name and Title: Lee Penrose, Vice Chair, CalOptima Board of Directors

Attest:
/s/_____
Suzanne Turf, Clerk of the Board

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~~Program: Administrative/Internal~~
Policy #: GA.8016
Title: **Unusual Occurrence**
Department~~t~~: ~~—~~Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 02/96 ~~Revised: 2/00, 7/07, 2/1/14~~
Last Review Date: 11/03/16
Last Revision Date: 11/03/16

I. PURPOSE

This policy~~o~~ ensures the safety of CalOptima staff, agents, or visitors of CalOptima Property, and ~~to~~ the documentation of U~~u~~nusual O~~o~~ccurrences at, or on, CalOptima Property, or involving a CalOptima employee or agent.

~~II. DEFINITIONS~~

~~A statement (verbal, written, or physical) which is intended to intimidate by expressing the intent to either harass, hurt, take the life of another person, or damage/destroy property. This includes threats made in jest or as a joke, but which others could perceive as serious.~~

~~A. CalOptima Property: Any property owned or operated by CalOptima including CalOptima's administration building located at 505 City Parkway West, Orange, CA 92868 and CalOptima's PACE Center located at 13300 Garden Grove Boulevard, Garden Grove, CA 92843, inclusive of inside the facility and up to and including the perimeter of the property line.~~

~~B. Threat: A statement (verbal, written, or physical) which is intended to intimidate by expressing the intent to either harass, hurt, take the life of another person, or damage/destroy property. This includes threats made in jest or as a joke, but which others could perceive as serious.~~

~~C. Unusual Occurrence: Any event which jeopardizes or has the potential to jeopardize the health and/or safety of CalOptima employees, members, and/or the community, including, but not limited to, physical injury and death, and/or property damage.~~

~~III.~~II. POLICY

A. The safety and security of CalOptima employees, M~~m~~embers, visitors, and others at, or on, CalOptima Property are of the utmost importance to CalOptima.

B. In the event of an emergency on CalOptima Property involving a sudden, unexpected incident that poses a clear and imminent danger requiring immediate action to prevent or mitigate the loss or impairment of life, health, or property, employees shall immediately call 911, the police, and/or an ambulance. Employees shall then call the Manager of Environmental Health and Safety, or the Director of Facilities, to report the emergency.

C. All U~~u~~nusual O~~o~~ccurrences require an Accident/Incident Report Form. This form is to be submitted to the Manager of Environmental Health and Safety via the employee's Department Director within twenty-four (24) hours after the U~~u~~nusual O~~o~~ccurrence and/or the employee becomes aware of the U~~u~~nusual O~~o~~ccurrence. The Accident/Incident Report Form shall be completed with as much relevant detail as possible.

D. For all Uunusual Ooccurrences involving any injury, or illness, to an employee, or resulting in the death of an employee, an Accident/Incident Report form shall be completed by the reporting employee and submitted to the Manager of Environmental Health and Safety, the Director of Human Resources, and the Director of Facilities. In all cases of employee injury, the appropriate steps in CalOptima's Injury and Illness Prevention Program shall be followed. In all cases of workplace violence, the appropriate steps in CalOptima's Policy No. GA 8053: Workplace Violence Policy shall be followed.

E. An Uunusual Ooccurrence resulting in the serious injury, or illness, or death, of an cEmployee while on CalOptima Property requires a Serious Incident Report Fax Form. The Serious Incident Report Fax Form will shall be completed by the Manager of Environmental Health and Safety Manager and faxed to the nearest District Office of the Division of Occupational Safety and Health Administration (OSHA) as soon as practically possible, but no later than eight (8) hours after the incident.

F. This policy does not replace, or affect, CalOptima's procedures as described in CalOptima Policy GG.1317: Response to Disruptive and Threatening Behavior by Members.

IV.III. PROCEDURE

A. In the event of an Uunusual Ooccurrence, the following procedure shall be followed:

1. An employee who witnesses such incident, or the employee to whom the incident was reported, shall:

   a. Call 911, if necessary, or call CalOptima's Manager of Environmental Health and Safety Manager for immediate assistance;

   b. If a call to 911 is not made, call CalOptima's Manager of Environmental Health and Safety Manager for immediate assistance;

   c. Complete the Accident/Incident Report, typed or clearly printed, and with sufficient detail to fully describe the incident to a non-observer, including the subsequent action taken; and

   d. Forward a copy of the report to the employee's immediate supervisor.

2. The immediate supervisor shall:

   a. Call 911, if necessary, or call CalOptima's Manager of Environmental Health and Safety Manager;

   b. Review the Accident/Incident Report to ensure it is completed correctly; and

   c. Distribute the Accident/Incident Report as follows:

      i. Original to the Environmental Health and Safety Manager to keep on file; and

      ii. A copy to the CalOptima Facilities Department.

3. The Department Director shall:

   a. Call 911, if necessary, or call CalOptima's Manager of Environmental Health and Safety Manager;

   b. Review the Accident/Incident Report;

   c. Initial the Accident/Incident Report and forward it to the Manager of Environmental Health and Safety Manager;

   d. Inform the appropriate chief executive of the Uunusual Ooccurrence; and

   e. For recurring problems, take appropriate, or corrective corrective, action at the program level.

4. The Manager of Environmental Health and Safety shall:

   a. Call 911, if necessary;

   b. Keep, on file, copies of all Accident/Incident Reports submitted;

   c. Take necessary actions to ensure appropriate response or corrective action to Uunusual Ooccurrence, including, but not limited to, security, safety, and efficiency; and

   d. Make information available to legal counsel related to any potential liability, Tthreats, or need for protective order and/or prosecution.

B. The Chief of Strategy and Public AffairsExecutive Director of Human Resources shall coordinate any necessary action with regard to Workers Compensation procedures, or employee correction.

V.IV. ATTACHMENTS

A. Accident/Incident Report Form – Employee
B. Accident/Incident Report Form – Member

VI.V. REFERENCES

A. CalOptima Injury and Illness Prevention Program (IIPP)
A.B. CalOptima Policy GA.8000: Glossary of Terms
B.C. CalOptima Policy GA.8053: Workplace Violence
C.D. CalOptima Policy GG.1317: Response to Disruptive and Threatening Behavior by Members
D. CalOptima's Injury and Illness Prevention Program (IIPP)
E. Title 8, California Code of Regulations (C.C.R.), Section§ 342
F.E. CalOptima's Injury and Illness Prevention Program (IIPP)

VI. REGULATORY AGENCY APPROVALS OR

None to Date

VII. BOARD ACTIONS

A. 11/03/16: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 05/01/14: ~~—~~Regular Meeting of the CalOptima Board ~~Meeting~~of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/1996	GA.8016	Unusual Occurrence	Administrative
Revised	02/2000	GA.8016	Unusual Occurrence	Administrative
Revised	07/01/2007	GA.8016	Unusual Occurrence	Administrative
Revised	02/01/2014	GA.8016	Unusual Occurrence	Administrative
Revised	11/03/2016	GA.8016	Unusual Occurrence	Administrative

~~A. 7/1/07: GA.8016: Unusual Occurrence~~

IX. GLOSSARY

Term	Definition
CalOptima Property	Any property owned or operated by CalOptima including CalOptima's administration building located at 505 City Parkway West, Orange, CA 92868 and CalOptima's PACE Center located at 13300 Garden Grove Boulevard, Garden Grove, CA 92843, inclusive of inside the facility and up to and including the perimeter of the property line.
Member	An enrollee-beneficiary of a CalOptima program.
Threat	A statement (verbal, written, or physical) which is intended to intimidate by expressing the intent to either harass, hurt, take the life of another person, or damage/destroy property. This includes threats made in jest or as a joke, but which others could perceive as serious.
Unusual Occurrence	Any event which jeopardizes or has the potential to jeopardize the health and/or safety of CalOptima employees, members, and/or the community, including, but not limited to, physical injury and death, and/or property damage.

~~B. 2/00: GA.8016: Unusual Occurrence~~

~~IX. KEYWORDS~~

Policy #: GA.8016
Title: **Unusual Occurrence**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 02/96
Last Review Date: 11/03/16
Last Revision Date: 11/03/16

I. PURPOSE

This policy ensures the safety of CalOptima staff, agents, or visitors of CalOptima Property, and the documentation of Unusual Occurrences at, or on, CalOptima Property, or involving a CalOptima employee or agent.

II. POLICY

A. The safety and security of CalOptima employees, Members, visitors, and others at, or on, CalOptima Property are of the utmost importance to CalOptima.

B. In the event of an emergency on CalOptima Property involving a sudden, unexpected incident that poses a clear and imminent danger requiring immediate action to prevent or mitigate the loss or impairment of life, health, or property, employees shall immediately call 911, the police, and/or an ambulance. Employees shall then call the Manager of Environmental Health and Safety, or the Director of Facilities, to report the emergency.

C. All Unusual Occurrences require an Accident/Incident Report Form. This form is to be submitted to the Manager of Environmental Health and Safety via the employee's Department Director within twenty-four (24) hours after the Unusual Occurrence and/or the employee becomes aware of the Unusual Occurrence. The Accident/Incident Report Form shall be completed with as much relevant detail as possible.

D. For all Unusual Occurrences involving any injury, or illness, to an employee, or resulting in the death of an employee, an Accident/Incident Report form shall be completed by the reporting employee and submitted to the Manager of Environmental Health and Safety, the Director of Human Resources, and the Director of Facilities. In all cases of employee injury, the appropriate steps in CalOptima's Injury and Illness Prevention Program shall be followed. In all cases of workplace violence, the appropriate steps in CalOptima Policy GA 8053: Workplace Violence shall be followed.

E. An Unusual Occurrence resulting in the serious injury, illness, or death, of an employee while on CalOptima Property requires a Serious Incident Report Fax Form. The Serious Incident Report Fax Form shall be completed by the Manager of Environmental Health and Safety and faxed to the nearest District Office of the Division of Occupational Safety and Health Administration (OSHA) as soon as practically possible, but no later than eight (8) hours after the incident.

F. This policy does not replace, or affect, CalOptima's procedures as described in CalOptima Policy GG.1317: Response to Disruptive and Threatening Behavior by Members.

III. PROCEDURE

A. In the event of an Unusual Occurrence, the following procedure shall be followed:

1. An employee who witnesses such incident, or the employee to whom the incident was reported, shall:

   a. Call 911, if necessary, or call CalOptima's Manager of Environmental Health and Safety for immediate assistance;

   b. If a call to 911 is not made, call CalOptima's Manager of Environmental Health and Safety for immediate assistance;

   c. Complete the Accident/Incident Report, typed or clearly printed, and with sufficient detail to fully describe the incident to a non-observer, including the subsequent action taken; and

   d. Forward a copy of the report to the employee's immediate supervisor.

2. The immediate supervisor shall:

   a. Call 911, if necessary, or call CalOptima's Manager of Environmental Health and Safety;

   b. Review the Accident/Incident Report to ensure it is completed correctly; and

   c. Distribute the Accident/Incident Report as follows:

      i. Original to the Environmental Health and Safety Manager to keep on file; and

      ii. A copy to the CalOptima Facilities Department.

3. The Department Director shall:

   a. Call 911, if necessary, or call CalOptima's Manager of Environmental Health and Safety;

   b. Review the Accident/Incident Report;

   c. Initial the Accident/Incident Report and forward it to the Manager of Environmental Health and Safety;

   d. Inform the appropriate chief executive of the Unusual Occurrence; and

   e. For recurring problems, take appropriate, or corrective, action at the program level.

4. The Manager of Environmental Health and Safety shall:

   a. Call 911, if necessary;

   b. Keep, on file, copies of all Accident/Incident Reports submitted;

c. Take necessary actions to ensure appropriate response or corrective action to Unusual Occurrence, including, but not limited to, security, safety, and efficiency; and

d. Make information available to legal counsel related to any potential liability, Threats, or need for protective order and/or prosecution.

B. The Executive Director of Human Resources shall coordinate any necessary action with regard to Workers Compensation procedures, or employee correction.

IV. ATTACHMENTS

A. Accident/Incident Report Form – Employee
B. Accident/Incident Report Form – Member

V. REFERENCES

A. CalOptima Injury and Illness Prevention Program (IIPP)
B. CalOptima Policy GA.8000: Glossary of Terms
C. CalOptima Policy GA.8053: Workplace Violence
D. CalOptima Policy GG.1317: Response to Disruptive and Threatening Behavior by Members
E. Title 8, California Code of Regulations (C.C.R.), §342

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/03/16: Regular Meeting of the CalOptima Board of Directors
B. 05/01/14: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/1996	GA.8016	Unusual Occurrence	Administrative
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IX. GLOSSARY

Term	Definition
CalOptima Property	Any property owned or operated by CalOptima including CalOptima's administration building located at 505 City Parkway West, Orange, CA 92868 and CalOptima's PACE Center located at 13300 Garden Grove Boulevard, Garden Grove, CA 92843, inclusive of inside the facility and up to and including the perimeter of the property line.
Member	An enrollee-beneficiary of a CalOptima program.
Threat	A statement (verbal, written, or physical) which is intended to intimidate by expressing the intent to either harass, hurt, take the life of another person, or damage/destroy property. This includes threats made in jest or as a joke, but which others could perceive as serious.
Unusual Occurrence	Any event which jeopardizes or has the potential to jeopardize the health and/or safety of CalOptima employees, members, and/or the community, including, but not limited to, physical injury and death, and/or property damage.

Accident/Incident Investigation Report

505 City Parkway West | Orange, CA 92868

SECTION 1 – EMPLOYEE INFORMATION (WHO)

Name	Home Address	DOB

Gender	Job Title	Supervisor Name

Job Location Address	Date of Report
	Click here to enter a date.

SECTION 2 – ACCIDENT/ INCIDENT INFORMATION (WHEN, WHERE, WHAT)

1. **When did the accident/incident occur? (Date & Time)**

2. **Where did the accident/incident happen? (*Example: in front of the sink in the 6th floor break room*)**

3. **What were you doing when the accident occurred? (Example: *lifting boxes from the floor to my desk*)**

4. **Accident / incident Witness(s)?** ☐ **Yes** ☐ **No**

a) **If yes, witness(s) name**

(***Attach a witness(s) statement if applicable***)

SECTION 3 – ACCIDENT / INCIDENT ROOT CAUSE (WHY, HOW)

1. **Describe exactly how the accident / injury / incident occurred**

2. **Describe the injury sustained (be *specific about body part(s) affected*)**

3. **Why did this accident / incident happen *(consider environment, conditions, training, lack of training)***

4. How could this accident / incident have been prevented?

SECTION 4 – CORRECTIVE ACTION AND DISPOSITION

1. Disposition:

a) First aid? ☐ Yes ☐ No

b) If first aid, describe

c) Sent to: ☐Clinic ☐Emergency room / hospital ☐ Pre-designated doctor

d) Returned to work? ☐Yes ☐No

e) Returned to work modified duty ☐

Emergency room / hospital address

2. Corrective action taken, if any, including date completed or date of anticipated completion *(e.g., repairs to equipment, ergonomic assessment with reasonable accommodation resolution, employee training, etc.)*

3. Does an unsafe condition continue to exist? ☐Yes ☐No

If yes, please describe

4. Employee recommendations / suggestions

5. Supervisor comments / recommendations

Name / Title of person completing report (print)	**Please print report and sign *in blue ink***

Accident/Incident Investigation Report

505 City Parkway West | Orange, CA 92868

SECTION 1 – MEMBER INFORMATION (WHO)

Name	Home Address	DOB

Gender	Job Title	Supervisor Name

Job Location Address	Date of Report
	Click here to enter a date.

SECTION 2 – ACCIDENT/ INCIDENT INFORMATION (WHEN, WHERE, WHAT)

1. **When did the accident/incident occur? (Date & Time)**

2. **Where did the accident/incident happen? (*Example: in front of the sink in the 6th floor break room*)**

3. **What were you doing when the accident occurred? (Example: *lifting boxes from the floor to my desk*)**

4. **Accident / incident Witness(s)?** ☐ **Yes** ☐ **No**

a) If yes, witness(s) name

(*Attach a witness(s) statement if applicable*)

SECTION 3 – ACCIDENT / INCIDENT ROOT CAUSE (WHY, HOW)

1. **Describe exactly how the accident / injury / incident occurred**

2. **Describe the injury sustained (be *specific about body part(s) affected*)**

3. **Why did this accident / incident happen *(consider environment, conditions, training, lack of training)***

4. **How could this accident / incident have been prevented?**

SECTION 4 – CORRECTIVE ACTION AND DISPOSITION

1. **Disposition:**

a) **First aid?** ☐ **Yes** ☐ **No**

b) **If first aid, describe**

c) **Sent to:** ☐**Clinic** ☐**Emergency room / hospital** ☐ **Pre-designated doctor**

d) **Returned to work?** ☐**Yes** ☐**No**

e) **Returned to work modified duty** ☐

Emergency room / hospital address

2. **Corrective action taken, if any, including date completed or date of anticipated completion** ***(e.g., repairs to equipment, ergonomic assessment with reasonable accommodation resolution, employee training, etc.)***

3. **Does an unsafe condition continue to exist?** ☐**Yes** ☐**No**

If yes, please describe

4. **Employee recommendations / suggestions**

5. **Supervisor comments / recommendations**

Name / Title of person completing report (print)	**Please print report and sign *in blue ink***

Policy #:	GA.8027
Title:	**Unlawful Harassment**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	01/05/12
Last Review Date:	11/03/16
Last Revised Date:	11/03/16

~~*Board Required Approved Policy*~~

I. PURPOSE

This policy~~o~~ outlines CalOptima's zero tolerance for harassment, ~~and~~ discrimination, and retaliation (collectively referred herein as "unlawful harassment.)"

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Abusive Conduct~~	~~Conduct of an employer or employee in the workplace, with malice, that a reasonable person would find hostile, offensive, and unrelated to an employer's legitimate business interests.~~
~~Discrimination:~~	~~Unfair treatment of a person or group on the basis of a protected class.~~
~~Harassment:~~	~~Behavior toward a person that a reasonable person would find unwelcome based on someone's protected characteristics.~~
~~Retaliation:~~	~~Adverse employment action against an employee because he or she filed a complaint or engaged in a protected activity.~~

~~III.~~II. POLICY

A. CalOptima is committed to providing a work environment that is free of harassment, ~~and~~ discrimination, and retaliation. Harassment and/or discrimination based on race, ~~sex~~~~s~~Sex, ~~s~~Sex ~~s~~Stereotype, gender, ~~gender~~ Gender ~~identity~~Identity, ~~gender~~ Gender ~~expression~~Expression, ~~transgender,~~ age, color, national origin, ancestry, mental or physical disability, sexual orientation, religion, religious creed, exercise of rights under Family and Medical Leave Act (FMLA), marital status, military and veteran status, medical condition, genetic information, or any other protected characteristic is a violation of state and federal law and is strictly prohibited by CalOptima. Any person who commits such a violation may be subject to personal liability as well as disciplinary action up to and including termination of employment.

B. This policy applies to all of CalOptima's agents, ~~and~~ persons providing services pursuant to a contract, volunteers, unpaid interns, temporary employees, and employees, including supervisors and non-supervisory employees, and to non-employees who engage in unlawful harassment in the workplace.

C. Prohibited harassment includes verbal, physical, and/or visually perceived conduct in any form that is based on a protected characteristic and which creates an intimidating, offensive, or hostile work

environment (must be severe or pervasive) or that interferes with work performance. Such conduct constitutes harassment when:

1. Submission to the conduct is made either an explicit or implicit condition of employment;

2. Submission to or rejection of the conduct is used as the basis for an employment decision; or

3. The harassment unreasonably interferes with an employee's work performance or creates an intimidating, hostile, or offensive work environment.

D. Prohibited unlawful harassment includes, but is not limited to, the following behaviors:

1. Verbal conduct such as epithets, stereotypes based on protected class, derogatory or sexual jokes or comments, slurs or unwanted sexual advances, invitations, or comments;

2. Visual displays, such as derogatory and/or sexually-oriented posters, photography, cartoons, drawings, or gestures;

3. Physical conduct including assault, unwanted touching, intentionally blocking normal movement, or interfering with work because of sex, race, or any other protected basis; and/or

4. Threats and demands to submit to sexual requests as a condition of continued employment, or to avoid some other loss and offers of employment benefits in return for sexual favors.

E. CalOptima encourages reporting of all perceived or actual incidents of discrimination or harassment. An employee, temporary employee, volunteer, or unpaid intern who believes he or she is being, or has been, harassed in any way, should report the facts of the incident or incidents immediately to his or her supervisor, manager, or, if he or she prefers, to the Human Resources (HR) Department. Supervisors and managers must report the incidents, or claims, immediately to the HR Department. A HR representative, or its designee, shall investigate any and all complaints of unlawful harassment based on a protected class and take appropriate preventive and/or corrective action, including disciplinary action, when it is warranted. ~~Every r~~Reported complaints of unlawful harassment based on protected class will be investigated fairly, thoroughly, promptly, and in a confidential manner to the extent possible, involving only the parties who have a need to know. If a complaint is not resolved to the employee's satisfaction, the employee or complainant may submit a request for re~~i~~v~~f~~iew of the complaint via email to CalOptima's Executive Director of Human Resources.

F. CalOptima will not tolerate retaliation against an employee, temporary employee, volunteer, unpaid intern, or persons providing services pursuant to a contract for reporting harassment and/or discrimination, for cooperating in an investigation, for making compliance complaints, or for engaging in similar protected activity ~~making any other complaint to the HR Department~~. Employees, temporary employees, volunteers, unpaid interns, or persons providing services pursuant to a contract engaging in any actions which are retaliatory against another employee, temporary employee, volunteer, unpaid intern, or persons providing services pursuant to a contract will be subjected to disciplinary action, up to and including termination of employment or contract.

G. CalOptima encourages all employees, temporary employees, volunteers, and unpaid interns to report any incidents of harassment prohibited by this policy immediately so that complaints can be

quickly and fairly resolved. Employees, temporary employees, volunteers, and unpaid interns should be aware that the Federal Equal Employment Opportunity Commission and the California Department of Fair Employment and Housing investigate and prosecute complaints of prohibited harassment in employment. If an ~~employee~~ individual believes that CalOptima has failed to adequately address a complaint of harassment, ~~an employee~~that person may file a complaint with one of these agencies.

~~IV.~~III. PROCEDURE

Responsible Party	Action
Employee	Report the facts of any incident(s) of harassment or discrimination based on a protected class or retaliation based on a protected activity immediately to your supervisor, manager, or, if you prefer, the HR Department.
Supervisor	Gather all relevant facts from reporting employee and report it immediately to the HR Department.
Human Resources	▪ Disseminate the Unlawful Harassment Policy to all employees, temporary employees, volunteers and unpaid interns and require all employees, temporary employees, volunteers, and unpaid interns to~~collect a signed~~ acknowledge~~ment form~~ electronically ~~from~~ that each individual ~~verifying that the individual~~ has received and understood the Policy. ▪ Upon receipt of a complaint, gather sufficient facts to evaluate and determine what level of investigation is needed and appropriate for the circumstances. ▪ If a determination is made that no further investigation is required, document the decision and the reasoning and inform the complainant of the decision. ▪ Complete an impartial and timely ~~I~~investigat~~e~~ion of the complaint~~s~~, document and track the investigation, ~~and~~ take appropriate preventive and/or corrective action, including disciplinary action, when it is warranted, and inform the complainant and/or offender of the decision. Every reported complaint of unlawful harassment based on a protected class will be investigated thoroughly, promptly, and in a confidential manner to the extent possible. HR will strive to maintain confidentiality during the investigation, but there is no guarantee of complete confidentiality. Only the parties who need to know will be involved.

~~V.~~IV. ATTACHMENTS

~~N/A~~ Not Applicable

~~VI.~~V. REFERENCES

~~2015 California Labor Law Digest~~

~~A. Assembly Bill 2053 an act to amend Section 12950.1 of the Government Code, relating to employment~~

A. California Government Code, ~~sections~~ §§12926, 12935 and 12940 *et seq.*

B. CalOptima Employee Handbook
~~—~~Title 2, California Code of Regulations (C.C.R.), ~~sections~~ §11008 *et seq.*
C. ~~CalOptima Employee Handbook~~
D. Title VII of the Civil Rights Act of 1964 (42, U.S.C., 2000e *et seq*.)

VI. REGULATORY AGENCY APPROVALS ~~OR~~

~~Not Applicable~~None to Date

VII. BOARD ACTIONS

A. 11/03/16: Regular Meeting of the CalOptima Board of Directors
B. 05/01/14: ~~———~~ Regular Meeting of the CalOptima Board of Directors~~Regular CalOptima Board of Directors Meeting~~
C. 01/05/12: ~~———~~ Regular Meeting of the CalOptima Board of Directors~~Regular CalOptima Board of Directors Meeting~~

VIII. REVIEW/REVISION HISTORY

Version	~~Version~~ Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	01/05/2012	GA.8027	Unlawful Harassment	Administrative
Revis~~ion Date 1~~ed	04/01/2014	GA.8027	Unlawful Harassment	Administrative
Revis~~ion Date 2~~ed	11/03/2016	GA.8027	Unlawful Harassment	Administrative

~~IX. KEYWORDS~~

~~Discrimination~~
~~Unlawful harassment~~
~~Compliance~~
~~Retaliation~~
~~———~~

IX. GLOSSARY

Term	Definition
Discrimination	Adverse employment action against an employee, volunteer, intern, or individual performing services pursuant to a contract on the basis of a protected class.
Harassment	Unwelcome conduct or comments, based on a protected class, that are so severe or pervasive as to create an abusive working environment. .
Retaliation	Adverse employment action against an employee because he or she filed a complaint or engaged in a protected activity.
Gender Expression	A person's gender-related appearance or behavior, whether or not stereotypically associated with the person's sex at birth.
Gender Identity	A person's identification as male, female, a gender different from the person's sex at birth, or transgender.
Sex	Includes the same definition as provided in Government Code section 12926 and Title 42 of the United States Code section 2000 e(k), which includes, but is not limited to, pregnancy, childbirth; breastfeeding, medical conditions related to pregnancy, childbirth, or breastfeeding, gender identity, and gender expression.
Sex Stereotype	An assumption about a person's appearance or behavior, or about an individual's ability or inability to perform certain kinds of work based on a myth, social expectation, or generalization about the individual's sex.
Transgender	A general term that refers to a person whose gender identity differs from the person's sex at birth. A transgender person may or may not have a gender expression that is different from the social expectations of the sex assigned at birth. A transgender person may or may not identify as “transsexual.”

Policy #:	GA.8027
Title:	**Unlawful Harassment**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	01/05/12
Last Review Date:	11/03/16
Last Revised Date:	11/03/16

I. PURPOSE

This policy outlines CalOptima's zero tolerance for harassment, discrimination, and retaliation (collectively referred herein as "unlawful harassment.)"

II. POLICY

A. CalOptima is committed to providing a work environment that is free of harassment, discrimination, and retaliation. Harassment and/or discrimination based on race, sex, Sex Stereotype, gender, Gender Identity, Gender Expression, age, color, national origin, ancestry, mental or physical disability, sexual orientation, religion, religious creed, exercise of rights under Family and Medical Leave Act (FMLA), marital status, military and veteran status, medical condition, genetic information, or any other protected characteristic is a violation of state and federal law and is strictly prohibited by CalOptima. Any person who commits such a violation may be subject to personal liability as well as disciplinary action up to and including termination of employment.

B. This policy applies to all of CalOptima's agents, persons providing services pursuant to a contract, volunteers, unpaid interns, temporary employees, and employees, including supervisors and non-supervisory employees, and to non-employees who engage in unlawful harassment in the workplace.

C. Prohibited harassment includes verbal, physical, and/or visually perceived conduct in any form that is based on a protected characteristic and which creates an intimidating, offensive, or hostile work environment (must be severe or pervasive) or that interferes with work performance. Such conduct constitutes harassment when:

1. Submission to the conduct is made either an explicit or implicit condition of employment;

2. Submission to or rejection of the conduct is used as the basis for an employment decision; or

3. The harassment unreasonably interferes with an employee's work performance or creates an intimidating, hostile, or offensive work environment.

D. Prohibited unlawful harassment includes, but is not limited to, the following behaviors:

1. Verbal conduct such as epithets, stereotypes based on protected class, derogatory or sexual jokes or comments, slurs or unwanted sexual advances, invitations, or comments;

2. Visual displays, such as derogatory and/or sexually-oriented posters, photography, cartoons, drawings, or gestures;

3. Physical conduct including assault, unwanted touching, intentionally blocking normal movement, or interfering with work because of sex, race, or any other protected basis; and/or

4. Threats and demands to submit to sexual requests as a condition of continued employment, or to avoid some other loss and offers of employment benefits in return for sexual favors.

E. CalOptima encourages reporting of all perceived or actual incidents of discrimination or harassment. An employee, temporary employee, volunteer, or unpaid intern who believes he or she is being, or has been, harassed in any way, should report the facts of the incident or incidents immediately to his or her supervisor, manager, or, if he or she prefers, to the Human Resources (HR) Department. Supervisors and managers must report the incidents, or claims, immediately to the HR Department. A HR representative, or its designee, shall investigate any and all complaints of unlawful harassment based on a protected class and take appropriate preventive and/or corrective action, including disciplinary action, when it is warranted. Reported complaints of unlawful harassment based on protected class will be investigated fairly, thoroughly, promptly, and in a confidential manner to the extent possible, involving only the parties who have a need to know. If a complaint is not resolved to the employee's satisfaction, the employee or complainant may submit a request for review of the complaint via email to CalOptima's Executive Director of Human Resources.

F. CalOptima will not tolerate retaliation against an employee, temporary employee, volunteer, unpaid intern, or persons providing services pursuant to a contract for reporting harassment and/or discrimination, for cooperating in an investigation, for making compliance complaints, or for engaging in similar protected activity . Employees, temporary employees, volunteers, unpaid interns, or persons providing services pursuant to a contract engaging in any actions which are retaliatory against another employee, temporary employee, volunteer, unpaid intern, or persons providing services pursuant to a contract will be subjected to disciplinary action, up to and including termination of employment or contract.

G. CalOptima encourages all employees, temporary employees, volunteers, and unpaid interns to report any incidents of harassment prohibited by this policy immediately so that complaints can be quickly and fairly resolved. Employees, temporary employees, volunteers, and unpaid interns should be aware that the Federal Equal Employment Opportunity Commission and the California Department of Fair Employment and Housing investigate and prosecute complaints of prohibited harassment in employment. If an individual believes that CalOptima has failed to adequately address a complaint of harassment, that person may file a complaint with one of these agencies.

III. PROCEDURE

Responsible Party	Action
Employee	Report the facts of any incident(s) of harassment or discrimination based on a protected class or retaliation based on a protected activity immediately to your supervisor, manager, or, if you prefer, the HR Department.
Supervisor	Gather all relevant facts from reporting employee and report it immediately to the HR Department.

Responsible Party	Action
Human Resources	▪ Disseminate the Unlawful Harassment Policy to all employees, temporary employees, volunteers and unpaid interns and require all employees, temporary employees, volunteers, and unpaid interns to acknowledge electronically that each individual has received and understood the Policy. ▪ Upon receipt of a complaint, gather sufficient facts to evaluate and determine what level of investigation is needed and appropriate for the circumstances. ▪ If a determination is made that no further investigation is required, document the decision and the reasoning and inform the complainant of the decision. ▪ Complete an impartial and timely investigation of the complaint, document and track the investigation, take appropriate preventive and/or corrective action, including disciplinary action, when it is warranted, and inform the complainant and/or offender of the decision. Every reported complaint of unlawful harassment based on a protected class will be investigated thoroughly, promptly, and in a confidential manner to the extent possible. HR will strive to maintain confidentiality during the investigation, but there is no guarantee of complete confidentiality. Only the parties who need to know will be involved.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. California Government Code, §§12926, 12935 and 12940 *et seq.*
B. CalOptima Employee Handbook
C. Title 2, California Code of Regulations (C.C.R.), §11008 *et seq.*
D. Title VII of the Civil Rights Act of 1964 (42, U.S.C., 2000e *et seq*.)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/03/16: Regular Meeting of the CalOptima Board of Directors
B. 05/01/14: Regular Meeting of the CalOptima Board of Directors
C. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8027	Unlawful Harassment	Administrative
Revised	04/01/2014	GA.8027	Unlawful Harassment	Administrative
Revised	11/03/2016	GA.8027	Unlawful Harassment	Administrative

IX. GLOSSARY

Term	Definition
Discrimination	Adverse employment action against an employee, volunteer, intern, or individual performing services pursuant to a contract on the basis of a protected class.
Harassment	Unwelcome conduct or comments, based on a protected class, that are so severe or pervasive as to create an abusive working environment. .
Retaliation	Adverse employment action against an employee because he or she filed a complaint or engaged in a protected activity.
Gender Expression	A person's gender-related appearance or behavior, whether or not stereotypically associated with the person's sex at birth.
Gender Identity	A person's identification as male, female, a gender different from the person's sex at birth, or transgender.
Sex	Includes the same definition as provided in Government Code section 12926 and Title 42 of the United States Code section 2000 e(k), which includes, but is not limited to, pregnancy, childbirth; breastfeeding, medical conditions related to pregnancy, childbirth, or breastfeeding, gender identity, and gender expression.
Sex Stereotype	An assumption about a person's appearance or behavior, or about an individual's ability or inability to perform certain kinds of work based on a myth, social expectation, or generalization about the individual's sex.
Transgender	A general term that refers to a person whose gender identity differs from the person's sex at birth. A transgender person may or may not have a gender expression that is different from the social expectations of the sex assigned at birth. A transgender person may or may not identify as “transsexual.”

Policy #: GA.8032
Title: **Employee Dress Code**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/05/12
Last Review Date: ~~2/1/14~~11/03/16
Last Revised Date: ~~2/1/14~~11/03/16

I. PURPOSE

This policy~~e~~ sets forth the guidelines CalOptima employees shall follow to maintain appropriate attire at the workplace.

~~II. DEFINITIONS~~

~~Business Casual Attire: Business Casual Attire includes suits, dress pants, dress shirts, dress shoes, dress sandals, sweaters, dresses, and skirts. Ties may be worn but are not required. All clothing should be clean, pressed, and in good repair. The height of heels should be suitable to the individual to prevent safety hazards. In all cases, management within each respective department will define "appropriate" Business Casual Attire.~~

~~Business Casual Attire does not include:~~

- ~~Jeans (or any type of denim or any color jeans)~~
- ~~Spaghetti strap shirts~~
- ~~See-through clothing~~
- ~~Short skirts~~
- ~~Any type of shorts (at or above the knee)~~
- ~~Casual sandals (such as flip-flops or beach attire)~~
- ~~Tennis shoes~~
- ~~Capri pants (unless part of a professional dress suit or two piece business outfit)~~
- ~~Clothing displaying any written words or symbols, with the exception of CalOptima logo attire or brand names or symbols~~
- ~~Clothing that reveals undergarments or parts of the body incompatible with a professional setting~~
  ~~Hats, unless prior approval from Human Resources is given~~

~~CalOptima Logo Attire: CalOptima Logo Attire includes dress shirts, polo shirts, or other shirts purchased through the Human Resources Department with CalOptima's logo displayed. Logo attire from any CalOptima program is allowed. These shirts must be partnered with dress pants or khaki pants in good condition. Logo attire is allowed Monday through Friday. CalOptima logo attire may not be worn with jeans, shorts or capri pants from Monday through Thursday.~~

~~Casual Attire: Casual Attire is a benefit permitted only on Fridays, unless otherwise specified. As with Business Casual Attire, Casual Attire should be neat in appearance and in good repair, with no tears or holes. Casual attire includes jeans, capri pants (loose and below the knee), casual sandals (no flip-flops), tennis shoes or other casual clothing in good condition. Leggings or lycra slacks are acceptable only when worn with a dress or long shirt that falls at least below the mid-thigh level. In all cases, management within each respective department will define "appropriate" casual attire.~~

~~Casual Attire does not include:~~

- ~~Jeans (or any type of denim or any color jeans)~~
- ~~Spaghetti strap shirts~~
- ~~See-through clothing~~
- ~~Short skirts~~
- ~~Any type of shorts (at or above the knee)~~
- ~~Casual sandals (such as flip-flops or beach attire)~~
- ~~Tennis shoes~~
- ~~Capri pants (unless part of a professional dress suit or two piece business outfit)~~
- ~~Clothing displaying any written words or symbols, with the exception of CalOptima logo attire or brand names or symbols~~
- ~~Clothing that reveals undergarments or parts of the body incompatible with a professional setting~~
  ~~Hats, unless prior approval from Human Resources is given~~

~~III.~~II. POLICY

A. CalOptima herein adopts a Business Casual Attire Dress Policy as the standard attire from Monday through Thursday. Employees must choose Business Casual Attire that communicates professionalism.

B. There may be time that Management may require employees to dress in customary Business Professional Attire, including, but not limited to, when presenting to the Board of Directors, meeting with members of the business community, or representing the company outside community function.

C. All employees are required to sign the Dress Code Acknowledgement Form upon hire.

D. As a benefit, employees may dress in Casual Attire every Friday and every year during the following times, unless otherwise specified:

1. The week of Thanksgiving;

2. The period between Christmas and New Year's Day;

3. The period between Memorial Day and Labor Day; and

4. National Customer Service Week (First week of October).

E. Management within each department shall have the discretion to determine appropriate attire and grooming requirements for employees and independent contractors based upon job duties.

~~IV.~~III. PROCEDURE

Responsible Party	Action
Employee	1. Sign the Dress Code Acknowledgment Form upon hire. 2. Adhere to the requirements in this policy.
Manager	1. Interpret and enforce dress and grooming standards in their area of responsibility. 2. If employee attire is inappropriate, the manager will address employee immediately.
Human Resources	1. Provide employees the Dress Code Policy and Agreement in the new hire packet. 2. File the Agreement in the employee's personnel file.

~~V.~~IV. ATTACHMENTS

A. Dress Code Acknowledgement Form

~~VI.~~V. REFERENCES

A. CalOptima Employee Handbook
~~B.~~ CalOptima Policy GA.8000: Glossary of Terms
~~C.~~B. ~~CalOptima Employee Handbook~~

VI. REGULATORY AGENCY APPROVALS ~~OR~~

None to Date

VII. BOARD ACTIONS

A. 11/03/16: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 05/01/14: Regular Meeting of the CalOptima Board of Directors~~Regular CalOptima Board Meeting~~
~~B.~~C. 01/05/12: Regular Meeting of the CalOptima Board of Directors~~Regular CalOptima Board Meeting~~

VIII. REVIEW/REVISION HISTORY
~~VIII.~~

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8032	Employee Dress Code	Administrative
Revised	02/01/2014	GA.8032	Employee Dress Code	Administrative

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	11/03/2016	GA.8032	Employee Dress Code	Administrative

~~A. 2/1/14: GA.8032: Employee Dress Code~~
~~B. 1/5/12: GA.8032: Employee Dress Code~~

IX. GLOSSARY

Term	Definition
Business Casual Attire	Business Casual Attire includes suits, dress pants, dress shirts, dress shoes, dress sandals, sweaters, dresses, and skirts. Ties may be worn but are not required. All clothing should be clean, pressed, and in good repair. The height of heels should be suitable to the individual to prevent safety hazards. In all cases, management within each respective department will define "appropriate" Business Casual Attire. Business Casual Attire does not include: ▪ Jeans (or any type of denim or any color jeans) ▪ Spaghetti strap shirts ▪ See-through clothing ▪ Short skirts ▪ Any type of shorts (at or above the knee) ▪ Casual sandals (such as flip flops or beach attire) ▪ Tennis shoes ▪ Capri pants (unless part of a professional dress suit or two piece business outfit) ▪ Clothing displaying any written words or symbols, with the exception of CalOptima logo attire or brand names or symbols ▪ Clothing that reveals undergarments or parts of the body incompatible with a professional setting ▪ Hats, unless prior approval from Human Resources is given
CalOptima Logo Attire	CalOptima Logo Attire includes dress shirts, polo shirts, or other shirts purchased through the Human Resources Department with CalOptima's logo displayed. Logo attire from any CalOptima program is allowed. These shirts must be partnered with dress pants or khaki pants in good condition. Logo attire is allowed Monday through Friday. CalOptima logo attire may not be worn with jeans, shorts or capri pants from Monday through Thursday.

Term	Definition
Casual Attire	Casual Attire is a benefit permitted only on Fridays, unless otherwise specified. As with Business Casual Attire, Casual Attire should be neat in appearance and in good repair, with no tears or holes. Casual attire includes jeans, capri pants (loose and below the knee), casual sandals (no flip flops), tennis shoes or other casual clothing in good condition. Leggings or lycra slacks are acceptable only when worn with a dress or long shirt that falls at least below the mid-thigh level. In all cases, management within each respective department will define "appropriate" casual attire. Casual Attire does not include: ▪ ~~Jeans (or any type of denim or any color jeans)~~ ▪ Any type of jogging or sweat suits/sweatpants ▪ Halter tops ▪ Spaghetti strap shirts ▪ See-through clothing ▪ ~~Short skirts~~ ▪ Ripped jeans ▪ ~~Any type of~~ Shorts (at or above the knee) ▪ ~~Casual sandals (such as flip flops or beach attire)~~ ▪ ~~Tennis shoes~~ ▪ ~~Capri pants (unless part of a professional dress suit or two piece business outfit)~~ ▪ Clothing that ~~reveals~~ exposes ~~undergarments~~ the stomach area or other parts of the body incompatible with a professional ~~setting~~ environment ▪ Clothing displaying any written words or symbols, with the exception of CalOptima logo attire, ~~or~~ brand names or symbols, sports teams, or university/school/club names or logos ▪ Hats, unless prior approval from Human Resources is given

1

Policy #: GA.8032
Title: **Employee Dress Code**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/05/12
Last Review Date: 11/03/16
Last Revised Date: 11/03/16

I. PURPOSE

This policy sets forth the guidelines CalOptima employees shall follow to maintain appropriate attire at the workplace.

II. POLICY

A. CalOptima herein adopts a Business Casual Attire Dress Policy as the standard attire from Monday through Thursday. Employees must choose Business Casual Attire that communicates professionalism.

B. There may be time that Management may require employees to dress in customary Business Professional Attire, including, but not limited to, when presenting to the Board of Directors, meeting with members of the business community, or representing the company outside community function.

C. All employees are required to sign the Dress Code Acknowledgement Form upon hire.

D. As a benefit, employees may dress in Casual Attire every Friday and every year during the following times, unless otherwise specified:

1. The week of Thanksgiving;
2. The period between Christmas and New Year's Day;
3. The period between Memorial Day and Labor Day; and
4. National Customer Service Week (First week of October).

E. Management within each department shall have the discretion to determine appropriate attire and grooming requirements for employees and independent contractors based upon job duties.

III. PROCEDURE

Responsible Party	Action

Responsible Party	Action
Employee	1. Sign the Dress Code Acknowledgment Form upon hire. 2. Adhere to the requirements in this policy.
Manager	1. Interpret and enforce dress and grooming standards in their area of responsibility. 2. If employee attire is inappropriate, the manager will address employee immediately.
Human Resources	1. Provide employees the Dress Code Policy and Agreement in the new hire packet. 2. File the Agreement in the employee's personnel file.

IV. ATTACHMENTS

A. Dress Code Acknowledgement Form

V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8000: Glossary of Terms

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/03/16: Regular Meeting of the CalOptima Board of Directors
B. 05/01/14: Regular Meeting of the CalOptima Board of Directors
C. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8032	Employee Dress Code	Administrative
Revised	02/01/2014	GA.8032	Employee Dress Code	Administrative
Revised	11/03/2016	GA.8032	Employee Dress Code	Administrative

IX. GLOSSARY

Term	Definition
Business Casual Attire	Business Casual Attire includes suits, dress pants, dress shirts, dress shoes, dress sandals, sweaters, dresses, and skirts. Ties may be worn but are not required. All clothing should be clean, pressed, and in good repair. The height of heels should be suitable to the individual to prevent safety hazards. In all cases, management within each respective department will define "appropriate" Business Casual Attire. Business Casual Attire does not include: ▪ Jeans (or any type of denim or any color jeans) ▪ Spaghetti strap shirts ▪ See-through clothing ▪ Short skirts ▪ Any type of shorts (at or above the knee) ▪ Casual sandals (such as flip flops or beach attire) ▪ Tennis shoes ▪ Capri pants (unless part of a professional dress suit or two piece business outfit) ▪ Clothing displaying any written words or symbols, with the exception of CalOptima logo attire or brand names or symbols ▪ Clothing that reveals undergarments or parts of the body incompatible with a professional setting ▪ Hats, unless prior approval from Human Resources is given
CalOptima Logo Attire	CalOptima Logo Attire includes dress shirts, polo shirts, or other shirts purchased through the Human Resources Department with CalOptima's logo displayed. Logo attire from any CalOptima program is allowed. These shirts must be partnered with dress pants or khaki pants in good condition. Logo attire is allowed Monday through Friday. CalOptima logo attire may not be worn with jeans, shorts or capri pants from Monday through Thursday.

Term	Definition
Casual Attire	Casual Attire is a benefit permitted only on Fridays, unless otherwise specified. As with Business Casual Attire, Casual Attire should be neat in appearance and in good repair, with no tears or holes. Casual attire includes jeans, capri pants (loose and below the knee), casual sandals (no flip flops), tennis shoes or other casual clothing in good condition. Leggings or lycra slacks are acceptable only when worn with a dress or long shirt that falls at least below the mid-thigh level. In all cases, management within each respective department will define "appropriate" casual attire. Casual Attire does not include: ▪ Any type of jogging or sweat suits/sweatpants ▪ Halter tops ▪ Spaghetti strap shirts ▪ See-through clothing ▪ Ripped jeans ▪ Shorts (at or above the knee) ▪ Clothing that exposes the stomach area or other parts of the body incompatible with a professional environment ▪ Clothing displaying any written words or symbols, with the exception of CalOptima logo attire, brand names or symbols, sports teams, or university/school/club names or logos ▪ Hats, unless prior approval from Human Resources is given

1

CalOptima has adopted a Business Casual Attire Dress Policy as the standard attire Monday through Thursday. Employees must choose Business Casual Attire that communicates professionalism. There may be times that Management may require employees to dress in customary Business Professional Attire, including, but not limited to, when presenting to the Board of Directors, meeting with members of the business community or representing the company at an outside community function.

The purpose of this memorandum is to obtain acknowledgement from the employee that they received the Employee Dress Code Policy and agree to abide by and cooperate with the requirements and expectations.

