NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, AUGUST 4, 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. Medi-Cal Rates
    b. Final FY 2016-17 State Budget
    c. Department of Health Care Services Audit
    d. OneCare Connect
    e. Mental Health Services Act Funds
    f. Whole-Person Care Pilot
    g. SB 75: Medi-Cal for All Children
    h. Medical Loss Ratio Audit Request for Proposal
    i. Behavioral Health Request for Proposal
    j. Illumination Foundation Award
    k. Key Meetings
    l. Studies, Reports and Surveys

PUBLIC COMMENTS

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

CONSENT CALENDAR

2. Minutes
    a. Approve Minutes of the June 2, 2016 Regular Meeting of the CalOptima Board of Directors
    b. Receive and File Minutes of the May 12, 2016 Meeting of the CalOptima Board of Directors' Member Advisory Committee; the May 12, 2016 Meeting of the CalOptima Board of Directors' Provider Advisory Committee; the May 26, 2016 and April 28, 2016 Meetings of the CalOptima Board of Directors' OneCare Connect Plan (Medicare-Medicaid Plan) Member Advisory Committee

3. Consider Adoption of Resolution Adding Vice Chair Positions to the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee and Provider Advisory Committee

4. Ratify Agreement 16-93274 with the California Department of Health Care Services

5. Consider Revising the Membership of the CalOptima Board of Directors' Finance and Audit Committee and the Board of Directors' Quality Assurance Committee

6. Authorize Issuance of a Request for Proposal for Consulting Services to Conduct a Compensation Study

7. Appoint Directors to the CalOptima Foundation Board of Directors

REPORTS

8. Consider Ratification of Medi-Cal Expansion (MCE) Member Rate Change for CalOptima Community Network Specialist Physicians and Contract Amendments Implementing the Rate Change and Aligning Contract Expiration Dates with CalOptima's Fiscal Year End

9. Consider Authorizing Rate Increase for CalOptima Community Network Primary Care Physicians (PCPs), except for St. Joseph Health Entities and Affiliates, for Services Provided to Medi-Cal Members and Contract Amendments Implementing the Rate Increase and Aligning Contract Expiration Dates with CalOptima's Fiscal Year End

10. Consider Authorizing Rate Increase for CalOptima Community Network St. Joseph Health Entities and Affiliates, Primary Care Physicians (PCPs), for Services Provided to Medi-Cal Members and Contract Amendments Implementing the Rate Increase and Aligning Contract Expiration Dates with CalOptima's Fiscal Year End

11. Consider Ratification of Rate Adjustments to Medi-Cal Fee-For-Service Hospital Inpatient Rates, Except for the Entities and Affiliates of Kindred Hospitals, St. Joseph Health, and UC Irvine Medical Center, for Classic (Non-Expansion) Medi-Cal Members; Rate Adjustments for Hospitals Reimbursed using the All Patient Refined Diagnosis Related Group (APR-DRG) Methodology for Medi-Cal Expansion Members; and Contract Amendments Implementing these Rate Changes

12. Consider Ratification of Rate Adjustments to Medi-Cal Fee-For-Service Hospital Inpatient Rates for UC Irvine Medical Center, for Classic (Non-Expansion) Medi-Cal Members; Rate Adjustments for Hospitals Reimbursed using the All Patient Refined Diagnosis Related Group (APR-DRG) Methodology for Medi-Cal Expansion Members as applicable; and Contract Amendments Implementing These Rate Changes

13. Consider Ratification of Rate Adjustments to Medi-Cal Fee-For-Service Hospital Inpatient Rates for St. Joseph Health Entities and Affiliates, for Classic (Non-Expansion) Medi-Cal Members; Rate Adjustments for Hospitals Reimbursed using the All Patient Refined Diagnosis Related Group (APR-DRG) Methodology for Medi-Cal Expansion Members; and Contract Amendments Implementing These Rate Changes

14. Consider Authorizing Policy Modifications to Eliminate Specialist Physician Aggregate Reimbursement Rate Requirement for Health Networks

15. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, AltaMed Health Services Corporation, for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

16. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, AMVI Health Network for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

17. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Arta Western Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

18. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, CHOC Physicians Network for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

19. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, Family Choice Medical Group, Inc. for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

20. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Health Maintenance Organization, Heritage Provider Network, Inc. for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

21. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Monarch HealthCare, A Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

22. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Orange County Physicians IPA Medical Group, Inc., dba Noble Community Medical Associates, Inc. of Mid-Orange County for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

23. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, Orange County Advantage Medical Group, Inc. for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

24. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Prospect Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

25. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Talbert Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

26. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, United Care Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

27. Consider Ratification of Rate Increase for Facility Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, Children's Hospital of Orange County for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase

28. Consider Ratification of Rate Increase for Facility Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, Fountain Valley Regional Hospital and Medical Center, for Classic (Non-Expansion) Medi-Cal Members and Contract Amendments Implementing the Rate Increase

29. Consider Ratification of Rate Increase for Facility Component of Capitation Rates for Contracted Medi-Cal Health Maintenance Organization, Heritage Provider Network, Inc. for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase

30. Consider Approval of Rate Increase for Contracted Community Based Adult Services (CBAS) Centers Serving Medi-Cal and OneCare Connect Members; Authorize Contract Amendments to Implement the Increase

31. Consider Proposed Changes to Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment Requirements

32. Consider Extension of Contract with National Committee for Quality Assurance (NCQA)-Certified Vendor Inovalon which Provides Healthcare Effectiveness Data and Information Set (HEDIS) Reporting Support

33. Authorize Submission of Proposal to the U.S. Department of Health and Human Services for a Quality Improvement Technical Assistance Grant

34. Authorize Extension of Contract with Healthcare Insight, a Division of Verisk Health, Inc.

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

36. Consider Authorization of License Agreement with the County of Orange for Usage of Space at the County Community Service Center

37. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Activities

38. Consider Authorization of Expenditures for Full Board Membership in the National Association of Corporate Directors

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

40. Consider Ratification of Supplemental Benefit Recommendations to the Centers for Medicare & Medicaid Services and the California Department of Health Care Services for the OneCare Connect Program *(to follow closed session)*

ADVISORY COMMITTEE UPDATES

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

42. Provider Advisory Committee Update

43. Member Advisory Committee Update

INFORMATION ITEMS

44. June 2016 Financial Summary

45. Compliance Report

46. Federal and State Legislative Advocates Reports

47. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

CS 1 Pursuant to Government Code Section 54956.87, subdivision (b), Health Plan Trade Secrets – OneCare Connect Program

ADJOURNMENT

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

MEMORANDUM

DATE:	August 4, 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

Medi-Cal Rates
At your Board's June meeting, CalOptima received approval of our FY 2016–17 Operating and Capital Budgets, which included rate adjustments for contracted providers in the Medi-Cal Classic and Medi-Cal Expansion (MCE) programs. However, staff had yet to propose a plan for implementing a budgeted 4 percent increase in Medi-Cal Classic rates for hospitals and professional services, including Community-Based Adult Services centers. Action was also continued on implementing MCE rate adjustments to specialists and aligning contract terms with the fiscal year. Further, an MCE rate adjustment is now being proposed for hospitals reimbursed using an All Patient Refined Diagnosis Related Group (APR-DRG) methodology to align their reimbursements with other contracted hospitals. Staff's recommended implementation plans for these rate changes will be presented to your Board this month. Medi-Cal Classic members represent three fourths of our overall membership, while our MCE population is one fourth.

Final FY 2016–17 State Budget
On June 27, Gov. Jerry Brown signed the state's FY 2016–17 budget into law. The budget is consistent with his overall focus on ensuring the state is prepared for a potential economic slowdown. As such, the budget transfers $2 billion more than the required amount into the state's Rainy Day Fund and pays down some existing debts and liabilities. At the same time, as a reflection of the state's current financial health, the budget increases funding for education and programs that address homelessness and poverty. Related to health care, Medi-Cal spending has increased marginally to account for additional items included in the budget, such as the limitation of Medi-Cal estate recovery and the restoration of acupuncture as a Medi-Cal benefit.

Department of Health Care Services (DHCS) Audit
In July, CalOptima received the final report from the annual DHCS audit of our Medi-Cal plan conducted in February 2016. Auditors stated that they found significant improvements, reporting only three findings compared with 31 in the prior year. Approximately 12 auditors came on-site, and the audit spanned two weeks and covered CalOptima and our health networks. Six categories were reviewed: utilization management, continuity of care, access and availability, members' rights, quality management, and administrative and organizational capacity.