Business Casual Attire:

Business casual attire includes suits, dress pants, dress shirts, dress shoes, dress sandals, sweaters, dresses and skirts. Ties may be worn but are not required. All clothing should be clean, pressed, and in good repair. The height of heels should be suitable to the individual to prevent safety hazards. In all cases, management within each respective department will define "appropriate" Business Casual Attire. Business Casual Attire does not include: jeans (or any type of denim or any color jeans), spaghetti strap shirts, see-through clothing, low-cut blouses, short skirts, any type of shorts (at or above the knee), casual sandals (such as flip flops or beach attire), tennis shoes, Uggs, Capri pants (unless part of a professional dress suit or two piece business outfit), clothing displaying any written words or symbols, with the exception of CalOptima logo attire or brand names or symbols, clothing that reveals undergarments or parts of the body incompatible with a professional setting, and hats (unless prior approval from Human Resources is given). Leggings or Lycra form-fitting pants are not allowed. In addition, we ask that you not wear any distracting, offensive, low cut and revealing clothes.

CalOptima Logo Attire:

CalOptima Logo Attire includes dress shirts, polo shirts, or other shirts purchased through the Employee Activities Committee with CalOptima's logo displayed. Logo attire from any CalOptima program is allowed. These shirts must be partnered with dress pants or khaki pants in good condition. Logo attire is allowed Monday through Friday. CalOptima Logo Attire may not be worn with jeans, shorts or capri pants from Monday through Thursday.

Casual Attire:

Casual Attire is a benefit permitted only on Fridays, unless otherwise specified. As with Business Casual Attire, Casual Attire should be neat in appearance and in good repair, with no tears or holes. Casual Attire includes jeans, Capri pants (loose and below the knee), casual sandals (no flip flops), tennis shoes or other casual clothing in good condition. Leggings or Lycra slacks are acceptable only when worn with a dress or long shirt that falls at least below the mid-thigh level. In all cases, management within each respective department will define

"appropriate" casual attire. Casual Attire does not include: any type of jogging or sweat suits/sweatpants, halter tops, spaghetti strap shirts, see-through clothing, ripped jeans, shorts (at or above the knee), clothing that exposes the stomach area or other parts of the body incompatible with a professional environment, clothing displaying any written words or symbols, with the exception of CalOptima logo attire, brand names or symbols, sports teams, or university/school/club names or logos, and hats (unless prior approval from Human Resources is given.

As a benefit, employees may dress in Casual Attire every Friday and every year during the following times, unless otherwise specified: the week of Thanksgiving, the period between Christmas and New Year's Day, the period between Memorial Day and Labor Day, and National Customer Service Week (first week of October).

Managers are responsible for interpreting and enforcing dress and grooming standards in their area of responsibility and within the guidelines of CalOptima's Employee Dress Code Policy. Any employee whose appearance does not meet these standards will be counseled by his/her manager. If the appearance is unduly distracting, unsafe, or inappropriate, the employee may be sent home to correct the problem. Repeated disregard for this dress policy may result in disciplinary action up to and including termination.

CalOptima Dress Code Outline

Business Casual Attire (Monday – Thursday)	Casual Attire (Friday, other exceptions)	Unacceptable Attire (never appropriate)
☑ Suits ☑ Dress pants ☑ Dress shirts ☑ Dress sandals ☑ Sweaters ☑ Dresses and skirts ☑ Ties (may be worn but are not required) ☑ CalOptima logo shirts paired with dress khaki pants ☑ Capri pants (only when worn as part of a professional dress suit or two-piece business outfit)	☑ Jeans ☑ Capri pants (loose and below the knee) ☑ Casual sandals (no flip-flops) ☑ Tennis shoes ☑ Leggings or Lycra form-fitting pants (acceptable only when worn with a dress or long shirt that falls at least below mid-thigh) ☑ Other casual clothing in good condition	☒ Any type of jogging or sweat suits/ sweatpants ☒ Halter tops ☒ Flip-Flops ☒ Spaghetti strap shirts ☒ Clothing that reveals undergarments or parts of the body incompatible with a professional setting ☒ Ugg-type shoes or boots ☒ Any type of shorts (at or above the knee) ☒ short skirts ☒ clothing with writing or symbols that contain profanity, or that advocate or are associated with violence against any persons ☒ Hats (unless employee obtains prior approval from HR)

Acknowledgement:

I acknowledge that I have received a copy of CalOptima's Employee Dress Code Policy, and I agree to abide by and cooperate with the above requirements and expectations.

_____

Employee Signature

_____

Date

Policy #:	GA.8034
Title:	**Service of Summons, Subpoenas, and Other Legal Documents**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	~~Richard Chambers~~Michael Schrader
Effective Date:	01/05/12
Last Review Date:	~~N/A~~11/03/16
Last Revised Date:	~~N/A~~11/03/16

~~*Board Approved Policy*~~

I. PURPOSE

This policy~~o~~ clarifies~~y~~ CalOptima's responsibility related to receipt of service of legal papers not pertaining to CalOptima business.

~~**DEFINITIONS**~~

~~Not Applicable~~

II. POLICY

A. CalOptima shall not accept, or facilitate, service of legal papers, such as subpoenas, summons, or complaints, except for those which are directed to CalOptima, or its agents, and which relate to the business of CalOptima. Most documents entitled Summons, Subpoena, Court Orders, Notices to Appear, etc., whether for civil, ~~or~~ criminal, or administrative matters, require personal service to the individual. CalOptima has no obligation to accept, or facilitate, such service when the legal papers are related to personal and not CalOptima business matters. Consistent with CalOptima Policy AA.1215: Public Records Requests and Subpoenas, CalOptima should not accept legal documents that are not directly related to CalOptima business, or CalOptima M~~m~~embers.

B. In the event a notice is left at the place of employment (e.g., with the receptionist), it will be forwarded on to the employee. However, this may not constitute proper service and the employee would need to discuss such a matter with his or her own legal counsel.

C. Employees are advised to keep personal matters away from their work location to avoid any interference with the proper conduct of CalOptima's business.

III. PROCEDURE

Responsible Party	Action

Receptionist (Admin Building and PACE)	1. Inform the process server that it is CalOptima's policy not to accept or facilitate service of legal papers at the work site. 2. If a problem arises, contact ~~Human Resources~~the Legal Affairs Department immediately.

IV. ATTACHMENTS

Not Applicable

~~V. DEFINITIONS~~

~~Not Applicable~~

~~VI.~~V. REFERENCES

A. ~~CalOptima Employee Handbook~~CalOptima Policy AA.1215: Public Records Requests and Subpoenas
B. CalOptima Policy AA.1217: Legal Claims and Judicial Review

VI. REGULATORY AGENCY APPROVALS ~~OR~~

None to Date

VII. BOARD ACTIONS

A. 11/03/16: Regular Meeting of the CalOptima Board of Directors
B. 01/05/12: Regular Meeting of the CalOptima Board of Directors~~Meeting~~

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8034	Service of Summons	Administrative
Revised	11/03/2016	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative

~~Not Applicable~~

~~IX. KEYWORDS~~

~~Court order~~
~~Subpoena~~

IX. GLOSSARY

Not Applicable

Policy #: GA.8034
Title: **Service of Summons, Subpoenas, and Other Legal Documents**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader

Effective Date: 01/05/12
Last Review Date: 11/03/16
Last Revised Date: 11/03/16

I. PURPOSE

This policy clarifies CalOptima's responsibility related to receipt of service of legal papers not pertaining to CalOptima business.

II. POLICY

A. CalOptima shall not accept, or facilitate, service of legal papers, such as subpoenas, summons, or complaints, except for those which are directed to CalOptima, or its agents, and which relate to the business of CalOptima. Most documents entitled Summons, Subpoena, Court Orders, Notices to Appear, etc., whether for civil, criminal, or administrative matters, require personal service to the individual. CalOptima has no obligation to accept, or facilitate, such service when the legal papers are related to personal and not CalOptima business matters. Consistent with CalOptima Policy AA.1215: Public Records Requests and Subpoenas, CalOptima should not accept legal documents that are not directly related to CalOptima business, or CalOptima Members.

B. In the event a notice is left at the place of employment (e.g., with the receptionist), it will be forwarded on to the employee. However, this may not constitute proper service and the employee would need to discuss such a matter with his or her own legal counsel.

C. Employees are advised to keep personal matters away from their work location to avoid any interference with the proper conduct of CalOptima's business.

III. PROCEDURE

Responsible Party	Action
Receptionist (Admin Building and PACE)	1. Inform the process server that it is CalOptima's policy not to accept or facilitate service of legal papers at the work site. 2. If a problem arises, contact the Legal Affairs Department immediately.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Policy AA.1215: Public Records Requests and Subpoenas
B. CalOptima Policy AA.1217: Legal Claims and Judicial Review

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/03/16: Regular Meeting of the CalOptima Board of Directors
B. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8034	Service of Summons	Administrative
Revised	11/03/2016	GA.8034	Service of Summons, Subpoenas, and Other Legal Documents	Administrative

IX. GLOSSARY

Not Applicable

Policy #: GA.8055
Title: **Retiree Health Benefit**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader

Effective Date: 05/01/14
Last Review Date: ~~06/02/16~~1
Last Revision Date: 1/03/16
~~06/02/16~~1
1/03/16

~~*Board Approved Policy*~~

I. PURPOSE

~~To~~ This policy provides detailed guidelines on how to administer retiree health benefits for CalOptima's Current Retirees and Eligible Employees who qualify for retiree health benefits under this policy.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Current Retiree~~	~~Former employee of CalOptima who:~~ ~~1. Was hired before January 1, 2004;~~ ~~2. Completed at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS); and~~ ~~3. Was already receiving retiree health benefits from CalOptima on January 1, 2014.~~
~~Eligible Dependent~~	~~The current spouse, registered domestic partner, dependent child up to age 26, and/or certified disabled dependent child over age 26, of a Current Retiree, Retired Eligible Employee, or Reinstated Eligible Retiree, who:~~ ~~1. Meets the definition of a dependent who is eligible for coverage under the employee health plan then maintained by CalOptima for its active employees; and~~ ~~2. Has been timely enrolled for coverage under this retiree health policy by the Eligible Retiree.~~
~~Eligible Employee~~	~~A current active employee of CalOptima meeting the following criteria:~~ ~~1. The most recent date of hire was before January 1, 2004, or whose initial date of hire was before January 1, 2004, and whose most recent rehire date was on or before December 31, 2013;~~

~~Term~~	~~Definition~~
	~~2. Completes at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS).~~
~~Eligible Retiree~~	~~Current Retiree, Retired Eligible Employee, Reinstated Eligible Retiree or Eligible Survivor Dependent.~~
~~Eligible Survivor Dependent~~	~~A Survivor Dependent who timely enrolls for Survivor Dependent health coverage within sixty (60) days of the death of the Eligible Retiree.~~
~~Reinstated Eligible Retiree~~	~~A Current Retiree or Retired Eligible Employee whose CalPERS retirement annuity and benefits under this Policy ended due to a reinstatement from retirement as defined in Government Code §§ 22838 and 21190 et.seq., or successor sections, and who (i) subsequently terminates employment from another state employer who does not provide retiree health benefits with a retiree share premium that is less than or equal to that being charged by CalOptima under this Policy; (ii) once again begins collecting retirement annuity payments from CalPERS within 120 days of such subsequent separation from employment; and (iii) timely enrolls for resumption of coverage under this Policy.~~
~~Retired Eligible Employee~~	~~Eligible Employee who:~~ ~~1. Retires within 120 days of such Eligible Employee's separation from employment with CalOptima and receives a monthly retirement allowance from CalPERS; and~~ ~~2. Timely applies for retiree health benefits in accordance with this policy on and after January 1, 2014.~~
~~Retirement Date~~	~~Date Eligible Employee becomes an annuitant with CalPERS within 120 days of such Eligible Employee's separation from employment with CalOptima.~~
~~Subsequent Retirement Date~~	~~Date Reinstated Eligible Retiree again begins collecting retirement annuity payments from CalPERS within 120 days of separating from employment with the subsequent state employer described in that definition.~~
~~Survivor Dependent~~	~~Eligible Dependent who:~~ ~~1. Survives an Eligible Retiree; and~~ ~~2. Is collecting monthly survivor benefits from CalPERS that is attributable to a deceased Current Retiree, Retired Eligible Employee, or Reinstated Eligible Employee.~~

~~III.~~II. POLICY

A. Retiree health benefits are not available to employees who were initially hired on or after January 1, 2004, or who were originally hired before January 1, 2004, separated from employment and was rehired on or after December 1, 2013.

B. Eligible Retirees and, if elected and paid for by the Eligible Retirees, the Eligible Dependents of Current Retirees, Retired Eligible Employees, or Reinstated Eligible Retirees, will, until the

CalOptima Board of Directors ("Board") decides that CalOptima will no longer continue the program or otherwise modifies it, be eligible to receive retiree health benefits as follows:

1. ***Not Medicare Eligible***: If the Eligible Retiree and/or the Eligible Dependent(s) is/are not yet eligible for Medicare, then the Eligible Retiree and/or the Eligible Dependent(s) will receive the same health insurance coverage as active employees and their dependents subject to the limitations below. The Eligible Retiree's share of premiums for the Eligible Retiree's health insurance coverage will be the same as those paid by active employees for similar coverage. In the event CalOptima is unable to reasonably obtain health insurance coverage for the Eligible Dependent(s) who are not Medicare eligible, CalOptima may provide a stipend to the Eligible Dependent(s) in lieu of health insurance coverage in an amount calculated based on the proportional amount CalOptima pays for the most closely analogous active employee health insurance coverage for active employees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima would have paid for the most closely analogous health insurance coverage for the Eligible Dependent(s). Proof of coverage, along with evidence of payments for health care coverage, must be submitted to CalOptima in order for the stipend to be paid.

~~—~~***Medicare Eligible*****:** If the Eligible Retiree and/or the Eligible Dependent(s) is/are Medicare eligible, then the Eligible Retiree and/or the Eligible Dependent(s) will be required to enroll, at the Eligible Retiree's expense, in Medicare Part A and/or Part B, as a condition of receiving retiree health benefits under this policy. The Eligible Retiree may select one (1) of the Medicare supplemental coverage options offered by CalOptima for the Medicare Eligible Retiree and/or the Eligible Dependent(s). The Eligible Retiree's share of the Medicare supplemental coverage premium will be calculated based on the same proportional amount active employees pay for the most closely analogous active employee health insurance coverage for the active employee and their dependents. In the event CalOptima is unable to reasonably obtain Medicare Supplemental coverage for the Eligible Dependent(s) who are Medicare eligible, CalOptima may provide a stipend to the Eligible Dependent(s) in lieu of Medicare Supplemental coverage in an amount calculated based on the proportional amount CalOptima pays for the most closely analogous Medicare supplemental coverage for Eligible Retirees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima would have paid for the most closely analogous Medicare Supplemental coverage for the Eligible Dependent(s). Proof of coverage, along with evidence of payments for Medicare Supplemental coverage, must be submitted to CalOptima in order for the stipend to be paid.

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C. This retiree health benefit policy is completely voluntary on the part of CalOptima and may be amended, or terminated, by the CalOptima Board at any time in its sole discretion. This policy shall not create any vested benefits for any person, or categories of persons.

D. The Chief Executive Officer of CalOptima is charged with administering and interpreting this policy. When addressing any issue that is not dealt with in the Policy, the Chief Executive Officer shall consider and give weight to what the result would have been if CalOptima were still providing its employee health insurance through CalPERS.

E. This policy shall supersede any and all prior Board actions or policies concerning retiree health benefits.

~~IV.~~III. PROCEDURE

A. The following provisions set forth the enrollment requirements for an Eligible Retiree to receive Retiree Health Benefits:

1. A Retired Eligible Employee must enroll him/herself and his/her Eligible Dependents within sixty (60) calendar days of the Retired Eligible Employee's Retirement Date, or must wait to enroll during the annual open enrollment period applicable to active employees.

2. An Eligible Retiree must elect the Medicare coverage option he or she wants within sixty (60) calendar days of the Eligible Retiree and/or the Eligible Dependent becoming Medicare eligible.

3. A Reinstated Eligible Employee must enroll within sixty (60) calendar days of his or her Subsequent Retirement Date.

4. A Survivor Dependent may continue coverage without interruption or enroll for Survivor Dependent coverage by submitting all necessary documentation within sixty (60) calendar days of the death of the Eligible Retiree.

5. Health insurance coverage options may be changed by an Eligible Retiree during the annual open enrollment period and for defined qualifying events applicable for active employees who are covered under CalOptima's employee health plan

B. Retiree health benefits coverage will begin upon one of the following:

1. If an Eligible Employee enrolls within sixty (60) calendar days of separation from CalOptima and his or her Retirement Date, then the retiree health benefits coverage for the Retired Eligible Employee and the Eligible Dependent(s) will begin on the first day of the month following the date CalOptima timely receives the completed health enrollment forms from the Eligible Employee.

2. If the Retired Eligible Employee fails to enroll within sixty (60) calendar days of his or her Retirement Date, but subsequently enrolls during any future open enrollment period applicable for active employees, retiree health benefits coverage will begin on the following January 1.

3. Retiree health benefits coverage for an Eligible Survivor Dependent will continue uninterrupted upon submission of all required documentation or begin on the first day of the month following timely enrollment for coverage as a Survivor Dependent.

4. If a Reinstated Eligible Employee timely enrolls within sixty (60) calendar days of his or her Subsequent Retirement Date, then the retiree health benefits coverage for the Reinstated Eligible Employee and the Eligible Dependent(s) will begin on the first day of the month following the date CalOptima timely receives the completed health enrollment forms from the Reinstated Eligible Employee.

C. If an Eligible Employee separates from CalOptima before CalOptima receives notice from CalPERS that the Eligible Employee has/will become an annuitant, the Eligible Employee will be offered termination of health coverage information and a COBRA health plan continuation packet. After CalOptima receives notice from CALPERS of the Eligible Employee's retirement effective date, CalOptima will forward a packet to the Retired Eligible Employee concerning retiree health

benefits. The Retired Eligible Employee must enroll him/herself and his/her Eligible Dependents within sixty (60) calendar days of the Retired Eligible Employee's Retirement Date or must wait to enroll during the next annual open enrollment period applicable to active employees. (NOTE: If the retirement effective date indicated by CalPERS is postdated to the date of separation or other earlier date, and CalOptima does not receive notice from CalPERS until more than sixty (60) calendar days after such date, the Retired Eligible Employee must wait to enroll during the next annual open enrollment period.). If the Retired Eligible Employee needs access to health coverage before the retiree health benefits coverage will begin, the Retired Eligible Employee will need to elect and pay for COBRA health plan continuation or pay for an alternative health plan until then.

D. Retiree health benefit coverage will terminate upon the following:

1. For Eligible Retirees, upon death of the Eligible Retiree.

2. For Eligible Dependents, upon death of the Eligible Retiree, unless the Eligible Dependent is an Eligible Survivor Dependent, or upon the failure of an Eligible Retiree to timely pay any required premiums.

3. For Current Retirees and Retired Eligible Employees who are reinstated from retirement:

   a. During the period of reinstatement that ends CalPERS retirement annuity payments; and

   b. During and after the Subsequent Retirement Date if the Current Retiree and/or Retired Eligible Employee subsequently terminates employment from another state employer who provides retiree health benefits with a retiree share premium that is less than, or equal to, that being charged by CalOptima under this Policy.

4. Upon the failure of an Eligible Retiree to timely pay any required premiums.

5. When the CalOptima Board elects to terminate retiree health benefits, in part, or in its entirety.

6. Upon the failure of an Eligible Retiree to timely obtain and certify Medicare coverage upon his/her or the Eligible Dependent(s) becoming Medicare eligible.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

Not Applicable

~~VII.~~VI. REGULATORY AGENCY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTIONS

A. 11/03/16: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 06/02/16: Regular Meeting of the CalOptima Board of Directors

~~B.~~C. 08/07/14: Regular Meeting of the CalOptima Board of Directors

~~IX.~~VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
~~Original~~Effective	05/01/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	08/07/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	06/02/2016	GA. 8055	Retiree Health Benefit	Administrative
Revised	11/03/2016	GA.8055	Retiree Health Benefit	Administrative

~~X.~~IX. ~~DEFINITIONS~~GLOSSARY

Term	Definition
Current Retiree	Former employee of CalOptima who: ~~4.~~1. Was hired before January 1, 2004; ~~5.~~2. Completed at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS); and ~~6.~~3. Was already receiving retiree health benefits from CalOptima on January 1, 2014.
Eligible Dependent	The current spouse, registered domestic partner, dependent child up to age 26, and/or certified disabled dependent child over age 26, of a Current Retiree, Retired Eligible Employee, or Reinstated Eligible Retiree, who: ~~3.~~1. Meets the definition of a dependent who is eligible for coverage under the employee health plan then maintained by CalOptima for its active employees; and ~~4.~~2. Has been timely enrolled for coverage under this retiree health policy by the Eligible Retiree.
Eligible Employee	A current active employee of CalOptima meeting the following criteria: ~~3.~~1. The most recent date of hire was before January 1, 2004, or whose initial date of hire was before January 1, 2004, and whose most recent rehire date was on or before December 31, 2013; ~~4.~~2. Completes at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS).
Eligible Retiree	Current Retiree, Retired Eligible Employee, Reinstated Eligible Retiree or Eligible Survivor Dependent.
Eligible Survivor Dependent	A Survivor Dependent who timely enrolls for Survivor Dependent health coverage within sixty (60) calendar days of the death of the Eligible Retiree.
Reinstated Eligible Retiree	A Current Retiree or Retired Eligible Employee whose CalPERS retirement annuity and benefits under this Policy ended due to a reinstatement from retirement as defined in Government Code §§ 22838 and 21190 et.seq., or successor sections, and who (i) subsequently terminates employment from another state employer who does not provide retiree health benefits with a retiree share premium that is less than or equal to that being charged by CalOptima under this Policy; (ii) once again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of such subsequent separation from employment; and (iii) timely enrolls for resumption of coverage under this Policy.
Retired Eligible Employee	Eligible Employee who:

Term	Definition
	~~3.~~1. Retires within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima and receives a monthly retirement allowance from CalPERS; and ~~4.~~2. Timely applies for retiree health benefits in accordance with this policy on and after January 1, 2014.
Retirement Date	Date Eligible Employee becomes an annuitant with CalPERS within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima.
Subsequent Retirement Date	Date Reinstated Eligible Retiree again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of separating from employment with the subsequent state employer described in that definition.
Survivor Dependent	Eligible Dependent who: ~~3.~~1. Survives an Eligible Retiree; and ~~4.~~2. Is collecting monthly survivor benefits from CalPERS that is attributable to a deceased Current Retiree, Retired Eligible Employee, or Reinstated Eligible Employee.

Policy #:	GA.8055
Title:	**Retiree Health Benefit**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	11/03/16
Last Revision Date:	11/03/16

I. PURPOSE

This policy provides detailed guidelines on how to administer retiree health benefits for CalOptima's Current Retirees and Eligible Employees who qualify for retiree health benefits under this policy.

II. POLICY

A. Retiree health benefits are not available to employees who were initially hired on or after January 1, 2004, or who were originally hired before January 1, 2004, separated from employment and was rehired on or after December 1, 2013.

B. Eligible Retirees and, if elected and paid for by the Eligible Retirees, the Eligible Dependents of Current Retirees, Retired Eligible Employees, or Reinstated Eligible Retirees, will, until the CalOptima Board of Directors ("Board") decides that CalOptima will no longer continue the program or otherwise modifies it, be eligible to receive retiree health benefits as follows:

1. ***Not Medicare Eligible***: If the Eligible Retiree and/or the Eligible Dependent(s) is/are not yet eligible for Medicare, then the Eligible Retiree and/or the Eligible Dependent(s) will receive the same health insurance coverage as active employees and their dependents subject to the limitations below. The Eligible Retiree's share of premiums for the Eligible Retiree's health insurance coverage will be the same as those paid by active employees for similar coverage. In the event CalOptima is unable to reasonably obtain health insurance coverage for the Eligible Dependent(s) who are not Medicare eligible, CalOptima may provide a stipend to the Eligible Dependent(s) in lieu of health insurance coverage in an amount calculated based on the proportional amount CalOptima pays for the most closely analogous active employee health insurance coverage for active employees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima would have paid for the most closely analogous health insurance coverage for the Eligible Dependent(s). Proof of coverage, along with evidence of payments for health care coverage, must be submitted to CalOptima in order for the stipend to be paid.

2. ***Medicare Eligible*:** If the Eligible Retiree and/or the Eligible Dependent(s) is/are Medicare eligible, then the Eligible Retiree and/or the Eligible Dependent(s) will be required to enroll, at the Eligible Retiree's expense, in Medicare Part A and/or Part B, as a condition of receiving retiree health benefits under this policy. The Eligible Retiree may select one (1) of the Medicare supplemental coverage options offered by CalOptima for the Medicare Eligible Retiree and/or the Eligible Dependent(s). The Eligible Retiree's share of the Medicare supplemental coverage premium will be calculated based on the same proportional amount active employees pay for

the most closely analogous active employee health insurance coverage for the active employee and their dependents. In the event CalOptima is unable to reasonably obtain Medicare Supplemental coverage for the Eligible Dependent(s) who are Medicare eligible, CalOptima may provide a stipend to the Eligible Dependent(s) in lieu of Medicare Supplemental coverage in an amount calculated based on the proportional amount CalOptima pays for the most closely analogous Medicare supplemental coverage for Eligible Retirees and their dependent(s), but in no event shall the total dollar amount for the stipend be more than the amount CalOptima would have paid for the most closely analogous Medicare Supplemental coverage for the Eligible Dependent(s). Proof of coverage, along with evidence of payments for Medicare Supplemental coverage, must be submitted to CalOptima in order for the stipend to be paid.

C. This retiree health benefit policy is completely voluntary on the part of CalOptima and may be amended, or terminated, by the CalOptima Board at any time in its sole discretion. This policy shall not create any vested benefits for any person, or categories of persons.

D. The Chief Executive Officer of CalOptima is charged with administering and interpreting this policy. When addressing any issue that is not dealt with in the Policy, the Chief Executive Officer shall consider and give weight to what the result would have been if CalOptima were still providing its employee health insurance through CalPERS.

E. This policy shall supersede any and all prior Board actions or policies concerning retiree health benefits.

III. PROCEDURE

A. The following provisions set forth the enrollment requirements for an Eligible Retiree to receive Retiree Health Benefits:

1. A Retired Eligible Employee must enroll him/herself and his/her Eligible Dependents within sixty (60) calendar days of the Retired Eligible Employee's Retirement Date, or must wait to enroll during the annual open enrollment period applicable to active employees.

2. An Eligible Retiree must elect the Medicare coverage option he or she wants within sixty (60) calendar days of the Eligible Retiree and/or the Eligible Dependent becoming Medicare eligible.

3. A Reinstated Eligible Employee must enroll within sixty (60) calendar days of his or her Subsequent Retirement Date.

4. A Survivor Dependent may continue coverage without interruption or enroll for Survivor Dependent coverage by submitting all necessary documentation within sixty (60) calendar days of the death of the Eligible Retiree.

5. Health insurance coverage options may be changed by an Eligible Retiree during the annual open enrollment period and for defined qualifying events applicable for active employees who are covered under CalOptima's employee health plan

B. Retiree health benefits coverage will begin upon one of the following:

1. If an Eligible Employee enrolls within sixty (60) calendar days of separation from CalOptima and his or her Retirement Date, then the retiree health benefits coverage for the Retired Eligible

Employee and the Eligible Dependent(s) will begin on the first day of the month following the date CalOptima timely receives the completed health enrollment forms from the Eligible Employee.

2. If the Retired Eligible Employee fails to enroll within sixty (60) calendar days of his or her Retirement Date, but subsequently enrolls during any future open enrollment period applicable for active employees, retiree health benefits coverage will begin on the following January 1.

3. Retiree health benefits coverage for an Eligible Survivor Dependent will continue uninterrupted upon submission of all required documentation or begin on the first day of the month following timely enrollment for coverage as a Survivor Dependent.

4. If a Reinstated Eligible Employee timely enrolls within sixty (60) calendar days of his or her Subsequent Retirement Date, then the retiree health benefits coverage for the Reinstated Eligible Employee and the Eligible Dependent(s) will begin on the first day of the month following the date CalOptima timely receives the completed health enrollment forms from the Reinstated Eligible Employee.

C. If an Eligible Employee separates from CalOptima before CalOptima receives notice from CalPERS that the Eligible Employee has/will become an annuitant, the Eligible Employee will be offered termination of health coverage information and a COBRA health plan continuation packet. After CalOptima receives notice from CALPERS of the Eligible Employee's retirement effective date, CalOptima will forward a packet to the Retired Eligible Employee concerning retiree health benefits. The Retired Eligible Employee must enroll him/herself and his/her Eligible Dependents within sixty (60) calendar days of the Retired Eligible Employee's Retirement Date or must wait to enroll during the next annual open enrollment period applicable to active employees. (NOTE: If the retirement effective date indicated by CalPERS is postdated to the date of separation or other earlier date, and CalOptima does not receive notice from CalPERS until more than sixty (60) calendar days after such date, the Retired Eligible Employee must wait to enroll during the next annual open enrollment period.). If the Retired Eligible Employee needs access to health coverage before the retiree health benefits coverage will begin, the Retired Eligible Employee will need to elect and pay for COBRA health plan continuation or pay for an alternative health plan until then.

D. Retiree health benefit coverage will terminate upon the following:

1. For Eligible Retirees, upon death of the Eligible Retiree.

2. For Eligible Dependents, upon death of the Eligible Retiree, unless the Eligible Dependent is an Eligible Survivor Dependent, or upon the failure of an Eligible Retiree to timely pay any required premiums.

3. For Current Retirees and Retired Eligible Employees who are reinstated from retirement:

   a. During the period of reinstatement that ends CalPERS retirement annuity payments; and

   b. During and after the Subsequent Retirement Date if the Current Retiree and/or Retired Eligible Employee subsequently terminates employment from another state employer who provides retiree health benefits with a retiree share premium that is less than, or equal to, that being charged by CalOptima under this Policy.

4. Upon the failure of an Eligible Retiree to timely pay any required premiums.

5. When the CalOptima Board elects to terminate retiree health benefits, in part, or in its entirety.

6. Upon the failure of an Eligible Retiree to timely obtain and certify Medicare coverage upon his/her or the Eligible Dependent(s) becoming Medicare eligible.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

Not Applicable

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/03/16: Regular Meeting of the CalOptima Board of Directors
B. 06/02/16: Regular Meeting of the CalOptima Board of Directors
C. 08/07/14: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	08/07/2014	GA.8055	Retiree Health Benefit Policy	Administrative
Revised	06/02/2016	GA. 8055	Retiree Health Benefit	Administrative
Revised	11/03/2016	GA.8055	Retiree Health Benefit	Administrative

IX. GLOSSARY

Term	Definition
Current Retiree	Former employee of CalOptima who: 1. Was hired before January 1, 2004; 2. Completed at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS); and 3. Was already receiving retiree health benefits from CalOptima on January 1, 2014.
Eligible Dependent	The current spouse, registered domestic partner, dependent child up to age 26, and/or certified disabled dependent child over age 26, of a Current Retiree, Retired Eligible Employee, or Reinstated Eligible Retiree, who: 1. Meets the definition of a dependent who is eligible for coverage under the employee health plan then maintained by CalOptima for its active employees; and 2. Has been timely enrolled for coverage under this retiree health policy by the Eligible Retiree.
Eligible Employee	A current active employee of CalOptima meeting the following criteria: 1. The most recent date of hire was before January 1, 2004, or whose initial date of hire was before January 1, 2004, and whose most recent rehire date was on or before December 31, 2013; 2. Completes at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS).
Eligible Retiree	Current Retiree, Retired Eligible Employee, Reinstated Eligible Retiree or Eligible Survivor Dependent.
Eligible Survivor Dependent	A Survivor Dependent who timely enrolls for Survivor Dependent health coverage within sixty (60) calendar days of the death of the Eligible Retiree.
Reinstated Eligible Retiree	A Current Retiree or Retired Eligible Employee whose CalPERS retirement annuity and benefits under this Policy ended due to a reinstatement from retirement as defined in Government Code §§ 22838 and 21190 et.seq., or successor sections, and who (i) subsequently terminates employment from another state employer who does not provide retiree health benefits with a retiree share premium that is less than or equal to that being charged by CalOptima under this Policy; (ii) once again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of such subsequent separation from employment; and (iii) timely enrolls for resumption of coverage under this Policy.
Retired Eligible Employee	Eligible Employee who:

Term	Definition
	1. Retires within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima and receives a monthly retirement allowance from CalPERS; and 2. Timely applies for retiree health benefits in accordance with this policy on and after January 1, 2014.
Retirement Date	Date Eligible Employee becomes an annuitant with CalPERS within one hundred twenty (120) calendar days of such Eligible Employee's separation from employment with CalOptima.
Subsequent Retirement Date	Date Reinstated Eligible Retiree again begins collecting retirement annuity payments from CalPERS within one hundred twenty (120) calendar days of separating from employment with the subsequent state employer described in that definition.
Survivor Dependent	Eligible Dependent who: 1. Survives an Eligible Retiree; and 2. Is collecting monthly survivor benefits from CalPERS that is attributable to a deceased Current Retiree, Retired Eligible Employee, or Reinstated Eligible Employee.

1

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/14
Last Review Date:	~~10/06~~11/03/16
Last Revised Date:	~~10/06~~11/03/16

~~*Board Approved Policy*~~

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years;

and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule, meeting the requirements above, are available at CalOptima's offices and immediately accessible for public review during normal business hours or posted on CalOptima's internet website.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of ~~10/06~~11/03/16)

V. REFERENCES

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVALS

~~Not Applicable~~None to Date

VII. BOARD ACTIONS

A. 11/03/16: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 10/06/16: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 09/01/16: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 08/04/16: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 06/02/16: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 03/03/16: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 12/03/15: Regular Meeting of the CalOptima Board of Directors
~~G.~~H. 10/01/15: Regular Meeting of the CalOptima Board of Directors
~~H.~~I. 06/04/15: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title

Version	Date	Policy Number	Policy Title
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule
Revised	06/04/2015	GA.8058	Salary Schedule
Revised	10/01/2015	GA.8058	Salary Schedule
Revised	12/03/2015	GA.8058	Salary Schedule
Revised	03/03/2016	GA.8058	Salary Schedule
Revised	06/02/2016	GA.8058	Salary Schedule
Revised	08/04/2016	GA.8058	Salary Schedule
Revised	09/01/2016	GA.8058	Salary Schedule
Revised	10/06/2016	GA.8058	Salary Schedule
Revised	11/03/2016	GA.8058	Salary Schedule

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IX. GLOSSARY

Not Applicable

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	11/03/16
Last Revised Date:	11/03/16

I. PURPOSE

A. This policy maintains a CalOptima Salary Schedule that lists all active job classifications including job title, salary grade, and salary ranges (minimum, midpoint, and maximum pay rate amounts).

B. This policy ensures the salary schedule is publicly available pursuant to the requirements of Title 2, California Code of Regulations (CCR) §570.5 so that employees who are members of the California Public Employees Retirement System (CalPERS) have their compensation considered qualified for pension calculation under CalPERS regulations.

II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) §570.5, CalOptima has established the attached salary schedule for each CalOptima job position. In order for CalPERS member's pay rates to be credited by CalPERS, the Human Resources Department (HR) shall maintain a salary schedule that meets the following eight (8) separate criteria:

1. Approval and adoption by the governing body in accordance with requirements applicable to public meetings laws;

2. Identification of position titles for every employee position;

3. Listing of pay rate for each identified position, which may be stated as a single amount or as multiple amounts with a range;

4. Specifies the time base, including, but not limited to, whether the time base is hourly, daily, bi-weekly, monthly, bi-monthly, or annually;

5. Posted at the employer's office or immediately accessible and available for public review from the employer during normal business hours or posted on the employer's internet website;

6. Indicates the effective date and date of any revisions;

7. Retained by the employer and available for public inspection for not less than five (5) years; and

8. Does not reference another document in lieu of disclosing the pay rate.

B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith.

III. PROCEDURE

A. The Human Resources Department (HR) will ensure that the salary schedule, meeting the requirements above, are available at CalOptima's offices and immediately accessible for public review during normal business hours or posted on CalOptima's internet website.

B. HR shall retain the salary schedule for not less than five (5) years.

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of 11/03/16)

V. REFERENCES

A. Title 2, California Code of Regulations, §570.5

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/03/16: Regular Meeting of the CalOptima Board of Directors
B. 10/06/16: Regular Meeting of the CalOptima Board of Directors
C. 09/01/16: Regular Meeting of the CalOptima Board of Directors
D. 08/04/16: Regular Meeting of the CalOptima Board of Directors
E. 06/02/16: Regular Meeting of the CalOptima Board of Directors
F. 03/03/16: Regular Meeting of the CalOptima Board of Directors
G. 12/03/15: Regular Meeting of the CalOptima Board of Directors
H. 10/01/15: Regular Meeting of the CalOptima Board of Directors
I. 06/04/15: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule

Version	Date	Policy Number	Policy Title
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule
Revised	06/04/2015	GA.8058	Salary Schedule
Revised	10/01/2015	GA.8058	Salary Schedule
Revised	12/03/2015	GA.8058	Salary Schedule
Revised	03/03/2016	GA.8058	Salary Schedule
Revised	06/02/2016	GA.8058	Salary Schedule
Revised	08/04/2016	GA.8058	Salary Schedule
Revised	09/01/2016	GA.8058	Salary Schedule
Revised	10/06/2016	GA.8058	Salary Schedule
Revised	11/03/2016	GA.8058	Salary Schedule

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IX. GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised November 3, 2016
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Accountant	K	39	$47,112	$61,360	$75,504	
	Accountant Int	L	TBD	$54,288	$70,512	$86,736	
	Accountant Sr	M	68	$62,400	$81,120	$99,840	
	Accounting Clerk	I	334	$37,128	$46,384	$55,640	
	Actuarial Analyst	L	558	$54,288	$70,512	$86,736	
	Actuarial Analyst Sr	M	559	$62,400	$81,120	$99,840	
	Actuary	O	357	$82,576	$107,328	$131,976	
	Administrative Assistant	H	19	$33,696	$42,224	$50,648	
	Analyst	K	562	$47,112	$61,360	$75,504	
	Analyst Int	L	563	$54,288	$70,512	$86,736	
	Analyst Sr	M	564	$62,400	$81,120	$99,840	
	Applications Analyst	K	232	$47,112	$61,360	$75,504	
	Applications Analyst Int	L	233	$54,288	$70,512	$86,736	
	Applications Analyst Sr	M	298	$62,400	$81,120	$99,840	
	Associate Director Customer Service	O	593	$82,576	$107,328	$131,976	
	Associate Director Human Resources	P	TBD	$95,264	$128,752	$162,032	New Position
	Associate Director Information Services	Q	557	$114,400	$154,440	$194,480	
	Auditor	K	565	$47,112	$61,360	$75,504	
	Auditor Sr	L	566	$54,288	$70,512	$86,736	
	Behavioral Health Manager	N	383	$71,760	$93,184	$114,712	
	Biostatistics Manager	N	418	$71,760	$93,184	$114,712	
	Board Services Specialist	J	435	$40,976	$53,352	$65,624	
	Business Analyst	J	40	$40,976	$53,352	$65,624	
	Business Analyst Sr	M	611	$62,400	$81,120	$99,840	
	Business Systems Analyst Sr	M	69	$62,400	$81,120	$99,840	
	Buyer	J	29	$40,976	$53,352	$65,624	
	Buyer Int	K	49	$47,112	$61,360	$75,504	
	Buyer Sr	L	67	$54,288	$70,512	$86,736	
	Care Transition Intervention Coach (RN)	N	417	$71,760	$93,184	$114,712	
	Certified Coder	K	399	$47,112	$61,360	$75,504	
	Certified Coding Specialist	K	TBD	$47,112	$61,360	$75,504	Replace Job Title
	Coding Specialist Sr	L	TBD	$54,288	$70,512	$86,736	Replace Job Title
	Change Control Administrator	L	499	$54,288	$70,512	$86,736	
	Change Control Administrator Int	M	500	$62,400	$81,120	$99,840	
	Change Management Analyst Sr	N	465	$71,760	$93,184	$114,712	
**	Chief Counsel	T	132	$197,704	$266,968	$336,024	
**	Chief Executive Officer	V	138	$319,740	$431,600	$543,600	
**	Chief Financial Officer	U	134	$237,224	$320,216	$403,312	
**	Chief Information Officer	T	131	$197,704	$266,968	$336,024	
**	Chief Medical Officer	U	137	$237,224	$320,216	$403,312	
**	Chief Operating Officer	U	136	$237,224	$320,216	$403,312	
	Claims - Lead	J	574	$40,976	$53,352	$65,624	
	Claims Examiner	H	9	$33,696	$42,224	$50,648	
	Claims Examiner - Lead	J	236	$40,976	$53,352	$65,624	

CalOptima - Annual Base Salary Schedule - Revised November 3, 2016
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Claims Examiner Sr	I	20	$37,128	$46,384	$55,640	
Claims QA Analyst	I	28	$37,128	$46,384	$55,640	
Claims QA Analyst Sr.	J	540	$40,976	$53,352	$65,624	
Claims Recovery Specialist	I	283	$37,128	$46,384	$55,640	
Claims Resolution Specialist	I	262	$37,128	$46,384	$55,640	
Clerk of the Board	O	59	$82,576	$107,328	$131,976	
Clinical Auditor	M	567	$62,400	$81,120	$99,840	
Clinical Auditor Sr	N	568	$71,760	$93,184	$114,712	
Clinical Documentation Specialist RN	N	TBD	$71,760	$93,184	$114,712	New Position
Clinical Pharmacist	P	297	$95,264	$128,752	$162,032	
Clinical Systems Administrator	M	607	$62,400	$81,120	$99,840	
Clinician (Behavioral Health)	M	513	$62,400	$81,120	$99,840	
Communications Specialist	J	188	$40,976	$53,352	$65,624	
Community Partner	K	575	$47,112	$61,360	$75,504	
Community Partner Sr	L	612	$54,288	$70,512	$86,736	
Community Relations Specialist	J	288	$40,976	$53,352	$65,624	
Compliance Claims Auditor	K	222	$47,112	$61,360	$75,504	
Compliance Claims Auditor Sr	L	279	$54,288	$70,512	$86,736	
Contract Administrator	M	385	$62,400	$81,120	$99,840	
Contracts Manager	N	207	$71,760	$93,184	$114,712	
Contracts Specialist	K	257	$47,112	$61,360	$75,504	
Contracts Specialist Int	L	469	$54,288	$70,512	$86,736	
Contracts Specialist Sr	M	331	$62,400	$81,120	$99,840	
* Controller	Q	464	$114,400	$154,440	$194,480	
Credentialing Coordinator	J	41	$40,976	$53,352	$65,624	
Credentialing Coordinator - Lead	J	510	$40,976	$53,352	$65,624	
Customer Service Coordinator	J	182	$40,976	$53,352	$65,624	
Customer Service Rep	H	5	$33,696	$42,224	$50,648	
Customer Service Rep - Lead	J	482	$40,976	$53,352	$65,624	
Customer Service Rep Sr	I	481	$37,128	$46,384	$55,640	
Data Analyst	K	337	$47,112	$61,360	$75,504	
Data Analyst Int	L	341	$54,288	$70,512	$86,736	
Data Analyst Sr	M	342	$62,400	$81,120	$99,840	
Data and Reporting Analyst - Lead	O	TBD	$82,576	$107,328	$131,976	
Data Entry Tech	F	3	$27,872	$34,840	$41,808	
Data Warehouse Architect	O	363	$82,576	$107,328	$131,976	
Data Warehouse Programmer/Analyst	O	364	$82,576	$107,328	$131,976	
Data Warehouse Project Manager	O	362	$82,576	$107,328	$131,976	
Data Warehouse Reporting Analyst	N	412	$71,760	$93,184	$114,712	
Data Warehouse Reporting Analyst Sr	O	522	$82,576	$107,328	$131,976	
Database Administrator	M	90	$62,400	$81,120	$99,840	
Database Administrator Sr	O	179	$82,576	$107,328	$131,976	
** Deputy Chief Counsel	S	160	$164,736	$222,352	$280,072	
** Deputy Chief Medical Officer	T	561	$197,704	$266,968	$336,024	

CalOptima - Annual Base Salary Schedule - Revised November 3, 2016
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
* Director Accounting	P	122	$95,264	$128,752	$162,032	
* Director Applications Management	R	170	$137,280	$185,328	$233,376	
* Director Audit & Oversight	Q	546	$114,400	$154,440	$194,480	
* Director Behavioral Health Services	P	392	$95,264	$128,752	$162,032	
* Director Budget and Procurement	Q	527	$114,400	$154,440	$194,480	
* Director Business Development	P	351	$95,264	$128,752	$162,032	
* Director Business Integration	Q	543	$114,400	$154,440	$194,480	
* Director Case Management	Q	318	$114,400	$154,440	$194,480	
* Director Claims Administration	P	112	$95,264	$128,752	$162,032	
* Director Clinical Outcomes	Q	602	$114,400	$154,440	$194,480	
* Director Clinical Pharmacy	R	129	$137,280	$185,328	$233,376	
* Director Coding Initiatives	P	375	$95,264	$128,752	$162,032	
* Director Communications	P	361	$95,264	$128,752	$162,032	
* Director Community Relations	P	292	$95,264	$128,752	$162,032	
* Director Configuration & Coding	Q	596	$114,400	$154,440	$194,480	
* Director Contracting	P	184	$95,264	$128,752	$162,032	
* Director COREC	Q	369	$114,400	$154,440	$194,480	
* Director Customer Service	P	118	$95,264	$128,752	$162,032	
* Director Electronic Business	P	358	$95,264	$128,752	$162,032	
* Director Enterprise Analytics	Q	520	$114,400	$154,440	$194,480	
* Director Facilities	P	428	$95,264	$128,752	$162,032	
* Director Finance & Procurement	P	157	$95,264	$128,752	$162,032	
* Director Financial Analysis	R	374	$137,280	$185,328	$233,376	
* Director Financial Compliance	P	460	$95,264	$128,752	$162,032	
* Director Fraud Waste & Abuse and Privacy	Q	581	$114,400	$154,440	$194,480	
* Director Government Affairs	P	277	$95,264	$128,752	$162,032	
* Director Grievance & Appeals	P	528	$95,264	$128,752	$162,032	
* Director Health Education & Disease Management	Q	150	$114,400	$154,440	$194,480	
* Director Health Services	Q	328	$114,400	$154,440	$194,480	
* Director Human Resources	Q	322	$114,400	$154,440	$194,480	
* Director Information Services	R	547	$137,280	$185,328	$233,376	
* Director Long Term Support Services	Q	128	$114,400	$154,440	$194,480	
* Director Medi-Cal Plan Operations	P	370	$95,264	$128,752	$162,032	
* Director Network Management	P	125	$95,264	$128,752	$162,032	
* Director OneCare Operations	P	425	$95,264	$128,752	$162,032	
* Director Organizational Training & Education	P	579	$95,264	$128,752	$162,032	
* Director PACE Program	Q	449	$114,400	$154,440	$194,480	
* Director Process Excellence	Q	447	$114,400	$154,440	$194,480	
* Director Program Implementation	Q	489	$114,400	$154,440	$194,480	
* Director Project Management	Q	447	$114,400	$154,440	$194,480	
* Director Provider Data Quality	Q	TBD	$114,400	$154,440	$194,480	
* Director Provider Services	P	597	$95,264	$128,752	$162,032	
* Director Public Policy	P	459	$95,264	$128,752	$162,032	
* Director Quality (LTSS)	Q	613	$114,400	$154,440	$194,480	

CalOptima - Annual Base Salary Schedule - Revised November 3, 2016
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
* Director Quality Analytics	Q	591	$114,400	$154,440	$194,480	
* Director Quality Improvement	Q	172	$114,400	$154,440	$194,480	
* Director Regulatory Affairs and Compliance	Q	625	$114,400	$154,440	$194,480	
* Director Strategic Development	P	121	$95,264	$128,752	$162,032	
* Director Systems Development	R	169	$137,280	$185,328	$233,376	
* Director Utilization Management	Q	265	$114,400	$154,440	$194,480	
Disease Management Coordinator	M	70	$62,400	$81,120	$99,840	
Disease Management Coordinator - Lead	M	472	$62,400	$81,120	$99,840	
EDI Project Manager	O	403	$82,576	$107,328	$131,976	
Enrollment Coordinator (PACE)	K	441	$47,112	$61,360	$75,504	
Enterprise Analytics Manager	P	582	$95,264	$128,752	$162,032	
Executive Assistant	K	339	$47,112	$61,360	$75,504	
Executive Assistant to CEO	L	261	$54,288	$70,512	$86,736	
** Executive Director, Behavioral Health Integration	S	614	$164,736	$222,352	$280,072	
** Executive Director Clinical Operations	S	501	$164,736	$222,352	$280,072	
** Executive Director Compliance	S	493	$164,736	$222,352	$280,072	
** Executive Director Human Resources	S	494	$164,736	$222,352	$280,072	
** Executive Director Network Operations	S	632	$164,736	$222,352	$280,072	
** Executive Director Operations	S	276	$164,736	$222,352	$280,072	
** Executive Director Program Implementation	S	490	$164,736	$222,352	$280,072	
** Executive Director Public Affairs	S	290	$164,736	$222,352	$280,072	
** Executive Director Quality Analytics	S	601	$164,736	$222,352	$280,072	
Facilities & Support Services Coord - Lead	J	631	$40,976	$53,352	$65,624	
Facilities & Support Services Coordinator	J	10	$40,976	$53,352	$65,624	
Facilities Coordinator	J	438	$40,976	$53,352	$65,624	
Financial Analyst	L	51	$54,288	$70,512	$86,736	
Financial Analyst Sr	M	84	$62,400	$81,120	$99,840	
Financial Reporting Analyst	L	475	$54,288	$70,512	$86,736	
Gerontology Resource Coordinator	M	204	$62,400	$81,120	$99,840	
Graphic Designer	M	387	$62,400	$81,120	$99,840	
Grievance & Appeals Nurse Specialist	N	226	$71,760	$93,184	$114,712	
Grievance Resolution Specialist	J	42	$40,976	$53,352	$65,624	
Grievance Resolution Specialist - Lead	L	590	$54,288	$70,512	$86,736	
Grievance Resolution Specialist Sr	K	589	$47,112	$61,360	$75,504	
~~HCC Coding Specialist~~	~~K~~	~~405~~	~~$47,112~~	~~$61,360~~	~~$75,504~~	Remove and Change Job Title
~~HCC Coding Specialist Sr~~	~~L~~	~~615~~	~~$54,288~~	~~$70,512~~	~~$86,736~~	Remove and Change Job Title
Health Coach	M	556	$62,400	$81,120	$99,840	
Health Educator	K	47	$47,112	$61,360	$75,504	
Health Educator Sr	L	355	$54,288	$70,512	$86,736	
Health Network Liaison Specialist (RN)	N	524	$71,760	$93,184	$114,712	
Health Network Oversight Specialist	M	323	$62,400	$81,120	$99,840	
HEDIS Case Manager	N	443	$71,760	$93,184	$114,712	
HEDIS Case Manager (LVN)	M	552	$62,400	$81,120	$99,840	
Help Desk Technician	J	571	$40,976	$53,352	$65,624	

CalOptima - Annual Base Salary Schedule - Revised November 3, 2016
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Help Desk Technician Sr	K	573	$47,112	$61,360	$75,504	
HR Assistant	I	181	$37,128	$46,384	$55,640	
HR Business Partner	M	584	$62,400	$81,120	$99,840	
HR Coordinator	J	316	$40,976	$53,352	$65,624	
HR Representative	L	278	$54,288	$70,512	$86,736	
HR Representative Sr	M	350	$62,400	$81,120	$99,840	
HR Specialist	K	505	$47,112	$61,360	$75,504	
HR Specialist Sr	L	608	$54,288	$70,512	$86,736	
HRIS Analyst Sr	M	468	$62,400	$81,120	$99,840	
ICD-10 Project Manager	O	411	$82,576	$107,328	$131,976	
Infrastructure Systems Administrator	J	541	$40,976	$53,352	$65,624	
Infrastructure Systems Administrator Int	K	542	$47,112	$61,360	$75,504	
Inpatient Quality Coding Auditor	L	TBD	$54,288	$70,512	$86,736	New Position
Intern	E	237	$25,272	$31,720	$37,960	
Investigator Sr	L	553	$54,288	$70,512	$86,736	
IS Coordinator	J	365	$40,976	$53,352	$65,624	
IS Project Manager	O	424	$82,576	$107,328	$131,976	
IS Project Manager Sr	P	509	$95,264	$128,752	$162,032	
IS Project Specialist	M	549	$62,400	$81,120	$99,840	
IS Project Specialist Sr	N	550	$71,760	$93,184	$114,712	
Kitchen Assistant	E	585	$25,272	$31,720	$37,960	
Legislative Program Manager	N	330	$71,760	$93,184	$114,712	
Licensed Clinical Social Worker	L	598	$54,288	$70,512	$86,736	
Litigation Support Specialist	M	588	$62,400	$81,120	$99,840	
LVN (PACE)	M	533	$62,400	$81,120	$99,840	
Mailroom Clerk	E	1	$25,272	$31,720	$37,960	
Manager Accounting	N	98	$71,760	$93,184	$114,712	
Manager Actuary	P	453	$95,264	$128,752	$162,032	
Manager Applications Management	P	271	$95,264	$128,752	$162,032	
Manager Audit & Oversight	O	539	$82,576	$107,328	$131,976	
Manager Behavioral Health	O	633	$82,576	$107,328	$131,976	
Manager Business Integration	O	544	$82,576	$107,328	$131,976	
Manager Case Management	O	270	$82,576	$107,328	$131,976	
Manager Claims	N	92	$71,760	$93,184	$114,712	
Manager Clinic Operations	O	551	$82,576	$107,328	$131,976	
Manager Clinical Pharmacist	Q	296	$114,400	$154,440	$194,480	
Manager Coding Quality	N	382	$71,760	$93,184	$114,712	
Manager Communications	N	398	$71,760	$93,184	$114,712	
Manager Community Relations	M	384	$62,400	$81,120	$99,840	
Manager Contracting	O	329	$82,576	$107,328	$131,976	
Manager Creative Branding	N	430	$71,760	$93,184	$114,712	
Manager Cultural & Linguistic	N	349	$71,760	$93,184	$114,712	
Manager Customer Service	N	94	$71,760	$93,184	$114,712	
Manager Decision Support	O	454	$82,576	$107,328	$131,976	

CalOptima - Annual Base Salary Schedule - Revised November 3, 2016
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Manager Disease Management	O	372	$82,576	$107,328	$131,976	
Manager Electronic Business	O	422	$82,576	$107,328	$131,976	
Manager Employment Services	N	420	$71,760	$93,184	$114,712	
Manager Encounters	N	516	$71,760	$93,184	$114,712	
Manager Environmental Health & Safety	N	495	$71,760	$93,184	$114,712	
Manager Facilities	N	209	$71,760	$93,184	$114,712	
Manager Finance	N	148	$71,760	$93,184	$114,712	
Manager Financial Analysis	O	356	$82,576	$107,328	$131,976	
Manager Government Affairs	N	437	$71,760	$93,184	$114,712	
Manager Grievance & Appeals	N	426	$71,760	$93,184	$114,712	
Manager Health Education	N	173	$71,760	$93,184	$114,712	
Manager HEDIS	O	427	$82,576	$107,328	$131,976	
Manager Human Resources	O	526	$82,576	$107,328	$131,976	
Manager Information Services	P	560	$95,264	$128,752	$162,032	
Manager Information Technology	P	110	$95,264	$128,752	$162,032	
Manager Integration Government Liaison	N	455	$71,760	$93,184	$114,712	
Manager Long Term Support Services	O	200	$82,576	$107,328	$131,976	
Manager Marketing & Enrollment (PACE)	O	414	$82,576	$107,328	$131,976	
Manager Medical Data Management	O	519	$82,576	$107,328	$131,976	
Manager Medi-Cal Program Operations	N	483	$71,760	$93,184	$114,712	
Manager Member Liaison Program	N	354	$71,760	$93,184	$114,712	
Manager Member Outreach & Education	N	616	$71,760	$93,184	$114,712	
Manager Member Outreach Education & Provider Relations	O	576	$82,576	$107,328	$131,976	
Manager MSSP	O	393	$82,576	$107,328	$131,976	
Manager OneCare Clinical	O	359	$82,576	$107,328	$131,976	
Manager OneCare Customer Service	N	429	$71,760	$93,184	$114,712	
Manager OneCare Regulatory	N	197	$71,760	$93,184	$114,712	
Manager OneCare Sales	O	248	$82,576	$107,328	$131,976	
Manager Outreach & Enrollment	N	477	$71,760	$93,184	$114,712	
Manager PACE Center	O	432	$82,576	$107,328	$131,976	
Manager Payroll & Benefits	N	144	$71,760	$93,184	$114,712	
Manager Pharmacy Operations	N	396	$71,760	$93,184	$114,712	
Manager Process Excellence	O	622	$82,576	$107,328	$131,976	
Manager Program Implementation	O	488	$82,576	$107,328	$131,976	
Manager Project Management	O	532	$82,576	$107,328	$131,976	
Manager Provider Data Management Services	N	TBD	$71,760	$93,184	$114,712	
Manager Provider Network	O	191	$82,576	$107,328	$131,976	
Manager Provider Relations	N	171	$71,760	$93,184	$114,712	
Manager Provider Services	O	TBD	$82,576	$107,328	$131,976	
Manager Purchasing	N	275	$71,760	$93,184	$114,712	
Manager QI Initiatives	N	433	$71,760	$93,184	$114,712	
Manager Quality Analytics	O	617	$82,576	$107,328	$131,976	
Manager Quality Improvement	O	104	$82,576	$107,328	$131,976	
Manager Regulatory Affairs and Compliance	O	626	$82,576	$107,328	$131,976	

CalOptima - Annual Base Salary Schedule - Revised November 3, 2016
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Manager Reporting & Financial Compliance	O	572	$82,576	$107,328	$131,976	
	Manager Strategic Development	O	603	$82,576	$107,328	$131,976	
	Manager Strategic Operations	N	446	$71,760	$93,184	$114,712	
	Manager Systems Development	P	515	$95,264	$128,752	$162,032	
	Manager Utilization Management	O	250	$82,576	$107,328	$131,976	
	Marketing and Outreach Specialist	J	496	$40,976	$53,352	$65,624	
	Medical Assistant	H	535	$33,696	$42,224	$50,648	
	Medical Authorization Asst	H	11	$33,696	$42,224	$50,648	
	Medical Case Manager	N	72	$71,760	$93,184	$114,712	
	Medical Case Manager (LVN)	L	444	$54,288	$70,512	$86,736	
*	Medical Director	S	306	$164,736	$222,352	$280,072	
	Medical Records & Health Plan Assistant	G	548	$30,576	$38,272	$45,968	
	Medical Records Clerk	E	523	$25,272	$31,720	$37,960	
	Medical Services Case Manager	K	54	$47,112	$61,360	$75,504	
	Member Liaison Specialist	I	353	$37,128	$46,384	$55,640	
	MMS Program Coordinator	K	360	$47,112	$61,360	$75,504	
	Nurse Practitioner (PACE)	P	TBD	$95,264	$128,752	$162,032	
	Occupational Therapist	N	531	$71,760	$93,184	$114,712	
	Occupational Therapist Assistant	M	623	$62,400	$81,120	$99,840	
	Office Clerk	C	335	$21,008	$26,208	$31,408	
	OneCare Operations Manager	O	461	$82,576	$107,328	$131,976	
	OneCare Partner - Sales	K	230	$47,112	$61,360	$75,504	
	OneCare Partner - Sales (Lead)	K	537	$47,112	$61,360	$75,504	
	OneCare Partner - Service	I	231	$37,128	$46,384	$55,640	
	OneCare Partner (Inside Sales)	J	371	$40,976	$53,352	$65,624	
	Outreach Specialist	I	218	$37,128	$46,384	$55,640	
	Paralegal/Legal Secretary	K	376	$47,112	$61,360	$75,504	
	Payroll Specialist	J	554	$40,976	$53,352	$65,624	
	Performance Analyst	L	538	$54,288	$70,512	$86,736	
	Personal Care Attendant	C	485	$21,008	$26,208	$31,408	
	Personal Care Attendant - Lead	E	498	$25,272	$31,720	$37,960	
	Personal Care Coordinator	I	525	$37,128	$46,384	$55,640	
	Pharmacy Resident	K	379	$47,112	$61,360	$75,504	
	Pharmacy Services Specialist	I	23	$37,128	$46,384	$55,640	
	Pharmacy Services Specialist Int	J	35	$40,976	$53,352	$65,624	
	Pharmacy Services Specialist Sr	K	507	$47,112	$61,360	$75,504	
	Physical Therapist	N	530	$71,760	$93,184	$114,712	
	Physical Therapist Assistant	M	624	$62,400	$81,120	$99,840	
	Policy Advisor Sr	O	580	$82,576	$107,328	$131,976	
	Privacy Manager	N	536	$71,760	$93,184	$114,712	
	Process Excellence Manager	O	529	$82,576	$107,328	$131,976	
	Program Assistant	I	24	$37,128	$46,384	$55,640	
	Program Coordinator	I	284	$37,128	$46,384	$55,640	
	Program Development Analyst Sr	M	492	$62,400	$81,120	$99,840	

CalOptima - Annual Base Salary Schedule - Revised November 3, 2016
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Program Manager	M	421	$62,400	$81,120	$99,840	
Program Manager Sr	O	594	$82,576	$107,328	$131,976	
Program Specialist	J	36	$40,976	$53,352	$65,624	
Program Specialist Int	K	61	$47,112	$61,360	$75,504	
Program Specialist Sr	L	508	$54,288	$70,512	$86,736	
Program/Policy Analyst	K	56	$47,112	$61,360	$75,504	
Program/Policy Analyst Sr	M	85	$62,400	$81,120	$99,840	
Programmer	L	43	$54,288	$70,512	$86,736	
Programmer Int	N	74	$71,760	$93,184	$114,712	
Programmer Sr	O	80	$82,576	$107,328	$131,976	
Project Manager	M	81	$62,400	$81,120	$99,840	
Project Manager - Lead	M	467	$62,400	$81,120	$99,840	
Project Manager Sr	O	105	$82,576	$107,328	$131,976	
Project Specialist	K	291	$47,112	$61,360	$75,504	
Project Specialist Sr	L	503	$54,288	$70,512	$86,736	
Projects Analyst	K	254	$47,112	$61,360	$75,504	
Provider Enrollment Data Coordinator	I	12	$37,128	$46,384	$55,640	
Provider Enrollment Data Coordinator Sr	J	586	$40,976	$53,352	$65,624	
Provider Enrollment Manager	K	190	$47,112	$61,360	$75,504	
Provider Network Rep Sr	L	391	$54,288	$70,512	$86,736	
Provider Network Specialist	K	44	$47,112	$61,360	$75,504	
Provider Network Specialist Sr	L	595	$54,288	$70,512	$86,736	
Provider Office Education Manager	L	300	$54,288	$70,512	$86,736	
Provider Relations Rep	K	205	$47,112	$61,360	$75,504	
Provider Relations Rep Sr	L	285	$54,288	$70,512	$86,736	
Publications Coordinator	J	293	$40,976	$53,352	$65,624	
QA Analyst	L	486	$54,288	$70,512	$86,736	
QA Analyst Sr	N	380	$71,760	$93,184	$114,712	
QI Nurse Specialist	N	82	$71,760	$93,184	$114,712	
QI Nurse Specialist (LVN)	M	445	$62,400	$81,120	$99,840	
Receptionist	F	140	$27,872	$34,840	$41,808	
Recreational Therapist	L	487	$54,288	$70,512	$86,736	
Recruiter	L	406	$54,288	$70,512	$86,736	
Recruiter Sr	M	497	$62,400	$81,120	$99,840	
Registered Dietitian	L	57	$54,288	$70,512	$86,736	
Regulatory Affairs and Compliance Analyst	K	628	$47,112	$61,360	$75,504	
Regulatory Affairs and Compliance Analyst Sr	L	629	$54,288	$70,512	$86,736	
Regulatory Affairs and Compliance Lead	M	630	$62,400	$81,120	$99,840	
RN (PACE)	N	480	$71,760	$93,184	$114,712	
Security Analyst Int	N	534	$71,760	$93,184	$114,712	
Security Analyst Sr	O	474	$82,576	$107,328	$131,976	
Security Officer	F	311	$27,872	$34,840	$41,808	
SharePoint Developer/Administrator Sr	O	397	$82,576	$107,328	$131,976	
Social Worker	K	463	$47,112	$61,360	$75,504	

CalOptima - Annual Base Salary Schedule - Revised November 3, 2016
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
* Special Counsel	R	317	$137,280	$185,328	$233,376	
Sr Manager Government Affairs	O	451	$82,576	$107,328	$131,976	
Staff Attorney	P	195	$95,264	$128,752	$162,032	
Supervisor Accounting	M	434	$62,400	$81,120	$99,840	
Supervisor Audit and Oversight	N	618	$71,760	$93,184	$114,712	
Supervisor Budgeting	M	466	$62,400	$81,120	$99,840	
Supervisor Case Management	N	86	$71,760	$93,184	$114,712	
Supervisor Claims	K	219	$47,112	$61,360	$75,504	
Supervisor Coding Initiatives	M	502	$62,400	$81,120	$99,840	
Supervisor Customer Service	K	34	$47,112	$61,360	$75,504	
Supervisor Data Entry	K	192	$47,112	$61,360	$75,504	
Supervisor Day Center (PACE)	K	619	$47,112	$61,360	$75,504	
Supervisor Dietary Services (PACE)	M	TBD	$62,400	$81,120	$99,840	New Position
Supervisor Disease Management	N	TBD	$71,760	$93,184	$114,712	New Position
Supervisor Encounters	L	253	$54,288	$70,512	$86,736	
Supervisor Facilities	L	162	$54,288	$70,512	$86,736	
Supervisor Finance	N	419	$71,760	$93,184	$114,712	
Supervisor Grievance and Appeals	M	620	$62,400	$81,120	$99,840	
Supervisor Health Education	M	381	$62,400	$81,120	$99,840	
Supervisor Health Services	N	506	$71,760	$93,184	$114,712	
Supervisor Information Services	N	457	$71,760	$93,184	$114,712	
Supervisor Long Term Support Services	N	587	$71,760	$93,184	$114,712	
Supervisor Member Outreach and Education	L	592	$54,288	$70,512	$86,736	
Supervisor MSSP	N	348	$71,760	$93,184	$114,712	
Supervisor OneCare Customer Service	K	408	$47,112	$61,360	$75,504	
Supervisor Payroll	M	517	$62,400	$81,120	$99,840	
Supervisor Pharmacy Services	K	146	$47,112	$61,360	$75,504	
Supervisor Pharmacist	P	610	$95,264	$128,752	$162,032	
Supervisor Provider Enrollment	K	439	$47,112	$61,360	$75,504	
Supervisor Regulatory Affairs and Compliance	N	627	$71,760	$93,184	$114,712	
Supervisor Social Work (PACE)	L	TBD	$54,288	$70,512	$86,736	
Supervisor Systems Development	O	456	$82,576	$107,328	$131,976	
Supervisor Therapy Services (PACE)	N	TBD	$71,760	$93,184	$114,712	
Supervisor Utilization Management	N	TBD	$71,760	$93,184	$114,712	
Supervisor Quality Analytics	M	609	$62,400	$81,120	$99,840	
Supervisor Quality Improvement	N	600	$71,760	$93,184	$114,712	
Systems Manager	N	512	$71,760	$93,184	$114,712	
Systems Network Administrator Int	M	63	$62,400	$81,120	$99,840	
Systems Network Administrator Sr	N	89	$71,760	$93,184	$114,712	
Systems Operations Analyst	J	32	$40,976	$53,352	$65,624	
Systems Operations Analyst Int	K	45	$47,112	$61,360	$75,504	
Technical Analyst Int	L	64	$54,288	$70,512	$86,736	
Technical Analyst Sr	M	75	$62,400	$81,120	$99,840	
Technical Writer	L	247	$54,288	$70,512	$86,736	

CalOptima - Annual Base Salary Schedule - Revised November 3, 2016
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Technical Writer Sr	M	470	$62,400	$81,120	$99,840	
Therapy Aide	J	521	$40,976	$53,352	$65,624	
Training Administrator	L	621	$54,288	$70,512	$86,736	
Training Program Coordinator	K	471	$47,112	$61,360	$75,504	
Translation Specialist	G	241	$30,576	$38,272	$45,968	
Web Architect	O	366	$82,576	$107,328	$131,976	

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution and are also Chief or Executive Director level positions.

Text in red indicates new changes to the salary schedule proposed for Board approval.

Summary of Changes to Salary Schedule

For November 2016 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Associate Director Human Resources	N/A	P	This is a new position that will provide supervision and oversight of staff in all functions of Human Resources.	N/A	November 2016
Certified Coding Specialist	N/A	K	The "Certified Coding Specialist" job title will replace the "HCC Coding Specialist" title.	N/A	November 2016
Certified Coding Specialist Sr	N/A	L	The "Certified Coding Specialist Sr" job title will replace the "HCC Coding Specialist Sr" title.	N/A	November 2016
Clinical Documentation Specialist RN	N/A	N	This is a new position that will provide expertise in auditing claims based on code assignment and utilizes clinical knowledge for reviewing appropriateness and completeness of documentation for specific claim types as determined by the Health Plan.	N/A	November 2016
HCC Coding Specialist	K	N/A	Remove title from salary schedule. Position is replaced with Certified Coding Specialist.	N/A	November 2016
HCC Coding Specialist Sr	L	N/A	Remove title from salary schedule. Position is replaced with Certified Coding Specialist Sr.	N/A	November 2016
Inpatient Quality Coding Auditor	N/A	L	This is a new position that will provide extensive knowledge of auditing protocol based on code assignment for paper based medical records and/or electronic medical records for inpatient, outpatient and professional services.	N/A	November 2016
Supervisor Dietary Services (PACE)	N/A	M	This is a new position that will provide supervision and oversight of staff, nutrition care, education, and food service management for the CalOptima PACE program.	N/A	November 2016

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Supervisor Disease Management	N/A	N	This is a new position that will provide guidance to staff, directly handle complex disease management referrals, participate in interdisciplinary care team meetings, monitor staff goals and productivity, and ensure compliance with desktop procedures, organizational policies, or contractual requirements.	N/A	November 2016

Summary of Market Adjustment Changes

For November 2016 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Community Relations Specialist	J	N/A	The salary and compensation levels under the Fair Labor Standards Act needed for executive, administrative, and provisional employees to be exempt has been increased by the Wage and Hour Division of the Department of Labor from $466/week to $913/week effective December 1, 2016.	1 Community Relations Specialist will receive an 11.59% adjustment. The total impact for the current fiscal year is $3,394.56 or $5,191.68 annualized.	November 2016

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Expenditures in Support of CalOptima's Participation in the Family Voices of California's (FVCA) 2017 Annual Health Summit, in Preparation for the Upcoming Transition of the California Children's Services (CCS) Benefit to CalOptima

Contact

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

Recommended Actions

1. Authorize expenditures for CalOptima's participation in the following community event:
    a. Up to $2,500 for CalOptima's participation in the FVCA 2017 Annual Health Summit, February 27–28, 2017 in Sacramento, California;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

Background

CCS provides financial assistance, medical case management as well as physical and occupational therapy services for approximately 180,000 medically fragile children statewide, including about 13,000 in Orange County. While CCS is a Medi-Cal program, it is currently "carved out" of managed care. The CCS program is administered by counties and is funded on a fee-for-service (FFS) basis by the Department of Health Care Services (DHCS). The CCS carve out is set to expire on January 1, 2017, and according to recently passed legislation, CalOptima will become responsible for most CCS services by January 1, 2018.

FVCA is a statewide collaborative of parent advocates focused on improving policies that ensure quality health care for children with special needs. FVCA also operates seven parent-run centers, providing information and support to help families make informed decisions about their children's health care. FVCA has been an influential advocacy organization working closely with DHCS and the Legislature on redesigning the CCS program. Specifically, FVCA has reached out to Medi-Cal managed care plans, including CalOptima, to begin working together to ensure the CCS transition from FFS to managed care is done in a responsible manner. FVCA representatives currently hold two seats on the DHCS CCS Advisory Group, which has been the primary vehicle for health plans, providers and children's advocates to discuss the CCS transition.

Discussion

Staff recommends authorizing $2,500 for participation in the FVCA 2017 Annual Health Summit in Sacramento. Participation will strengthen CalOptima's partnership with FVCA and ensure that Orange County CCS member advocates are engaged with the changes to the program, so the transition takes place in a seamless manner.

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The $2,500 financial commitment includes CalOptima's logo on all marketing materials for the event, the FVCA website, social media, follow-up materials and publications, as well as admittance to the summit. The summit will bring together families, advocates, state agency representatives, Medi-Cal managed care plans, health policy advocates, legislative representatives and CCS providers to address issues that affect this vulnerable population. Last year's summit drew 138 participants, including 71 family members throughout California. Orange County families with children enrolled in the CCS program have expressed interest in attending the event.

Fiscal Impact
Funding for the recommended action of up to $2,500 to participate in the FVCA 2017 Annual Health Summit is included as part of the Community Events Budget under the CalOptima Fiscal Year 2016–17 Operating Budget approved by the CalOptima Board of Directors on June 2, 2016.

Rationale for Recommendation
Staff recommends approval of the recommended action in order to support events that help our members, reflect CalOptima's mission, and enhance the CCS transition into Medi-Cal managed care.

Concurrence
Gary Crockett, Chief Counsel

Attachments
2017 Request Letter and Sponsorship Information

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

9/28/2016 — **Date**

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FAMILY VOICES of California

The voice of families
The vision of quality health care
The future for children and youth with special health care needs

Alpha Resource Center
Family First Program
4501 Cathedral Oaks Road
Santa Barbara, CA 93110
805/683-2145 F: 805/967-3647
info@alphasb.org

Eastern Los Angeles Family Resource Center
1000 South Fremont Ave.
Suite 6050, Unit 35
Alhambra, CA 91803
626-300-9171 F: 626-300-9164
info@elafrc.org

Exceptional Family Resource Center
9245 Sky Park Court, Ste #130
San Diego, CA 92123
619/594-7416 F: 858/268-4275
efrc@projects.sdsu.edu

Exceptional Parents Unlimited
4440 North First Street
Fresno, CA 93726
559/229-2000 F: 559/229-2956
rquimont@exceptionalparents.org

Family Resource Network
5232 Claremont Avenue
Oakland, CA 94618
510/547-7322 F: 510/658.8354
fm@fmoakland.org

Rowell Family Empowerment of Northern California, Inc.
982 Maraglia
Redding, CA 96002
530/226-5129 F: 530/226-5141
Toll: 877/227-3471
wendyl@rfenc.org

Support for Families of Children with Disabilities
1663 Mission Street, 7th Floor
San Francisco, CA 94103
415/282-7494 F: 415/282-1226
info@supportorfamilies.org

Westside Family Resource and Empowerment Center
5901 Green Valley Circle #320
Culver City, CA 90230-6953
310/258-4063 F: (310) 338-9664
family@westsiderc.org

FAMILY VOICES OF CALIFORNIA
1663 Mission Street, 7th Floor
San Francisco, CA 94103
415/282-7494 F: 415/282-1226
info@familyvoicesofca.org
www.familyvoicesofca.org

August 29, 2016

Tiffany Kaaiakamanu
Manager, Community Relations
CalOptima
505 City Parkway West
Orange, CA 92868

Re: **Request for Sponsorship**
2017 Family Voices of CA Health Summit & Legislative Day

Dear Tiffany:

I am writing on behalf of Family Voices of California (FVCA) to request sponsorship support for our **2017 Annual Health Summit and Legislative Advocacy Day, to be held February 27-28, 2017 in Sacramento.**

The full day Summit, scheduled for Monday, February 27, 2017 will bring together families, advocates, state agency representatives, health policy advocates, legislative representatives, providers and insurers. Speakers help participants become informed about issues in California that significantly affect the health care of children with special needs; in break-out sessions and discussions, participants work to develop strategies to ensure that California families are able to access affordable and family-centered care for their children and youth with special health care needs (CYSHCN).

On the following day, Tuesday, February 28, the Health Summit participants will gather at the State Capitol to learn how to impact legislation that could provide access to quality, affordable health care for CYSHCN. Participants meet with legislators to discuss policy issues and exchange information to continue the dialogue beyond the Summit. As parents and youth discuss the special health care needs of their families, they put a personal face on the impact of legislation and budget decisions. Please see the attached report for information regarding the scope and impact of the event in 2016.

For our 2017 Summit, we would like to increase the number of families and professionals and hope to have many California counties represented. With your help, we can do this and make a difference for children and youth with special health care needs. Sponsors will be prominently recognized in program materials, outreach on the Family Voices of California website, and in follow-up materials and publications.

Thank you for your consideration of this request!

Sincerely,

Pip Marks
Project Director
Family Voices of California

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FAMILY VOICES of California

2017 Health Summit Sponsorship Commitment

February 27-28, 2017
Courtyard Marriott, Sacramento

Please return Sponsorship Commitment to Pip Marks by MAIL OR EMAIL:
1663 Mission Street, Suite 700, San Francisco, CA 94103
pipmarks@familyvoicesofca.org

☐ **YES!** I am interested in **sponsoring** the Family Voices 2017 Health Summit (Cost per family = $800)

☐ **$15,000**

Listed as **Lead Presenting Sponsor** in all press releases; full page insert in event program; logo will be displayed on FVCA Website, all Summit materials if logo and sponsorship pledge is received by January 1, 2017

☐ **$10,000**

Listed as **Major Sponsor** in press release; logo will be displayed on FVCA Website and Summit materials if logo and sponsorship is received by January 1, 2017

☐ **$5,000**

Listed as Significant Sponsor in program; logo displayed on FVCA Website and Summit materials if logo and sponsorship is received by January 1, 2017

☐ **$1,000**

Listed as Valued Sponsor in program if logo and sponsorship are received by January 1, 2017

☐ **$800**

Listed as Supportive Sponsor in program if logo and sponsorship are received by January 1, 2017

☐ **$Other**

Please list amount you wish to donate

TOTAL SPONSORSHIP CONTRIBUTION $_____

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COMPLETE THE FOLLOWING CONTACT AND PAYMENT INFORMATION:

Contact Name:_____

Company/Agency:_____

Address:_____

_____

Phone:_____

Email:_____

PAYMENT DETAILS

☐ Please make check payable to Support for Families of Children with Disabilities (MEMO: FVCA 2017 SUMMIT)

Please send to:
FVCA, 1663 Mission Street, Suite 700, San Francisco, CA 94103
Attention: Pip Marks

OUR 2016 HEALTH SUMMIT FAMILY MEMBER ATTENDEES AND FVCA THANK YOU FOR YOUR WONDERFUL SUPPORT!!!

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Ratification and Approval of Expenditures Related to Health Insurance Portability and Accountability Act (HIPAA) Security Breach Response; Authorize Contract(s) and Contract Amendment(s) with Vendors Providing HIPAA Security Breach Response Services

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400

Recommended Actions

1. Ratify:
   a. Identified expenditures of up to $330,000 related to HIPAA security breach response;
   b. Contracts with vendors to provide services related to HIPAA security breach response; and
2. Authorize:
   a. The expenditure of up to $300,000 in additional consulting support and other remediation efforts; and
   b. The Chief Executive Officer, with the assistance of Legal Counsel, to contract with vendor(s) as appropriate to provide services related to HIPAA security breach response, consistent with CalOptima Board-approved procurement policies.

Background

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the Secretary of the U.S. Department of Health and Human Services (HHS) to develop regulations protecting the privacy and security of certain health information. To fulfill this requirement, HHS published what are commonly known as the HIPAA Privacy Rule and the HIPAA Security Rule. The HIPAA Privacy Rule (45 CFR Part 160 and Subparts A and E of Part 164) establishes national standards to protect individuals' medical records and other protected health information (PHI) and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The HIPAA Security Rule (45 CFR Part 160 and Subparts A and C of Part 164) establishes national standards to protect individuals' electronic PHI that is created, received, used, or maintained by a covered entity. The Security Rule requires appropriate administrative, physical and technical safeguards to ensure the confidentiality, integrity, and security of electronic PHI.

The HIPAA Breach Notification Rule, 45 CFR §§ 164.400-414, requires HIPAA covered entities and their business associates to provide notification to affected individuals following a breach of unsecured PHI. These individual notifications must be provided without unreasonable delay and in no case later than sixty (60) days following the discovery of a breach. If a breach affects 500 or more individuals, covered entities must also notify the Secretary of HHS without unreasonable delay and in no case later than 60 days following a breach. The covered entity must also include a toll-free phone number that remains active for at least 90 days where individuals can learn if their information was involved in the breach.

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Discussion

On or about August 17, 2016, a departing CalOptima employee downloaded data, which included PHI, to an unencrypted USB flash drive. Shortly after, the departing employee returned the USB flash drive to CalOptima.

To meet the HIPAA breach notification requirements and mitigate potential member harm, CalOptima engaged vendors to provide the following services:

- Fulfillment services (e.g., printing, postage, etc.): $39,402
- Translation services: estimated $3,754
- Customer service call center services: estimated $52,925
- Credit monitoring services: estimated $128,000
- Legal services: estimated $74,000

As summarized on the attached table, the total estimate of expenses to date is approximately $330,000. In addition, staff anticipates expenditures of up to $300,000 for additional remediation consulting and other related items. Staff will return to the Board with recommendations should additional recommended expenditure be identified (e.g., system enhancements, additional consulting support, etc.)

Fiscal Impact

The recommended action to authorize expenditure of an additional $630,000 to fund the HIPAA security breach response is an unbudgeted item. Management is requesting Board approval to authorize these additional administrative and medical expenses to fund the cost of these services. These figures do not include any potential monetary sanction(s), if any, imposed by regulator(s).

Rationale for Recommendation

To ensure compliance with HIPAA privacy and security rules and contractual obligations with the Department of Health Care Services (DHCS), CalOptima staff recommends approval of the recommended actions.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Expenditures Summary

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

9/28/2016 — **Date**

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Attachment 1: Summary of Expenditures to HIPAA Security Breach Response

A. Ratification

	Amount (Not to Exceed)	Existing Contract	New Contract
Fulfillment services (e.g., printing, postage)	$39,402	X	
Translation services	$3,754	X	
Customer service call center services	$52,925	X	
Credit monitoring services	$128,000		X
Legal services	$74,000	X	
Contingency (10%)	$31,919	X	
Estimated Total	**$330,000**		

B. Authorization

	Amount (Not to Exceed)	Existing Contract	New Contract
Additional consulting support and other remediation efforts	**$300,000**		X

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Board of Directors Meeting
November 3, 2016

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

The OneCare Connect Member Advisory Committee (OCC MAC) opened nominations for the chair and vice chair positions and received one interested candidate for each position. Patty Mouton, Home and Community-Based Services (HCBS) Representative Serving Seniors, applied for the chair position and Gio Corzo, Community-Based Adult Services (CBAS) Provider Representative, applied for the vice chair position. OCC MAC members considered the two candidates at its September 22, 2016 meeting and recommended the candidates be forwarded to the Board for consideration at the next meeting. The OCC MAC thanks the Board for following its recommendation and appointing Committee Members Mouton and Corzo to the Chair and Vice Chair positions, respectively, for the remainder of Fiscal Year 2016-17 at the Board's October 6, 2016 meeting.

OCC MAC members received an overview on CalOptima's Program of All-Inclusive Care for the Elderly (PACE) Center, including eligibility requirements, services provided and PACE in the continuum of care. OCC MAC members also received an update on OCC member enrollment, which indicated that enrollment was 17,750 members as of September 14, 2016. OCC MAC member Josefina Diaz presented an overview on the Legal Aid Society of Orange County (LASOC), outlining the programs and services offered by LASOC.

MAC also received the following updates from CalOptima's executive staff at the September 22, 2016 meeting: Chief Executive Officer update; Chief Medical Officer update; and State and Federal Legislative update.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

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Board of Directors Meeting
November 3, 2016

Member Advisory Committee Update

The Member Advisory Committee (MAC) did not have a meeting scheduled in October, as the committee meets bi-monthly. The next scheduled MAC meeting is November 10, 2016 and MAC will provide an update at the subsequent Board meeting.

At the November 10, 2016 MAC meeting, MAC will consider the recommendation from the MAC Nominations Ad Hoc for a candidate to fill the vacant Recipients of CalWORKs' seat, as well as candidates to fill the Chair and Vice Chair positions. Following MAC's recommendation, MAC will forward the candidates to the CalOptima Board for consideration at the next Board meeting.

The MAC appreciates the opportunity to provide the CalOptima Board with input and updates on the MAC's activities.

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Board of Directors Meeting
November 3, 2016

Provider Advisory Committee (PAC) Update

October 13, 2016 PAC Meeting

Eleven (11) PAC members were in attendance for the October PAC meeting.

Michael Schrader, Chief Executive Officer, updated the PAC on the California Children's Services (CCS) Program, National Committee for Quality Assurance (NCQA) rating, Program for All-Inclusive Care for the Elderly (PACE) and the Strategic Plan.

Chet Uma, Chief Financial Officer reviewed the August 2016 Financial Report with the PAC and informed the PAC that payments had been delayed by the State for the months of July and August. CalOptima was able to pay the providers due to their reserves.

Dr. Richard Helmer, Chief Medical Officer, provided updates on the Long-Term Care program, Pay for Value program, Care Management and the transition of the new behavioral health vendor, Magellan scheduled to begin on January 1, 2017. PAC members requested that Magellan be invited to the December PAC meeting to discuss their provider network and their plan to transition members from existing providers on January 1, 2017.

Ladan Khamseh, Chief Operating Officer, provided an update on OneCare and OneCare Connect plan additions of the gym and taxi ride benefits.

PAC members received informative presentations from the Quality Initiatives department on the CAHPS Medi-Cal and OneCare plan level survey results, as well as results from a survey based on the primary care physician experience. Based on these surveys, the PAC CAHPS ad hoc committee will be scheduling another meeting to discuss how to raise scores above the current benchmark level.

PAC also received a State and Federal Legislative update.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's activities.

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Financial Summary

September 2016

Board of Directors Meeting

November 3, 2016

Chet Uma

Chief Financial Officer

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FY 2016-17: Consolidated Enrollment

- September 2016 MTD:
  - Overall enrollment was 796,173 member months
    - Actual lower than budget by 4,879 or 0.6%
      - Medi-Cal: unfavorable variance of 483 members
        - Medi-Cal Expansion (MCE) growth higher than budget
        - SPD enrollment higher than budget due to less than anticipated dual eligible members transferring to OneCare Connect
        - Offset by lower than budget TANF enrollment
      - OneCare Connect: unfavorable variance of 4,365 members
    - 0.3% decrease from prior month
      - OneCare Connect: decrease of 518 from August
      - Medi-Cal: decrease of 1,580 from August
    - 3.8% or 29,065 increase in enrollment from prior year

FY 2016-17: Consolidated Enrollment

- September 2016 YTD:
  - Overall enrollment was 2,393,499 member months
    - Actual lower than budget by 5,825 or 0.2%
      - Medi-Cal: favorable variance of 6,033 members
        - Medi-Cal Expansion (MCE) growth higher than budget
        - SPD enrollment higher than budget due to less than anticipated dual eligible members transferring to OneCare Connect
        - Offset by lower than budget TANF enrollment
      - OneCare Connect: unfavorable variance of 11,691 members
      - OneCare: unfavorable variance of 192 members

FY 2016-17: Consolidated Revenues

- September 2016 MTD:
  - ➢ Actual lower than budget by $4.8 million or 1.7%
    - Medi-Cal: favorable to budget by $5.3 million
      - Favorable price variance of $5.5 million, which includes an IHSS favorable variance of $2.4 million
      - Unfavorable volume variance of $0.1 million
    - OneCare Connect: unfavorable variance of $9.6 million
      - Unfavorable price variance of $0.6 million due to cohort experience
      - Unfavorable volume variance of $9.0 million due to lower enrollment
    - OneCare: unfavorable to budget by $0.5 million due to direct subsidy restatement

- September 2016 YTD:
  - ➢ Actual lower than budget by $8.4 million or 1.0%
    - Medi-Cal: favorable to budget by $21.6 million
    - OneCare Connect: unfavorable variance of $29.5 million

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FY 2016-17: Consolidated Medical Expenses

- September 2016 MTD:
  - ➢ Actual higher than budget by $1.9 million or 0.7%
    - ▪ Medi-Cal: unfavorable variance of $11.6 million
      - MLTSS unfavorable variance $9.4 million
        - ➢ IHSS $4.2 million due to higher utilization
        - ➢ LTC unfavorable due to less than anticipated LTC members enrolled in OneCare Connect
      - Facilities unfavorable $3.0 million due to Shared Risk Pool variance of $2.1 million
    - ▪ OneCare Connect: favorable variance of $9.3 million
      - Favorable volume variance of $8.4 million
        - ➢ $2.1 million in LTC
        - ➢ $1.9 million in Provider Capitation
        - ➢ $1.6 million in Prescription Drugs
      - Favorable price variance of $0.9 million

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FY 2016-17: Consolidated Medical Expenses (Cont.)

- September 2016 YTD:
  - Actual higher than budget by $2.2 million or 0.3%
    - Medi-Cal: unfavorable variance of $31.4 million
      - Unfavorable price variance of $29.6 million
        - IHSS estimated expenses $12.5 million higher than budget
        - Long Term Care expense $10.4 million higher than budget
        - Facilities cost $8.9 million over budget
      - Unfavorable volume variance of $1.7 million
    - OneCare Connect: favorable variance of $28.1 million
      - Favorable volume variance of $22.5 million
      - Favorable price variance of $5.6 million

- Medical Loss Ratio (MLR):
  - September 2016 MTD: Actual: 96.9% Budget: 94.6%
  - September 2016 YTD: Actual: 96.7% Budget: 95.5%

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FY 2016-17: Consolidated Administrative Expenses

- September 2016 MTD:
  - Actual lower than budget by $2.1 million or 18.3%
    - Salaries and Benefits: favorable variance of $1.9 million driven by lower than budgeted FTE of 89
    - Other categories: favorable variance of $0.2 million
- September 2016 YTD:
  - Actual lower than budget by $7.6 million or 21.5%
    - Salaries and Benefits: favorable variance of $5.2 million driven by lower than budgeted FTE of 286
    - Other categories: favorable variance of $2.3 million

- Administrative Loss Ratio (ALR):
  - September 2016 MTD: Actual: 3.4% Budget: 4.1%
  - September 2016 YTD: Actual: 3.3% Budget: 4.2%

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FY 2016-17: Change in Net Assets

- September 2016 MTD:
  - $1.0 million surplus
  - $2.9 million unfavorable to budget
    - Attributable to:
      - Lower than budgeted revenue of $4.8 million
      - Higher medical expenses of $1.9 million
      - Lower administrative expenses of $2.1 million
      - Higher investment income of $1.6 million

- September 2016 YTD:
  - $2.6 million surplus
  - $1.1 million unfavorable to budget
    - Attributable to:
      - Lower than budgeted revenue of $8.4 million
      - Higher medical expenses of $2.2 million
      - Lower administrative expenses of $7.6 million
      - Higher investment income of $1.8 million

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Enrollment Summary: September 2016

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
57,834	55,078	2,756	5.0%	Aged	172,232	164,755	7,477	4.5%
623	676	(53)	(7.8%)	BCCTP	1,892	2,026	(134)	(6.6%)
48,325	47,476	849	1.8%	Disabled	145,109	142,524	2,585	1.8%
335,393	339,437	(4,044)	(1.2%)	TANF Child	1,004,569	1,015,998	(11,429)	(1.1%)
102,827	109,755	(6,928)	(6.3%)	TANF Adult	309,882	329,241	(19,359)	(5.9%)
3,303	2,685	618	23.0%	LTC	9,819	8,033	1,786	22.2%
228,770	222,451	6,319	2.8%	MCE	691,060	665,955	25,105	3.8%
777,075	**777,557**	**(482)**	**(0.1%)**	**Medi-Cal**	**2,334,563**	**2,328,527**	**6,036**	**0.3%**
17,727	**22,093**	**(4,366)**	**(19.8%)**	**OneCare Connect**	**54,874**	**66,565**	**(11,691)**	**(17.6%)**
179	**175**	**4**	**2.3%**	**PACE**	**535**	**510**	**25**	**4.9%**
1,192	**1,227**	**(35)**	**(2.9%)**	**OneCare**	**3,527**	**3,719**	**(192)**	**(5.2%)**
796,173	**801,052**	**(4,879)**	**(0.6%)**	**CalOptima Total**	**2,393,499**	**2,399,321**	**(5,822)**	**(0.2%)**

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Financial Highlights: September 2016

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
796,173	801,052	(4,879)	(0.6%)	Member Months	2,393,499	2,399,324	(5,825)	(0.2%)
276,932,895	281,720,851	(4,787,956)	(1.7%)	Revenues	835,720,311	844,151,625	(8,431,314)	(1.0%)
268,383,373	266,531,225	(1,852,148)	(0.7%)	Medical Expenses	807,999,274	805,773,822	(2,225,452)	(0.3%)
9,341,536	11,428,453	2,086,917	18.3%	Administrative Expenses	27,591,433	35,153,600	7,562,168	21.5%
(792,014)	**3,761,173**	**(4,553,187)**	**(121.1%)**	**Operating Margin**	**129,605**	**3,224,203**	**(3,094,598)**	**(96.0%)**
1,779,007	143,250	1,635,757	1141.9%	Non Operating Income (Loss)	2,434,789	429,750	2,005,039	466.6%
986,993	**3,904,423**	**(2,917,430)**	**(74.7%)**	**Change in Net Assets**	**2,564,394**	**3,653,953**	**(1,089,559)**	**(29.8%)**
96.9%	94.6%	(2.3%)		Medical Loss Ratio	96.7%	95.5%	(1.2%)	
3.4%	4.1%	0.7%		Administrative Loss Ratio	3.3%	4.2%	0.9%	
(0.3%)	1.3%	(1.6%)		Operating Margin Ratio	0.0%	0.4%	(0.4%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: September 2016 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(1.4)	3.0	(4.4)	Medi-Cal	(1.2)	2.3	(3.6)
(0.3)	0.0	(0.3)	OneCare	(0.1)	0.1	(0.3)
0.9	0.9	(0.1)	OCC	1.4	1.6	(0.1)
0.0	(0.2)	0.2	PACE	0.0	(0.8)	0.8
(0.8)	**3.8**	**(4.6)**	**Operating**	**0.1**	**3.2**	**(3.1)**
1.8	0.1	1.6	Inv./Rental Inc, MCO tax	2.4	0.4	2.0
1.8	**0.1**	**1.6**	**Non-Operating**	**2.4**	**0.4**	**2.0**
1.0	**3.9**	**(2.9)**	**TOTAL**	**2.6**	**3.7**	**(1.1)**

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Consolidated Revenue & Expense: September 2016 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	545,322	231,753	$ 777,075	1,192	17,727	179	796,173
REVENUES							
Capitation Revenue	133,571,873	105,444,331	$ 239,016,205	$ 906,303	$ 35,927,342	$ 1,083,046	$ 276,932,895
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	133,571,873	105,444,331	239,016,205	906,303	35,927,342	1,083,046	276,932,895
MEDICAL EXPENSES							
Provider Capitation	31,116,432	42,129,491	73,245,923	384,652	6,420,083	-	80,050,658
Facilitities	27,196,915	31,354,932	58,551,846	181,928	9,961,026	170,526	68,865,327
Ancillary				52,020	840,696	-	892,716
Skilled Nursing				56,204	7,797,295	-	7,853,499
Professional Claims	9,551,621	8,141,524	17,693,145	-	-	193,374	17,886,520
Prescription Drugs	15,779,122	18,624,085	34,403,207	353,410	6,643,608	78,236	41,478,462
Quality Incentives					354,840		354,840
Long-term Care Facility Payments	39,576,802	6,315,960	45,892,763	-	-	42,818	45,935,581
Contingencies	-	-	-	-	-	-	-
Medical Management	2,868,487	-	2,868,487	24,763	1,036,097	387,481	4,316,829
Reinsurance & Other	(348,553)	948,643	600,090	2,129	58,785	87,938	748,942
Total Medical Expenses	125,740,826	107,514,636	233,255,462	1,055,105	33,112,431	960,375	268,383,373
Medical Loss Ratio	**94.1%**	**102.0%**	**97.6%**	**116.4%**	**92.2%**	**88.7%**	**96.9%**
GROSS MARGIN	7,831,047	(2,070,305)	**5,760,743**	**(148,802)**	**2,814,911**	**122,671**	**8,549,522**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			5,063,139	80,260	721,472	87,430	5,952,301
Professional Fees			131,037	12,346	92,486	1,938	237,808
Purchased Services			697,296	21,043	136,042	4,041	858,422
Printing and Postage			238,907	1,659	42,696	90	283,351
Depreciation and Amortization			445,978			2,014	447,992
Other Expenses			1,123,157	263	33,244	378	1,157,042
Indirect Cost Allocation, Occupancy Expense			(564,864)	29,493	937,491	2,499	404,619
Total Administrative Expenses			7,134,650	145,064	1,963,432	98,390	9,341,536
Admin Loss Ratio			**3.0%**	**16.0%**	**5.5%**	**9.1%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			(1,373,907)	(293,866)	851,479	24,281	(792,014)
INVESTMENT INCOME			-	-	-	-	1,785,993
NET RENTAL INCOME			-	-	-	-	4,158
OTHER INCOME			111	-	-	-	111
CHANGE IN NET ASSETS			**$ (1,385,052)**	**$ (293,866)**	**$ 851,479**	**$ 24,281**	**$ 986,993**
BUDGETED CHANGE IN ASSETS			3,002,498	38,405	942,012	(221,741)	3,904,423
VARIANCE TO BUDGET - FAV (UNFAV)			(4,387,549)	(332,271)	(90,533)	246,022	(2,917,430)

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Consolidated Revenue & Expense: September 2016 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	1,872,273	462,290	$ 2,334,563	3,527	54,874	535	2,393,499
REVENUES							
Capitation Revenue	511,025,792	209,956,483	$ 720,982,275	$ 3,786,574	$ 107,714,292	$ 3,237,171	$ 835,720,311
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	511,025,792	209,956,483	720,982,275	3,786,574	107,714,292	3,237,171	835,720,311
MEDICAL EXPENSES							
Provider Capitation	138,022,700	84,177,000	222,199,699	1,163,320	21,346,410	-	244,709,429
Facilitities	111,168,345	66,183,805	177,352,149	878,355	29,624,827	668,212	208,523,543
Ancillary				133,979	2,262,985	-	2,396,963
Skilled Nursing				121,209	18,014,897	-	18,136,106
Professional Claims	36,471,262	15,609,385	52,080,647	-	-	545,498	52,626,145
Prescription Drugs	70,032,629	34,617,688	104,650,316	1,251,166	24,680,604	273,017	130,855,103
Quality Incentives					1,098,740		1,098,740
Long-term Care Facility Payments	122,032,119	12,348,805	134,380,925	-	-	28,011	134,408,935
Contingencies	-	-	-	-	-	-	-
Medical Management	8,776,649	-	8,776,649	69,532	2,940,686	1,094,795	12,881,661
Reinsurance & Other	(127,535)	1,921,099	1,793,565	12,379	293,602	263,103	2,362,648
Total Medical Expenses	486,376,169	214,857,782	701,233,950	3,629,939	100,262,749	2,872,635	807,999,274
Medical Loss Ratio	**95.2%**	**102.3%**	**97.3%**	**95.9%**	**93.1%**	**88.7%**	**96.7%**
GROSS MARGIN	24,649,624	(4,901,299)	19,748,325	156,635	7,451,542	364,535	27,721,037
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			15,851,504	93,057	2,230,540	268,311	18,443,412
Professional Fees			512,735	47,227	274,541	8,815	843,318
Purchased Services			1,969,430	65,377	420,397	9,281	2,464,485
Printing and Postage			617,346	4,843	164,479	532	787,199
Depreciation and Amortization			972,666			6,043	978,709
Other Expenses			2,862,022	1,572	99,834	16,581	2,980,009
Indirect Cost Allocation, Occupancy Expense			(1,814,067)	88,481	2,812,473	7,415	1,094,301
Total Administrative Expenses			20,971,636	300,556	6,002,264	316,977	27,591,433
Admin Loss Ratio			**2.9%**	**7.9%**	**5.6%**	**9.8%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			(1,223,311)	(143,921)	1,449,279	47,558	129,605
INVESTMENT INCOME			-	-	-	-	2,432,917
NET RENTAL INCOME			-	-	-	-	12,669
OTHER INCOME			459	-	-	-	459
CHANGE IN NET ASSETS			**$ (1,234,108)**	**$ (143,921)**	**$ 1,449,279**	**$ 47,558**	**$ 2,564,394**
BUDGETED CHANGE IN ASSETS			2,316,077	106,496	1,556,299	(754,669)	3,653,953
VARIANCE TO BUDGET - FAV (UNFAV)			(3,550,185)	(250,418)	(107,020)	802,228	(1,089,559)

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Balance Sheet: As of September 2016

ASSETS			LIABILITIES & FUND BALANCES	
Current Assets			Current Liabilities	
	Operating Cash	$262,324,977	Accounts payable	$12,824,182
	Catastrophic Reserves	11,631,071	Medical claims liability	606,370,807
	Investments	1,513,326,449	Accrued payroll liabilities	10,648,887
	Capitation receivable	234,956,079	Deferred revenue	807,306,921
	Receivables - Other	17,952,559	Deferred lease obligations	254,352
	Prepaid Expenses	11,434,421	Capitation and withholds	449,380,688
	Total Current Assets	**2,051,625,556**	**Total Current Liabilities**	**1,886,785,836**
Capital Assets	Furniture and equipment	28,851,790		
	Leasehold improvements	12,967,181		
	505 City Parkway West	46,707,144	Other employment benefits liability	28,128,517
		88,526,114		
	Less: accumulated depreciation	(33,396,458)	Net Pension Liabilities	8,755,170
	Capital assets, net	**55,129,657**	Long Term Liabilities	150,000
			TOTAL LIABILITIES	**1,923,819,523**
Other Assets	Restricted deposit & Other	283,186		
			Deferred inflows of Resources - Excess Earnings	502,900
	Board-designated assets		Deferred inflows of Resources - changes in Assumptions	1,651,640
	Cash and cash equivalents	8,977,633		
	Long term investments	467,086,587	Tangible net equity (TNE)	91,182,287
	Total Board-designated Assets	476,064,220	Funds in excess of TNE	570,949,286
	Total Other Assets	**476,347,406**		
			Net Assets	**662,131,573**
	Deferred outflows of Resources - Pension Contributions	3,787,544		
	Deferred outflows of Resources - Difference in Experience	1,215,473		
TOTAL ASSETS & OUTFLOWS		**2,588,105,636**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,588,105,636**

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Board Designated Reserve and TNE Analysis
As of September 2016

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Market - Low	Market - High
	Tier 1 - Payden & Rygel	135,408,667				
	Tier 1 - Logan Circle	125,473,000				
	Tier 1 - Wells Capital	125,410,994				
Board-designated Reserve						
		386,292,661	284,976,271	446,187,081	101,316,390	(59,894,420)
TNE Requirement	Tier 2 - Logan Circle	89,771,559	91,182,287	91,182,287	(1,410,728)	(1,410,728)
	Consolidated:	476,064,220	376,158,558	537,369,368	99,905,662	(61,305,148)
	Current reserve level	1.77	1.40	2.00		

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CalOptima A Public Agency Better. Together.

UNAUDITED FINANCIAL STATEMENTS

September 2016

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CalOptima - Consolidated
Financial Highlights
For the Three Months Ended September 30, 2016

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
796,173	801,052	(4,879)	(0.6%)	Member Months	2,393,499	2,399,324	(5,825)	(0.2%)
276,932,895	281,720,851	(4,787,956)	(1.7%)	Revenues	835,720,311	844,151,625	(8,431,314)	(1.0%)
268,383,373	266,531,225	(1,852,148)	(0.7%)	Medical Expenses	807,999,274	805,773,822	(2,225,452)	(0.3%)
9,341,536	11,428,453	2,086,917	18.3%	Administrative Expenses	27,591,433	35,153,600	7,562,168	21.5%
(792,014)	**3,761,173**	**(4,553,187)**	**(121.1%)**	**Operating Margin**	**129,605**	**3,224,203**	**(3,094,598)**	**(96.0%)**
1,779,007	143,250	1,635,757	1141.9%	Non Operating Income (Loss)	2,434,789	429,750	2,005,039	466.6%
986,993	**3,904,423**	**(2,917,430)**	**(74.7%)**	**Change in Net Assets**	**2,564,394**	**3,653,953**	**(1,089,559)**	**(29.8%)**
96.9%	94.6%	(2.3%)		Medical Loss Ratio	96.7%	95.5%	(1.2%)	
3.4%	4.1%	0.7%		Administrative Loss Ratio	3.3%	4.2%	0.9%	
(0.3%)	1.3%	(1.6%)		Operating Margin Ratio	0.0%	0.4%	(0.4%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima
Financial Dashboard
For the Three Months Ended September 30, 2016

MONTH

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	777,075	777,558	(483)	(0.1%)
OneCare	1,192	1,227	(35)	(2.9%)
OneCare Connect	17,727	22,092	(4,365)	(19.8%)
PACE	179	175	4	2.3%
Total	796,173	801,052	(4,879)	(0.6%)

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (1,385)	$ 3,002	$ (4,388)	(146.1%)
OneCare	(294)	38	(332)	(865.2%)
OneCare Connect	851	942	(91)	(9.6%)
PACE	24	(222)	246	111.0%
505 Bldg.	4	(65)	69	106.4%
Investment Income & Other	1,786	208	1,578	757.3%
Total	$ 987	$ 3,904	$ (2,917)	(74.7%)

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.6%	94.9%	(2.7)
OneCare	116.4%	90.5%	(25.9)
OneCare Connect	92.2%	93.0%	0.9

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 7,135	$ 8,983	$ 1,848	20.6%
OneCare	145	95	(50)	(52.0%)
OneCare Connect	1,963	2,238	274	12.3%
PACE	98	113	14	12.8%
Total	$ 9,342	$ 11,428	$ 2,087	18.3%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	835	886	50
OneCare	2	3	1
OneCare Connect	218	239	21
PACE	39	57	18
Total	1,095	1,184	89

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	930	878	52
OneCare	518	409	109
OneCare Connect	81	93	(11)
PACE	5	3	1
Total	1,534	1,382	151

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	2,334,563	2,328,530	6,033	0.3%
OneCare	3,527	3,719	(192)	(5.2%)
OneCare Connect	54,874	66,565	(11,691)	(17.6%)
PACE	535	510	25	4.9%
Total	2,393,499	2,399,324	(5,825)	(0.2%)

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (1,234)	$ 2,316	$ (3,550)	(153.3%)
OneCare	(144)	106	(250)	(235.1%)
OneCare Connect	1,449	1,556	(107)	(6.9%)
PACE	48	(755)	802	106.3%
505 Bldg.	13	(195)	208	106.5%
Investment Income & Other	2,433	625	1,808	289.3%
Total	$ 2,565	$ 3,654	$ (1,089)	(29.8%)

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.3%	95.8%	(1.5)
OneCare	95.9%	90.8%	(5.0)
OneCare Connect	93.1%	93.6%	0.5

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 20,972	$ 27,251	$ 6,280	23.0%
OneCare	301	286	(14)	(5.0%)
OneCare Connect	6,002	7,275	1,273	17.5%
PACE	317	341	24	7.1%
Total	$ 27,591	$ 35,154	$ 7,562	21.5%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	2,459	2,658	198
OneCare	11	9	(2)
OneCare Connect	682	716	34
PACE	113	170	56
Total	3,266	3,552	286

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	949	876	73
OneCare	320	413	(93)
OneCare Connect	80	93	(13)
PACE	5	3	2
Total	1,355	1,385	(31)

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CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended September 30, 2016

	Month					
	Actual		Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	796,173		801,052		(4,879)	
Revenues						
Medi-Cal	$ 239,016,205	$ 307.58	$ 233,667,057	$ 300.51	$ 5,349,147	$ 7.07
OneCare	906,303	760.32	1,404,974	1,145.05	(498,671)	(384.73)
OneCare Connect	35,927,342	2,026.70	45,542,884	2,061.51	(9,615,542)	(34.81)
PACE	1,083,046	6,050.54	1,105,936	6,319.63	(22,890)	(269.10)
Total Operating Revenue	276,932,895	347.83	281,720,851	351.69	(4,787,956)	(3.86)
Medical Expenses						
Medi-Cal	233,255,462	300.17	221,681,901	285.10	(11,573,561)	(15.07)
OneCare	1,055,105	885.16	1,271,137	1,035.97	216,032	150.82
OneCare Connect	33,112,431	1,867.91	42,363,283	1,917.58	9,250,852	49.68
PACE	960,375	5,365.22	1,214,903	6,942.30	254,528	1,577.08
Total Medical Expenses	268,383,373	337.09	266,531,225	332.73	(1,852,148)	(4.37)
Gross Margin	8,549,522	10.74	15,189,626	18.96	(6,640,104)	(8.22)
Administrative Expenses						
Salaries and benefits	5,952,301	7.48	7,803,641	9.74	1,851,339	2.27
Professional fees	237,808	0.30	372,966	0.47	135,157	0.17
Purchased services	858,422	1.08	875,942	1.09	17,519	0.02
Printing and Postage	283,351	0.36	458,234	0.57	174,883	0.22
Depreciation and amortization	447,992	0.56	385,117	0.48	(62,875)	(0.08)
Other	1,157,042	1.45	1,102,131	1.38	(54,912)	(0.08)
Indirect Cost Allocation, Occupancy Expense	404,619	0.51	430,424	0.54	25,805	0.03
Total Administrative Expenses	9,341,536	11.73	11,428,453	14.27	2,086,917	2.53
Income (Loss) From Operations	(792,014)	(0.99)	3,761,173	4.70	(4,553,187)	(5.69)
Investment income						
Interest income	1,371,640	1.72	208,333	0.26	1,163,307	1.46
Realized gain/(loss) on investments	144,817	0.18	-	-	144,817	0.18
Unrealized gain/(loss) on investments	269,536	0.34	-	-	269,536	0.34
Total Investment Income	1,785,993	2.24	208,333	0.26	1,577,660	1.98
Net Rental Income	4,158	0.01	(65,083)	(0.08)	69,241	0.09
Other Income	111	0.00	-	-	111	0.00
Change In Net Assets	**986,993**	**1.24**	**3,904,423**	**4.87**	**(2,917,430)**	**(3.63)**
Medical Loss Ratio	**96.9%**		**94.6%**		**(2.3%)**	
Administrative Loss Ratio	**3.4%**		**4.1%**		**0.7%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

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CalOptima - Consolidated - Year to Date
Statement of Revenue and Expenses
For the Three Months Ended September 30, 2016

	Year to Date					
	Actual		Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	2,393,499		2,399,324		(5,825)	
Revenues						
Medi-Cal	$ 720,982,275	$ 308.83	$ 699,428,318	$ 300.37	$ 21,553,957	$ 8.46
OneCare	3,786,574	1,073.60	4,276,207	1,149.83	(489,634)	(76.23)
OneCare Connect	107,714,292	1,962.94	137,221,857	2,061.47	(29,507,565)	(98.53)
PACE	3,237,171	6,050.79	3,225,243	6,324.01	11,928	(273.22)
Total Operating Revenue	835,720,311	349.16	844,151,625	351.83	(8,431,314)	(2.67)
Medical Expenses						
Medi-Cal	701,233,950	300.37	669,860,926	287.68	(31,373,024)	(12.70)
OneCare	3,629,939	1,029.19	3,883,519	1,044.24	253,580	15.05
OneCare Connect	100,262,749	1,827.14	128,390,682	1,928.80	28,127,932	101.66
PACE	2,872,635	5,369.41	3,638,696	7,134.70	766,061	1,765.29
Total Medical Expenses	807,999,274	337.58	805,773,822	335.83	(2,225,452)	(1.75)
Gross Margin	27,721,037	11.58	38,377,803	16.00	(10,656,766)	(4.41)
Administrative Expenses						
Salaries and benefits	18,443,412	7.71	23,659,181	9.86	5,215,769	2.16
Professional fees	843,318	0.35	1,083,829	0.45	240,511	0.10
Purchased services	2,464,485	1.03	2,708,601	1.13	244,116	0.10
Printing and Postage	787,199	0.33	1,373,759	0.57	586,560	0.24
Depreciation and amortization	978,709	0.41	1,155,352	0.48	176,643	0.07
Other	2,980,009	1.25	3,886,116	1.62	906,107	0.37
Indirect cost allocation, Occupancy Expense	1,094,301	0.46	1,286,763	0.54	192,462	0.08
Total Administrative Expenses	27,591,433	11.53	35,153,600	14.65	7,562,168	3.12
Income (Loss) From Operations	129,605	0.05	3,224,203	1.34	(3,094,598)	(1.29)
Investment income						
Interest income	3,299,129	1.38	625,000	0.26	2,674,129	1.12
Realized gain/(loss) on investments	240,799	0.10	-	-	240,799	0.10
Unrealized gain/(loss) on investments	(1,107,011)	(0.46)	-	-	(1,107,011)	(0.46)
Total Investment Income	2,432,917	1.02	625,000	0.26	1,807,917	0.76
Net Rental Income	12,669	0.01	(195,250)	(0.08)	207,919	0.09
Other Income	459	0.00	-	-	459	0.00
Change In Net Assets	**2,564,394**	**1.07**	**3,653,953**	**1.52**	**(1,089,559)**	**(0.45)**
Medical Loss Ratio	**96.7%**		**95.5%**		**(1.2%)**	
Administrative Loss Ratio	**3.3%**		**4.2%**		**0.9%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended September 30, 2016

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	548,305	228,770	$ 777,075	1,192	17,727	179	796,173
REVENUES							
Capitation Revenue	135,287,786	103,728,418	$ 239,016,205	$ 906,303	$ 35,927,342	$ 1,083,046	$ 276,932,895
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	135,287,786	103,728,418	239,016,205	906,303	35,927,342	1,083,046	276,932,895
MEDICAL EXPENSES							
Provider Capitation	37,329,044	35,916,879	73,245,923	384,652	6,420,083	-	80,050,658
Facilities	26,852,780	31,699,067	58,551,846	181,928	9,961,026	170,526	68,865,327
Ancillary				52,020	840,696	-	892,716
Skilled Nursing				56,204	7,797,295	-	7,853,499
Professional Claims	9,834,515	7,858,631	17,693,145	-	-	193,374	17,886,520
Prescription Drugs	18,866,955	15,536,252	34,403,207	353,410	6,643,608	78,236	41,478,462
Quality Incentives					354,840		354,840
Long-term Care Facility Payments	39,758,085	6,134,677	45,892,763	-	-	42,818	45,935,581
Contingencies	-	-	-	-	-	-	-
Medical Management	2,868,487	-	2,868,487	24,763	1,036,097	387,481	4,316,829
Reinsurance & Other	(312,347)	912,437	600,090	2,129	58,785	87,938	748,942
Total Medical Expenses	135,197,519	98,057,943	233,255,462	1,055,105	33,112,431	960,375	268,383,373
Medical Loss Ratio	**99.9%**	**94.5%**	**97.6%**	**116.4%**	**92.2%**	**88.7%**	**96.9%**
GROSS MARGIN	**90,267**	**5,670,475**	**5,760,743**	**(148,802)**	**2,814,911**	**122,671**	**8,549,522**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			5,063,139	80,260	721,472	87,430	5,952,301
Professional Fees			131,037	12,346	92,486	1,938	237,808
Purchased Services			697,296	21,043	136,042	4,041	858,422
Printing and Postage			238,907	1,659	42,696	90	283,351
Depreciation and Amortization			445,978			2,014	447,992
Other Expenses			1,123,157	263	33,244	378	1,157,042
Indirect Cost Allocation, Occupancy Expense			(564,864)	29,493	937,491	2,499	404,619
Total Administrative Expenses			7,134,650	145,064	1,963,432	98,390	9,341,536
Admin Loss Ratio			**3.0%**	**16.0%**	**5.5%**	**9.1%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			(1,373,907)	(293,866)	851,479	24,281	(792,014)
INVESTMENT INCOME			-	-	-	-	1,785,993
NET RENTAL INCOME			-	-	-	-	4,158
OTHER INCOME			111	-	-	-	111
CHANGE IN NET ASSETS			**$ (1,385,052)**	**$ (293,866)**	**$ 851,479**	**$ 24,281**	**$ 986,993**
BUDGETED CHANGE IN ASSETS			3,002,498	38,405	942,012	(221,741)	3,904,423
VARIANCE TO BUDGET - FAV (UNFAV)			(4,387,549)	(332,271)	(90,533)	246,022	(2,917,430)

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Three Months Ended September 30, 2016

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	1,643,503	691,060	$ 2,334,563	3,527	54,874	535	2,393,499
REVENUES							
Capitation Revenue	407,297,374	313,684,901	$ 720,982,275	$ 3,786,574	$ 107,714,292	$ 3,237,171	$ 835,720,311
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	407,297,374	313,684,901	720,982,275	3,786,574	107,714,292	3,237,171	835,720,311
MEDICAL EXPENSES							
Provider Capitation	102,105,820	120,093,879	222,199,699	1,163,320	21,346,410	-	244,709,429
Facilities	79,469,278	97,882,871	177,352,149	878,355	29,624,827	668,212	208,523,543
Ancillary				133,979	2,262,985	-	2,396,963
Skilled Nursing				121,209	18,014,897	-	18,136,106
Professional Claims	28,612,631	23,468,015	52,080,647	-	-	545,498	52,626,145
Prescription Drugs	54,496,377	50,153,940	104,650,316	1,251,166	24,680,604	273,017	130,855,103
Quality Incentives					1,098,740		1,098,740
Long-term Care Facility Payments	115,897,442	18,483,483	134,380,925	-	-	28,011	134,408,935
Contingencies	-	-	-	-	-	-	-
Medical Management	8,776,649	-	8,776,649	69,532	2,940,686	1,094,795	12,881,661
Reinsurance & Other	(1,039,972)	2,833,536	1,793,565	12,379	293,602	263,103	2,362,648
Total Medical Expenses	388,318,226	312,915,725	701,233,950	3,629,939	100,262,749	2,872,635	807,999,274
Medical Loss Ratio	**95.3%**	**99.8%**	**97.3%**	**95.9%**	**93.1%**	**88.7%**	**96.7%**
GROSS MARGIN	**18,979,148**	**769,177**	**19,748,325**	**156,635**	**7,451,542**	**364,535**	**27,721,037**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			15,851,504	93,057	2,230,540	268,311	18,443,412
Professional Fees			512,735	47,227	274,541	8,815	843,318
Purchased Services			1,969,430	65,377	420,397	9,281	2,464,485
Printing and Postage			617,346	4,843	164,479	532	787,199
Depreciation and Amortization			972,666			6,043	978,709
Other Expenses			2,862,022	1,572	99,834	16,581	2,980,009
Indirect Cost Allocation, Occupancy Expense			(1,814,067)	88,481	2,812,473	7,415	1,094,301
Total Administrative Expenses			20,971,636	300,556	6,002,264	316,977	27,591,433
Admin Loss Ratio			**2.9%**	**7.9%**	**5.6%**	**9.8%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			(1,223,311)	(143,921)	1,449,279	47,558	129,605
INVESTMENT INCOME			-	-	-	-	2,432,917
NET RENTAL INCOME			-	-	-	-	12,669
OTHER INCOME			459	-	-	-	459
CHANGE IN NET ASSETS			**$ (1,234,108)**	**$ (143,921)**	**$ 1,449,279**	**$ 47,558**	**$ 2,564,394**
BUDGETED CHANGE IN ASSETS			2,316,077	106,496	1,556,299	(754,669)	3,653,953
VARIANCE TO BUDGET - FAV (UNFAV)			(3,550,185)	(250,418)	(107,020)	802,228	(1,089,559)

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September 30, 2016 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $1.0 million, ($2.9) million unfavorable to budget
- Operating deficit is ($0.8) million with a surplus in non-operating of $1.8 million

YEARLY RESULTS:

- Change in Net Assets is $2.6 million, ($1.1) million unfavorable to budget
- Operating surplus is $0.1 million with a surplus in non-operating of $2.4 million

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(1.4)	3.0	(4.4)	Medi-Cal	(1.2)	2.3	(3.6)
(0.3)	0.0	(0.3)	OneCare	(0.1)	0.1	(0.3)
0.9	0.9	(0.1)	OCC	1.4	1.6	(0.1)
0.0	(0.2)	0.2	PACE	0.0	(0.8)	0.8
(0.8)	**3.8**	**(4.6)**	**Operating**	**0.1**	**3.2**	**(3.1)**
1.8	0.1	1.6	Inv./Rental Inc, MCO tax	2.4	0.4	2.0
1.8	**0.1**	**1.6**	**Non-Operating**	**2.4**	**0.4**	**2.0**
1.0	**3.9**	**(2.9)**	**TOTAL**	**2.6**	**3.7**	**(1.1)**

CalOptima

Enrollment Summary

For the Three Months Ended September 30, 2016

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
57,834	55,078	2,756	5.0%	Aged	172,232	164,755	7,477	4.5%
623	676	(53)	(7.8%)	BCCTP	1,892	2,026	(134)	(6.6%)
48,325	47,476	849	1.8%	Disabled	145,109	142,524	2,585	1.8%
335,393	339,437	(4,044)	(1.2%)	TANF Child	1,004,569	1,015,998	(11,429)	(1.1%)
102,827	109,755	(6,928)	(6.3%)	TANF Adult	309,882	329,241	(19,359)	(5.9%)
3,303	2,685	618	23.0%	LTC	9,819	8,033	1,786	22.2%
228,770	222,451	6,319	2.8%	MCE	691,060	665,955	25,105	3.8%
777,075	**777,558**	**(483)**	**(0.1%)**	**Medi-Cal**	**2,334,563**	**2,328,530**	**6,033**	**0.3%**
17,727	**22,092**	**(4,365)**	**(19.8%)**	**OneCare Connect**	**54,874**	**66,565**	**(11,691)**	**(17.6%)**
179	**175**	**4**	**2.3%**	**PACE**	**535**	**510**	**25**	**4.9%**
1,192	**1,227**	**(35)**	**(2.9%)**	**OneCare**	**3,527**	**3,719**	**(192)**	**(5.2%)**
796,173	**801,052**	**(4,879)**	**(0.6%)**	**CalOptima Total**	**2,393,499**	**2,399,324**	**(5,825)**	**(0.2%)**
				Enrollment (By Network)				
48,280	47,402	878	1.9%	HMO	143,259	141,045	2,214	1.6%
231,333	234,271	(2,938)	(1.3%)	PHC	694,361	701,712	(7,351)	(1.0%)
339,996	340,886	(890)	(0.3%)	Shared Risk Group	1,029,027	1,024,172	4,855	0.5%
157,466	154,999	2,467	1.6%	Fee for Service	467,916	461,603	6,313	1.4%
777,075	**777,558**	**(483)**	**(0.1%)**	**Medi-Cal**	**2,334,563**	**2,328,530**	**6,033**	**0.3%**
17,727	**22,092**	**(4,365)**	**(19.8%)**	**OneCare Connect**	**54,874**	**66,565**	**(11,691)**	**(17.6%)**
179	**175**	**4**	**2.3%**	**PACE**	**535**	**510**	**25**	**4.9%**
1,192	**1,227**	**(35)**	**(2.9%)**	**OneCare**	**3,527**	**3,719**	**(192)**	**(5.2%)**
796,173	**801,052**	**(4,879)**	**(0.6%)**	**CalOptima Total**	**2,393,499**	**2,399,324**	**(5,825)**	**(0.2%)**

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CalOptima
Enrollment Trend by Network Type
Fiscal Year 2017

Network Type	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	MMs
HMO													
Aged	351	350	355	-	-	-	-	-	-	-	-	-	1,056
BCCTP	1	1	1	-	-	-	-	-	-	-	-	-	3
Disabled	1,799	1,797	1,813	-	-	-	-	-	-	-	-	-	5,409
TANF Child	24,211	24,455	24,733	-	-	-	-	-	-	-	-	-	73,399
TANF Adult	7,929	7,872	7,914	-	-	-	-	-	-	-	-	-	23,715
LTC	-	-	-	-	-	-	-	-	-	-	-	-	-
MCE	12,989	13,224	13,464	-	-	-	-	-	-	-	-	-	39,677
	47,280	47,699	48,280	-	-	-	-	-	-	-	-	-	143,259
PHC													
Aged	1,495	1,464	1,488	-	-	-	-	-	-	-	-	-	4,447
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	7,903	7,872	7,862	-	-	-	-	-	-	-	-	-	23,637
TANF Child	169,358	168,529	169,733	-	-	-	-	-	-	-	-	-	507,620
TANF Adult	15,260	14,945	14,649	-	-	-	-	-	-	-	-	-	44,854
LTC	-	-	-	-	-	-	-	-	-	-	-	-	-
MCE	38,002	38,200	37,601	-	-	-	-	-	-	-	-	-	113,803
	232,018	231,010	231,333	-	-	-	-	-	-	-	-	-	694,361
Shared Risk Group													
Aged	7,658	7,627	7,635	-	-	-	-	-	-	-	-	-	22,920
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	14,428	14,307	14,189	-	-	-	-	-	-	-	-	-	42,924
TANF Child	118,748	118,149	118,421	-	-	-	-	-	-	-	-	-	355,318
TANF Adult	63,849	62,814	62,579	-	-	-	-	-	-	-	-	-	189,242
LTC	-	-	-	-	-	-	-	-	-	-	-	-	-
MCE	140,640	140,811	137,172	-	-	-	-	-	-	-	-	-	418,623
	345,323	343,708	339,996	-	-	-	-	-	-	-	-	-	1,029,027
Fee for Service (Dual)													
Aged	43,684	45,173	45,173	-	-	-	-	-	-	-	-	-	134,030
BCCTP	27	26	24	-	-	-	-	-	-	-	-	-	77
Disabled	19,790	20,086	20,071	-	-	-	-	-	-	-	-	-	59,947
TANF Child	3	2	2	-	-	-	-	-	-	-	-	-	7
TANF Adult	1,179	1,162	1,184	-	-	-	-	-	-	-	-	-	3,525
LTC	2,868	2,910	2,941	-	-	-	-	-	-	-	-	-	8,719
MCE	2,960	2,975	2,721	-	-	-	-	-	-	-	-	-	8,656
	70,511	72,334	72,116	-	-	-	-	-	-	-	-	-	214,961
Fee for Service (Non-Dual)													
Aged	3,746	2,850	3,183	-	-	-	-	-	-	-	-	-	9,779
BCCTP	606	608	598	-	-	-	-	-	-	-	-	-	1,812
Disabled	4,533	4,269	4,390	-	-	-	-	-	-	-	-	-	13,192
TANF Child	22,710	23,011	22,504	-	-	-	-	-	-	-	-	-	68,225
TANF Adult	15,792	16,253	16,501	-	-	-	-	-	-	-	-	-	48,546
LTC	368	370	362	-	-	-	-	-	-	-	-	-	1,100
MCE	35,946	36,543	37,812	-	-	-	-	-	-	-	-	-	110,301
	83,701	83,904	85,350	-	-	-	-	-	-	-	-	-	252,955
MEDI-CAL TOTAL													
Aged	56,934	57,464	57,834	-	-	-	-	-	-	-	-	-	172,232
BCCTP	634	635	623	-	-	-	-	-	-	-	-	-	1,892
Disabled	48,453	48,331	48,325	-	-	-	-	-	-	-	-	-	145,109
TANF Child	335,030	334,146	335,393	-	-	-	-	-	-	-	-	-	1,004,569
TANF Adult	104,009	103,046	102,827	-	-	-	-	-	-	-	-	-	309,882
LTC	3,236	3,280	3,303	-	-	-	-	-	-	-	-	-	9,819
MCE	230,537	231,753	228,770	-	-	-	-	-	-	-	-	-	691,060
	778,833	778,655	777,075	-	-	-	-	-	-	-	-	-	2,334,563
PACE	177	179	179	-	-	-	-	-	-	-	-	-	535
OneCare	1,171	1,164	1,192	-	-	-	-	-	-	-	-	-	3,527
OneCare Connect	18,902	18,245	17,727	-	-	-	-	-	-	-	-	-	54,874
TOTAL	799,083	798,243	796,173	-	-	-	-	-	-	-	-	-	2,393,499

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ENROLLMENT:

Overall MTD enrollment was 796,173

- Unfavorable to budget by 4,879
- Decreased 2,070 or 0.3% from prior month
- Increased 29,065 or 3.8% from prior year (September 2015)

Medi-Cal enrollment was 777,075

- Unfavorable to budget by 483 primarily driven by:
    - Medi-Cal Expansion favorable by 6,319 and SPD by 3,552
    - Offset by TANF unfavorable by 10,972

- Decreased 1,580 from prior month

OneCare enrollment was 1,192

- Unfavorable to budget by 35
- Increased 28 from prior month

OneCare Connect enrollment was 17,727

- Unfavorable to budget by 4,365
- Decreased 518 from prior month

PACE enrollment at 179

- Favorable to budget by 4
- No change from prior month

CalOptima - MediCal Total
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
777,075	777,558	(483)	(0.1%)	Member Months	2,334,563	2,328,530	6,033	0.3%
				Revenues				
239,016,205	233,667,057	5,349,147	2.3%	Capitation revenue	720,982,275	699,428,318	21,553,957	3.1%
239,016,205	233,667,057	5,349,147	2.3%	Total Operating Revenues	720,982,275	699,428,318	21,553,957	3.1%
				Medical Expenses				
73,245,923	74,940,833	1,694,910	2.3%	Provider capitation	222,199,699	224,672,589	2,472,890	1.1%
58,551,846	55,581,746	(2,970,100)	(5.3%)	Facilities	177,352,149	168,420,281	(8,931,868)	(5.3%)
17,693,145	16,672,389	(1,020,757)	(6.1%)	Professional Claims	52,080,647	49,905,652	(2,174,995)	(4.4%)
34,403,207	33,532,210	(870,998)	(2.6%)	Prescription drugs	104,650,316	102,395,217	(2,255,100)	(2.2%)
45,892,763	36,498,887	(9,393,876)	(25.7%)	MLTSS	134,380,925	110,996,277	(23,384,648)	(21.1%)
2,868,487	4,409,170	1,540,683	34.9%	Medical Management	8,776,649	13,330,911	4,554,262	34.2%
600,090	46,667	(553,424)	(1,185.9%)	Reinsurance & other	1,793,565	140,000	(1,653,565)	(1,181.1%)
233,255,462	221,681,901	(11,573,561)	(5.2%)	Total Medical Expenses	701,233,950	669,860,926	(31,373,024)	(4.7%)
5,760,743	11,985,156	(6,224,414)	(51.9%)	Gross Margin	19,748,325	29,567,393	(9,819,068)	(33.2%)
				Administrative Expenses				
5,063,139	6,749,758	1,686,619	25.0%	Salaries, wages & employee benefits	15,851,504	20,465,178	4,613,674	22.5%
131,037	287,222	156,185	54.4%	Professional fees	512,735	853,872	341,136	40.0%
697,296	706,154	8,858	1.3%	Purchased services	1,969,430	2,119,311	149,881	7.1%
238,907	310,612	71,706	23.1%	Printing and postage	617,346	935,257	317,911	34.0%
445,978	383,061	(62,917)	(16.4%)	Depreciation & amortization	972,666	1,149,183	176,517	15.4%
1,123,157	1,083,434	(39,722)	(3.7%)	Other operating expenses	2,862,022	3,345,773	483,751	14.5%
(564,864)	(537,583)	27,281	5.1%	Indirect cost allocation	(1,814,067)	(1,617,258)	196,809	12.2%
7,134,650	8,982,659	1,848,009	20.6%	Total Administrative Expenses	20,971,636	27,251,315	6,279,680	23.0%
				Operating Tax				
10,104,429	8,818,566	(1,285,863)	(14.6%)	Tax Revenue	30,899,477	26,412,636	(4,486,840)	(17.0%)
10,113,016	0	(10,113,016)	0.0%	Premium tax expense	30,675,939	0	(30,675,939)	0.0%
(8,588)	8,818,566	8,827,154	100.1%	Sales tax expense	223,538	26,412,636	26,189,099	99.2%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
50,000	287,500	(237,500)	(82.6%)	Grant Revenue	207,500	862,500	(655,000)	(75.9%)
42,618	250,000	207,382	83.0%	Grant expense - Service Partner	176,493	750,000	573,507	76.5%
18,637	37,500	18,863	50.3%	Grant expense - Administrative	42,262	112,500	70,238	62.4%
(11,256)	0	(11,256)	0.0%	Total Net Grant Income	(11,256)	0	(11,256)	0.0%
111	0	111	0.0%	Other income	459	0	459	0.0%
(1,385,052)	3,002,498	(4,387,549)	(146.1%)	Change in Net Assets	(1,234,108)	2,316,077	(3,550,185)	(153.3%)
97.6%	94.9%	-2.7%	-2.9%	Medical Loss Ratio	97.3%	95.8%	-1.5%	-1.6%
3.0%	3.8%	0.9%	22.4%	Admin Loss Ratio	2.9%	3.9%	1.0%	25.3%

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MEDI-CAL INCOME STATEMENT – SEPTEMBER MONTH:

REVENUES of $239.0 million are favorable to budget by $5.3 million, driven by:

- Price related variance of: $5.5 million includes an IHSS favorable variance of $2.4 million
- Volume related unfavorable variance of: $0.1 million

MEDICAL EXPENSES: Overall $233.3 million, unfavorable to budget by $11.6 million due to:

- **Long term care claim payments (MLTSS)** are unfavorable to budget $9.4 million due to:
    - Price related unfavorable variance of: $11.7 million related to actuarial experience and County IHSS expense reporting
    - Volume related favorable variance of: $0.1 million
- **Facilities** are unfavorable to budget $3.0 million due to:
    - Price related unfavorable variance of: $3.0 million related to claims actuarial experience

ADMINISTRATION EXPENSES are $7.1 million, favorable to budget $1.8 million, driven by:

- Salary & Benefits: $1.7 million favorable to budget
- Non-Salary: $0.2 million favorable to budget across most categories

CHANGE IN NET ASSETS is $(1.4) million for the month, unfavorable to budget by $4.4 million

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
17,727	22,092	(4,365)	(19.8%)	Member Months	54,874	66,565	(11,691)	(17.6%)
				Revenues				
35,927,342	45,542,884	(9,615,542)	(21.1%)	Capitation revenue	107,714,292	137,221,857	(29,507,565)	(21.5%)
35,927,342	45,542,884	(9,615,542)	(21.1%)	Total Operating Revenue	107,714,292	137,221,857	(29,507,565)	(21.5%)
				Medical Expenses				
6,420,083	9,572,443	3,152,360	32.9%	Provider capitation	21,346,410	28,842,015	7,495,605	26.0%
9,961,026	11,450,962	1,489,936	13.0%	Facilities	29,624,827	34,706,591	5,081,763	14.6%
840,696	691,264	(149,433)	(21.6%)	Ancillary	2,262,985	2,082,796	(180,188)	(8.7%)
7,797,295	10,435,359	2,638,064	25.3%	Long Term Care	18,014,897	31,441,998	13,427,100	42.7%
6,643,608	7,925,697	1,282,089	16.2%	Prescription drugs	24,680,604	24,376,403	(304,200)	(1.2%)
354,840	455,923	101,083	22.2%	Quality incentives	1,098,740	1,373,706	274,966	20.0%
1,036,097	1,195,402	159,305	13.3%	Medical management	2,940,686	3,650,183	709,497	19.4%
58,785	636,234	577,449	90.8%	Other medical expenses	293,602	1,916,990	1,623,388	84.7%
33,112,431	42,363,283	9,250,852	21.8%	Total Medical Expenses	100,262,749	128,390,682	28,127,932	21.9%
2,814,911	3,179,601	(364,690)	(11.5%)	Gross Margin	7,451,542	8,831,175	(1,379,633)	(15.6%)
				Administrative Expenses				
721,472	940,642	219,169	23.3%	Salaries, wages & employee benefits	2,230,540	2,850,404	619,864	21.7%
92,486	69,077	(23,410)	(33.9%)	Professional fees	274,541	179,957	(94,584)	(52.6%)
136,042	149,312	13,269	8.9%	Purchased services	420,397	527,956	107,559	20.4%
42,696	133,886	91,191	68.1%	Printing and postage	164,479	398,286	233,807	58.7%
33,244	7,182	(26,062)	(362.9%)	Other operating expenses	99,834	505,801	405,967	80.3%
937,491	937,491	(0)	(0.0%)	Indirect cost allocation, Occupancy Expense	2,812,473	2,812,472	(1)	(0.0%)
1,963,432	2,237,589	274,157	12.3%	Total Administrative Expenses	6,002,264	7,274,876	1,272,613	17.5%
				Operating Tax				
493	0	493	0.0%	Tax Revenue	(1,046)	0	(1,046)	0.0%
493	0	(493)	0.0%	Sales tax expense	(1,046)	0	1,046	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
851,479	942,012	(90,533)	(9.6%)	Change in Net Assets	1,449,279	1,556,299	(107,020)	(6.9%)
92.2%	93.0%	0.9%	0.9%	Medical Loss Ratio	93.1%	93.6%	0.5%	0.5%
5.5%	4.9%	-0.6%	-11.2%	Admin Loss Ratio	5.6%	5.3%	-0.3%	-5.1%

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ONECARE CONNECT INCOME STATEMENT – SEPTEMBER MONTH:

REVENUES of $35.9 million are unfavorable to budget by $9.6 million driven by:

- Price related unfavorable variance of: $0.6 million due to cohort experience
- Volume related unfavorable variance of: $9.0 million due to the lower enrollment

MEDICAL EXPENSES are favorable to budget $9.2 million due to:

- Volume related favorable variance of: $8.4 million corresponding with lower enrollment
- Provider Capitation: $1.1 million favorable adjustment for prior year Part B Drugs

ADMINISTRATIVE EXPENSES are favorable to budget by $0.3 million

CHANGE IN NET ASSETS is $0.9 million, unfavorable to budget by $0.1 million

CalOptima - OneCare
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,192	1,227	(35)	(2.9%)	Member Months	3,527	3,719	(192)	(5.2%)
				Revenues				
906,303	1,404,974	(498,671)	(35.5%)	Capitation revenue	3,786,574	4,276,207	(489,634)	(11.5%)
906,303	1,404,974	(498,671)	(35.5%)	Total Operating Revenue	3,786,574	4,276,207	(489,634)	(11.5%)
				Medical Expenses				
384,652	381,122	(3,530)	(0.9%)	Provider capitation	1,163,320	1,162,102	(1,218)	(0.1%)
181,928	310,956	129,028	41.5%	Inpatient	878,355	952,955	74,600	7.8%
52,020	47,616	(4,404)	(9.2%)	Ancillary	133,979	147,193	13,214	9.0%
56,204	22,590	(33,614)	(148.8%)	Skilled nursing facilities	121,209	69,986	(51,223)	(73.2%)
353,410	468,949	115,539	24.6%	Prescription drugs	1,251,166	1,421,106	169,940	12.0%
24,763	12,500	(12,263)	(98.1%)	Medical management	69,532	43,500	(26,032)	(59.8%)
2,129	27,404	25,275	92.2%	Other medical expenses	12,379	86,677	74,297	85.7%
1,055,105	1,271,137	216,032	17.0%	Total Medical Expenses	3,629,939	3,883,519	253,580	6.5%
(148,802)	133,837	(282,639)	(211.2%)	Gross Margin	156,635	392,688	(236,054)	(60.1%)
				Administrative Expenses				
80,260	21,197	(59,063)	(278.6%)	Salaries, wages & employee benefits	93,057	64,402	(28,655)	(44.5%)
12,346	13,333	987	7.4%	Professional fees	47,227	40,000	(7,227)	(18.1%)
21,043	19,422	(1,621)	(8.3%)	Purchased services	65,377	58,226	(7,151)	(12.3%)
1,659	11,897	10,238	86.1%	Printing and postage	4,843	34,818	29,976	86.1%
263	89	(174)	(196.9%)	Other operating expenses	1,572	266	(1,306)	(491.4%)
29,493	29,494	1	0.0%	Indirect cost allocation, Occupancy Expense	88,481	88,481	0	0.0%
145,064	95,431	(49,632)	(52.0%)	Total Administrative Expenses	300,556	286,192	(14,364)	(5.0%)
(293,866)	38,405	(332,271)	(865.2%)	Change in Net Assets	(143,921)	106,496	(250,418)	(235.1%)
116.4%	90.5%	-25.9%	-28.7%	Medical Loss Ratio	95.9%	90.8%	-5.0%	-5.6%
16.0%	6.8%	-9.2%	-135.6%	Admin Loss Ratio	7.9%	6.7%	-1.2%	-18.6%

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CalOptima - PACE
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
179	175	4	2.3%	Member Months	535	510	25	4.9%
				Revenues				
804,836	782,918	21,919	2.8%	Medi-Cal capitation revenue	2,387,445	2,281,160	106,285	4.7%
278,209	323,018	(44,809)	(13.9%)	MediCare capitation revenue	849,725	944,083	(94,357)	(10.0%)
1,083,046	1,105,936	(22,890)	(2.1%)	Total Operating Revenues	3,237,171	3,225,243	11,928	0.4%
				Medical Expenses				
279,934	394,969	115,035	29.1%	Clinical salaries & benefits	782,242	1,195,489	413,247	34.6%
0	0	0	0.0%	Pace Center Support salaries & benefits	0	0	0	0.0%
				Provider capitation				
170,526	220,477	49,950	22.7%	Claims payments to hospitals	668,212	656,600	(11,612)	(1.8%)
193,374	232,810	39,435	16.9%	Professional Claims	545,498	691,460	145,962	21.1%
78,236	125,988	47,752	37.9%	Prescription drugs	273,017	375,204	102,187	27.2%
42,818	22,581	(20,238)	(89.6%)	Long-term care facility payments	28,011	67,247	39,237	58.3%
55,778	70,094	14,316	20.4%	Patient Transportation	170,830	208,746	37,916	18.2%
48,342	49,349	1,007	2.0%	Depreciation & amortization	145,026	148,047	3,021	2.0%
37,655	37,214	(441)	(1.2%)	Occupancy expenses	112,965	111,642	(1,323)	(1.2%)
21,231	13,833	(7,398)	(53.5%)	Utilities & Facilities Expense	53,898	41,499	(12,399)	(29.9%)
319	257	(62)	(24.1%)	Purchased Services	664	765	101	13.2%
22,315	24,547	2,232	9.1%	Indirect Allocation	65,033	73,641	8,608	11.7%
9,845	22,785	12,941	56.8%	Other Expenses	27,239	68,355	41,116	60.2%
960,375	1,214,903	254,528	21.0%	Total Medical Expenses	2,872,635	3,638,696	766,061	21.1%
122,671	(108,967)	231,638	212.6%	Gross Margin	364,535	(413,453)	777,988	188.2%
				Administrative Expenses				
87,430	92,044	4,613	5.0%	Salaries, wages & employee benefits	268,311	279,197	10,886	3.9%
1,938	3,333	1,395	41.9%	Professional fees	8,815	10,000	1,185	11.9%
4,041	1,054	(2,987)	(283.4%)	Purchased services	9,281	3,108	(6,173)	(198.6%)
90	1,839	1,749	95.1%	Printing and postage	532	5,398	4,866	90.2%
2,014	2,056	42	2.0%	Depreciation & amortization	6,043	6,168	126	2.0%
378	11,426	11,047	96.7%	Other operating expenses	16,581	34,277	17,696	51.6%
2,499	1,023	(1,476)	(144.3%)	Indirect cost allocation, Occupancy Expense	7,415	3,068	(4,347)	(141.7%)
98,390	112,774	14,384	12.8%	Total Administrative Expenses	316,977	341,216	24,239	7.1%
24,281	(221,741)	246,022	111.0%	Change in Net Assets	47,558	(754,669)	802,228	106.3%
88.7%	109.9%	21.2%	19.3%	Medical Loss Ratio	88.7%	112.8%	24.1%	21.3%
9.1%	10.2%	1.1%	10.9%	Admin Loss Ratio	9.8%	10.6%	0.8%	7.4%

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CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
24,056	21,285	2,772	13.0%	Rental income	72,169	63,855	8,315	13.0%
24,056	21,285	2,772	13.0%	Total Operating Revenue	72,169	63,855	8,315	13.0%
				Administrative Expenses				
1,525	2,085	560	26.8%	Professional fees	3,995	6,255	2,260	36.1%
26,303	22,405	(3,899)	(17.4%)	Purchase services	95,362	67,214	(28,148)	(41.9%)
180,764	210,141	29,377	14.0%	Depreciation & amortization	469,217	630,422	161,206	25.6%
16,000	14,300	(1,700)	(11.9%)	Insurance expense	48,001	42,901	(5,101)	(11.9%)
77,419	189,537	112,118	59.2%	Repair and maintenance	257,908	568,612	310,704	54.6%
60,349	0	(60,349)	0.0%	Other Operating Expense	209,049	0	(209,049)	0.0%
(342,462)	(352,100)	(9,637)	(2.7%)	Indirect allocation, Occupancy Expense	(1,024,032)	(1,056,299)	(32,268)	(3.1%)
19,898	86,368	66,470	77.0%	Total Administrative Expenses	59,500	259,105	199,604	77.0%
4,158	(65,083)	69,241	106.4%	Change in Net Assets	12,669	(195,250)	207,919	106.5%

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OTHER STATEMENTS – SEPTEMBER MONTH:

ONECARE INCOME STATEMENT

REVENUES of $0.9 million are unfavorable to budget by $0.5 million due to direct subsidy restatement

CHANGE IN NET ASSETS is ($0.3) million, $0.3 million unfavorable to budget

PACE INCOME STATEMENT

- **Change in Net Assets** for the month is $24.3 thousand, which is operating favorable to budget by $246.0 thousand

505 CITY PARKWAY BUILDING INCOME STATEMENT

- **Change in Net Assets** for the month is $4.2 thousand which is favorable to budget $69.2 thousand

CalOptima
BALANCE SHEET
September 30, 2016

ASSETS				**LIABILITIES & FUND BALANCES**	
Current Assets				Current Liabilities	
	Operating Cash	$262,324,977		Accounts payable	$12,824,182
	Catastrophic Reserves	11,631,071		Medical claims liability	606,370,807
	Investments	1,513,326,449		Accrued payroll liabilities	10,648,887
	Capitation receivable	234,956,079		Deferred revenue	807,306,921
	Receivables - Other	17,952,559		Deferred lease obligations	254,352
	Prepaid Expenses	11,434,421		Capitation and withholds	449,380,688
				Total Current Liabilities	**1,886,785,836**
	Total Current Assets	**2,051,625,556**			
Capital Assets	Furniture and equipment	28,851,790			
	Leasehold improvements	12,967,181			
	505 City Parkway West	46,707,144		Other employment benefits liability	28,128,517
		88,526,114			
	Less: accumulated depreciation	(33,396,458)		Net Pension Liabilities	8,755,170
	Capital assets, net	**55,129,657**		Long Term Liabilities	150,000
				TOTAL LIABILITIES	**1,923,819,523**
Other Assets	Restricted deposit & Other	283,186			
				Deferred inflows of Resources - Excess Earnings	502,900
	Board-designated assets			Deferred inflows of Resources - changes in Assumptions	1,651,640
	Cash and cash equivalents	8,977,633			
	Long term investments	467,086,587		Tangible net equity (TNE)	91,182,287
	Total Board-designated Assets	476,064,220		Funds in excess of TNE	570,949,286
	Total Other Assets	**476,347,406**			
				Net Assets	**662,131,573**
	Deferred outflows of Resources - Pension Contributions	3,787,544			
	Deferred outflows of Resources - Difference in Experience	1,215,473			
TOTAL ASSETS & OUTFLOWS		**2,588,105,636**		**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,588,105,636**

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CalOptima
Board Designated Reserve and TNE Analysis
as of September 30, 2016

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	135,408,667				
	Tier 1 - Logan Circle	125,473,000				
	Tier 1 - Wells Capital	125,410,994				
Board-designated Reserve		386,292,661	284,976,271	446,187,081	101,316,390	(59,894,420)
TNE Requirement	Tier 2 - Logan Circle	89,771,559	91,182,287	91,182,287	(1,410,728)	(1,410,728)
	Consolidated:	**476,064,220**	**376,158,558**	**537,369,368**	**99,905,662**	**(61,305,148)**
	Current reserve level	1.77	1.40	2.00		

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CalOptima
Statement of Cash Flows
September 30, 2016

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	986,993	2,564,394
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	447,992	978,709
Changes in assets and liabilities:		
Prepaid expenses and other	169,645	(4,650,174)
Catastrophic reserves		
Capitation receivable	15,456,899	233,842,369
Medical claims liability	(5,706,114)	7,675,949
Deferred revenue	55,326,358	216,604,279
Payable to providers	18,209,420	47,554,386
Accounts payable	10,366,250	6,225,999
Other accrued liabilities	868,424	2,595,403
Net cash provided by/(used in) operating activities	96,125,869	513,391,314
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	(2,703,221)	(494,061,817)
Purchase of property and equipment	(552,652)	(1,112,801)
Change in Board designated reserves	(672,234)	(212,041)
Net cash provided by/(used in) investing activities	(3,928,108)	(495,386,657)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	92,197,761	18,004,655
CASH AND CASH EQUIVALENTS, beginning of period	$181,758,286	255,951,393
CASH AND CASH EQUIVALENTS, end of period	**$ 273,956,048**	**$ 273,956,048**

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BALANCE SHEET:

ASSETS Increased $80.1 million from August

- **Cash and Cash Equivalents** increased by $92.2 million from August based upon timing of state checks received, month-end cut-off and cash funding requirements
- **Net Capitation Receivables** decreased $15.9 million based upon receipt timing and receivables

LIABILITIES increased $79.0 million from August

- **Deferred Revenue** increased by $55.3 million from August due to:
    - DHS overpayments
- **Total Capitation Payable** increased $18.2 million based upon timing of pool estimates, recalculations and payouts

NET ASSETS are $662.1 million

CalOptima Foundation
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2016
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
6,887	2,264	4,623	204.1%	Income - Grant	27,164	6,793	20,371	299.9%
30,874	0	30,874	100.0%	In Kind Revenue - HITEC Grant	72,959	0	72,959	100.0%
37,761	2,264	35,496	1567.6%	Total Operating Revenue	100,123	6,793	93,330	1373.9%
				Operating Expenditures				
18,900	6,184	(12,716)	(205.6%)	Personnel	35,772	18,553	(17,219)	(92.8%)
9,845	2,985	(6,860)	(229.8%)	Taxes and Benefits	30,708	8,954	(21,753)	(242.9%)
0	0	0	0.0%	Travel	(3)	0	3	100.0%
6,932	0	(6,932)	100.0%	Supplies	7,009	10,000	2,991	29.9%
0	0	0	0.0%	Contractual	20,388	17,174	(3,214)	(18.7%)
2,083	232,065	229,982	99.1%	Other	6,249	696,196	689,947	99.1%
37,761	241,234	203,474	84.3%	Total Operating Expenditures	100,123	750,877	650,754	86.7%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
0	(238,970)	(238,970)	(100.0%)	Program Income	0	(744,083)	(744,083)	(100.0%)

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CalOptima Foundation
Balance Sheet
September 30, 2016

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,894,727	Accounts payable-Current	0
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	-118
Total Current Assets	**2,894,727**	Grants-Foundation	0
		Total Current Liabilities	**-118**
		Total Liabilities	**-118**
		Net Assets	**2,894,845**
TOTAL ASSETS	**2,894,727**	**TOTAL LIABILITIES & NET ASSETS**	**2,894,727**

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CALOPTIMA FOUNDATION

INCOME STATEMENT:

Revenues

- Revenues from Health Information Technology for Economics and Clinical Health (HITEC) and in-kind contributions from CalOptima
- The Foundation recognized $37.8 thousand for September, 2016
    - HITEC Grant revenue totaled $27.2 thousand, which leaves $0.0 remaining in HITEC Grant funding as of September, 2016
    - CalOptima in-kind contribution totaled $73.0 thousand
- Revenue budget variances attributed to:
    - Grant funding originally allocated July-September 2016 for original extension, later ONC extended it through September 2016
    - CalOptima in-kind revenue was not included in FY17 budget

Expenses

- $100.1 thousand for grant related activities incurred YTD FY17
- Expense categories include staff services, travel and miscellaneous supplies
    - $651 thousand favorable to variance YTD
    - FY17 budget was based on remaining fund balance in Foundation total assets
    - Actual expenses were much lower than anticipated for CalOptima support activities

BALANCE SHEET:

Assets

- Cash of $2.9 million remains from the FY14 $3.0 million transfer from CalOptima for grants and programs in support of providers and community
- $0.0 current month grant receivable for ONC draw down of HITEC grant

Liabilities

- $0.0 current month provider payable for HITEC grant services

Budget Allocation Changes
Reporting changes for September 2016

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	OneCare Connect	Office of Compliance - Professional Fees (Consultant for Annual CPE Audit & CMS Mock Audit)	Office of Compliance - Professional Fees - Consultant for DMHC Mock Audit	$69,000	Re-purpose $53,631 from Professional Fees (Consultant for Annual CPE Audit) and $15,369 from Professional Fees (Consultant for CMS Mock Audit) to pay for consultant for DMHC Mock Audit	2017
July	COREC	REC - Other	REC - Comp Supply/Minor Equip	$10,000	Re-allocate funds to cover costs for computer equipment upgrade which is approved ONC grant managers	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$63,810	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for FY17 Ceridian Software Maintenance	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$15,010	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for FY17 Talentova Learning Management System	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$23,900	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for Silk Road	2017
July	Medi-Cal	Claims Administration - Purchased Services - Integration of Claim Editing Software	Claims Administration - Purchased Services - LTC Rate Adjustments	$98,000	Re-purpose funds from within Purchased Services (Integration of Claim Editing Software) to pay for LTC Adjustments (TriZetto Robot Process)	2017
July	Medi-Cal	Human Resources - Advertising, Travel, Comp Supply/Minor Equip, Subscriptions, Courier/Delivery	Human Resources - Professional Fees (Salary & Compensation Research), Public Activities, Office Supplies, Food Service Supplies, Professional Dues, Training & Seminars, Cert./Cont. Education	$84,491	Re-allocate HR FY17 Budget based on HR dept's past spending trends to better meet department's need	2017
July	Medi-Cal	IS-Infrastructure - Telephone - General Telecommunication and Network Connectivity	IS-Infrastructure - Purchased Services - Disaster Recovery Services	$35,575	Re-allocate funds from Telephone (General Telecommunication and Network Connectivity) to Purchased Services to pay for Disaster Recovery Services	2017
August	Medi-Cal	Other Pay	Quality Analytics - Purchased Services	$67,000	Re-allocate funds to Quality Analytics Purchased Services for additional funds that is needed for CG-CAHPS survey	2017
August	Medi-Cal	Other Pay	Community Relations - Professional Fees & Printing	$43,640	Re-allocate funds to Community Relations Professional Fees and Printing budgets for contracts with Tony Lam and Communications Lab and printing costs of Community Option Fair	2017
August	Medi-Cal	IS-Application Management - Purchased Services - Healthcare Productivity Automation	IS-Application Management - Purchased Services - Direct Hire Fees	$10,957	Re-purpose funds from Purchased Services (Healthcare Productivity Automation) to pay for Direct Hire fees	2017
August	Medi-Cal	Other Pay	IS-Application Development - Comp Supplies/Minor Equipments	$20,400	Re-allocate funds to cover costs of DocuSign, Box, and Primal Script 2016	2017
August	Medi-Cal	Claims Administration - Purchased Services	Claims Administration - Office Supplies, Training & Seminars, Printing	$15,000	Re-allocate funds from Purchased Services (Integration of Claim Editing Software & Inventory Management Forecasting) to Office Supplies, Training & Seminars, and Printing to better meet department's needs	2017
September	Medi-Cal	Health Education & Disease Management - Professional Fees	Health Education & Disease Management - Other Operating Expenses	$30,000	Re-allocate funds from Professional Fees (Childhood Obesity Program Design & Evaluation) to Member & Provider Incentives to support incentives for the Group Needs Assessment (GNA) and other Health Education / Disease Management activities.	2017

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

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Board of Directors' Meeting
November 3, 2016

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and external audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare Connect

- OneCare Connect CMS Mock Audit: In preparation for a full-scope CMS program audit of its OneCare Connect program, CalOptima has engaged a consultant to conduct a mock audit on its OneCare Connect program using the 2016 CMS audit protocols. Mock audit activities began in June 2016 and will continue through November 2016. Remediation of mock audit findings, including improvements made to policies and procedures, is currently ongoing.

- OneCare Connect DMHC Audit: The Department of Managed Health Care (DMHC) will begin an audit of Medicaid-based services for OneCare Connect beginning on February 6, 2017. The DMHC will conduct this audit on behalf of the Department of Health Care Services (DHCS) as part of an inter-agency agreement. To prepare, CalOptima engaged a consultant and conducted a mock audit on its OneCare Connect program using the DMHC Cal MediConnect Technical Assistance Guide (TAG) tools.

2. PACE

- 2016 Annual PACE Audit: On September 29, 2016, CMS issued the final audit report to CalOptima PACE, which identified three (3) findings in the following areas --- Infection Control, Internal Quality Assessment and Performance Improvement Program Activities, and Transportation Services. Corrective action plans (CAPs) are due to CMS and DHCS by October 29, 2016.

- 2016 PACE Level of Care (LOC) Audit: On August 2, 2016, DHCS issued an engagement notice to CalOptima PACE for the level of care (LOC) audit scheduled to occur on October 26, 2016. The purpose of the audit is to ensure the information submitted on the initial LOC documents is consistent with the assessments documented by the Interdisciplinary Care Team.

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3. Medi-Cal

- 2015 Medi-Cal Audit: The DHCS conducted an onsite audit of CalOptima's Medi-Cal program from February 8 – 19, 2016. The DHCS Medi-Cal audit consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, organization and administration of CalOptima, facility site reviews, and medical records review. On July 13, 2016, DHCS issued the final audit report, which identified findings in the following three (3) areas --- case management and care coordination, member's rights, and administrative and organizational capacity. CalOptima submitted its corrective action plans (CAPs) to the DHCS by the August 15, 2016 deadline. CalOptima is pending acceptance of the CAPs and closure of the audit by the DHCS.

- 2017 Medi-Cal Audit: The DHCS has informally advised CalOptima that it intends to engage CalOptima in an audit of its Medi-Cal program in February 2017. The DHCS last audited CalOptima's Medi-Cal program in February 2016.

- DMHC 1115 Waiver Seniors and Persons with Disabilities (SPD) Audit: The DMHC has notified CalOptima that it has expanded the scope of its planned audit for February 2017 to include Medi-Cal SPDs in addition to Medicaid-based services for CalOptima's OneCare Connect program. DMHC will conduct this audit on behalf of the DHCS as part of an inter-agency agreement. CalOptima was last subject to this tri-annual audit in 2014.

4. Other

- 2016 DMHC Routine Examination: The DMHC began an onsite routine examination of CalOptima's financial and administrative affairs on August 15, 2016. The onsite portion of the audit concluded the week ending September 16, 2016. The audit primarily focused on CalOptima's Healthy Families Program in place during the review period, and on CalOptima's organization-wide finances and administration. The DMHC will provide CalOptima with a draft/preliminary audit report within sixty (60) days of the last day of the audit, and will give CalOptima a chance to review and comment on the report prior to its finalization.

B. Regulatory Compliance Notices

- There were no regulatory compliance notices received since last month's Compliance Report to the Board of Directors.

C. Updates on Internal /External Audits

1. Internal Audits: Medi-Cal

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness for Routine	Timeliness for Denials	Clinical Decision Making (CDM) for Denials	Letter Score for Denials	Timeliness for Extended
May 2016	7%	NA	NA	23%	88%	89%	87%	38%
June 2016	10%	NA	NA	0%	60%	90%	77%	14%
July 2016	100%	67%	89%	0%	70%	90%	93%	25%

- The lower scores for timeliness of urgent PA requests were due to the following reasons:
  - Failure to meet decision timeframe (72 hours)

- The lower scores for timeliness of routine PA requests were due to the following reasons:
  - Failure to meet provider initial notification timeframe (24 hours)

- The lower scores for timeliness of denials were due to the following reasons:
  - Failure to meet decision timeframe (5 business days)
  - Failure to meet provider initial notification timeframe (24 hours)

- The lower scores for timeliness of extended PA requests were due to the following reasons:
  - Failure to meet provider initial notification timeframe (24 hours)
  - Failure to meet member written notification timeframe (2 business days)
  - Failure to meet provider delay notification timeframe (2 business days)

- The lower scores for clinical decision making (CDM) of denials were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision

- The lower letter scores for denials were due to the following reasons:
  - Failure to use lay language for services description
  - Failure to describe reason the request did not meet criteria in lay language
  - Failure to provide alternative direction
  - Failure to provide language assistance program (LAP) insert with approved threshold languages

- Medi-Cal Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2016	90%	100%	100%	97%
June 2016	70%	97%	87%	100%
July 2016	100%	100%	97%	70%

  - The compliance rate for paid claims timeliness and accuracy has increased to 100% from June to July 2016.
  - The compliance rate for denied claims timeliness has increased from 87% to 97% from June to July 2016.
  - The compliance rate for denied claims accuracy has decreased from 100% to 70% due to incorrect coding of denial claim.

- Medi-Cal Claims: Provider Dispute Resolution (PDR)

Month	Letter Accuracy	Determination Timeliness	Acknowledgement Timeliness
May 2016	94%	94%	100%
June 2016	100%	83%	100%
July 2016	100%	50%	100%

  - The compliance rate for letter accuracy has remained at 100% compliant for the past two (2) months.
  - The compliance rate for determination timeliness decreased from 83% to 50% from June 2016 to July 2016 due to PDR was incorrectly processed.
  - The compliance rate for acknowledgement timeliness has remained at 100% from May 2016 to July 2016.

- Medi-Cal Customer Service: Review for appropriate classification, routing and privacy handling for Medi-Cal Call Center and Member Liaison Call Center

Month	Medi-Cal Call Center	Member Liaison Call Center
May 2016	98%	100%
June 2016	98%	100%
July 2016	99%	98%

- The compliance rate for the Medi-Cal Call Center has remained at or above 98% from May 2016 to July 2016.

- The compliance rate for the Member Liaison Call Center has remained at or above 98% from May 2016 to July2016.

2. Internal Audits: OneCare

- OneCare Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
May 2016	100%
June 2016	100%
July 2016	100%

- The compliance rate for coverage determination timeliness remains consistent at 100% from May 2016 to July 2016.

- OneCare Pharmacy: Coverage determinations for protected classes of drugs are reviewed weekly to ensure that they are processed in accordance with the regulatory requirements and the appropriate timeframe.

Month	Protected Drug Cases Reviewed	Protected Drug Cases Failed	Overall Compliance
May 2016	3	0	100%
June 2016	1	0	100%
July 2016	0	0	NA

- The compliance rate for protected classes of drugs remains consistent at 100% from May 2016 to June 2016.

- OneCare Pharmacy: Coverage determinations for unprotected classes of drugs are reviewed weekly to ensure that they are processed in accordance with the regulatory requirements and appropriate timeframe.

Month	Unprotected Drug Cases Reviewed	Unprotected Drug Cases Failed	Overall Compliance
May 2016	29	2	93%
June 2016	19	0	100%
July 2016	8	0	100%

  - The compliance rate for unprotected classes of drugs remains consistent from June 2016 to July 2016.

- OneCare Pharmacy: Direct member reimbursement (DMR) requests are reviewed on a monthly basis to ensure that they are processed in accordance with the regulatory requirements and appropriate timeframe.

Month	% of DMR Cases Compliant
May 2016	100%
June 2016	50%
July 2016	100%

  - The DMR compliance rate has increased from 50% to 100% from June 2016 to July 2016.

- OneCare Utilization Management

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
May 2016	Nothing to Report	Nothing to Report	Nothing to Report	100%	67%	Nothing to Report	Nothing to Report	Nothing to Report
June 2016	Nothing to Report	Nothing to Report	Nothing to Report	100%	50%	Nothing to Report	Nothing to Report	Nothing to Report
July 2016	Nothing to Report	Nothing to Report	Nothing to Report	75%	33%	Nothing to Report	Nothing to Report	Nothing to Report

  - The lower letter scores for SODs were due to the following reasons:
    - Failure to use approved CMS letter template(s)
    - Failure to use lay language
    - Failure to meet member written notification requirement (2 business days) and provider delay notification timeframe (2 business days)

- OneCare Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2016	100%	100%	100%	100%
June 2016	100%	100%	100%	100%
July 2016	100%	100%	100%	100%

  - The compliance rate for paid and denied claims timeliness has remained consistent at 100% from May 2016 to July 2016.
  - The compliance rate for paid and denied claims accuracy has remained consistent at 100% from May 2016 to July 2016.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check Lag
May 2016	90%	100%	75%	100%
June 2016	60%	100%	90%	NA
July 2016	100%	100%	100%	NA

  - The compliance rate for determination accuracy increased from 60% to 100% from June 2016 to July 2016.
  - The compliance rate for letter accuracy has remained at 100% from May 2016 to July 2016.
  - The compliance rate for acknowledgement timeliness has increased from 90% to 100% from June 2016 to July 2016.

- OneCare Customer Service: Review for appropriate classification, routing and privacy handling for OneCare Call Center.

Month	OneCare Call Center
May 2016	99%
June 2016	99%
July 2016	99%

  - The compliance rate for the OneCare Call Center has been at 99% from May 2016 to July 2016.

3. Internal Audits: OneCare Connect

- OneCare Connect Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
May 2016	100%
June 2016	100%
July 2016	99.49%

  - Coverage determination timeliness remained consistent at or above 99% from May 2016 to July 2016.

- OneCare Connect Pharmacy: Coverage determinations for protected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements and in the appropriate timeframe.

Month	Protected Drug Cases Reviewed	Protected Drug Cases Failed	Overall Compliance
May 2016	29	0	100%
June 2016	22	0	100%
July 2016	28	0	100%

  - The compliance rate for coverage determinations for protected drug cases remains consistent at 100% from May 2016 to July 2016.

- OneCare Connect Pharmacy: Coverage determinations for unprotected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements and in the appropriate timeframe.

Month	Unprotected Drug Cases Reviewed	Unprotected Drug Cases Failed	Overall Compliance
May 2016	121	7	94%
June 2016	98	1	99%
July 2016	122	2	98%

  - The compliance rate for coverage determinations for unprotected classes of drugs ranges from 94% to 99% from May 2016 to July 2016.

- OneCare Connect Pharmacy: Direct member reimbursement (DMR) requests are reviewed on a monthly basis to ensure that they are processed in accordance with regulatory requirements and in the appropriate timeframe.

Month	DMR Cases Reviewed	DMR Cases Failed	Overall Compliance
May 2016	8	0	100%
June 2016	5	0	100%
July 2016	3	0	100%

  - The compliance rate for DMRs is consistent at 100% from May 2016 to July 2016.

- OneCare Connect Utilization Management: Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Review for Urgents	Timeliness For Routine	Letter Review for Routine	Timeliness for Denials	Clinical Decision Making (CDM) for Denials	Letter Review for Denials	Timeliness for Deferrals	Clinical Decision Making (CDM) for Deferrals	Letter Review for Deferrals
May 2016	57%	NA	71%	91%	78%	75%	92%	100%	Nothing to Report	Nothing to Report	Nothing to Report
June 2016	0%	NA	70%	40%	70%	50%	92%	100%	Nothing to Report	Nothing to Report	Nothing to Report
July 2016	100%	67%	89%	20%	60%	100%	100%	88%	Nothing to Report	Nothing to Report	Nothing to Report

  - The compliance rate for timelines of urgent PA requests has increased from 0% to 100% from June 2016 to July 2016.

  - The lower scores for letter review of urgent PA requests were due to failure to use lay language.

  - The lower scores for timeliness of routine PA requests were due to the following reasons
    - Failure to meet the decision timeframe (5 business days).
    - Failure to meet provider initial notification timeframe (24 hours).

  - The lower scores for letter review of routine PA requests were due to the following reasons
    - Failure to use lay language.
    - Failure to use correct letter template.

  - The compliance rate for timeliness of denials has increased from 50% to 100% from June 2016 to July 2016.

- The compliance rate for clinical decision making for denied PA requests has increased from 92% to 100% from June 2016 to July 2016.

- The lower scores for letter review of denied PA requests were due to the following reasons
  - Failure to cite specific criteria utilized to make the decision.
  - Failure to use correct letter template.

- OneCare Connect Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2016	77%	87%	100%	100%
June 2016	67%	93%	100%	100%
July 2016	7%	73%	100%	85%

- The compliance rate for paid claims timeliness decreased from June 2016 to July 2016 due to incorrect development of claim.

- The compliance rate for paid claims accuracy has decreased from 93% to 73% from June 2016 to July 2016 due to the following reasons:
  - Incorrect development of claim
  - Incorrect interest amount applied

- The compliance rate for denied claims timeliness has remained at 100% from May 2016 through July 2016.

- The compliance rate for denied claims accuracy has decreased from 100% to 85% from June 2016 to July 2016 due the following reasons:
  - Incorrect development of claim
  - Incorrectly processed as a denied claim

- OneCare Connect Claims: Provider Dispute Resolution (PDR) Claims

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check Lag
May 2016	94%	100%	100%	100%
June 2016	94%	100%	100%	50%
July 2016	100%	100%	100%	100%

- The compliance rate for determination accuracy has increased from 94% to 100% from June 2016 to July 2016.

- The compliance rate for both letter accuracy and acknowledgement timeliness has remained at 100% from May 2016 to July 2016.

- The compliance rate for check lag has increased from 50% to 100% from June 2016 to July 2016.

- OneCare Connect Customer Service: Review for appropriate classification, routing and privacy handling for OneCare Connect Call Center.

Month	OneCare Call Center
May 2016	99%
June 2016	100%
July 2016	100%

- The compliance rate for the OneCare Connect Call Center has remained at 100% from June 2016 to July 2016.

- PACE Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2016	100%	100%	100%	100%
June 2016	100%	100%	100%	92%
July 2016	77%	100%	100%	100%

- The compliance rate for paid claims timeliness has decreased from 100% to 77% due to the following reasons:
  - Incorrect development of claim
  - Claim not paid within timeframe (30 calendar days).

- The compliance rate for paid claims accuracy and denied claims timeliness has remained consistent at 100% from May 2016 to July 2016.

- The compliance rate for denied claims accuracy has increased from 92% to 100% from June 2016 to July 2016.

- PACE Claims: Provider Dispute Resolution (PDR)

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check LAG
May 2016	100%	100%	100%	100%

June 2016	100%	100%	100%	NA
July 2016	100%	100%	100%	NA

- The compliance rate for determination accuracy, letter accuracy, and acknowledgement timeliness has remained consistent at 100% from May 2016 to July 2016.

4. Health Network Audits: Results for each audit area are reported in the aggregate across all health networks by program.

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM for Urgents	Letter Score for Urgents	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
May 2016	80%	100%	100%	77%	79%	86%	96%	91%	93%	97%	50%	67%	77%
June 2016	86%	83%	100%	89%	80%	91%	94%	92%	95%	99%	50%	87%	78%
July 2016	85%	100%	98%	93%	70%	91%	94%	94%	98%	97%	50%	67%	45%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days);
  - Failure to meet timeframe for member notification (Routine – 2 business days);
  - Failure to meet timeframe for provider initial notification (24 hours);
  - Failure to provide proof of successful initial written notification to requesting provider (24 hours);
  - Failure to meet timeframe for member delay notification (5 business days); and
  - Failure to meet timeframe for provider delay notification (5 business days).

- The lower scores for clinical decision making (CDM) were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision; and
  - No indication of adequate clinical information obtained to make the decision to deny.

- The lower letter scores were due to the following reasons:
  - Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document;
  - Failure to provide letter with description of services in lay language;
  - Failure to provide letter in member's primary language;

- Failure to include name and contact information for health care professional responsible for decision to deny;
- Failure to notify member of delayed decision and anticipated decision date; and
- Failure to notify provider of delayed decision and anticipated decision date.

- Medi-Cal Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
May 2016	98%	99%
June 2016	100%	89%
July 2016	97%	96%

➢ The compliance rate for misclassified paid claims decreased from June 2016 to July 2016 due to adjusted claims and line item denials that were found on the universe that should not have been reported.

➢ The compliance rate for misclassified denied claims increased to 96% from June 2016 to July 2016.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2016	93%	98%	98%	95%
June 2016	93%	81%	86%	91%
July 2016	93%	92%	92%	87%

➢ The compliance rate for paid claims timeliness remained stable at 93% from May 2016 through July 2016.

➢ The compliance rate for paid claims accuracy and denied claims timeliness increased from June 2016 to July 2016.

➢ The compliance rate for denied claims accuracy decreased to 87% from June 2016 to July 2016 due to urgent care claims being denied for authorization.

- Medi-Cal Claims: Misclassified Hospital Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
May 2016	100%	74%
June 2016	100%	57%
July 2016	100%	77%

  - The compliance rate for misclassified paid claims remained stable at 100%, while denied claims increased to 77% from June 2016 to July 2016.

- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2016	100%	100%	100%	100%
June 2016	100%	100%	93%	100%
July 2016	100%	97%	100%	100%

  - The compliance rate for paid claims timeliness and denied claims accuracy has remained at 100% from May 2016 to July 2016.

  - The compliance rate for paid claims accuracy decreased to 97% from June 2016 to July 2016 due to claim paid under Medi-Cal rate.

  - The compliance rate for denied claims timeliness increased to 100% from June 2016 to July 2016.

5. Health Network Audits: OneCare

- OneCare Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timelines for Denials	Clinical Decision Making for Denials	Letter Score for Denials
May 2016	100%	Nothing to Report	100%	100%	83%	100%	75%	95%
June 2016	100%	Nothing to Report	98%	98%	94%	100%	89%	97%
July 2016	83%	Nothing to Report	95%	97%	93%	100%	100%	100%

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- The lower letter scores were due to the following reasons:
  - Failure to use approved CMS letter template; and
  - Failure to provide letter with description of services in lay language.

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for member written notification (Expedited – 72 hours); and
  - Failure to meet timeframe for provider initial notification (24 hours).

- OneCare Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
May 2016	100%	100%
June 2016	99%	97%
July 2016	98%	100%

- The compliance rate for misclassified paid claims decreased to 98% from June 2016 to July 2016 due to inappropriate application of 2% sequestration rate and duplicate claims and line item denials were located on the universe.

- The compliance rate for misclassified denied claims increased to 100% from June 2016 to July 2016.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2016	100%	100%	100%	100%
June 2016	91%	92%	100%	95%
July 2016	100%	100%	100%	95%

- The compliance rate for denied claims accuracy remained at 95% for July 2016 due to the following reasons:
  - Two (2) line items were denied, while only one (1) line item was included in the member notification.

- The compliance rate for paid claims timeliness, paid claims accuracy and denied claims timeliness were at 100% for July 2016.

6. Health Network Audits: OneCare Connect

- OneCare Connect Utilization Management (UM): Prior Authorization (PA) Requests

Month	imelines for Urgents	Clinical Decision Making for Urgents	Letter Score for Jrgent	imelines For Routine	Letter Score for Routin	imelines for Denials	Clinical Decisior Making for Denials	Letter Score for Denials	imelines for Modifieds	Clinical Decision Making for Modifieds	Letter Score for lodified	imelines for Deferrals	Clinical Decision Making for Deferrals	Letter Score for Deferrals
May 2016	80%	100%	73%	80%	77%	45%	85%	81%	25%	83%	82%	100%	100%	100%
June 2016	76%	99%	74%	71%	75%	58%	98%	84%	50%	90%	77%	Nothing to Report	Nothing to Report	Nothing to Report
July 2016	75%	100%	72%	79%	72%	51%	81%	80%	60%	89%	75%	Nothing to Report	Nothing to Report	Nothing to Report

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days);
  - Failure to meet timeframe for member notification (2 business days);
  - Failure to meet timeframe for provider initial notification (24 hours); and
  - Failure to provide proof of successful initial written notification to requesting provider (24 hours).

- The lower scores for clinical decision making were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision;
  - No indication of adequate clinical information obtained to make the decision to deny; and
  - No indication that the medical reviewer was involved in the denial determination.

- The lower letter scores were due to the following reasons:
  - Failure to provide letter in member's primary language;
  - Failure to outline reason for not meeting the criteria (lay language) in denial letter;
  - Failure to include name and contact information for health care professional responsible for decision to deny;
  - Failure to provide letter with description of services in lay language; and
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer.

- OneCare Connect Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
May 2016	98%	92%
June 2016	99%	100%
July 2016	99%	98%

  - The compliance rate for misclassified paid claims remained stable at 99% from June 2016 to July 2016.

  - The compliance rate for misclassified denied claims decreased to 98% from June 2016 to July 2016 due to:
    - Misclassified claim denial that should have been excluded from the universe; and
    - Misclassified paid claim identified on denial universe.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2016	98%	98%	100%	89%
June 2016	94%	96%	100%	94%
July 2016	96%	96%	91%	89%

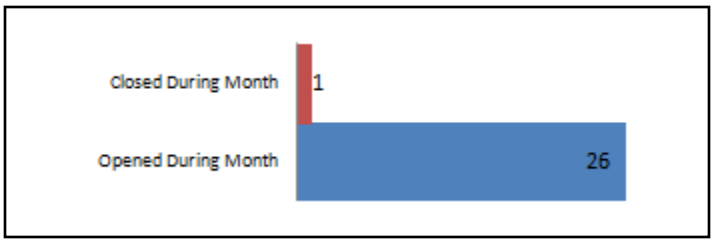
  - The compliance rate for paid claims timeliness increased to 96% from June 2016 to July 2016.

  - The compliance rate for paid claims accuracy remained stable at 96% from June 2016 to July 2016 due to unpaid claims.

  - The lower compliance rates for denied claims timeliness and accuracy were due to the following reasons:
    - Misclassified line item denial;
    - Claims processed beyond the turnaround time; and
    - Failure to pay correct amount on claim.

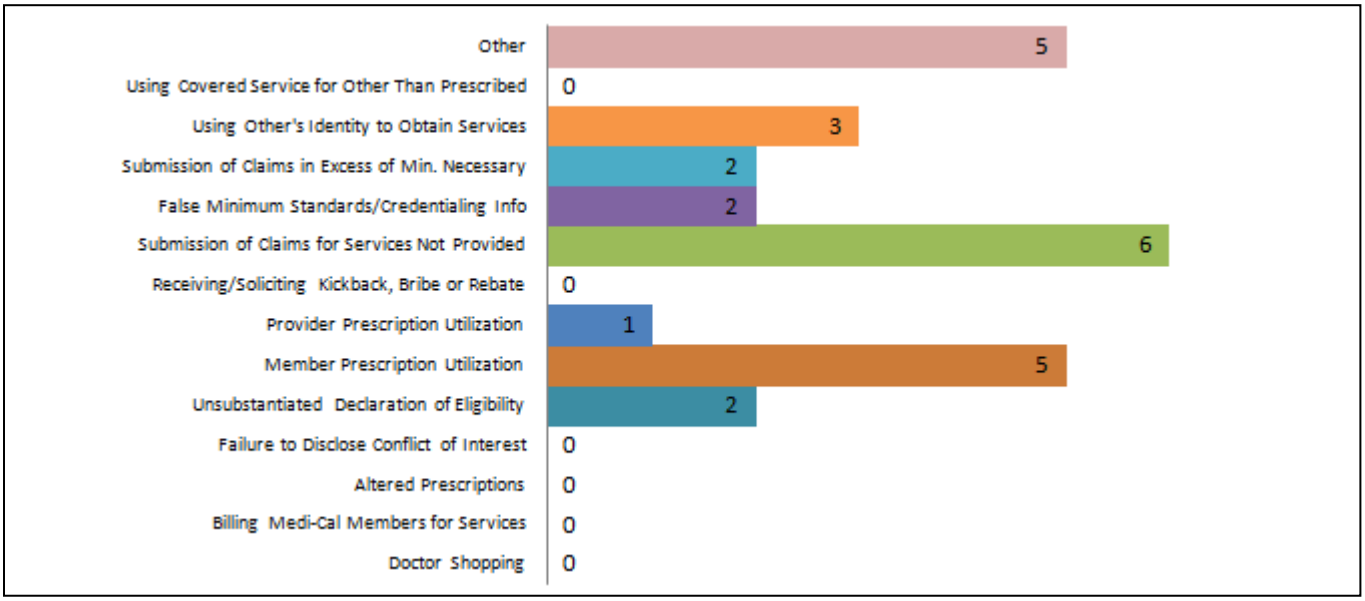
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations (September 2016)

Case Status
Case status at the end of September 2016



Note: Cases that are referred to DHCS or the MEDIC are not "closed" until CalOptima receives notification of case closure from the applicable government agency.

Types of FWA Cases:
(Received in September 2016)



A Public Agency

CalOptima

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Federal & State Legislative Advocate Reports

Board of Directors Meeting

November 3, 2016

James McConnell / Edelstein Gilbert Robson & Smith

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JAMES F. MCCONNELL
ATTORNEY-AT-LAW
1130 CONNECTICUT AVENUE, N.W.
SUITE 300
WASHINGTON, D.C. 20036
Mobile: 917-434-3603
E-mail: jmcconnell@tfgnet.com

CalOptima
Washington Report
October 26, 2016

The Affordable Care Act (ACA) is the only major law enacted in the modern era that has never been amended after enactment to make legislative fixes and remedy anomalies not noticed or understood until the law went into operation. The ACA was enacted without bi-partisan support and Congress reverted to Republican control after the 2010 elections.

Republicans have vowed for six years to repeal it. They have voted to do so dozens of times, despite knowing any measures would be vetoed by President Obama. But if elected, a President Donald Trump—or any anti-ACA Republican—would not have to wait for Congress to once again pass repeal legislation to stop the health law from functioning. He could do much of it administratively.

The Republican-led Congress has refused to make changes to the law that would help it work better—such as offering a fix when insurers cancelled policies that individuals thought they would be able to keep. As opponents of the law, they have had no incentive to improve it.

When problems in the operation of the ACA have arisen, the Obama Administration has often used the President's executive authority to try to solve them. And through executive authority, a Republican President could undermine the law. A new President could reverse the previous President's actions in many cases. A President cannot undo the basic architecture of the law, but he could administratively "gum up the works."

Formal regulations would take time to undo some administrative fixes to ACA, because they must follow a lengthy process allowing for public comment. But there are several measures any President could take on day one of his Administration to cripple the law's effectiveness.

Perhaps the easiest action—and the one that would produce the largest impact—would be to drop the Administration's appeal of a lawsuit filed by Republican Members of the House of Representatives in 2014. That suit, *House* v. *Burwell*, charged that the Obama Administration was unconstitutionally spending money that Congress had not formally appropriated; and, that it was spending funds to reimburse health insurers who were providing coverage to working-poor policyholders—those earning between 100 and 250 percent of the federal poverty line. More than half of people who purchase insurance in

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the health exchanges get the additional help, which reduces out-of-pocket health spending on deductibles and coinsurance. While that aid for consumers is required under the law, the funding for it was not specifically included.

In April of 2016, Federal District Court Judge Rosemary Collyer of the United States District Court for the District of Columbia ruled in favor of plaintiff House Republicans. "Such an appropriation cannot be inferred," she wrote of the payments, and insurer "reimbursements without an appropriation thus violates the Constitution." However, Judge Collyer declined to enforce her decision, pending an appeal to a higher court. That appeal was filed in July and is still months away from resolution.

If a Republican President wanted to seriously damage Obamacare, he could simply order the appeal dropped—letting the lower-court ruling stand—and stop reimbursing insurers who are giving deep discounts to half their customers. That would wreak havoc on the operation of the law. The insurers would still have to provide the discounts, as required by law but they would no longer be getting subsidies from the Federal Government to cover the cost!

Even those who support the law say that would effectively shut down the insurance exchanges, because insurers would simply drop out. A new Administration could thus collapse the federal exchange marketplace and the state exchanges by ending cost-sharing payments to insurers. There is already some concern about the continuing viability of the exchanges after several large insurers, including Aetna and United Health Care, announced they would not participate in 2017.

Another way a Republican Administration could undermine the law would be by simply not enforcing its provisions, particularly the individual mandate that requires most people to have insurance. That requirement is supposed to ensure that both healthy and sick people sign up, thus spreading the costs of people with high bills across a larger population. But Executive Branch non-enforcement could make a difference to the vitality of the exchanges going forward. If healthy people do not sign up, sick people would need to pay more money for their insurance.

A new President could also affect the law's operations by refusing to approve states' adjustments to their Medicaid programs. States rely on federal regulators to sign off on changes large and small, including to their eligibility standards, to keep their Medicaid programs operating.

Perhaps most important, is not whether a President could single-handedly undo the ACA, but whether he (or she) could undermine it enough to force Congress to take action. If the Administration were to do just enough to cause the insurance exchanges to fail, that would put pressure on Congress to reopen the law.

And reopening ACA is what Democrats have been trying to avoid. They fear that once any part of the complex health law is up for reconsideration, everything will be.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Alan L. Edelstein OF COUNSEL

CalOptima
2016 General Election Preview / Initiative Edition

by Don Gilbert and Trent Smith
October 26, 2016

October 10 marked the day when absentee ballots are mailed to voters in California, thus voting will commence immediately thereafter right up until polls close on November 8. Given that nearly 60 percent of all ballots cast will be done through the mail, it is likely that most elections will be decided before the campaigns finish their messaging. Of course votes will not be counted until after the polls close at 8 p.m. on election night.

While most media is focused on the Presidential election and its associated drama, those paying attention to California electoral politics speculate on how the race for President will impact the down-ticket races and ballot measures. Much of that speculation is focused on whether the Presidential election will energize California Democrats, who historically vote in higher numbers in Presidential election years, to turn out to vote in even higher numbers than normal.

Another factor that drives election turnout are statewide ballot initiatives. High profile and contentious issues tend to bring out voters. However, with 17 initiatives on the statewide ballot that have collectively spent more than $350 million, it is hard for any one initiative to dominate the public's attention.

Below is a discussion on a handful of some of the more high profile initiatives on the ballot that may be of interest to CalOptima.

Proposition 55 -- Tax Extension to Fund Education and Healthcare.
In 2012, with California government in deep deficit, the California Legislature could not cut enough services to bring the budget into balance. At that time, Governor Brown with significant support from the teachers union, public employees and business successfully passed Proposition 30 to temporarily raise income tax on couples making over $500,000 per year and to temporarily increase the statewide sales tax. This measure passed and yielded significant new revenues which has since helped the Legislature pass a balanced budget in a timely manner, without cutting services.

Proposition 55 will continue the increased income tax until 2030, while allowing the sales tax increase to expire. If passed, the state would continue to see between $4 billion to $9 billion in revenues, of which half would go to K-14 education. If Proposition 55 does not pass, the California Legislature would likely find it difficult to find replacement revenues and/or make the necessary budget cuts to balance future state budgets.

Proposition 64 -- Legalize Recreational Use of Marijuana.
Marijuana for medical use is already allowed in California. Proposition 64 would allow non-medical use, sale, and cultivation in California. If approved, this measure could generate more

1127 11TH Street SUITE 1030 Sacramento, CA 95814 (916) 443-6400 FAX (916) 443-6445
www.edelsteingilbert.com

than $1 billion in annual state and local tax revenue over time. Initial state tax revenue would come from a new state tax on marijuana growing and production plus a new excise tax at the retail level. There would also be additional revenues from applying the existing sales tax at the retail level and state and local governments would be allowed to impose other taxes as well.

The initiative specifically does not preclude employers from having anti-marijuana workplace policies and nothing prohibits drug testing of employees and prospective employees in accordance with federal law. If passed, however, these questions will begin to emerge in the future.

Proposition 54 Legislative Transparency
This Constitutional Amendment is a bit of inside-baseball as it pertains to the California Legislature and the legislative process. It is being pushed by Republicans and open-government advocates and would require that all legislation be in print and online for 72 hours before the Legislature could vote on the bill. It would also require all public meetings to be recorded and available to the public via the internet.

The main goal of this initiative is to slow the legislative process down and to make sure that all legislation is afforded a level of public scrutiny that is sometimes lost in the hectic, waning hours of the legislative session.

Proposition 61 State Drug Purchasing
This proposition would prohibit state agencies from paying more on any prescription drug than what is paid by the United States Department of Veteran Affairs. Proponents argue that this measure will save the state money through lower drug costs. Opponents argue that it could actually lead to higher drug costs. The independent Legislative Analyst argues that savings are purely speculative.

Proposition 56 Tobacco Tax
This ballot measure would raise the state excise tax on tobacco products $2.00 from 87 cents per pack of cigarettes to $2.87. If passed by voters it would generate over $1 billion in new revenues to the state that would be earmarked primarily to support the Medi-Cal program and to make up for tobacco tax revenues that have been lost due to the reduction in smoking.

Proposition 52 – Hospital Fee.
This measure would make permanent the existing Hospital Quality Assurance Fee which is due to expire in 2018. Fee revenue is used to support public and private hospital's care for Medi-Cal services to children and offsets state General Fund dollars that would otherwise be needed to pay for these services. This new revenue also helps draw down an equal amount of federal revenue thereby doubling the support for hospitals.

The race for President could also easily impact the down-ticket races in California. Much of that will hinge on whether the Presidential election will energize California Democrats. That, combined with polling showing that significant numbers of California Republicans are not supportive of Trump and will not vote, leads many to speculate that some down-ticket Republicans in California will suffer election losses in November. The likely outcome of such a

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scenario is that Democrats in the California Legislature will secure two-third supermajorities in both the Assembly and the Senate. Two of the big "battle ground" campaigns that may determine if Democrats increase their margins in the State Legislature are in Orange County.

65th District, Orange County -- Young Kim (R) vs. Sharon Quirk-Silva (D). This is a rematch of the 2014 race in which Kim defeated the incumbent Quirk-Silva who had won in the previous Presidential election. Republican turnout in the primary was low and Quirk-Silva was the high vote-getter, leading many to speculate that this will be a pick-up seat for the Democrats. This race has already generated approximately $3 million in spending, not including independent expenditure on behalf of each candidate.

29th District, Orange, Riverside, LA Counties -- Ling-Ling Chang (R) vs. Josh Newman (D). This seat, sitting in the corner of three counties, has always been a Republican seat. Changing demographics, voter registration, and the fact that the two Democrats who ran in the primary had enough votes combined to have significantly more votes than Chang means this seat could go either way.

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Board of Directors Meeting
November 3, 2016
CalOptima Community Outreach Summary – October 2016

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in any of CalOptima's programs.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

Requests for sponsorship are considered based on several factors including: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in a number of community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues. CalOptima strives to address issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Resource Fair

On September 29, 2016, CalOptima's Community Relations and Case Management departments hosted the CalOptima Community Resource Fair, the purpose of which was to increase the knowledge of CalOptima staff and our health network partners of resources available in the community for seniors and people with disabilities.

The resource fair was well received and attracted more than 300 staff from CalOptima and our delegated health network partners. Attendees had an opportunity to visit 28 community-based organizations and obtain information on a variety of resources and services available in the community. Many of the resources and services provided by the community partners are available to our members or potential members free or at low cost.

More than 95 percent of the participant evaluations collected indicated that attendees agree or strongly agree they had an overall positive experience at the event. More than 90 percent of the exhibitor evaluations collected indicated that participating community partners thought the event was good or excellent.

For additional information or questions, please contact Tiffany Kaaiakamanu, Manager of Community Relations at **657-235-6872** or via email at tkaaiakamanu@caloptima.org.

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Summary of Public Activities
CalOptima participated in 49 community events and coalition and committee meetings:

Date	Events/Meetings	Audience Reached
10/01	• Third Annual Conference and Expo hosted by Cal State Fullerton Center for Successful Aging (*Registration Fee: $50 included 1 table for outreach and opportunity to attend available workshops*)	Members/Potential Members
	• 2016 Senior Health and Information Fair hosted by City of Santa Ana Senior Center	Members/Potential Members
	• Twelfth Annual NAMIWalks Orange County hosted by NAMI Orange County (*Sponsorship Fee: $1,000 included 1 table for outreach, name and logo on route sign, website and t-shirts, 1/4 page ad in program brochure and banner display at event*)	Members/Potential Members
10/03	• Orange County Health Care Agency — Mental Health Services Act Steering Committee	Health and Human Service Providers
10/04	• Resource Fair hosted by HealthCare Partners	Health and Human Service Providers
10/05	• Orange County Aging Services Collaborative	Health and Human Service Providers
	• Anaheim Human Services Network	Health and Human Service Providers
10/06	• Capacity Building Series hosted by Orange County Department of Education Office of Continuous Improvement	Health and Human Service Providers
	• Resource Fair hosted by CHOC Children's Hospital Orange County and Courtney's Sandcastle Park	Members/Potential Members
10/07	• Help Me Grow Advisory Meeting	Health and Human Service Providers
	• Covered Orange County — General Meeting	Health and Human Service Providers
	• Senior Wellness Fair hosted by City of Orange Senior Center (*Registration Fee: $50 and 2 raffle items included 2 tables for outreach*)	Members/Potential Members
10/08	• PhoCovery Celebration 2016 hosted by VietCARE (*Registration Fee: $500 included 1 table for outreach*)	Members/Potential Members
	• Health and Resource Fair for Families hosted by City of Anaheim	Members/Potential Members
10/10	• Fullerton Collaborative Meeting	Health and Human Service Providers
10/11	• Buena Clinton Neighborhood Coalition	Health and Human Service Providers
	• Annual Resource Fair hosted by CHOC Children's	Members/Potential Members
10/12	• Buena Park Collaborative Meeting	Health and Human Service Providers

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	• Anaheim Homeless Collaborative	Health and Human Service Providers
	• Annual Community Resource and Health Fair hosted by Clinton Corner Family Campus	Members/Potential Members
10/13	• FOCUS Collaborative Meeting	Health and Human Service Providers
	• Orange County Women's Health Project Advisory Board Meeting	Health and Human Service Providers
10/14	• Conferencia Anual 2016 hosted by Fiesta Educativa Orange County (*Registration Fee: $100 included 1 table for outreach*)	Members/Potential Members
	• 2016 Health Fair and Flu Clinic hosted by City of Brea Senior Center (*Registration Fee: $100 included 2 tables for outreach*)	Members/Potential Members
10/15	• 2016 Diocesan Ministries Celebration and Resource Fair hosted by the Diocese of Orange *(Registration Fee: $450 included 1 table for outreach and a 1/4 page ad in event program*)	Members/Potential Members
	• Eighth Annual Health Fair hosted by North Orange County Regional Health Foundation	Members/Potential Members
10/17	• Annual Community Health and Resource Fair hosted by Friendly Center	Health and Human Service Providers
10/18	• Placentia Community Collaborative Meeting	Health and Human Service Providers
	• Coordinated Entry's Healthcare and Housing Integration Workgroup Meeting	Health and Human Service Providers
10/19	• La Habra Collaborative Meeting	Health and Human Service Providers
	• Covered Orange County — Steering Committee Meeting	Health and Human Service Providers
	• Minnie Street Family Resource Center Professional Roundtable	Health and Human Service Providers
	• Orange County Promotoras	Health and Human Service Providers
10/20	• Orange County Children's Partnership Committee Meeting	Health and Human Service Providers
	• Surf City Senior Providers Network and Lunch	Health and Human Service Providers
10/21	• Resource Fair and Community Event: Caring for Others, Caring for Self, Which Resources Can Help Along the Way? Hosted by Orange County Aging Services Collaborative and the Office of Senator Patricia Bates	Members/Potential Members
	• Fourth Orange County Women's Health Summit hosted by Orange County Women's Health Project	Members/Potential Members

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	(*Sponsorship Fee: $1,000 included 1 table for outreach, registration and reserved seating for 2 staff, display logo on event marketing materials and program)*	
10/22	• 2016 Oasis Senior Resources Expo hosted by Oasis Senior Center	Members/Potential Members
	• Children and Families Forum and Fair hosted by Office of Supervisor Lisa Bartlett, Orange County Children's Partnership, and Orange County United Way	Members/Potential Members
	• Thirteenth Annual Senior Health and Wellness Expo hosted by City of Stanton *(Registration Fee: $120 included 2 tables for outreach*)	Members/Potential Members
10/23	• Free Health Fair hosted by the Vietnamese Physician Association of Southern California (*Sponsorship Fee: $2,000 included 1 table for outreach, display banner inside event building, business card and brochure in attendee gift bag)*	Members/Potential Members
10/24	• Community Health Research and Exchange Meeting	Health and Human Service Providers
	• Stanton Collaborative Meeting	Health and Human Service Providers
10/25	• Orange County Senior Roundtable	Health and Human Service Providers
	• Orange County Transportation Authority Special Needs Advisory Committee Meeting	Health and Human Service Providers
	• Santa Ana Building Healthy Communities	Health and Human Service Providers
10/26	• Orange County Human Trafficking Task Force — General Meeting	Health and Human Service Providers
	• Medicare Information Fair hosted by Cypress Senior Center	Health and Human Service Providers
10/27	• Medicare Marketplace hosted by Community Civic Association of Laguna Woods Village (*Sponsorship Fee: $350 included 1 table for outreach and a full page ad in Medicare Booklet)*	Members/Potential Member

CalOptima organized or convened the following six community stakeholder events, meetings and presentations:

Date	Event/Meeting	Audience Reached
9/01	• CalOptima Speakers Bureau Presentation at Cal State Fullerton — Topic: Aging Process and Available Services for the Elderly	Health and Human Service Providers
10/14	• County Community Service Center Education Seminar — Topic: Dementia: The Basics (English)	Member/Potential Member Providers

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10/15	• OneCare Connect Forum hosted for the Chinese Parents Association for the Disabled Orange County Chapter — Topic: OneCare Connect	Member/Potential Member Providers
10/20	• Community-Based Organization Presentation for Orange County Head Start — Topic: CalOptima Overview	Health and Human Service Providers
10/21	• County Community Service Center Education Seminar — Topic: Avoid Zika (*Spanish)*	Members/Potential Member Providers
10/28	• County Community Service Center Education Seminar — Topic: Understanding the OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) (*Vietnamese*)	Members/Potential Member Providers

CalOptima endorsed the following seven events during this reporting period (e.g., letters of support, program/public activity event with support, or use of name/logo):

1. Letter of Support for North Orange County Regional Health Foundation's Change in Scope to add oral and mental health services and staff at primary care clinic in Fullerton, CA.

2. Letter of Support for Legal Aid Society Orange County (LASOC) — Health Consumer Action Center's (HCAC) application to the California Department of Managed Health Care for the Consumer Assistance Project (CAP) 4 grant.

3. Twelfth Annual NAMIWalks Orange County hosted by NAMI Orange County.
(Listed in Public Activities)

4. 2016 Diocesan Ministries Celebration and Resource Fair hosted by Diocese of Orange.
(Listed in Public Activities)

5. Fourth Orange County Women's Health Summit hosted by Orange County Women's Health Project.
(Listed in Public Activities)

6. Free Health Fair hosted by the Vietnamese Physician Association of Southern California.
(Listed in Public Activities)

7. Medicare Marketplace hosted by Community Civic Association of Laguna Woods Village.
(Listed in Public Activities)

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CalOptima Board of Directors
Community Activities

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
November 2016			
Tuesday, 11/1 9:30-11am	++Collaborative to Assist Motel Families	**Steering Committee Meeting: Open to Collaborative Members**	250 East Center St. Anaheim
Wednesday, 11/2 9am-12pm	+La Habra Collaborative Senior Salute Week Health Fair	**Health/Resource Fair Open to the Public**	101 W. La Habra Blvd. La Habra
Thursday, 11/3 9-10:30am	++Refugee Forum of OC	**Steering Committee Meeting: Open to Collaborative Members**	631 S. Brookhurst St. Anaheim
Thursday, 11/3 9-11am	++Homeless Provider Forum	**Steering Committee Meeting: Open to Collaborative Members**	1855 Orange Olive Rd. Orange
Thursday, 11/3 9am-12pm	+Supervisor Todd Spitzer and OC Social Services Senior Abuse Awareness Event	**Health/Resource Fair Open to the Public**	170 S. Olive St. Orange
Thursday, 11/3 10am-1pm	+Golden Rain Foundation of Laguna Woods Village Transportation Awareness Day	**Health/Resource Fair Open to the Public**	24262 Punta Alta Laguna Woods

* *CalOptima Hosted*

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

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Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Friday, 11/4 9-10:30am	++Covered Orange County General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	1575 E. 17th St. Santa Ana
Friday, 11/4 9am-12pm	+Tustin Senior Center Resource Fair and Flu Shot	**Health/Resource Fair Open to the Public**	200 South C St. Tustin
Saturday, 11/5 7:30am-2pm	+ Alzheimer's OC 7th Annual Alzheimer's Latino Conference	**Conference: Open to conference attendees** ***Registration Required***	2501 W. 5th St. Santa Ana
Saturday, 11/5 10am-2pm	+Vietnamese Community Health UCLA Vietnamese Community Health Fair	**Health/Resource Fair Open to the Public**	8200 Westminster Blvd. Westminster
Monday, 11/7 1-4pm	++OCHCA Mental Health Services Act Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	505 E. Central Ave. Santa Ana
Monday, 11/7 3-4pm	++State Council on Developmental Disabilities Orange County	**Steering Committee Meeting: Open to Collaborative Members**	2000 E. Fourth St. Santa Ana
Tuesday, 11/8 10am-1pm	++Susan G. Komen OC Unidos Contra el Cancer del Seno Coalition Round Table	**Steering Committee Meeting: Open to Collaborative Members**	3191-A Airport Loop Dr. Costa Mesa
Tuesday, 11/8 11:30am-12:30pm	++Buena Clinton Neighborhood Coalition	**Steering Committee Meeting: Open to Collaborative Members**	12661 Sunswept Ave. Garden Grove
Wednesday, 11/9 10-11:30am	++Buena Park Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	7150 La Palma Ave. Buena Park
Wednesday, 11/9 12-1:30pm	++Anaheim Homeless Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	500 W. Broadway Anaheim

+ Exhibitor/Attendee
++ Meeting Attendee

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Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Thursday, 11/10 2-4pm	++OC Health Improvement Partnership	**Steering Committee Meeting: Open to Collaborative Members**	1725 W. 17th St. Santa Ana
Monday, 11/14 2:30-3:30pm	++Fullerton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	353 West Commonwealth Ave. Fullerton
Tuesday, 11/15 10-11:30am	++Placentia Community Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	849 Bradford Ave. Placentia
Tuesday, 11/15 2-3:30pm	++Coordinated Entry's Healthcare and Housing Integration Workgroup	**Steering Committee Meeting: Open to Collaborative Members**	1505 E. 17th St. Santa Ana
Wednesday, 11/16 9:15-10:45am	++Covered Orange County Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	18012 Mitchell S. Irvine
Wednesday, 11/16 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	1300 McFadden Ave. Santa Ana
Wednesday, 11/16 1-4pm	++Orange County Promotoras	**Steering Committee Meeting: Open to Collaborative Members**	Location varies
Wednesday, 11/16 Thursday, 11/17 8am-5pm	+California Assoc. for Area Agencies on Aging Annual Meeting/Conference	**Conference: Open to conference attendees** ***Registration Required***	6101 W. Century Blvd. Los Angeles
Wednesday, 11/16 Thursday, 11/17 8am-6pm	+California Assoc. for Adult Day Services (CAADS) 2016 CAADS Fall Conference and Annual Mtg.	**Conference: Open to conference attendees** ***Registration Required***	12015 Harbor Blvd. Garden Grove
Thursday, 11/17 8:30-10am	++Orange County Children's Partnership Committee	**Steering Committee Meeting: Open to Collaborative Members**	10 Civic Center Plaza Santa Ana

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Thursday, 11/17 3-5pm	++OC Women's Health Project Advisory Board	**Steering Committee Meeting: Open to Collaborative Members**	1505 E. 17th St. Santa Ana
Tuesday, 11/22 7:30-9am	++OC Senior Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	170 S. Olive Orange
Tuesday, 11/22 3:30-4:30pm	++Santa Ana Building Healthy Communities	**Steering Committee Meeting: Open to Collaborative Members**	1902 W. Chestnut Ave. Santa Ana
Wednesday, 11/23 9:30am-12pm	++California Association of Area Agencies on Aging Advisory Board	**Steering Committee Meeting: Open to Collaborative Members**	980 9th St. Sacramento
Events Pending			
Saturday, 11/5 10am-1pm	+Walnut Elementary School Fall Health Fair	**Health/Resource Fair Open to the Public**	625 N. Walnut St.
Sunday, 11/6 10am-2pm	+Vietnamese Community Health UCLA Vietnamese Community Health Fair	**Health/Resource Fair Open to the Public**	8200 Westminster Blvd. Westminster
Saturday, 12/3 Sunday, 12/4 8am-2pm	+City of Anaheim, GBS Linens, Anekant Community Center and Lestonnac Free Clinic Anaheim Health Fair	**Health/Resource Fair Open to the Public**	800 W. Katella Ave. Anaheim

Strategic Planning

Board of Directors Planning Session

November 3, 2016

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Today's Discussion

- **Keynote: Landscape of Medi-Cal and Statewide Initiatives**
  - *Jennifer Kent, Director, CA Department of Health Care Services*
- **2013-2016 Strategic Plan and Accomplishments**
  - *Michael Schrader, CEO, CalOptima*
- **New Strategic Plan and Process to Date**
  - *Bobbie Wunsch, Pacific Health Consulting Group*
- **Advisory Committee Remarks**
  - *Teri Miranti, PAC Chair*
  - *Mallory Vega, MAC Chair*
  - *Patty Mouton, OCC MAC Chair*
- **Strategic Priorities and Initiatives**
  - *Bobbie Wunsch, Pacific Health Consulting Group*
- **Next Steps**
  - *Lee Penrose, Vice Chair, CalOptima Board of Directors*
  - *Michael Schrader, CEO, CalOptima*

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Landscape of Medi-Cal and Statewide Initiatives

Jennifer Kent, Director

CA Department of Health Care Services

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2013-2016 Strategic Plan and Accomplishments

Michael Schrader, CalOptima CEO

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2013-2016 Strategic Plan Implementation

- Board
  - Made decisions in the present based on current information linked to CalOptima's Mission, Vision and Strategic Plan

- CEO
  - Utilized Strategic Plan to drive development of specific annual goals for executive team

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2013-2016 Strategic Plan Priorities

- Quality Program and Services
- Financial Stability
- Strong Internal Processes
- Culture, Learning, and Innovation

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2013-2016 Accomplishments

- **Quality Programs and Services**
  - Growth: 380,000 to nearly 800,000 members
  - Launch of the Program of All-Inclusive Care for the Elderly (PACE) Center
  - Launch of OneCare Connect
  - Transition of Healthy Families and County MSI programs into Medi-Cal
  - Transition of autism benefit from Regional Center to CalOptima
  - Launch of the CalOptima Community Network
  - Addition of new private-sector health networks

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2013-2016 Accomplishments (Cont.)

- **Strong Internal Processes**
  - Successful resolution of CMS sanction
  - Development of delegation oversight and audit unit
  - Developed and implemented a best-in-class Model of Care including Personal Care Coordinators
  - Implemented new member care coordination software system
  - Transitioned to new Pharmacy Benefit Manager

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2013-2016 Accomplishments (Cont.)

- **Financial Stability**
  - Consistently maintained MLR between 95%-96%
  - Met board-approved budget targets

- **Culture, Learning, and Innovation**
  - Strengthened employee engagement
    - Quarterly Leadership and All-Hands meetings
    - Annual Employee Wellness Picnic and Halloween event
  - Strengthened ties with community
    - 20th Anniversary celebrations
    - Monthly PAC, MAC, OCC MAC and Health Network Forum meetings
    - CalOptima Information Series
  - Supported innovative programs through IGT funding
    - School-based dental and vision services
    - Recuperative care for homeless members

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2017-2019 Strategic Planning Process to Date

Bobbie Wunsch

Pacific Health Consulting Group

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Why Do Strategic Planning?

- High level **plan** to achieve one or more goals under conditions of uncertainty
- **Roadmap** for future initiatives
- Provides Board, Staff and Community with **common focus and perspective**
- Focus on **members**

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CalOptima's Mission & Vision

Mission

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

Vision

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

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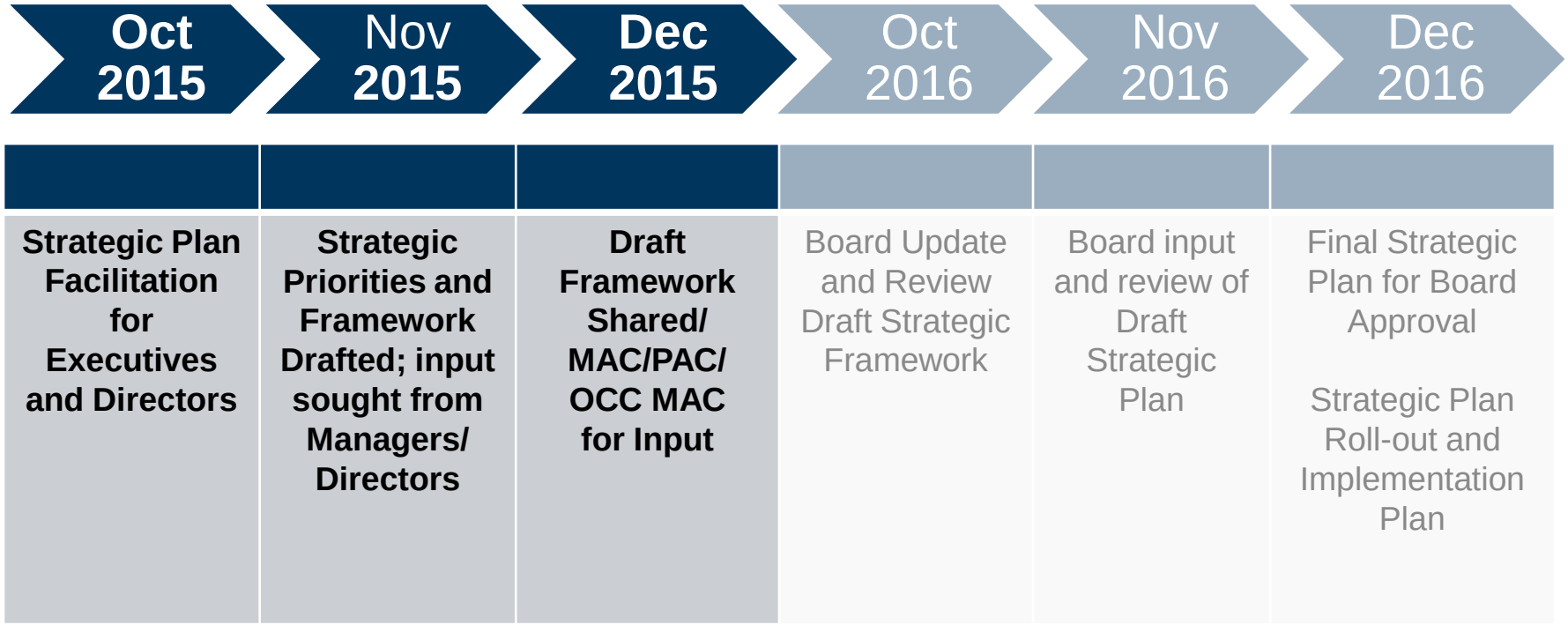
2017-2019 Strategic Planning Timeline



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2017-2019 Strategic Planning Inputs

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Advisory Committee Remarks

Teri Miranti, PAC Chair

Mallory Vega, MAC Chair

Patty Mouton, OCC MAC Chair

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2017-2019 Strategic Priorities and Initiatives

Bobbie Wunsch

Pacific Health Consulting Group

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Strategic Priorities and Initiatives

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

Building Blocks

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

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Innovation

- Delivery System Innovation
- Program Integration
- Program Incubation

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Value

- Data Analytics Infrastructure
- Pay for Value
- Cost-Effectiveness

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Partnership and Engagement

- Provider Collaboration
- Member Engagement
- Community Partnerships
- Shared Advocacy

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Building Blocks

Workforce Performance

- Employer of Choice
- Collaborative Culture
- Operation Excellence

Financial Strength

- Strategic Goal Alignment
- Fiscal Management

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Board Discussion

- How can CalOptima be best prepared to respond to the evolving health care environment and strengthen our position as a valued asset in our community?

- What big ideas do you have that staff should consider as they move toward implementation of the new CalOptima strategic plan and priorities?

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Next Steps

Lee Penrose, Vice Chair
CalOptima Board of Directors

Michael Schrader, CEO
CalOptima

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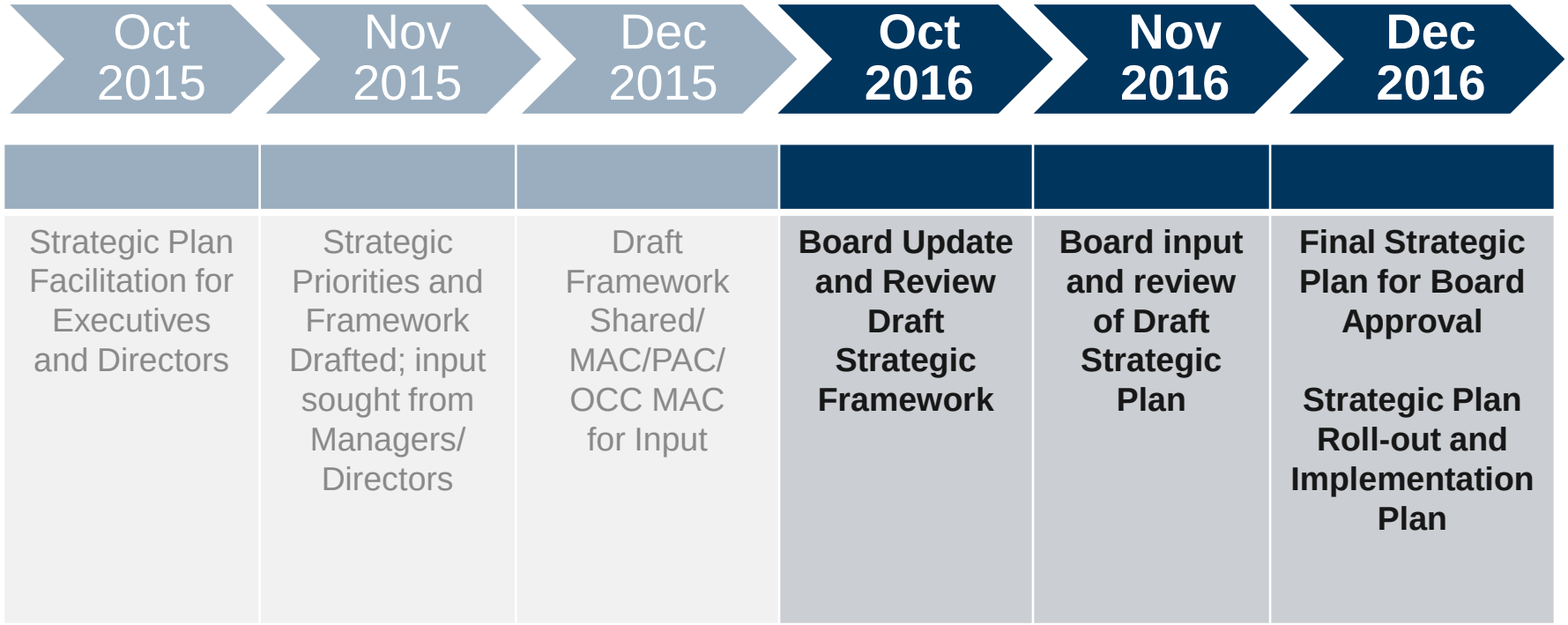
2017-2019 Strategic Planning Timeline



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STRATEGIC PLAN 2013–16

CalOptima
A Public Agency
Better. Together.

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Strategic Planning Process

A MESSAGE **FROM THE CEO**

The 2013–16 Strategic Plan is a collaboration by the Board of Directors, CalOptima leadership and staff, and our Member and Provider Advisory Committees. The Strategic Plan includes:

- A new vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all our members
- Reconfirmation of our mission, coupled with values that are our guiding principles every day
- Strategic priorities, objectives and action plans that we will implement during the next three years

Consistent with our commitment to stewardship and accountability, CalOptima is sharing this Strategic Plan with you to reinforce that we are here to serve Orange County and maintain an open and responsive relationship with our members, partners and stakeholders.

The Strategic Plan is a living document that will continually evolve to meet shifting challenges and opportunities, particularly in light of the Affordable Care Act. We encourage your input along the way.

Michael Schrader
Chief Executive Officer, CalOptima

The Foundation

CalOptima reconfirmed our mission and developed a new vision with a set of values to support our roles as both a public agency and a health plan.

The Framework

CalOptima assessed our Strengths, Weaknesses, Opportunities and Threats (SWOT analysis). Working with the Board of Directors, we identified strategic priorities, particularly given our pending expansion with the implementation of the Affordable Care Act.

The Action Plans

We formed cross-departmental Action Planning Teams to develop action plans for each strategic priority. Work to implement the action plans is underway, and performance measures will monitor the progress and signal success of desired outcomes.

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Whom We Serve

468,800 members*

We serve 1 in 7 Orange County residents.

62 percent are children

We serve 1 in 3 Orange County children.

58 percent live in five cities

The majority of CalOptima members live in Santa Ana, Anaheim, Garden Grove, Westminster and Orange.

Diverse members

Members speak English, Spanish, Vietnamese, Farsi, Korean and other languages.

WHO WE ARE

As the second largest health insurer and only Medi-Cal plan in Orange County, CalOptima is a county organized health system that administers health insurance through three major programs:

- Medi-Cal (California's Medicaid program) for low-income families, children, seniors and people with disabilities
- OneCare (HMO SNP) (a Medicare Advantage Special Needs Plan) for low-income seniors and people with disabilities who qualify for both Medicare and Medi-Cal
- PACE (Program of All-Inclusive Care for the Elderly) for older adults, providing comprehensive health services through the CalOptima PACE center

CalOptima has more than 600 employees. All of our members are enrolled in Medi-Cal and 85 percent of our $1.5 billion budget is dedicated to Medi-Cal in fiscal year 2014.

CalOptima has:

- ***Higher enrollment than 17 state Medicaid programs***
- ***Higher Medicare Advantage Special Needs Plan enrollment than 24 of the 41 states with such plans***

**Source: CalOptima Fast Facts, October 2013*

Our *Unique* Dual Role

CalOptima is unique in that we must exhibit being the best of both a **public agency**, upholding public trust, and a **health plan**, seeking efficiency and member satisfaction. As both, CalOptima must:

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

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

County Organized Health System: CalOptima is a county organized health system (COHS), which is a model unique to California that is governed by a locally appointed Board of Directors. As a COHS, CalOptima is a public agency authorized by county, state and federal actions, which requires:

- Single-plan responsibility for providing Medi-Cal in the county
- Mandatory enrollment of all full-scope Medi-Cal beneficiaries, including dual eligibles
- Responsibility for almost all medical acute services, including custodial long-term care

Certain benefits are carved out of CalOptima's Medi-Cal program, meaning that these benefits are administered by other entities (e.g., specialty mental health, dental and catastrophic coverage for children).

In Orange County, CalOptima has an integral role in the health care safety net since there are no county-run hospitals or clinics. As the only Medi-Cal plan in Orange County, CalOptima has a duty to meet our COHS obligations and to:

- Preserve access and quality of care
- Consider members' needs in determining what new programs to implement
- Implement a shared-risk model
- Assume ultimate accountability

BETTER. TOGETHER.

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

We are **Better. Together.**

Strategic Plan Framework

CalOptima works in collaboration with providers, community stakeholders and government agencies to achieve our mission and vision. Our mission statement has been fundamental to us since CalOptima was founded almost 20 years ago. Our vision is newly created as a result of work on this Strategic Plan.

Our Mission

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

Our Vision

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

HEALTH CARE PROGRAM CONTINUUM

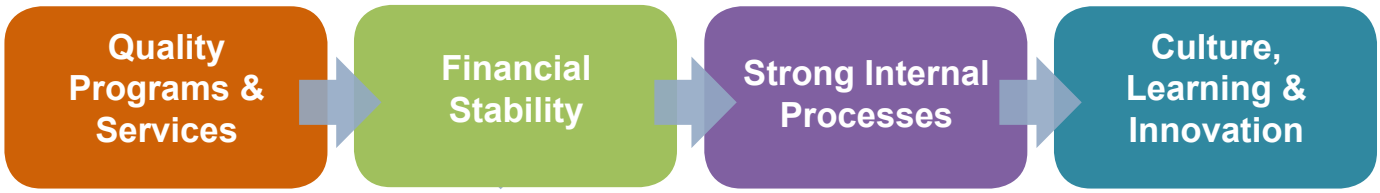
CalOptima developed a decision-making framework for determining the feasibility of offering new programs. We categorize all new programs into core business, mission critical, added value or unmet needs.

As a public agency, we must ensure, first and foremost, that we deliver our core business and mission-critical programs. Programs beyond those depend on our operational capacity and budget.

Whenever possible, we partner with others to maximize existing delivery systems to help fill unmet needs or deliver services that bring added value to the community. Some examples are noted in the table below.

Core Business	Mission Critical	Added Value	Unmet Needs
Medi-Cal	Medicare for Dual Eligibles	PACE CalOptima Regional Extension Center	Dental Services Autism Services Health Education

Strategic Priorities



QUALITY PROGRAMS & SERVICES

CalOptima's core function is to provide quality programs and services. With significant changes in the health care delivery system, CalOptima will be working to meet new requirements under the Affordable Care Act; adding new programs, such as PACE and integrated behavioral health; and serving more members through Medi-Cal expansion and the proposed launch of Cal MediConnect. Medi-Cal expansion, coupled with the ongoing enrollment of currently eligible children and families, requires significant growth in capacity, both internally and in our provider network, to ensure members continue to receive quality health care services.

Goals

- Provide members with access to quality health care services
- Integrate and coordinate care to ensure optimal health outcomes for all our members
- Integrate physical and behavioral health

Objectives

- Launch new and expanded programs, such as:
  - Affordable Care Act and Medi-Cal expansion
  - Cal MediConnect
  - PACE
  - Bridge or Basic Health Plan
- Further integrate behavioral health

FINANCIAL STABILITY

CalOptima's Board of Directors recognizes that, while CalOptima is well-positioned to help address a wide array of community health needs and gaps that impact our members and Orange County at large, it is important to focus CalOptima resources on core services and mission-critical activities. To do that, we must ensure we operate in a fiscally sustainable manner. At the same time, Board members see the CalOptima Foundation as a promising vehicle to implement initiatives that complement the work of the health plan in better serving members, particularly in addressing unmet needs. Therefore, expanding the function of the Foundation for this purpose is a strategic priority.

Goals

- Be accountable to the community as stewards of public funds
- Support initiatives that complement the work of the health plan in better serving members, particularly in addressing unmet needs in the community

Objectives

- Ensure CalOptima's financial stability
- Preserve provider reimbursement to ensure members' access to quality care
- Employ sound fiscal management practices
- Evaluate one-time-funded programs
- Align financial rewards with quality health care outcomes
- Use the CalOptima Foundation to support unmet needs in the community that are consistent with our mission

STRONG INTERNAL PROCESSES

CalOptima has a unique organizational model, balancing our role as a public agency and a health plan. The model places demands on our governance structure, requiring the flexibility and innovation needed of a health plan, and the transparency and accountability of a public entity, particularly in fundamental processes such as procurement. Further, the changing health care environment calls for robust and flexible information systems that improve communication among providers, business partners and members, strengthen internal operations, and promote efficiency.

Goals

- Support expansion with improved infrastructure for optimal capability, flexibility and integration of key information systems
- Achieve measurable improvements in service and quality of care for CalOptima's members
- Continuously enhance governance processes

Objectives

- Develop and implement a multiyear information systems strategy
- Increase the use of benchmarking and comparisons to national standards and rankings
- Apply best practices to Board governance processes

CULTURE, LEARNING & INNOVATION

CalOptima's work culture, values and ability to be innovative are critical to our success as we adapt to the unprecedented changes in health care. Moreover, CalOptima's leaders recognize that highly motivated, engaged and well-trained employees are CalOptima's most valuable resource, particularly during a time of rapid change. Further, developing an employee culture of cooperative learning and information exchange fosters trust and helps set the stage for innovation.

Goals

- Promote an engaged workforce that builds on staff members' deep commitment to and compassion for CalOptima's members
- Increase staff's ability to execute efficiently for optimal use of resources

Objectives

- Strengthen employee engagement
- Expand staff development opportunities
- Enhance internal communications

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Our Values

As a public agency, we abide by our core values to ensure the public's trust and to meet our members' health care needs. As a health plan, we must ensure sufficient provider reimbursement while operating cost-effectively and compassionately, as stated in our mission.

CalOptima CARES about our members and providers.

C

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.

A

Accountability

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

R

Respect

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

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

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

E

Excellence

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

S

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.

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STRATEGIC PLAN ACTION PLANNING TEAMS

This Strategic Plan was made possible by the dedication and focus of CalOptima employees. Approximately 55 CalOptima staff members were part of the following seven teams charged with developing action plans:

- Governance and Procurement
- Culture, Learning and Innovation
- Mission and Values
- Foundation
- Finance
- Information Systems
- Programs and Services

Board of Directors

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Supervisor,
Orange County Board of Supervisors, First District

Mark Refowitz (Chair)
Director,
Orange County Health Care Agency

Michael Riley, Ph.D.
Director,
Orange County Social Services Agency

Todd Spitzer (Alternate)
Supervisor,
Orange County Board of Supervisors, Third District

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Pediatrician

Viet Van Dang, M.D.
Ophthalmologist

Lee Penrose (Vice Chair)
President and CEO,
St. Jude Medical Center

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Vice President, Citizens Business Bank

Steven Knoblock
Counsel, Multimedia LED and Craig Realty Group

This plan was adopted by the CalOptima Board of Directors on September 5, 2013, and provides a framework for future direction. This document does not authorize expenditure of funds or commitment of resources.

Models may be used in photos. All models used for illustrative purposes only.

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Our Mission

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

Our Vision

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

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Main: 714.246.8400 | Fax: 714.246.8492 | TDD/TTY: 714.246.8523

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manatt

JUNE 2016

Moving Medi-Cal Forward on the Path to Delivery System Transformation

Cindy Mann, Partner
Naomi Newman, Director
Alice Lam, Director
Keith Nevitt, Consultant

This paper was prepared with the support of the California Health Care Foundation.

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California Health Care Foundation
HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

Introduction

Over the past few years, California's Medicaid program, known as Medi-Cal, has been catapulted into a new role. It has evolved from a program designed to provide health coverage to a subset of low income individuals and help counties meet their longstanding obligations to provide indigent care to a program that is the largest single source of health insurance in the state and the foundation of the state's healthcare coverage continuum for people who do not have affordable insurance through the workplace. Medi-Cal needs a vision and structure that recognize and support this evolution.

In 2015, Medi-Cal covered one in three Californians and was responsible in large part for helping to drive the state's uninsurance rate to a record low.[1]

The program is at a pivotal juncture. Medi-Cal has brought coverage, care and long-term services and supports to millions of Californians, but key aspects of the design and financing of the program have not kept pace with the dramatic changes in the size and composition of the Medi-Cal population and the responsibilities of the program. The relationship between Medi-Cal and the counties continues to have a large impact on how care is delivered and financed, and the county construct, along with the overlay of marketplace developments and multiple initiatives that have been adopted throughout the years, have resulted in a complex, patchwork and somewhat opaque system for providing and paying for care. The results in terms of quality of care, access to care, care coordination and patient satisfaction are mixed.

Like other states, California is looking to advance delivery system and payment reforms to drive greater value, defined as timely access to high quality, coordinated and cost effective care. Medi-Cal is not alone in its "hunt for value" – the Affordable Care Act (ACA) has triggered a shift toward value-based purchasing in the commercial marketplace, Medicare

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and Medicaid. These reforms are challenging in any environment, but the structural underpinnings of California's Medicaid program make such changes all the more difficult to address.

Medi-Cal has accomplished a great deal in a short time, including a significant expansion of coverage, and important delivery system innovations are underway in a number of communities throughout the state. With Medi-Cal's augmented role and the new Medi-Cal 2020 waiver recently launched, the state and its partners have an extraordinary opportunity to reset the table and establish a clear direction for Medi-Cal to spearhead delivery system reform in collaboration with other California payers. To do so, California needs a vision and a plan for advancing the goal of delivering better care and promoting better health in ways that serve the needs of enrollees and that are sustainable for both those who finance and those who provide the services.

The California Health Care Foundation (CHCF) retained Manatt Health to consider the current state of the Medi-Cal program and potential pathways for the next chapter of delivery reform, focusing particularly on Medi-Cal managed care.[2] Manatt conducted a landscape review and in-depth interviews with a diverse array of Medi-Cal stakeholders and thought leaders, including current and former Medi-Cal officials, other state and local government officials, legislators and their staff, representatives from managed care and provider organizations, patient representatives and advocates, labor groups and policy experts.[3]

This report provides an overview of the Medi-Cal landscape and stakeholder perspectives, assesses the key challenges and opportunities, and articulates a pathway for advancing Medi-Cal delivery system and payment reform.

Research and support for this report and the Landscape Assessment were provided by Rashi Kesarwani, Consultant, Manatt Health.

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Medi-Cal Today

Medi-Cal is the largest Medicaid program in the nation as measured by both enrollment and total spending. It is a significant source of insurance coverage and its purchasing power has enormous potential to improve care and health outcomes throughout the state.

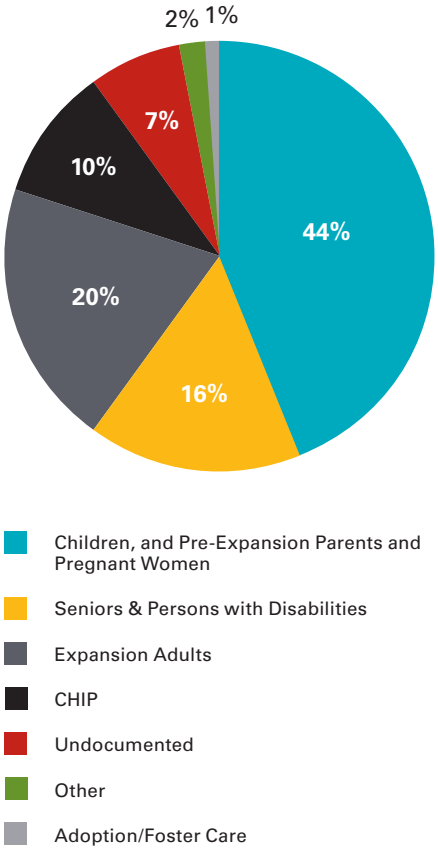
- **Enrollment:** Medi-Cal covers over 13 million individuals, more than 30% of the state's population. Between December 2013 and January 2015, total Medi-Cal enrollment grew by 41% as a result of California's adoption of the ACA's Medicaid expansion for low income adults.
- **Spending:** Medi-Cal costs have grown nearly threefold over the last 10 years and today total $92 billion in annual expenditures (including federal and nonfederal funds). Medi-Cal is one of the largest state budget items, accounting for nearly 16% of California's general fund budget and, at the same time, it is the largest source of federal revenues for the state.[4,5,6] A review of the spending data revealed three important facts:

1. Spending growth has been driven largely by new coverage, with only modest growth occurring on a per beneficiary basis of just 3.1% annually between 2005-06 and 2015-16.
2. Even with the expansion, most of the spending remains focused on high needs beneficiaries, with just 5% of beneficiaries accounting for 51% of all spending.
3. Fiscal responsibilities for the program have shifted significantly in the past decade – the shares paid by the federal government, providers and counties have grown while the share borne by the state general fund has dropped by nearly half. Beginning in calendar year (CY) 2017, the state will start to assume some financial responsibility for the expansion population – as reflected in the Governor's fiscal year (FY) 2017 budget proposals.

While Medi-Cal is the largest Medicaid program in the country in terms of people enrolled and total expenditures, California's Medi-Cal spending per enrollee ranks among the ten lowest-spending states in the country.

Figure 1. Medi-Cal Enrollees

Distribution of Medi-Cal Enrollees, December 2014



Source: Medi-Cal Statistical Brief, August 2015

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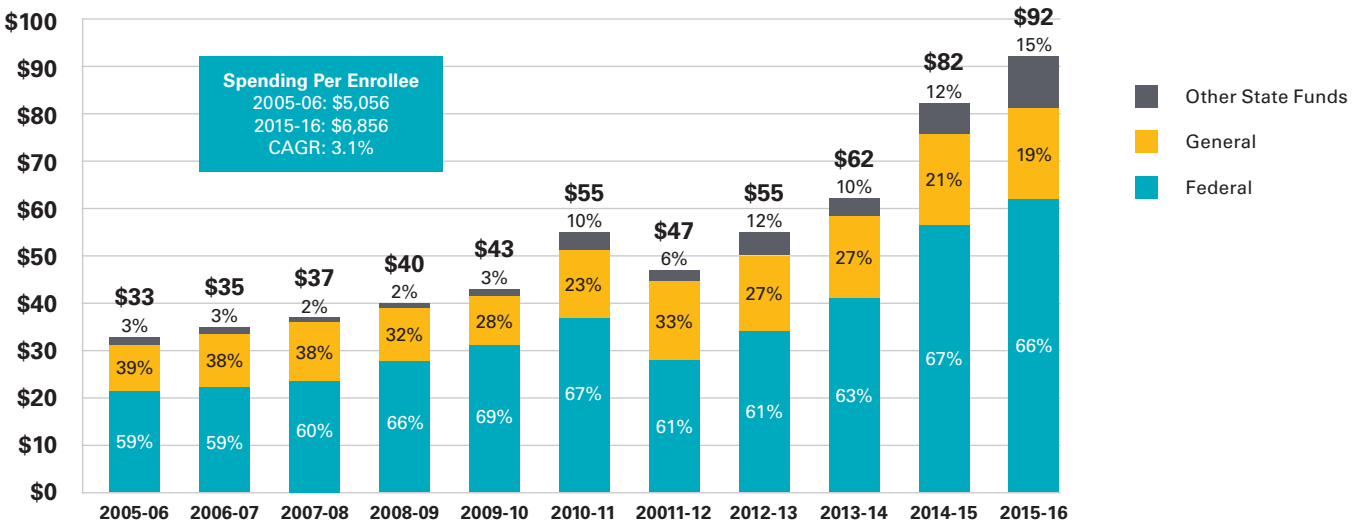
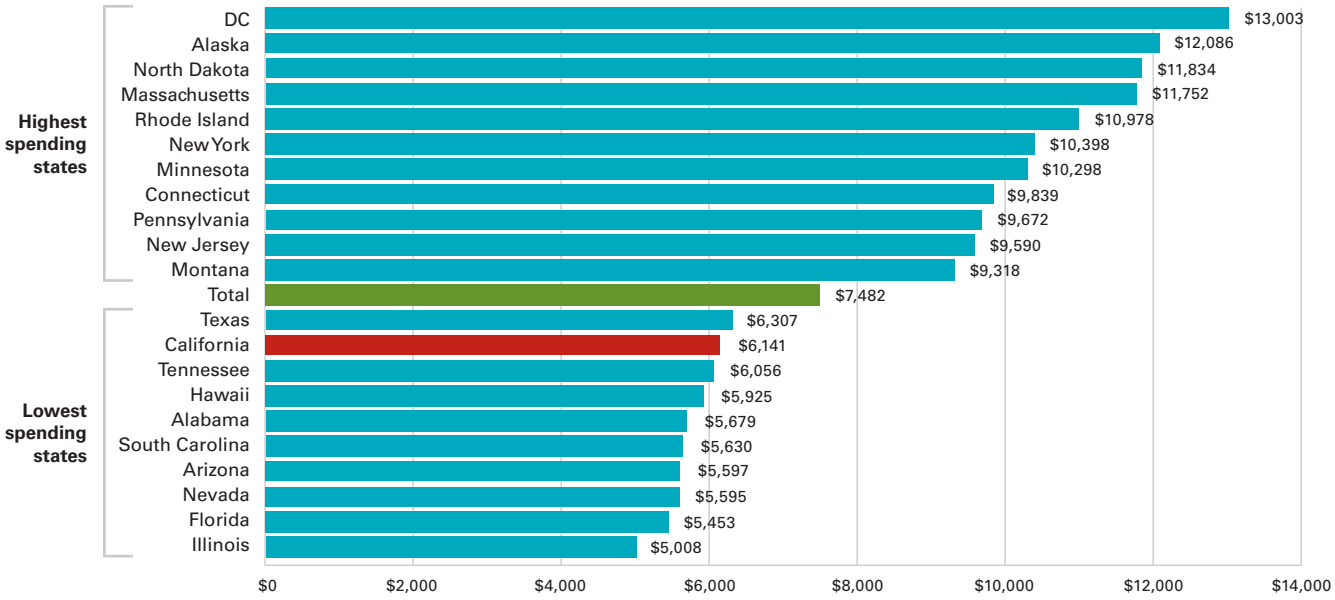
Figure 2. Medi-Cal Spending Over the Last Decade ($B)



Note: Total annual spending is pulled from the Department of Health Care Services (DHCS) May Estimate for the subsequent year (i.e., 2005-06 costs sourced from May 2006 Medi-Cal Estimate), except in the case of 2015-16, in which total spending is pulled from the November 2015 Estimate.

Source: State Budget Appropriations, Medi-Cal Local Assistance Estimates, DHCS.

Figure 3. Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Full Benefit Enrollees For Top Highest and Lowest Spending States, FY 2012



Note: Excludes enrollees reported by states in the Medicaid Statistical Information System (MSIS) as receiving coverage of only family planning services, assistance with Medicare premiums and cost sharing, or emergency services.

Source: Medicaid Benefit Spending Per Full-Year Equivalent (FYE) Enrollee by State and Eligibility Group, FY 2012, MACPAC, December 2015.

- **Managed Care:** In recent years, California has moved aggressively to enroll more people, including those with significant healthcare needs, into managed care. Over 10 million of the 13 million Medi-Cal beneficiaries (nearly 80%) are now enrolled in managed care, including most of the elderly and people with disabilities who the program covers. As a result, the state and managed care organizations (MCOs) are changing their contracting and care management models to serve beneficiaries who have very different healthcare needs than those who have traditionally been cared for through managed care. Four primary models of managed care – Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), and the Regional Model (RM) – operate in California's 58 counties resulting in state contracts with 21 MCOs. In some areas, the plan or county subcontracts to other plans and in many areas, the plans (the primary plan and/or the subcontracted plan) delegate risk to independent practice associations (IPAs), medical groups, and sometimes hospitals.
- **Medi-Cal Delivery System:** Beneficiaries covered by Medi-Cal get their primary and acute care in doctors' offices, at community clinics and health centers, and in hospitals. Federally Qualified Health Centers (FQHCs) play an important role in delivering care to Medi-Cal enrollees, and their importance has grown with the ACA expansion; they now serve 41% of Medi-Cal MCO enrollees – with both county-based and commercial MCOs relying on FQHCs to deliver primary care to their beneficiaries. For hospital-based care, California has 21 designated public hospitals (DPHs) and 40 district and municipal hospitals (DMPHs) which account for 21% of the inpatient care for Medi-Cal beneficiaries;[7] other hospitals (i.e., private, nonprofit, and publically-traded hospitals) make up the remaining 79%.[8]
- **Beneficiary Characteristics:** Medi-Cal beneficiaries are, by definition, low-income. The expansion has shifted the demographic characteristics of the Medi-Cal population, spurring an influx of adults into the program, such that today nonelderly adults and children make up 84% of the population, up from 77% in 2011. Even with the coverage expansion, seniors and nonelderly adults with disabilities – who are now mostly served through managed care – account for most (60%) of the spending.

  Medi-Cal covers a diverse population that includes the very young and the very old, full-time workers and the unemployed, and people from many different ethnicities, who speak many different languages, and have a wide range of educational backgrounds. Medi-Cal enrollees are more likely than the general population to have chronic illnesses and disabilities that may constrain their daily activities.[9] Overall, Medi-Cal beneficiaries report lower health status than other Californians. Mental health and serious mental illness are some of the most commonly treated conditions among Medi-Cal patients, particularly for the most costly enrollees, and tend to co-occur with physical health conditions.[10]
- **Access, Quality and Health Outcomes:** While publicly available data on utilization and outcomes are limited, reports suggest that Medi-Cal is not meeting expectations of health access, quality, and equity throughout the state. For example, adult Medi-Cal enrollees are twice as

likely as Californians with employer-sponsored coverage to report difficulty getting care from a provider due to insurance and four times more likely to visit the ER for a chronic condition because they couldn't see their own doctors.[11] Emergency room use is significantly higher for the Medi-Cal population than for other Californians.[12]

Within Medi-Cal managed care, quality reports show that MCOs have highly variable performance on quality of care indicators; while some consistently perform above the minimum contractually required levels in all indicators and in all counties they service and there are examples of exceptional performance, innovation and investment (see *"Examples of Local Innovation in Medi-Cal Managed Care"*), many MCOs are performing below the minimum performance benchmark and national averages.[13] MCO members are generally satisfied with their personal doctors, but their overall ratings of their health plans and their ability to get care quickly is below national benchmarks.[14]

Figure 4. Medi-Cal Managed Care 2013 Consumer Assessment of Healthcare Providers and Systems (CAHPS) National Comparison Results

Measure	Adult Medicaid	Child Medicaid
Global Ratings		
Rating of Health Plan	★★	★★
Rating of All Health Care	★★	★
Rating of Personal Doctor	★★★	★★★
Rating of Specialist Seen Most Often	★★★	★★★★
Composite Measures		
Getting Needed Care	★★	★
Getting Care Quickly	★	★
How Well Doctors Communicate	★★	★
Customer Service	★★★	★★★

Note: To conduct a national comparison, results for four Consumer Assessment of Healthcare Providers and Systems (CAHPS) global ratings and four composite measures were aggregated and then compared to NCQA's Healthcare Effectiveness Data and Information Set (HEDIS) Benchmarks and Thresholds for Accreditation. Based on comparison, each measure received one to five stars, with one being the lowest possible (i.e., "poor") and five being the highest possible rating (i.e., "excellent").

Source: Medi-Cal Managed Care 2013 CAHPS Survey Summary Report, DHCS, April 2014.

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Examples of Local Innovation in Medi-Cal Managed Care

Expanding Capacity

Many Medi-Cal plans have ramped up investment earmarked to expand capacity. For example, the Central California Alliance for Health (CCAH) has created a Medi-Cal Capacity Grant Program to increase service capacity for its more than 340,000 Medi-Cal members in Santa Cruz, Monterey and Merced counties. It focuses on increasing provider capacity, improving access to behavioral health and substance abuse services, and expanding the availability of support resources for frequent users of health services. CCAH's Provider Recruitment Program makes $20 million available to subsidize recruitment-related expenses for primary care, specialty care, and behavioral health professionals. CCAH's Equipment Program makes $1.5 million available to providers to subsidize the cost of equipment. A third program, the Practice Coaching Program, will invest $1 million in technical assistance and coaching to practices committed to adopting the Patient Centered Medical Home model of care. Through this program, CCAH intends to advance engaged leadership, patient empanelment, evidence-based care, same-day access to primary care appointments, team-based and patient-centered care, greater coordination of care, and data-driven quality improvement.

Integrating Physical and Behavioral Health

Several Medi-Cal plans have prioritized better integration of physical and behavioral healthcare for their members. One standout is Inland Empire Health Plan (IEHP), which has created an in-house behavioral health program to address the mild-to-moderate mental health needs of its members, integrated behavioral health into every department, trained staff, and expanded its behavioral health provider network to ensure timely access. The network design was based on the "No Gate Keeper" model where the member can freely access mental health or substance abuse treatment services without a referral from his or her primary care physician (PCP) or any requirement of symptom severity.

IEHP created a state-of-the-art web-based coordination of care (COC) system to facilitate communication and collaboration among behavioral health providers, the member's PCP and IEHP behavioral healthcare managers. The online system enables behavioral health providers to view their members' health histories through the electronic health record (EHR). IEHP reports that, as a result of these and other changes, the number of outpatient behavioral visits has increased while inpatient behavioral health bed days have dropped significantly.

IEHP is also investing in a $20 million initiative to integrate behavioral healthcare at the point of care with 13 entities across 34 sites (including county-operated primary care clinics; FQHCs; a community-based adult services center; an assisted living facility; and behavioral health clinics). IEHP support includes staffing, consulting, active coaching and data management and transfer, all designed to provide integrated, collaborative physical, behavioral and substance use treatment for members. UC San Diego will conduct a formal evaluation of this initiative.

Medi-Cal Managed Care Vision

Gleaned from months of an inclusive public process, the state articulated a high-level vision for Medi-Cal in its "Medi-Cal 2020" waiver application – to foster "shared accountability among all providers to achieve high-value, high-quality, and whole person care."[15] Overall, the stakeholders interviewed expressed strong agreement with this vision. These stakeholders focused on the following three components:

- **Coordinated systems of care:** The next generation of Medi-Cal managed care needs to support and advance systems of care, or at least much deeper and more effective coordination of health services across the spectrum of care delivery sites, with special focus on the integration of physical and behavioral health services, particularly for members with highly complex health needs.
- **Value and accountability:** The flow of funds between the state and these systems of care, and among the entities within the systems of care, needs to be oriented to invest in and reward initiatives that support explicitly defined goals consistent with the vision. Tying funding to value requires mechanisms for holding components of the system accountable for achieving results.
- **Stable and adequate financing and strong state-level leadership:** Stakeholders consistently noted that delivery system and payment reform efforts will only be successful if built upon a platform of sustainable financing – one that can weather recessionary impacts on the state budget – and guided by strong leadership and management at the state level. There were diverse views on whether California's overall investment was adequate; many felt the program has long suffered from underinvestment while some believe that investing current resources in new ways could be sufficient to support reform.

Stakeholders also articulated barriers to achieving this vision for Medi-Cal and noted that it will take more than a "business as usual" approach to bring about meaningful improvements in today's highly fractured delivery and financing system. Their vantage points varied, but overall their views offered a telling story of structural roadblocks to reform.

Barriers to Achieving the Vision

1. Fragmented Administration and Delivery of Care

The current Medi-Cal delivery system is composed of a complex mix of plans, counties and provider systems with lines drawn based on geography, beneficiary age and health condition, funding source, and a mix of older and more recent policy goals.

California's managed care system typically involves multiple layers of delegation and sub-delegation of risk and responsibilities for the coordination and provision of patient care. California is somewhat unique in its use of delegation of risk from plans to providers, not just in Medi-Cal but across business lines, including Medicare Advantage and commercial products. In some ways, its history of delegating risk can pave the way for successful delivery system reform since plan-to-provider delegation can align the goals of MCOs and providers around managing the total cost of care and achieving quality outcomes. However, although many MCOs use pay-for-performance programs to foster improvements in access and quality, much of the delegation and sub-delegation that exists in Medi-Cal today is not necessarily designed to create accountable systems of care across primary, specialty, behavioral health, hospital and post-acute care. Rather, most are arrangements to pass along risk from the plans to different (largely siloed) segments of their provider networks.

> "We can't get to five star performance in Medi-Cal managed care without changing the structure of the program"
> *– Provider trade group*

Plan-to-plan delegation in Los Angeles County, which accounts for 28% of Medi-Cal beneficiaries, adds yet another

L.A. County Sub-Contracting and Delegation

Los Angeles County, which operates the so-called two-plan model, actually has six plans – the two plans that contract with the State (HealthNet and LA Care), three additional plans (Anthem, CareFirst and Kaiser) that subcontract with LA Care and a sixth plan (Beacon) that subcontracts with some plans to provide some mental healthcare for enrollees with mild to moderate mental health conditions. Together, the enrollment for the three subcontracted health plans (not including Beacon) exceeds the direct enrollment of LA Care and HealthNet, the two plans that have a direct contractual relationship with the state. All but one plan shares risk with some of its providers, in most cases not for managing the total cost of care, but for the provision of and payment for a particular service (e.g., physician care, hospital care). In some cases, provider organizations contract with other providers, meaning that some providers that are carrying out the plan's responsibilities have no contractual relationship with that plan.

layer to an already complex system. The two plans that contract directly with the state subcontract to other plans, retaining a portion of the premium for administrative services that may be redundant to services being delivered by the delegated entity. Given the complex and often nontransparent arrangements, stakeholders noted that the organization of care often leads to confusion in roles and responsibilities for providers and plans, challenges for consumers to navigate and oversight complexities.

These complexities are further exacerbated because certain services (e.g., treatment for serious mental illness, pediatric services for certain complex conditions and some long-term services and supports) are "carved out" of the primary health plan's responsibilities, leaving no single entity responsible for the whole person. While it is critical to ensure that patients with complex care needs have the specialized care they require, bifurcating the organization, payment and oversight of care for these populations and services fractures the delivery of care. This problem is particularly acute for mental healthcare. The counties administer services to treat serious mental health problems, while the state administers care through the managed care system to address physical healthcare and mild to moderate mental healthcare needs of the same population. Plans are now required to establish memoranda of understanding (MOUs) with the counties to promote systems for coordinating care, but interviewees indicated that integration efforts have either not begun or are at a very early stage in many parts of the state.[16]

2. Fragmented Financing

Like the delivery system, financing of the care delivered to managed care enrollees is highly fragmented, with large dollar amounts being transferred as institutional subsidies rather than as payments for services and outcomes. An estimated 25% to 30% of the payments for hospital services provided under contract to the plans are made through supplemental payments that are passed through to the counties and hospitals at the end of the plan year. Public and private hospitals generate the nonfederal share of these payments through the hospital provider tax and county-generated intergovernmental transfers, both legal and common sources of financing for Medicaid programs. The payments, however, are not tied to particular services or any quality measures but are generally seen as a way to compensate for low base payments to the hospitals, and support counties' care delivery systems. While these are both legitimate objectives, this method of payment limits the state's ability to use its purchasing power to promote accountability and reward value.

The Challenge of Care Coordination

"The mental health system for Medi-Cal is broken. The carve-in of mild to moderate mental illness into MCOs has helped bring greater clarity regarding the division of responsibilities between MCOs and counties, but there is limited accountability and transparency for mental health services at the county, and clinicians don't have the systems to talk to each other to coordinate care."
– Medi-Cal provider

FQHCs are also compensated for their care of Medi-Cal beneficiaries partly through supplemental payments; these payments, which are required by federal law, are based on the volume of care provided to patients. Recent state legislation seeks to pilot ways to shift this volume-based system of payment to one that is more grounded in value-based principles.

Medi-Cal's payment structure is further fragmented by carve out arrangements. Under federal law, the state is responsible for the care provided to Medi-Cal beneficiaries for mental health conditions, but in California the funds for the care of people with serious mental illness go to the counties (which pay the nonfederal share), and the state Medi-Cal agency, pursuant to a provision adopted in the state constitution in 2012, has no authority over how those funds are spent. Mental health is a major cost driver for the program. Over half (59%) of Medi-Cal's top 5% most costly enrollees have a mental health condition, including 45% of enrollees with a serious mental illness.[17]

Medi-Cal's rate setting methodology further undermines efforts to advance accountable, coordinated systems of care and reward value. Rates are generally based on prior year utilization and are pegged at the lower end of the range of what is determined to be actuarially sound. There is no mechanism for the state to share savings to provide financial incentives that drive improvements in care delivery and redirect care to less costly settings. In fact, to the extent that plans and providers are successful in reducing utilization of costly care (e.g., reducing preventable hospital inpatient admissions), they are likely to see a reduction in payments in subsequent years.

The lack of a payment methodology that provides incentives for and helps to finance care improvements, combined with what are generally viewed as low payment rates, has important implications for the system overall. It prompts more sub-capitation arrangements and system fragmentation as risk continues to get shifted downstream, challenging the drive towards the desired accountable, coordinated systems of care.

3. Uneven Access to Providers

Historically, provider participation in Medi-Cal has been lower than participation in the commercial market.[18] With respect to primary care, California still falls significantly short of the national benchmark for a sufficient supply of Medi-Cal participating primary care providers to meet the needs of beneficiaries.[19] While the data indicate that California has a sufficient supply of Medi-Cal specialty care providers overall to meet the needs of beneficiaries, there is variation in access by specialty and by geography,[20] and anecdotal reports of significant access challenges. In some cases, plans report having to pay higher than contracted rates to providers, such as specialists, to ensure access and meet network adequacy requirements. In the case of hospitals, payments by plans include retroactive supplemental payments intended to compensate for low base payments. Unfortunately, there is little publicly available information on network capacity or on utilization within the managed care system, which could shed more light on access questions. In addition to addressing provider reimbursement rates, stakeholders suggested that provider participation could be improved, to the extent that the State or its contracting plans reduced administrative hurdles to enrollment and certification and streamlined prior authorization procedures within and across plans.

4. Workforce Challenges

Stakeholders noted challenges recruiting primary care physicians and specialists, especially to safety net institutions and FQHCs, which do not have the resources to offer salaries on par with health systems that serve an exclusively or heavily commercially insured population. The state had outlined workforce development initiatives in its original waiver renewal proposal to provide incentives to providers to participate in Medi-Cal, expand the workforce, and enhance their cultural competency to serve Medi-Cal beneficiaries, but these proposals were dropped in the approved waiver terms.

5. Lack of Transparency and Effective Accountability Mechanisms

Under federal law, the Department of Health Care Services (DHCS) is accountable for the overall administration and oversight of Medi-Cal, including its managed care system. DHCS contracts with plans, sets the rates for the plans with which it contracts directly and establishes the rules and regulations for the program. To carry out its plan oversight, DHCS works with the Department of Managed Health Care (DMHC), the state agency that oversees full-service health plans (whether or not they are contracting with Medi-Cal) and their compliance with California's Knox-Keene Health Care Service Plan Act of 1975.[21] Some stakeholders raised concerns that the state's oversight activities do not necessarily ensure accountability, noting that the DHMC's requirements are typically more process- than outcomes-oriented.

Compounding the challenge of program oversight is the limited visibility into (and oversight of) the networks and performance of contracted and delegated entities. For instance, DHCS requires all plans to collect and report on HEDIS measures for quality oversight, but the reports do not provide the performance of subcontracted plans or provider groups. Therefore, in locales with a high degree of subcontracting or delegation, it is not possible to identify outlier performance issues and underperforming plans or provider groups from publicly available data. DHCS has a responsibility to ensure members have the information they need to make good choices about the network they choose, but without visibility down to the delegated entity level, members often do not have adequate information to make well-informed decisions.

> "Consumers and regulators are challenged to understand true adequacy of provider networks. Consumers will review the parent plan network information but it's the delegated IPA network that reflects actual access and is the level on which utilization is managed."
> *– Consumer Advocate*

State representatives noted that the state has limited levers for achieving a high degree of accountability, citing that previous attempts at removing under-performing plans from the Medi-Cal program were appealed and overturned, and that, due to litigation-related settlements, the state is locked into certain contracts with plans for several more years.

Additionally, as noted, under the state constitution, DHCS has very limited ability to oversee the provision of services for Medi-Cal beneficiaries with serious mental health conditions treated by the county systems.

6. Under-Resourced Program Management

Stakeholders interviewed noted that bandwidth, skill sets, and the infrastructure for accountability functions have not kept pace with the growth and changes in Medi-Cal managed care. Recently the effectiveness of the state's oversight of network adequacy, consumer complaints, and quality has been called into question.[22] The state has taken steps to address these concerns, including passing legislation to establish accurate provider directories, increasing the frequency of health plan audits, and regularly publishing a Medi-Cal managed care performance dashboard.[23,24] Implementing Medi-Cal reform at the scale described in this paper will require enhanced capabilities at the agency level.

A Path Forward

Stakeholders are generally very supportive of the program and proud of its accomplishments. They are also eager for reform, but worry that there are clear limits as to what can be done within current constraints. They point to there being little appetite at the federal or state level to increase investments, dysfunctional care delivery mechanisms and financing arrangements entrenched in statute, and political barriers to change. Yet, given the evolution of Medi-Cal's role, its size and importance to Californians and the state's healthcare system, maintaining the status quo is not a viable option. The interviews and a review of the landscape suggest that it is time to reconsider the longstanding assumptions and constraints that underpin the Medi-Cal program – including how it is financed and how care is delivered, and to engage in a more far-reaching and disruptive dialogue than has yet occurred.

The recently renewed "Medi-Cal 2020" waiver will contribute to positive change but it does not tackle the significant realignment, restructuring and financing issues many stakeholders identified as being critical to successful transformation. The new initial federal investment is limited to just over $6 billion, well below the $17 billion request but similar to the level of support provided under the previous waiver. And like the previous waiver, the primary focus of the new waiver is largely on the public hospitals, a critical component of the Medi-Cal delivery system and California's healthcare safety net, but still only a slice of the healthcare system.[25] While the waiver presents new opportunities and investments, its scope is limited and implementation will generally not address the system as a whole.

The newly released federal managed care regulations present new opportunities but will also prompt some changes in the Medi-Cal managed care system. Certain rate setting practices relied on by California may no longer be viable, and payments to providers passed through managed care plans will need to be revised over time. At the same time, the regulations encourage state-designed value-based payment strategies and provide some new tools for accomplishing those strategies.

Achieving the broadly shared vision of accountable, coordinated systems of care will require a phased, multi-year approach. Below are a set of near term priorities to improve care and strengthen the foundation for reform.

Many of these priorities take the waiver initiatives to a higher level. They are considered near term because they are on the state's agenda, largely triggered by the new waiver and do not require new state legislation or waivers to be implemented. But they still will require significant state resources and stakeholder commitment to be implemented successfully.

At the same time as these near term initiatives are pursued, a process is needed to delineate and implement the type of structural reforms discussed in the final section of this paper.

Near Term Change

1. Intensify efforts to coordinate care for people with serious mental illness. Given the high burden of mental illness and the consensus among stakeholders that coordination of care for people with serious mental health issues is particularly challenging in the current environment, a more concerted effort to promote integration of care is needed.[26] Achieving complete integration for people with serious mental illness would require a change to the state's Constitution, but there are steps that can be taken today, under current law, to improve coordination of care for this vulnerable population. The MOUs between plans and counties can help clarify roles and responsibilities, but stakeholders generally seem disconnected from or even unaware of this process. The state and counties should take the following steps:

- Establish a clear and public set of expectations and milestones for achieving integration of care.
- Actively engage plans, providers, and consumer groups in implementation.
- Ensure that care teams have systems in place to communicate and coordinate patient care across the physical and mental health divide.

2. Invest in initiatives that address the pressing health-related needs of the Medi-Cal population with complex health conditions. The Medi-Cal 2020 waiver includes funding to implement voluntary, county-based "whole-person" care pilot programs, which present an opportunity for bringing together healthcare, social services and community-based service providers to design and test innovative models of care that go beyond the traditional definition of healthcare.

Based on the experiences of other states, this is difficult work. There is much interest among stakeholders in this

Meeting the Needs of Populations with Limited Income

"The current Medi-Cal delivery system is a "middle class" healthcare system; it assumes people can drop everything and go see the doctor in the middle of the day, and it assumes health is everyone's number one priority. The truth is that low-income people have a variety of other issues that may be more pressing, like access to housing or food, and they often cannot leave work to go to a healthcare appointment, but there is no interested party advocating for coverage for those services, the way there is for imaging or surgery." – Medi-Cal Provider

initiative, but the waiver financing is limited and the infrastructure to support the effort is not in place. To promote success, the pilots should, where possible, align and coordinate with the health home initiative for people with multiple chronic conditions. Furthermore, the pilots should be supported with model contracting and cross-learning opportunities on roles and responsibilities. To supplement the funds provided through the waiver, revisions in rate setting (discussed below) can help support these efforts, particularly if they are targeted to those for whom interventions are most likely to result in lower costs.

3. Strengthen accountability by revising rate setting methodologies. Medi-Cal can address the current disincentives to shifting care out of emergency departments and costly institutional settings and into ambulatory, community-based care settings; waiver authority and special waiver funding are not essential to moving forward. Given the strong and consistent message from plans and other stakeholders that the current rate setting methodology not only does not reward care improvements, but is actually a disincentive for such improvements, a change in rate setting and payment strategies is needed. One approach would be to allow health plans to share savings achieved through improvements in care; this approach was proposed in the state's waiver proposal, but was eventually dropped from the finalized waiver. A variation to this approach is to develop a new rate setting methodology that allows plans to keep the savings if those savings are reinvested in care improvements (which could be defined by the state in collaboration with plans and providers). This would not add costs relative to current rates and is a way to promote needed investments.

These relatively modest rate setting changes could be a prelude to and dovetail with the implementation of the alternate payment methodologies (APMs) required under the waiver for the Designated Public Hospitals (DPHs). The APM initiative could help achieve the vision of greater value and accountability for patient outcomes, but if limited to the DPHs, this initiative will have modest impact and would further fragment how care is financed and quality is measured. With the goal of eventual statewide adoption, APMs should be extended to health systems that are prepared to take on some level of "whole person" risk, particularly given that multiple

Alternative Payment Models

Payment approaches designed to drive better outcomes are often referred to as "alternative payment models," (APMs) meaning they are alternatives to paying for the volume of care provided. APMs can take different forms, ranging from relatively modest pay for performance type mechanisms (which are already being pursued by some Medi-Cal managed care plans today) to the assumption of full risk for the total cost of care. States are adopting different systems, recognizing that many providers are not ready to take on full risk. Arkansas and Tennessee are building payment models around episodes of care while New York is planning to have four different types of alternative payment methodologies, each with different levels of risk, and to phase in those arrangements over time.

plans will need to be engaged to implement APMs for the public hospital systems. Instead of the bottom up approach adopted in the Bridge to Reform Delivery Systems Reform Incentive Payment (DSRIP) program, the development of APMs, whether or not limited to DPHs, will need direction from the State in close collaboration with the DPHs, plans and other stakeholders to effectively serve as a building block to broader payment reform.

4. Align incentives across Medi-Cal and across the marketplace. With some exceptions[27], Medi-Cal lacks common goals that it is seeking to achieve across its managed care delivery system, such as improved performance on a core set of quality indicators, or reduced readmissions and emergency room use. A core set of initiatives can help stimulate reform while simultaneously allowing for local strategies that take into account regional assets, challenges, and community needs. Greater standardization also makes sense given that providers are often contracting with multiple managed care plans and yet are pushed in different directions by the different plans. The development of APMs and new rate setting methods presents new opportunities for DHCS to encourage greater standardization of performance expectations within Medi-Cal managed care.

Medi-Cal should also intensify its collaboration with Covered California and CalPERS to promote opportunities for the three payers to align their delivery system reform strategies. Together, Medi-Cal, CalPERS and Covered California purchase health insurance for approximately 15 million Californians, with Medi-Cal representing by far the largest share. Each program may well have different emphases driven by the needs of its specific populations, but there are many cross-cutting priorities (for instance, the adoption of interoperable health information technology or the management of chronic conditions). Reform is most likely to take hold if the three state systems are moving in the same direction for those areas of overlapping priority.[28] Through greater collaboration, DHCS would benefit from the resources invested by other payers in analyzing performance incentive initiatives, and the efforts of these other payers would be strengthened by alignment with Medi-Cal, given its large footprint in the California health care market, and the churn of members across programs. Alignment could be promoted if the three state payers regularly report on key areas of delivery system and payment reform and how each of the programs is addressing areas of overlapping priority.

5. Focus on data improvement. Little can be accomplished

Aligning Value-Based Initiatives Across the State

The Integrated Healthcare Association (IHA) has been facilitating multi-stakeholder work groups to align quality measurement and incentive programs both within Medi-Cal (promoting the standardization of MCOs' pay-for-performance (P4P) program metrics across the state) and across state payers. It is currently facilitating a multi-stakeholder work group, led by CalPERS, DHCS, and Covered California, to reduce inappropriate and unnecessary care across public and private payers.

without a robust and dynamic data environment. Cost, quality, utilization, patient satisfaction, equity and access data from all plans and subcontractors/delegated entities (by entity) should be made publicly available to allow for an ongoing, meaningful assessment of the health of the system, how well it is meeting the needs of its diverse members and how effectively it is deploying its resources.

6. Invest in Health Information Technology and Health Information Exchange across the state. To promote the level of coordination of care and care management that can result in more appropriate utilization of resources, cost savings, and better patient outcomes, the state should deepen its efforts to help equip providers with the tools, technology and incentives to go digital.

7. Address workforce shortages. Though not approved as part of the renewed waiver, workforce investments are necessary to ensure access to care and the cultural competence of the workforce in treating the Medi-Cal population – many for whom English is not their first language. These investments can help ensure people get basic primary care services and prevent the need for costly emergency and acute care services. The programs envisioned in the waiver concepts are sound, including incentives for providers to participate in Medi-Cal, cultural competence training, and leveraging non-physician and front-line workers to help beneficiaries navigate the system and provide health education.

Structural Transformation

In parallel to these important near-term initiatives, the landscape review and the interviews suggest that a far more ambitious agenda of re-structuring the underlying Medi-Cal delivery and payment system is needed to achieve the vision of **coordinated and accountable systems of care**. This level of transformation cannot be achieved without further analysis and stakeholder engagement, and will likely require legislation (and perhaps a change in the state Constitution), regulatory changes, re-procurement, or all three.

1. Rethink the core structures of Medi-Cal managed care delivery. The current structure of Medi-Cal's managed care delivery system was designed when a much smaller and more homogenous group of enrollees was enrolled in managed care; much has changed since that system first took shape in 1993. Perhaps most notable is that the number of people served by managed care has grown almost threefold in the past six years and the demographics of those enrollees have changed just as dramatically.[29]

These developments, along with the highly variable performance across plans, suggest that it is time to consider whether these delivery models are best suited to achieve the level of performance and accountability that California and stakeholders believe should be achieved. The inquiry will raise difficult questions: Should all plans have a direct contractual relationship with the state? How can delegation be transformed to advance accountable systems of care? Should procurement cycles, plan and provider requirements and expectations be revised? What factors promote or hinder a county-run plan's ability to be successful?

Medicaid Delivery System Reform in Other States

Many states are developing new ways to organize their Medicaid care delivery systems. For example, Oregon has established locally driven regional coordinated care organizations (which bear full risk and, under federal rules, are considered managed care organizations); they have flexibility for how they will design their system of care and, to some degree, for the services they will provide, but are all responsible for meeting statewide metrics for quality and cost. Massachusetts and New York are moving to require health plans to contract with accountable care organizations or to adopt alternative payment methodologies with a large portion of their providers. Colorado does not rely on managed care plans but rather contracts directly with accountable care organizations.

Should counties' roles evolve, given the imperative of focusing on population health? Where should responsibilities for care management reside? Can the impact of value-based initiatives be measured and responsibility for results be attributed in the system that is in place today?

2. Re-examine Medi-Cal's financing system. Financing also needs a thorough examination including resolution of the following four financing-related questions:

- **Is the overall level of funding sufficient to support adequate networks and encourage coordinated systems of care?** There are strong opinions but neither a consensus among stakeholders nor sufficient data upon which to draw a definitive answer to this question. Nor is there any accepted measure of adequacy of funding – markets differ, as do population needs and costs. Medi-Cal is a lean program by any standard, and the evidence available indicates that it is not achieving the outcomes Californians expect. A robust examination of access, utilization, outcomes and the opportunities for achieving savings through care improvements should drive the determination of whether the overall level of resources or the distribution of resources is appropriate. Informative data on networks should be forthcoming; utilization data may require more time and resources, although the state has noted that it relies on such data to set rates. If so, such data could be made publicly available. In addition, federal regulators are requiring all states to improve their data systems or face compliance action.[30]
- **Is it possible to move to a value-based system of paying for care given how much money is directed to hospitals through supplemental payments?** Federal concern about the lack of transparency and efficacy of supplemental payments and new managed care regulations will trigger change, but California will need to drive that change and consider how to bring rates for hospitals and other providers to an appropriate level without relying on end-of-year payments that are not connected to services or outcomes, and how best to support safety net institutions. [31,32] Tying supplemental payments to the attainment of quality outcomes could be one way to begin to reorient this aspect of program financing towards

value and ensure that existing resources are being used to incentivize and reward system transformation. Payment rates within managed care can also be designed to specifically address the unique needs of safety net hospitals that serve a large number of Medicaid and uninsured patients.

- **Should the financing for serious mental healthcare be revised so that payment strategies support integration between mental healthcare and physical healthcare?** County financing and control of the funding for serious mental healthcare has a long history in the state, but now, with the expansion, many of those services are provided to Medi-Cal beneficiaries, leaving people who are receiving the care with a bifurcated delivery system financed through different funding streams. To align financing with delivery and promote accountability, options to "carve in" the care (while assuring capacity to care for patients) or to construct incentive payments that cross delivery system sites should be considered so that payment strategies promote alignment of care for the whole person. Carving in mental health would require a change to the California Constitution, which currently codifies the counties' role in the delivery of mental health services.
- **What are the implications of these issues for the nonfederal funding for the program?** Consideration of each of the first three questions inevitably raises the issue of who pays and what will make up the sources of the nonfederal share of Medi-Cal spending. Diversified financing, for example, through provider taxes and intergovernmental transfers, can help states fund the nonfederal share of Medicaid costs, and there is nothing inherently problematic about such diversification. However, if the source of funding drives payments in ways that do not promote accountable coordinated systems of care, efforts to promote value are compromised. In addition, a patchwork financing system can result in added costs. The financing of mental healthcare contributes to some of the highest cost Medi-Cal beneficiaries getting caught in the cracks between the county-based mental health system and the Medi-Cal managed care system. All those who contribute to financing Medi-Cal, including the state's general fund, are bearing additional and unnecessary costs.

California has tackled financing realignment many times over the years, and it is never easy. Many factors, including county indigent care obligations, the importance of sustaining the safety net hospitals, local property tax limitations, state laws directing certain resources to education, and the demands of other state priorities have shaped and will continue to shape California's Medi-Cal financing arrangements. These are all important considerations, but given the size and importance of Medi-Cal, it is also critical to consider the impact of the current financing structure on Medi-Cal's overall costs and its ability to serve its beneficiaries well and move forward with the next chapter of delivery system and payment reform. And, as California has just seen, it cannot continue to expect and rely on increases in federal funding through waivers to finance key initiatives.

Conclusion

California is a national leader in extending Medicaid to low-income people and in other aspects of healthcare reform. And yet, the Medi-Cal program's current status and trajectory raise deep concerns among stakeholders and external observers alike. In parallel to a series of near term and more incremental steps that can advance the program down the path of achieving greater value, open dialogue is required about how to address the structural impediments to change.

Medi-Cal is too large and too important to miss this opportunity to achieve the vision of accountable, coordinated systems of care.

About Manatt

Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is a fully integrated, multidisciplinary legal, regulatory, advocacy and strategic business advisory healthcare practice. Manatt Health's extensive experience spans the major issues reinventing healthcare, including payment and delivery system transformation; health IT strategy; health reform implementation; Medicaid expansion, redesign and innovation; healthcare mergers and acquisitions; regulatory compliance; privacy and security; corporate governance and restructuring; pharmaceutical market access, coverage and reimbursement; and game-changing litigation shaping emerging law. With 80 professionals dedicated to healthcare—including attorneys, consultants, analysts and policy advisors—Manatt Health has offices on both coasts and projects in more than 20 states. For more information about Manatt Health, visit www.manatt.com/HealthcareIndustry.aspx.

For more information, contact:

Cindy Mann
Partner
202.585.6572
cmann@manatt.com

Naomi Newman
Director
415.291.7569
nnewman@manatt.com

Alice Lam
Director
212.790.4583
alam@manatt.com

Appendix A: Interviewees

Maya Altman
Health Plan of San Mateo

Scott Bain
California Senate
Health Committee

Bill Barcellona
California Association of
Physician Groups

Kirsten Barlow
County Behavioral Health
Directors Association

Kim Belshé
First 5 LA (formerly, Secretary,
California Department of Health
and Human Services)

Catherine Blakemore and Deborah Doctor
Disability Rights California

Michelle Cabrera
SEIU State Council

Carmela Castellano-Garcia
California Primary
Care Association

Richard Chambers
Molina Healthcare of California

Dustin Corcoran
California Medical Association

Sarah de Guia
California Pan-Ethnic
Health Network

Diana Dooley
California Health and Human
Services Agency

Toby Douglas
Independent Health Care
Consultant (formerly, Director,
California Department of Health
Care Services)

Susan Ehrlich
San Mateo Medical Center

Susan Fleischman
Kaiser Permanente

Bob Freeman
CenCal Health

Brad Gilbert
Inland Empire Health Plan

Stuart Gray
Accountable Health Care IPA

Ed Hernandez
California State Senate

Russell Judd
Kern Medical Center

Mitch Katz
Los Angeles County Department
of Health Services

Jennifer Kent and Mari Cantwell
California Department of Health
Care Services

Don Kingdon and Molly Brassil
Harbage Consulting

Elizabeth Landsberg
Western Center on Law & Poverty

Agnes Lee
Office of Assembly Speaker
Toni Atkins

Peter Lee
Covered California

Chris Manson
St. Joseph Health

Ana Matosantos
Independent Financial and Budget
Consultant (formerly, Director,
California Department of Finance)

Louise McCarthy
Community Clinic Association
of Los Angeles County

Steve Melody
Anthem Blue Cross

Santiago Muñoz
UCLA Health System

Erica Murray and David Shearn
California Association of Public
Hospitals and Health Systems/
California Health Care Safety
Net Institute

Richard Pan
California State Senate

Jeff Rideout and Jill Yegian
Integrated Healthcare Association

Shelley Rouillard
Department of Managed
Health Care

Michael Schrader
CalOptima

Ralph Silber
Alameda Health Consortium

Marjorie Swartz
Office of Senate President Pro
Tempore Kevin de León

Farrah McDaid Ting and Michelle Gibbons
California State Association of
Counties

Tammy Wilcox
Dignity Health

Anthony Wright and Beth Capell
Health Access

[1] "Adult Medi-Cal Enrollment Surges, Uninsured Rate Plummets in 2014," *UCLA Center for Health Policy Research*, August 2015. Accessed at: http://healthpolicy.ucla.edu/publications/Documents/PDF/2015/Medi-Cal-factsheet-aug2015.pdf

[2] Long-term services and supports (LTSS) were not part of the focus of the interviews and report.

[3] See Appendix A for list of interviewees.

[4] "Medi-Cal Statistical Brief," *DHCS Research and Analytic Studies Division*, August 2015. Accessed at: http://www.dhcs.ca.gov/dataandstats/statistics/Documents/New_24_Month_Examination.pdf
"California Enacted Budget Summary," *Department of Finance*, June 2015. Accessed at: http://www.ebudget.ca.gov/2015-16/Enacted/BudgetSummary/BSS/BSS.html

[5] The Medi-Cal budget estimated total spending of $91,305,437,300, with the General Fund providing $18,039,896,000. The total General Fund, as enacted by the 2015 Budget Act, was $115,369,000,000. Therefore, 15.6% of total General Fund spending was used for Medi-Cal. "Medi-Cal May 2015 Local Assistance Estimate for Fiscal Years 2014-15 and 2015-16," *DHCS*, May 2015. Accessed at: http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Pages/may_2015_estimate.aspx

[6] "Medicaid Financing: How Does it Work and What are the Implications?" *Kaiser Commission on Medicaid and the Uninsured*, May 2015. Accessed at: http://kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/

[7] "Medi-Cal Managed Care Plans and Safety Net Clinics Under the ACA" *California Health Care Foundation*, Dec 2015. Accessed at: http://www.chcf.org/publications/2015/12/medical-winwin-surging-enrollment

[8] Manatt analysis of OSHPD Hospital Data, 2014.

[9] "California Health Interview Survey," *UCLA Center for Health Policy Research*, 2014. Accessed at: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

[10] "Understanding Medi-Cal's High-Cost Populations," *DHCS Research and Analytic Studies Division*, March 2015. Accessed at: http://www.chcf.org/events/2015/medical-data-symposium

[11] California Health Care Foundation, "*Medi-Cal Versus Employer-Based Coverage: Comparing Access to Care*," July 2015. Accessed at: http://www.chcf.org/publications/2015/07/medical-access-compared

[12] Over 23% of those covered by Medi-Cal reported visiting an emergency room in the past 12 months, as compared to 15% of those not covered by Medi-Cal. "California Health Interview Survey," *UCLA Center for Health Policy Research*, 2014. Accessed at: http://healthpolicy.ucla.edu/chis/Pages/default.aspx

[13] In 2013, MCP [Medi-Cal Managed Care Plan] performance fell below the minimum contractually required performance for 21% of the 22 DHCS quality indicators [...] This means one in five Medi-Cal performance metrics was in the bottom 25% of all Medicaid-contracted health plans in the US. "Medi-Cal Managed Care Program, Quality Strategy Annual Assessment," *DHCS*, October 2014 (Rev. February 2015). Accessed at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/Studies_Quality_Strategy/MgdCareQualityStrategy2015.pdf

[14] "Medi-Cal Managed Care 2013 CAHPS Survey Summary Report," *DHCS*, April 2014. Accessed at: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/CAHPS_Reports/CA2012-13_CAHPS_Summary_Report_F3.pdf

[15] "Medi-Cal 2020: Key Concepts for Renewal," *DHCS*, March 2015. Accessed at: http://www.dhcs.ca.gov/provgovpart/Pages/1115-Waiver-Renewal-Official-Submission.aspx

[16] See also: Nov 27, 2013 All-Plan Letter Regarding the Memorandum of Understanding requirements for Medi-Cal Managed Care Plans: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-018.pdf

[17] "Understanding Medi-Cal's High-Cost Populations," *DHCS Research and Analytic Studies Division*, March 2015. Accessed at: http://www.chcf.org/events/2015/medical-data-symposium

[18] "Physician Participation in Medi-Cal: Ready for the Enrollment Boom?," *California Health Care Foundation*, August 2014. Accessed at: http://www.chcf.org/publications/2014/08/physician-participation-medical

[19] The national benchmark is 60 to 80 primary care physicians per 100,000 in population and California is at 35 to 49 Medi-Cal providers per 100,000 Medi-Cal beneficiaries. "Physician Participation in Medi-Cal: Ready for the Enrollment Boom?," *California Health Care Foundation*, August 2014. Accessed at: http://www.chcf.org/publications/2014/08/physician-participation-medical

[20] The national benchmark is 85 to 105 specialty care physicians per 100,000 in population and California is at 68 to 102 Medi-Cal providers per 100,000 Medi-Cal beneficiaries. 69% of all physicians accept-Medi-Cal, however only 47% of psychiatrists accept Medi-Cal. "Physician Participation in Medi-Cal: Ready for the Enrollment Boom?," *California Health Care Foundation*, August 2014. Accessed at: http://www.chcf.org/publications/2014/08/physician-participation-medical

[21] While Knox-Keene applies to most of California's managed care systems, it does not apply to most of Medi-Cal's County Organized Health Systems (COHS) which account for over 21% of the Medi-Cal managed care population. As such, some stakeholders raise concerns about the lack of consistent oversight of the plans contracting with Medi-Cal, though others noted that the COHS have among the highest quality scores. Pending legislation would require that COHS be Knox-Keene licensed and confer more robust consumer protections for coverage through COHS, such as independent medical review and external review by DMHC. "SB-260: Medi-Cal: County Organized Health Systems Pilot Program," *California State Senate*, 2015-2016. Accessed at: https://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201520160SB260

[22] "Improved Monitoring of Medi-Cal Managed Care Health Plans Is Necessary to Better Ensure Access to Care," *California State Auditor*, June 2015. Accessed at: https://www.auditor.ca.gov/pdfs/reports/2014-134.pdf

[23] "SB-137 Health care coverage: provider directories," California State Senate, 2015-2016. Accessed at: https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB137

[24] "Medi-Cal Managed Care Performance Dashboard," DHCS. Accessed at: http://www.dhcs.ca.gov/services/Pages/MngdCarePerformDashboard.aspx

[25] In 2013, the public hospitals accounted for 21% of California's total inpatient Medicaid discharges. Manatt analysis of 2013 Hospital Annual Financial Disclosure Reports from the Office of Statewide Health Planning and Development. Reports available at: http://www.oshpd.ca.gov/HID/Hospital-Financial.asp#Profile

[26] California is not alone in tackling this challenge. States and health systems are pursuing a spectrum of approaches to achieving greater integration – including universal screening programs, patient navigators, co-location of services, health home models of care – with many showing promise. "Integrating Physical and Behavioral Health Care: Promising Medicaid Models," *The Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation*, February 2014. Accessed at: https://kaiserfamilyfoundation.files.wordpress.com/2014/02/8553-integrating-physical-and-behavioral-health-care-promising-medicaid-models.pdf

[27] DHCS produces an annual statewide quality strategy, and a Medi-Cal Managed Care Quality Dashboard to define quality goals across the program. Additionally, select HEDIS measures are used in the auto assignment process, with higher-performing health plans receiving a higher share of enrollees who do not affirmatively pick a plan.

[28] Covered California recently updated its contracts with plans for 2017 to enhance the quality performance requirements, address disparities, and promote quality over quantity of care. For more information, see http://news.coveredca.com/2016/04/covered-californias-board-adopts.html

[29] Medi-Cal managed care enrollment totaled 3.9 million in December 2009 and 10.2 million in December 2015. "MMC Enrollment Report," DHCS. Accessed at: http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDMonthlyEnrollment.aspx

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Many Routes to the Top: Efforts to Improve Care Quality, Coordination, and Costs Through Provider Collaborations

In response to the federal Patient Protection and Affordable Care Act of 2010 (ACA) and a combination of broader market forces, hospitals, physicians, and other health care providers around the country have been increasingly collaborating among themselves and with public and private payers on efforts to reform care delivery systems and payment methods. While their structures vary widely, most of these initiatives share the overarching aims of slowing the growth of health care spending and improving the coordination and quality of patient care.

California providers have been particularly active in developing collaborations with other providers and with commercial health plans. Many of these provider partnerships have been driven in part by key market factors characteristic of many California communities — most notably the presence of large providers experienced in managing financial risk for patient care, as well as competitive pressure on both insurers and providers from the growing dominance of Kaiser Permanente's integrated delivery system and health plan.

The California Health Care Foundation's longitudinal Regional Markets Study of seven California health care markets provided a unique opportunity to track the development of collaborative relationships that hospital and physician organizations have formed in the state over the past several years. This paper describes major types of provider collaborations that have proliferated in California since 2013, highlights leading examples from the seven regions studied, discusses providers' key goals and strategies, and explores how market conditions spurred each major type of partnership and influenced their structure. The analysis also considers some of the key effects that these collaborations might have on cost, quality, and access to care in local health care markets. The intent of the paper is not to provide an exhaustive catalog of all collaborations undertaken by providers; instead, the focus is on those initiatives highlighted by hospital and physician executives, as well as market observers, as particularly important to the overall strategies and objectives of provider organizations.

The focus of this paper is on collaborations formed by mainstream health care providers — those that serve large populations of commercial and Medicare patients.

Integrating Care: Provider Collaborations to Form Region-Wide Integrated Care Networks

An increase in efforts by major providers — primarily hospital systems — to pursue population health strategies represents one of the most significant developments in several major California health care markets over the past few years. In response to policy changes and market forces that are moving both public and private payment away from fee-for-service toward value-based models that reward efficiency, providers are seeking to transform themselves into region-wide integrated systems of care. While these efforts vary widely in structure and organization, they share the common aim of building a care network that is broad and attractive enough to

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purchasers and consumers to compete vigorously for sizable populations of well-insured patients while also achieving enough efficiency in managing patient care that providers can fare well financially in competition against the likes of Kaiser Permanente.

Not surprisingly, most of these efforts to develop region-wide population health strategies are taking place in major metropolitan markets with large populations of well-insured patients. In Northern California, these markets include the San Francisco Bay Area and Sacramento; in the southern part of the state, Los Angeles, Orange, and San Diego Counties all are seeing active efforts to develop integrated care networks. These are also markets that have large, financially strong hospital systems capable of making the capital investments in such ambitious initiatives. Many of these systems have long thrived as high-priced providers exercising strong leverage against commercial payers in a fee-for-service environment and still have a large proportion of their payments under lucrative volume-based arrangements. However, as one market observer noted, "Large systems [are] taking major, proactive steps to try to transform themselves into high-value regional systems of care . . . while [financial] margins are still strong . . . so they don't get left behind by a changing market."

Another key characteristic common to these markets is the strong and growing presence of Kaiser, whose HMO products emphasizing moderate premiums and out-of-pocket costs, combined with seamless access to services (especially primary care), has put pressure on competing providers and insurers to offer similar combinations of value and access.

Some large systems — most notably Sutter Health in Northern California and Sharp Healthcare San Diego — have sufficient breadth of services and geographic coverage to pursue regional population health strategies on their own, but a number of other prominent systems instead have chosen to team up with other systems in their own regions to build integrated, region-wide networks together. Systems that are taking a collaborative approach to their pursuit of population health are often those with a strong, even dominant, presence within a particular submarket but a more limited presence in the larger region. By aligning with one or more providers based elsewhere in the same region, systems are seeking to expand their clinical footprint to compete for patients over a significantly broader geographic area.

In seeking strategic partners for building a region-wide network, systems also have been seeking partners that possess complementary strengths, so that the combined entity can better compete for patients by offering a full range of clinical services efficiently across the region. For example, academic medical centers focused on high-end tertiary services tend to join forces with systems that have expertise in building physician networks (particularly of primary care physicians) and managing patient care — typically an area of relative weakness for AMCs.

Among the seven markets in this study, Orange County was particularly active in developing such population health collaborations. Two of the region's major systems, St. Joseph Health System and Hoag Health, embarked on a joint venture in 2013, forming a new operating company called St. Joseph Hoag Health (SJHH) to develop a system of care and work toward population health management. The two systems entered into a joint operating agreement — a "virtual merger" that aligned the two systems very closely but did not merge their assets.[1,2] This arrangement gave St. Joseph access to the very affluent coastal region, where Hoag has long been dominant, as well as to Hoag's well-known surgical specialty hospital in Irvine, a large, well-insured population center. The partnership reportedly gave Hoag an opportunity to diversify beyond its limited geographic base and its historic focus on high-cost specialty services by opening up access to St. Joseph's broad primary care base. In aligning with St. Joseph's, Hoag also sought to leverage the latter's foundation model to help launch Hoag's first medical group.

Also in 2013, another of Orange County's major providers, MemorialCare Health System, developed a partnership with the county's only academic medical center, UC Irvine Health. This affiliation represented the expansion of a

decades-old relationship between the two organizations surrounding teaching programs. Unlike St. Joseph and Hoag, MemorialCare and UC Irvine continue to operate as two independent entities. However, the partnership does share with SJHH the same overall goal of establishing a broader geographic network of integrated care delivery. Under the arrangement, MemorialCare supplies its primary care expertise while UC Irvine provides more specialty and tertiary services, backed by its 500-strong faculty practice.

One of the ways these Orange County partnerships are seeking to compete for commercial patients is by introducing new models for sharing risk with employers. Recently, SJHH and MemorialCare separately created tiered-network products for self-insured employers. Under these arrangements, the provider and employer jointly set a spending target for total cost of care for the employer's total covered lives, and share in savings or losses. While these arrangements are still quite new, with relatively low enrollment to date, in mid-2016 the MemorialCare Health Alliance (which includes not only MemorialCare and UC Irvine but also Torrance Memorial Health System and PIH Health) won a direct contract with large national employer Boeing. Under the arrangement, a new HMO product whose provider network consists of the MemorialCare Health Alliance partners will be offered to Boeing's Southern California employees, who are concentrated in Orange County and the adjacent Long Beach / South Bay areas of Los Angeles County. The new product is being offered to Boeing's employees and dependents in the region alongside existing options such as a Kaiser HMO.[3] Coverage is slated to begin in January 2017 for the new product, which offers incentives to enroll such as low premiums, zero out-of-pocket costs for primary care visits and generic drugs (after the deductible has been met), and increased Boeing contributions to health savings accounts for eligible employees.[4]

The San Francisco Bay Area — a region historically characterized by many segmented, distinct submarkets — also saw two of its key providers collaborating to build a region-wide integrated care network. In early 2015, the University of California, San Francisco Medical Center (now part of UCSF Health) formed a strategic partnership with John Muir Health, a system with a dominant presence in the East Bay's Contra Costa County. Initially known as the Bay Area Accountable Care Network, and recently renamed Canopy Health, the partnership aims to build a region-wide integrated network to compete with Kaiser and Sutter for commercial patients. UCSF and Muir also set up a separate but related development company, Bay Health, to build new ambulatory facilities and to integrate their clinical IT systems. Adding ambulatory capacity in submarkets such as North Oakland and Berkeley would allow Canopy Health to better compete for patients against Kaiser and Sutter — the two providers that have historically dominated that well-insured submarket. As with the Orange County collaborations, Muir and UCSF bring complementary strengths to their partnership: Muir's strong track record of building physician networks and managing care, and UCSF's substantial footprint and status as a premier destination for highly specialized services.

In mid-2016, it was announced that three IPAs (Hill Physicians Medical Group, Muir Medical Group IPA, and Meritage Medical Network) had joined Canopy's two founding hospital partners as both shareholders and participating providers.[5] Canopy Health also added seven hospitals to its network, including five in the East Bay and two in the North Bay.[6] Pending final state approval of a restricted insurance license, Canopy Health is expected to partner with health plans to offer HMO products to mid-sized and large groups. Open enrollment would begin in the fall of 2016 for coverage starting in 2017. One health plan contract already in place is an agreement between Health Net and Canopy Health for the latter to assume financial risk for about 13,000 University of California employees and dependents already covered by Health Net's HMO product.[7]

In Los Angeles and neighboring Orange County, a high-profile collaboration known as Vivity brought together one of California's largest commercial health plans, Anthem Blue

Cross, and seven health care systems — including renowned institutions such as Cedars-Sinai Medical Center and UCLA Health.[8] As one participant described it, Vivity's "uniqueness and novel nature . . . [stems from] the experiment of teaming up seven systems that previously competed quite strongly against each other, and still do compete outside of Vivity, and working to create one integrated entity . . . [that delivers] seamless and cost-efficient care." Each of the eight partners shares equal risk in the joint venture, which was announced in 2014 and began offering HMO products to select large groups in 2015. The most prominent of those groups was the California Public Employees' Retirement System (CalPERS), the state's largest purchaser of health benefits. In its first year, Vivity made very modest inroads in the CalPERS market, capturing just 1% of CalPERS members in the region.[9] However, Vivity's total enrollment of 24,000 in its first year of business, across all its large groups, exceeded its initial first-year projection of 15,000 enrollees.

Like other collaborations aimed at forming integrated systems of care, Vivity focuses on offering HMO products whose efficiency, as well as convenience and access for patients, can rival or surpass those of Kaiser. To achieve efficiency, Vivity is pursuing clinical integration aggressively, but is still in the early stages of pooling and integrating all the participants' clinical data — a task that one participant described as a "Herculean effort . . . with costs and challenges to match." The initiative also has a long way to go in attaining its eventual objective of creating a system of seamless referrals that would allow physicians to identify which providers within the broad network offer the best-in-class options for a given service and refer patients to those providers. As one market observer noted, "That's not only a big challenge from a clinical data standpoint . . . [but] it's a major paradigm shift for all these hospitals. . . . It remains to be seen whether docs [aligned with] hospital A will actually refer patients away from their own hospital and steer them to hospitals B, C, and D instead . . . if those [offer] higher value for, say, a hip replacement. It's a tall order, but that's what Vivity has to achieve if they're going to be cost-competitive in the long run."

Such challenges are not unique to Vivity. Indeed, they confront each of the initiatives seeking to transform providers rooted in conventional fee-for-service payment into integrated delivery systems prioritizing efficiency and value. This paradigm shift needs to occur both within each provider organization and across all providers within a collaboration, as pointed out by both providers and market observers. Within each provider organization, incentives and culture need to be shifted away from longstanding fee-for-service strategies under which many have thrived. How much, and how fast, to pivot away from these approaches is a debate of interest to all large systems pursuing population health strategies, whether they're doing so largely on their own, like Sutter Health in Northern California and Scripps Health in San Diego, or are doing so through major collaborations. (An exception is Scripps' major competitor, Sharp Healthcare, which has long embraced capitation and positioned itself as a reasonably priced, high-value provider in the San Diego market.)[10]

For providers collaborating with others in pursuit of an integrated network, these challenges are compounded by the need to balance potentially conflicting cultures, interests, and incentives across all the partners. As one participant in such a collaboration observed, "One of the biggest challenges we face in making [the collaboration] work is the reality that we're not one organization; we're separate organizations, with separate boards of directors [and] governance structures." This respondent also highlighted another key challenge: "The providers we're partnering with are our direct competitors [outside the collaboration], so we recognize we might, to a certain extent, be cannibalizing our own business in pursuing [this collaboration]." However, participation in joint ventures also has stimulated dialogue among partnering providers, leading to the opportunity for some new collaborations.

Several providers and observers pointed to yet another challenge faced by these partnerships: the fundamental trade-off that exists between provider network breadth on the one

hand, and the degree of care integration, coordination, and efficiency that can be achieved on the other. Although building a broad network composed of many provider partners may help achieve "greater access and convenience for consumers and better marketability [of the related insurance products], it amplifies the challenges of creating a single unified, high-value delivery system," as one hospital executive noted.

Reducing the Total Cost of Care:
Commercial ACO Collaborations Between Providers and Health Plans

In the last round of this study in 2011-12, a few large California providers had begun collaborating with major health plans to form commercial accountable care organizations (ACOs). These partnerships aim to better compete for commercial business by collaborating to control total health care costs, which in turn helps keep insurance premium increases in check. While commercial ACOs share some key objectives with the population health collaborations described above, they generally expose providers to far less financial risk for patient care and do not require the same level of system transformation.

California's first commercial ACO was launched in the Sacramento market as a 2010 pilot by Blue Shield and its provider partners — Dignity Health, a hospital system, and Hill Physicians, an IPA — in an effort to reduce premium trends in Blue Shield's HMO product for the state's largest purchaser, CalPERS. The arrangement, under which the three partners shared both upside and downside risk for the total cost of care, was successful enough in generating savings that Blue Shield soon expanded it to other purchasers and other regions, including the 2011 launch of two ACOs for the San Francisco Health Service System, which purchases benefits for employees of the City and County of San Francisco. Over the past few years, Blue Shield's ACO collaborations have expanded to include a growing number of provider partners as part of the health plan's Trio ACO HMO network, which is now offered to both large and small groups across many California markets.[11]

Along with Sacramento, San Diego was one of the first markets to see health plans and providers experimenting with commercial ACO collaborations. The Anthem Blue Cross ACO, introduced as a pilot in 2011, launched full-fledged commercial products in 2012. Anthem's first provider partners were Sharp Healthcare's physician organizations: Sharp Community Medical Group (Sharp's closely affiliated IPA) and Sharp Rees-Stealy (Sharp's multispecialty medical group). In contrast to Blue Shield, Anthem Blue Cross based its ACO on a PPO platform, attributing patients to primary care physicians (PCPs) based on past utilization patterns. Like most ACO PPO arrangements in other markets nationwide, PCPs continued to be paid on a fee-for-service basis but also received per-member, per-month care management fees for their attributed patients and were eligible to participate in a shared-savings pool.

In the years since those early ACO collaborations, the major national insurers Aetna, Cigna, and United Healthcare all have formed their own ACO collaborations with providers. Like Anthem, these insurers all based their ACOs on PPO platforms and share similar approaches to key program features such as patient attribution, care management fees, and shared savings, though the specifics of their methodologies differ. All ACOs — including Blue Shield's ACO HMO model — emphasize the exchange of data between health plan and providers as a critical part of managing patient care more efficiently.

By 2015, commercial ACOs had spread to all seven of the California regions in this study. Even Fresno, which historically has lagged behind other health care markets, saw the launch of its first commercial ACO when Santé Community Physicians, the market's largest IPA, began partnering with Anthem Blue Cross. Not surprisingly, in large markets where major providers have a long track record of successfully assuming financial risk for managing patient care, some large physician organizations participate in ACOs with multiple

health plans. In San Diego, for example, Sharp-Rees-Stealy and Sharp Community Medical Group currently take part in ACOs with Aetna, Anthem Blue Cross, and United. In the Bay Area, Brown & Toland Physicians, a large IPA, participates in ACOs with four health plans: Aetna, Anthem Blue Cross, Blue Shield, and Cigna.

Despite their growing participation in commercial ACOs, several large providers expressed reservations and frustrations about these initiatives. Some noted that sharing risk with health plans in ACOs is less advanced from a provider standpoint than accepting full risk under capitation — an arrangement that gives them much greater control over patient care. "In some ways, [ACOs] represent a frustrating step backward compared to our capitated business . . . where we've already built a strong infrastructure to manage care," an executive of a large physician organization commented. A fundamental limitation of the shared-savings approach common to ACOs is that it requires the partners to continue identifying new sources of savings over time in order to keep earning shared savings, after the "savings have already been wrung out of the low-hanging fruit" early in the initiative, as one health plan executive noted. This stands in contrast to capitation, which allows providers to be rewarded consistently from one contract to the next as long as they continue to manage care efficiently.

In addition, providers and health plans noted the many data and logistical challenges of ACO collaborations. While data-sharing between providers and health plans has progressed significantly since the earliest days of ACOs, the patient data currently available to providers for ACO lives are still not nearly as timely or comprehensive as the data that providers have for their capitated patients, according to several providers. Care management represents another key logistical challenge for ACOs, with health plans and providers often treading on each other's toes with separate programs whose lack of coordination not only reduces efficiency for the ACO partners, but also can lead to confusion and frustration for patients.

Despite these challenges, providers across most markets continue to explore ways to expand their ACO collaborations. As commercial capitation continues to erode slowly in most markets, participation in ACO PPOs is widely seen as a way for providers to increase (or at least maintain) their patient volumes. As one San Diego physician executive observed, "However clunky [ACOs] are . . . they allow us to reach people who have never been in, and will never be in, HMOs. . . . It gives us a chance to capture people who might not [otherwise] be our patients."

Consolidating Services:
Clinical Affiliations Between Hospitals

Clinical affiliations between hospitals have long been common, with the most typical partnerships being those between a large system or academic medical center and a smaller community hospital. These partnerships serve multiple objectives, ranging from traditional fee-for-service strategies to newer population health approaches that many hospitals have begun to pursue in recent years. A longstanding and still critical motivation for clinical affiliations has always been to drive tertiary and other specialty referrals to the large system or AMC. The affiliation also expands the range of clinical expertise available to the community hospital, thus potentially enhancing its brand and increasing its patient volume. In addition to increasing mutually beneficial referrals, these affiliations can enhance efficiency by directing care to the most appropriate setting — keeping routine secondary care in community hospitals (which may also increase convenience and access for patients) while allowing the AMC or other large tertiary hospital to focus on more highly specialized services. In recent years, this has become a more central focus as large systems increasingly pursue population health strategies, as described above. As a result, their existing affiliations with community hospitals have tightened, as the systems seek to incorporate these smaller hospitals into new region-wide clinically integrated networks. Large systems also have been forming new

affiliations with more community hospitals, both within and beyond their immediate geographic markets.

San Diego is among the markets to experience a recent surge in clinical affiliations. In 2015, UC San Diego Health (UCSD) announced an affiliation with Tri-City Medical Center, a district hospital that had struggled in recent years to compete against larger rivals encroaching on its geographic service area. In addition, UCSD and Scripps both reached beyond the boundaries of San Diego County to form affiliations with district hospitals in neighboring Imperial County — and in UCSD's case, with a hospital in Riverside County as well.

In the Los Angeles market, UCLA has been particularly active in expanding its partnerships with community hospitals. In large part, these affiliations are intended to relieve capacity constraints at UCLA's flagship, Ronald Reagan UCLA Medical Center, which has been consistently operating at or near full capacity. Developing a full network of affiliated community hospitals to which more routine inpatient care can be directed allows Reagan to focus on the tertiary and quaternary services for which it is widely known, and allocates resources more efficiently across inpatient settings — a key consideration as the UCLA system prepares to take on greater financial risk for more patients. By the fall of 2016, the number of community hospitals affiliating with UCLA will have risen to 10. UCLA has established hospitalist programs in each of these affiliated hospitals to oversee care for its own patients.

In the Bay Area, numerous affiliations formed in the past few years, including Muir's joint venture with San Ramon Regional Medical Center and UCSF's partnerships with Washington Hospital Healthcare System in Alameda County and Marin General Hospital in Marin County. These affiliated hospitals were recently announced as participating providers in the Canopy Health network led by UCSF and Muir.

In addition to these affiliations, the Bay Area also saw some hospital acquisitions, including deep-pocketed Stanford Health Care and UCSF each acquiring an East Bay hospital. Across the markets in this study, however, there were few recent instances of large hospitals acquiring smaller ones. Instead, most hospital systems have been pursuing an array of different affiliations that expose their organizations to far lower costs and fewer risks — and less regulatory scrutiny — than outright acquisitions. Respondents pointed to the need for all inpatient facilities to meet stringent state seismic standards as a particular deterrent to hospital acquisitions. More broadly, respondents agreed that the continuing decline in inpatient use over time — the result of advances in medical technology as well as changes in payment incentives — makes inpatient facilities less attractive as acquisition targets.

A particular type of clinical affiliation that has gained prominence in recent years is a partnership between a pediatric hospital and another hospital in the same region — either a large hospital focusing on adult medicine, or a smaller community hospital. Given the limited size of the market for inpatient and specialty pediatrics, this collaborative approach helps avoid needless duplication of pediatric services. These collaborations allow the pediatric hospital to expand its geographic reach while keeping costly capital investments in check, and gives partnering hospitals access to a prestigious pediatric brand and specialized pediatric expertise. By making pediatric specialists and services available at more locations throughout a region, these partnerships can also improve convenience and access for patients.

The most prominent examples of these affiliations come from the Bay Area, where highly regarded pediatric hospitals at both Stanford and UCSF expanded their geographic reach through multiple partnerships. Stanford Children's Health (Lucile Packard Children's Hospital) developed separate partnerships with Sutter's California Pacific Medical Center and John Muir Health, allowing pediatric patients to be seen by Packard specialists in both San Francisco and Contra Costa Counties. In 2015, Muir and Packard jointly launched a pediatric intensive care unit at Muir's Walnut Creek flagship hospital. Meanwhile, UCSF extended its reach into the North Bay by partnering with Marin General and Santa Rosa

hospitals as well as expanding into the East Bay by acquiring Children's Hospital Oakland.

Preventing Unnecessary Hospital Use: Collaborations Between Hospital Systems and Social Service / Safety-Net Providers

In common with hospitals nationwide, California hospitals have become more focused on reducing preventable readmissions since the Centers for Medicare and Medicaid Services (CMS) began levying financial penalties for excessive Medicare readmissions in 2012. In San Diego, four of the county's five largest hospital systems (Palomar Health, Scripps, Sharp, and UCSD) joined forces with the county government in an initiative known as the San Diego Care Transitions Partnership, aimed at reducing readmissions for high-risk Medicare patients discharged from hospitals into the community. Part of a nationwide CMS demonstration project, the San Diego program has proved successful at reducing readmissions and costs for CMS since its 2013 launch.

Although CMS is likely discontinuing the program nationwide in late 2016 to focus on other payment reforms, the local participants in the San Diego collaboration reportedly plan to continue some of the program's most effective interventions. These include a bundle of "care enhancement" social services provided by the county to a subset of frail patients deemed most at risk for readmissions, with funding to be provided by the four systems to replace discontinued CMS funding. One hospital executive observed that, before the collaboration, most hospitals had not been aware of how cost-effective the targeted provision of social services could be in reducing readmissions and other costly outcomes.

California hospitals also have paid increasing attention to preventing avoidable hospital utilization by Medi-Cal and other low-income patients. Since the beginning of 2014, when the ACA provision to expand Medicaid eligibility took effect, hospitals in most communities experienced surges in the use of their emergency departments (EDs) by newly insured Medi-Cal enrollees. This increased demand led to serious ED capacity constraints in some communities. In response, hospitals have stepped up collaborations with safety-net providers in an effort to reduce avoidable use of EDs and other hospital services and to connect low-income patients with a medical home that can provide them with the primary and urgent care for which many people seek ED treatment. Typically, hospitals collaborate with Federally Qualified Health Centers (FQHCs) — community health centers that receive federal grants and enhanced, cost-based payments for serving Medi-Cal patients. While hospital-FQHC collaborations can take many forms, one common arrangement has been for a hospital to provide an FQHC funding to establish a clinic site, or expand capacity of an existing clinic site, on or near the hospital campus.

Competing on Price, Access, and Convenience: Collaborations by Hospital Systems to Expand Ambulatory Care

Consistent with trends seen across the country, hospital systems in California have expanded their presence in a wide variety of ambulatory settings. These ambulatory expansions include the development of physician networks through many outright acquisitions of independent practices, as well as various affiliations with physician organizations. Systems also have been very active in adding a wide variety of ambulatory facilities to their networks, ranging from convenience clinics to ambulatory surgery centers and imaging centers — often in collaboration with a variety of other organizations. Two types of ambulatory facilities where providers have engaged in the most collaborative activity are highlighted here.

Convenience/retail clinics. Hospital systems in multiple California markets have launched several forms of convenience care — most notably health clinics located in retail stores. Most of these clinics, typically staffed by nurse practitioners, provide basic preventive services and treat uncomplicated minor conditions on a walk-in basis, often with extended hours. For consumers, these clinics offer the potential to increase access, convenience, price transparency,

and low-cost options for a basic set of primary and preventive services. For providers, the clinics can offer a way of boosting visibility for their brands in the community and gaining new patients, as well as expanding convenient options for existing patients.

The growth of convenience clinics has been most pronounced in San Diego, where most of the major systems have formed partnerships to operate clinics at busy retail locations. Since 2008, Palomar Health has partnered with the Albertsons grocery and pharmacy chain to run clinics located in Albertsons stores, but the retail clinic phenomenon gained real traction only over the past few years. San Diego's largest system, Sharp, began partnering with CVS/MinuteClinic in 2013, followed by Kaiser affiliating with Target in 2014. Within the past year, Scripps launched its first convenience clinic, taking a somewhat different approach: partnering with a commercial real estate firm, The Irvine Company, to open a health clinic in an office tower near a large shopping mall. In addition to the usual set of convenience care services, the new clinic partners with employers to offer wellness services. The Irvine Company's partnership with Scripps is similar to affiliations the company has formed with other prominent providers in the state, including St. Joseph Hoag Health in Orange County and Stanford Health in Santa Clara.[12] In the past year, the number of California providers partnering with CVS/MinuteClinic has expanded to include Sutter and Muir in Northern California.[13]

Freestanding ambulatory facilities. Hospital systems increasingly have been bringing more freestanding facilities such as ambulatory surgery centers (ASCs) and imaging centers into their networks, with some transactions structured as joint ventures and others as outright acquisitions. These freestanding facilities have long provided services at substantially lower prices than either hospital inpatient or outpatient departments. Under the traditional fee-for-service payment methods that prevailed in past decades, it was a common strategy for hospitals to acquire these facilities and then promptly absorb them into hospital outpatient departments, thus increasing the number of ambulatory sites that could charge higher outpatient-department unit prices to both commercial payers and Medicare.

Over the past several years, however, hospitals' primary motivations and strategies for bringing these freestanding facilities into their own networks have undergone a dramatic reversal. As hospitals have come under pressure to compete on value, the attribute of freestanding facilities that now appeals the most to hospitals is their low cost structure. As a result, hospitals are "focused on keeping the facilities they acquire [or affiliate with] staffed and operating as before, to maintain cost-efficiency. . . . It's quite a turnaround from what we saw hospitals doing 10, 15, 20 years ago," commented a market observer.

This approach of adding low-cost ambulatory facilities to their networks helps hospital systems manage the cost of care for the growing number of patients for whom they are taking on varying degrees of financial risk, in arrangements varying from bundled payments to ACOs to provider-sponsored health plans. Having ambulatory facilities with a lower cost structure also helps systems better compete for the many privately insured patients covered by high-deductible health plans: patients who have strong incentives to minimize their own out-of-pocket costs by price-shopping and choosing a lower-priced provider over a hospital outpatient department. In addition, expanding the number of locations in the community where patients can receive services such as imaging tests or ambulatory surgeries helps the systems better compete on the basis of access and convenience.

Several of California's historically high-priced hospital systems have formed partnerships with freestanding facilities in the past few years. Sutter Health has been particularly active in this regard. The system not only has engaged in numerous joint ventures with physician-owned ASCs throughout its home base of Northern California, but is accumulating a growing network of ASCs in Southern California as well.[14] In the Los Angeles market, UCLA Health also is engaging in ASC joint ventures, partnering with a national company with

an established track record in operating freestanding surgical facilities. In San Diego, after Scripps Health acquired a chain of radiology centers in 2015, it kept the facilities' brand name (Imaging Healthcare Specialists) and operations unchanged, and continues to use the same independent radiologists who had staffed the facilities previously.

Supporting Continuity of Care: Collaborations Between Acute Care Providers and Post-Acute Care Providers

Rehabilitation hospitals. Acute rehabilitation hospitals, also known as inpatient rehabilitation facilities, occupy a key space in the care continuum between acute care hospitals and post-acute providers such as skilled nursing facilities (SNFs). These facilities often are the most appropriate setting for many patients recovering from conditions such as major strokes, brain and spinal cord injuries, and joint replacements, who can be discharged from a tertiary setting but require more intensive rehabilitation and physician oversight than SNFs can provide. Because most communities lack sufficient acute rehab capacity, many patients who could be discharged to such facilities continue occupying beds in tertiary hospitals for longer periods, and at higher cost, than necessary, according to hospital executives.

To meet the dual goals of freeing up tertiary beds for sicker patients and providing more cost-efficient care for patients needing intensive rehab, major hospital systems are forming partnerships to create more acute rehab capacity. In Los Angeles, the two most prominent hospital systems, Cedars-Sinai Medical Center and UCLA Health, jointly collaborated with Select Medical, a national company specializing in long-term acute care and rehab services, to develop the California Rehabilitation Institute, a 138-bed facility that opened in 2016. Select Medical's reputation and track record of being able to operate acute rehab facilities efficiently is reported to have made the company an especially attractive partner for Cedars-Sinai and UCLA. Major hospitals in other California markets reportedly are exploring similar partnerships to expand acute rehab capacity.

Post-acute care providers. Some large providers — such as the physician organizations Healthcare Partners and Heritage Provider Network, both based in Southern California — have long taken full risk for sizable Medicare Advantage populations. As a result, they have focused on the efficiency and value of care provided along the entire care continuum, including post-acute care. Because Medicare Advantage plans — in contrast to Medicare fee-for-service providers — are permitted to limit their provider networks, providers accepting full risk can develop relationships with a subset of affiliated SNFs and other post-acute providers to whom they send their Medicare Advantage patients. These network providers are selected based on cost and quality metrics as well as geographic service areas. To oversee care for their Medicare Advantage patients in the post-acute setting, Healthcare Partners, Heritage, and other providers taking full risk also have long placed their own physicians and other clinicians in SNFs to oversee care for their patients. Care by these "SNFists" (also referred to as "post-acute hospitalists" by some organizations) often helps reduce SNF lengths of stay and prevent hospital readmissions, and improves the overall quality and frequency of clinical oversight for SNF patients.[15]

In contrast to Medicare Advantage plans, fee-for-service providers — even those subject to partial financial risk under Medicare ACOs or bundled payments — must allow Medicare patients the freedom to select the post-acute provider of their choice.[16] Hospitals and physician organizations accepting partial risk may develop networks of preferred SNFs for their patients, but the process is intended to guide, rather than dictate, patient choice of a SNF. Some fee-for-service providers use "soft steering" approaches such as describing to patients and their families the relative merits of preferred facilities (e.g., higher quality, better coordinated care), but ultimately, Medicare fee-for-service patients retain their right to choose any accredited facility, whether or not it is included in the preferred network.

Hospital systems and physician organizations expressed uncertainty and frustration at what they viewed as lack of clear CMS guidelines on the extent to which preferred networks and soft steering are permitted. Providers also pointed out that they are increasingly being exposed to more risk under Medicare payment reforms ranging from readmission penalties to bundled payment programs. As a result, several providers suggested that CMS change current rules to allow providers who are subject to partial financial risk to establish limited networks to steer Medicare fee-for-service patients to high-value SNFs and other post-acute providers — much in the way Medicare Advantage plans are already able to.

According to some providers, CMS rules do not pose the only barrier to developing effective SNF networks. Another key limitation stems from the limited pool of high-quality, low-cost SNFs that are available to serve as strong partners for acute care providers. "Here in Southern California, there are lots of skilled nursing beds — the sector is probably overbedded overall — but our problem is finding enough good facilities to partner with: the ones that are well managed . . . financially stable, have appropriate standards of clinical care, [and] are amenable to working with us on care protocols," a hospital executive said.

Hospital systems and large physician organizations have focused the most attention on relationships with SNFs — in large part because these facilities represent the largest share of post-acute spending — but acute care providers also have been forming or exploring affiliations with the full range of post-acute providers, including home health agencies and palliative care / hospice organizations. For example, in 2015 UCSF formed an affiliation with Hospice by the Bay aimed at expanding high-value care for seriously and terminally ill patients. Other large acute care providers expressed the need for their own organizations to form similar partnerships with providers along all parts of the care continuum if they are to be successful in increasingly taking on full or substantial financial risk for patients — as UCSF is slated to do in its Canopy Health venture.

Developing New Primary Care Practice Models: Collaborations Between IPAs and Other Organizations

Over the last few years, the physician sector saw the continuation of an ongoing trend: small, independent practices becoming a progressively less viable option for primary care physicians. Driving this trend nationally has been a combination of low reimbursement from public and private payers, along with the long and unpredictable work hours required in independent practice. In addition, specific to California, most physicians have long relied on the capitated HMO model — which pays better than PPO fee schedules — to sustain their practices financially. As commercial HMO products continue losing ground to high-deductible PPOs, financial strains on primary care practices have worsened to the point that many have been joining large system-affiliated groups, while some PCPs have retired without being able to sell their practice. New PCPs coming out of residency programs are overwhelmingly choosing the stability, security, and predictable work hours of the employment model over the autonomy of private practice.

This continuing decline of the small, independent primary care practice model poses major challenges for IPAs, whose core business is based on providing HMO contracting and practice support services to these practices. One San Diego provider even described the situation as an "existential threat to IPAs." If current trends continue, IPA physician membership and patient volumes are almost inevitably going to continue shrinking, and membership will skew more toward older physicians and specialists.

Some of California's largest IPAs are responding to these challenges by seeking to develop sustainable new models of primary care practice that can attract PCPs and prove financially viable for them. These new models are envisioned as smaller-scale, integrated group practices that aim to accommodate physicians seeking to practice part-time, keep practice overhead costs manageable and predictable, and provide physicians with clinical and administrative support without subjecting them to the bureaucracy of large groups.

Because IPAs lack the capital to pursue the development of these new models on their own, they have been forming or exploring partnerships with other organizations to gain access to capital.[17] In 2014, Hill Physicians, which has networks of independent physicians in several of Northern California's largest markets, began partnering with two of the state's largest health plans, Anthem Blue Cross and Blue Shield of California. Under the arrangement, the two plans provided Hill with capital by purchasing ownership stakes in PriMed, Hill's management services organization. Brown & Toland, a large IPA based in San Francisco and serving the Bay Area, reportedly has been exploring joint ventures and other affiliations with a range of partners but had not finalized any plans at the time of the site visits for these reports.

San Diego saw the emergence of a different type of collaboration — between one of the market's largest systems, Sharp Healthcare, and its tightly aligned IPA, Sharp Community Medical Group (SCMG) — to develop a new practice model for PCPs seeking employment. The new entity, SharpCare Medical Group, is to be rolled out in 2016 under Sharp's medical foundation. SharpCare is organized along very different lines than Sharp's large integrated group model, Sharp Rees-Stealy. The new medical group aims to retain some key attributes of small community-based practices that many independent physicians are reluctant to give up, while also offering physicians the stability and security of employment. Members would practice in relatively small offices with only about 3 to 10 primary care practitioners per site and would be able to continue referring patients to community-based specialists. At the same time, they would receive clinical support from the Sharp system — including from care management nurses, pharmacists, and other clinicians rotating among the primary care sites. Within the Sharp system, SharpCare would be most closely aligned with SCMG and would be a member of SCMG for HMO contracting and ACO participation. Fee-for-service PPO contracting for SharpCare will be done through Sharp Healthcare, which would have the leverage to obtain higher rates than small practices would receive on their own.

Discussion and Implications

Among the many types of provider collaborations that have proliferated in California over the past few years, by far the most ambitious — and potentially the most far-reaching in impact — are the initiatives aimed at creating region-wide integrated care networks. These efforts seek to transform the culture, incentives, and operations of provider organizations built largely to compete in a fee-for-service environment, and develop them into virtual Kaiser-like integrated systems emphasizing efficiency and value.

As noted above, the markets where most of these population health initiatives have been launched share some common characteristics: the presence of large, well-insured commercial populations; competitive pressure from a strong and expanding Kaiser; and large, deep-pocketed systems with strong infrastructure and sufficient capital to make major investments in building clinical integration, ambulatory capacity, and other essential elements of an integrated network. Markets with these traits tend to be the large population centers in more affluent communities, primarily along the coast. Although providers in other regions — such as the Inland Empire market in Riverside and San Bernardino Counties — also have begun to take tentative steps to establish integrated delivery systems, those efforts are more nascent, in part because key infrastructure such as medical foundations — essential for building strong physician networks — have only recently been launched.

Except for a handful of major systems that are pursuing population health management largely as a "go-it-alone" strategy, most large systems are partnering with other large systems to create integrated networks within their region. One key reason is that many systems, on their own, may not have a large enough clinical footprint to compete effectively for patients throughout an entire regional market, either in terms of geographic location of facilities or clinical expertise

and reputation. As a result, several systems have formed affiliations with other systems that can both add key geographic submarkets and bring complementary clinical strengths to the partnership. Compared to outright mergers and acquisitions, these collaborations allow systems to maintain greater autonomy, and subjects them to less regulatory scrutiny and lower costs and risks.

Many of the collaborations highlighted above whose scope and objectives are more limited — such as partnerships between hospital systems and providers of ambulatory or post-acute care — also play an important role in the larger population management strategies pursued by large systems. These partnerships can help fill key gaps along parts of the care continuum that hospitals had little incentive to focus on under a traditional fee-for-service environment — but that now become critical under arrangements rewarding coordinated and efficient care. At the same time, many of these collaborations also support hospital systems' ability to pursue other, more traditional strategies. For example, adding lower-cost freestanding ambulatory facilities to their networks helps systems better compete for the large population of price-conscious consumers whose insurance coverage subjects them to significant out-of-pocket costs. Several providers noted that the ability of certain collaborations to serve multiple, differing strategies in this way was particularly valued by their organizations as they seek to navigate a course between the two worlds of fee-for-service and value-based payment. Given the uncertainty about how much, and how fast, they will be able to transform their own care delivery systems to achieve population health management, investing in collaborations that can also serve other strategies allows large providers to "hedge their bets somewhat . . . [instead of] staking everything on [a strategy] that might not ultimately come to fruition . . . or might take a lot longer than anticipated to get there," a market observer noted.

As providers increasingly explore and engage in a range of partnerships and affiliations with other providers (and with health plans), the web of relationships among providers has become more complex. One market expert described providers in several large markets as taking a "more pluralistic approach to collaborations [and] avoiding getting locked into exclusive arrangements that might cause them . . . to miss out on the volume . . . and the opportunities . . . that other collaborations can bring."

An example is MemorialCare Health System, which is pursuing population health opportunities with different, though overlapping, sets of partners in Los Angeles and Orange Counties. As a member of Vivity, MemorialCare is sharing full risk for large groups with seven other systems and Anthem Blue Cross; at the same time, its MemorialCare Health Alliance (which includes two other Vivity members as well as UC Irvine, which is not part of Vivity) is pursuing risk contracts with other large groups and recently signed a contract with large employer Boeing. Meanwhile, in the Bay Area, John Muir Health is engaging in simultaneous, separate strategic partnerships with UCSF and Stanford for adult medicine and pediatrics, respectively — another example of how the web of provider linkages has grown, and become more complex, over the past few years.

If the new region-wide integrated networks being launched by large providers succeed in gaining widespread traction, they could help revive commercial capitation — which has long been in slow decline relative to high-deductible PPOs and Kaiser HMOs across major markets in the state. The new networks also are expected to intensify price competition and expand the range of choices of insurance products and provider networks available to purchasers and consumers. Some markets have felt these beneficial impacts already, as the launch or expansion of provider-sponsored health plans has led to strong competition with Kaiser, resulting in reduced premiums (or at least a moderation of premium trends) for some purchasers.

However, increased provider competition and its resulting benefits to purchasers and consumers will prove sustainable only if providers can continue lowering their cost structures and moving toward truly integrated and efficient care

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delivery. Currently, some providers appear to be undercutting Kaiser premiums and gaining market share only by subsidizing their new HMO products substantially — clearly not a viable approach beyond the short term. Most systems are still in the very early stages of the long and difficult journey toward clinical integration, a journey complicated by conflicting incentives both within their own organizations and across partnering providers.

Several observers also expressed concern that growing provider consolidation — even in the form of affiliations and joint ventures rather than outright mergers — would increase the market clout held by large providers, which would ultimately raise the potential for reduced competition and higher prices in health care markets.

ABOUT THE AUTHOR

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Background on Regional Markets Study

In 2015, a team of researchers from Mathematica Policy Research visited seven California regions to understand these markets' local health care systems and capture change since 2011/2012, the prior round of this Regional Market Study, funded by the California Health Care Foundation. The purpose of the study is to gain insights into the organization, delivery, and financing of health care in California and to understand differences across regions and over time. The seven markets included in the project — Fresno (including Fresno, Tulare, Kings, Madera, and Mariposa Counties), Los Angeles County, Orange County*, Riverside and San Bernardino Counties, Sacramento (including Sacramento, Yolo, El Dorado, and Placer Counties), San Diego County, and the San Francisco Bay Area (including San Francisco, Alameda, Contra Costa, Marin, and San Mateo Counties) — together are home to three-quarters of California residents and reflect a range of economic, demographic, health care delivery, and financing conditions in California. Mathematica researchers interviewed over 200 respondents for this study. Respondents included executives from hospitals, physician organizations, community health centers and other community clinics, Medi-Cal health plans, and other local health care leaders. For this cross-site analysis, researchers conducted follow-up interviews with select respondents (primarily market observers and executives from hospital systems and physician organizations) and tracked local media sources to capture updates since the site-visit interviews.

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*Orange County was added to this study in 2015; the research team had familiarity with this market through the prior Community Tracking Study conducted by the Center for Studying Health System Change (HSC), which merged with Mathematica in January 2014.

ENDNOTES

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15. Paula S. Katz, "Walking the Walk in Transitional Care," *Today's Hospitalist*, February 2012, www.todayshospitalist.com.
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17. Because IPAs must distribute all surplus earnings to their members at the end of each year, they tend to lack sufficient capital internally to fund such initiatives.