Back to Agenda

OneCare Connect (OCC)
This summer marks two milestones for OCC, a Cal MediConnnect (CMC) plan authorized by California's Coordinated Care Initiative (CCI). July 2016 was the one-year anniversary of OCC operations and the completion of the passive enrollment process. As of August 2016, OCC has more than 19,000 members, which makes it the second largest CMC plan in California. Work continues within CalOptima and at the state level to enhance awareness of and enrollment in CMC plans. Below are updates about recent activities:
Direct Mail: Given that passive enrollment is complete, OCC is now focused on voluntary enrollment to continue its growth. To generate enrollment leads, CalOptima has launched a direct mail campaign, the marketing approach that proved successful with OneCare. Started in July, the campaign has two target audiences. First, individuals soon turning 65 will receive three notices over a 90-day period in advance of their birthdays, inviting these people "aging into" Medicare to consider OCC. CalOptima will mail to approximately 1,200 people a month. Second, all dual eligibles in Orange County will receive sales letters highlighting the benefits of the plan on a recurring basis.
Community Outreach: In partnership with the state's outreach contractor Harbage Consulting, CalOptima participated in an OCC Forum on July 20 for more than 40 stakeholders and other referral sources. I provided opening remarks, and a panel of stakeholders responded to questions. Other events are planned for the coming months to ensure awareness remains high.
Continuity of Care Provisions: As part of a broader CCI sustainability strategy, DHCS released in July a revised continuity of care policy designed to remove barriers between members and their current providers and encourage enrollment in CMC plans. Effective October 1, the continuity of care period for Medicare services will be increased from six months to 12 months to match the Medi-Cal continuity of care period, and the requirement to show an existing relationship with a specialist is just one visit within the prior 12 months, like it is with primary care providers. Continuity of care provisions allow members to receive care for a period to time from non-contracted providers with whom they have existing relationships while those providers enter into contracts with the plans.

Mental Health Services Act (MHSA) Funds
Orange County will have more options to support people experiencing a mental health crisis, thanks to Sen. John Moorlach's SB 1273 and new DHCS guidance. Supported by CalOptima, the legislation highlights the need to clarify the allowable uses for MHSA funds, and it passed unanimously in the Senate. With that impetus, DHCS took up the issue on the administrative side, issuing guidance in late July stating that counties may use MHSA funds to provide crisis stabilization services on a voluntary or involuntary basis. This will provide counties with more flexibility in funding outpatient care, which may help relieve emergency room overcrowding by people with mental health needs.

Whole-Person Care (WPC) Pilot
WPC pilots are part of the new five-year 1115 Medicaid Waiver. These pilots will be funded by county dollars, which are matched with federal funds through Intergovernmental Transfers (IGTs). On July 1, Orange County submitted an application to DHCS for a WPC pilot designed to better serve the homeless population. As the lead entity, OC Health Care Agency would contribute $2.35 million a year for the next five years and receive matching federal dollars, and

Back to Agenda

program spending would total $23.5 million. As the county's Medi-Cal plan, CalOptima is a required participating entity. Among the proposed elements of the pilot is WPC Connect, a system to alert participating entities when a person experiencing homelessness is treated in the emergency room. Those entities would then connect the individual to recuperative care or other supportive services. After reviewing WPC applications, the state will select counties in October.

SB 75: Medi-Cal for All Children
In the past few months, CalOptima has gained about 8,400 children members who are now eligible for full-scope Medi-Cal under SB 75, a bill that extends coverage to children under 19 regardless of immigration status. While the transition of about 9,800 Orange County children from limited-scope to full-scope Medi-Cal was originally supposed to occur June 1, the state encountered data issues that led to a phased transition process. About 6,000 children moved in June, another 2,400 transitioned in July, and the final group is expected in August.

Medical Loss Ratio (MLR) Audit Request for Proposal (RFP)
At your Board's request and through an RFP process, CalOptima will contract with a third-party auditor to verify the MLR for capitated entities, including health networks and hospitals. The RFP generated three responses, and an internal team is in the process of selecting a vendor. Upon selection, we will seek your Board's approval for funding the auditing engagement. The auditor will use the Centers for Medicare & Medicaid Services (CMS) definition of MLR to determine expenses included and excluded. The audit results will show MLR by line of business, including Medi-Cal Classic, MCE, Medi-Cal overall, OCC and CalOptima overall.

Behavioral Health RFP
CalOptima is in the midst of a Behavioral Health RFP process to engage a new vendor for Medi-Cal, OCC and OneCare. We received five proposals, which were evaluated by subject matter experts and then scored by a panel. The next steps are as follows:

- August 4: Panel discusses final scoring/ranking; selects finalists for on-site interview
- August 8–10: Panel conducts interviews
- September 1: Board receives presentation; considers approval of staff recommendation
- October 3: Implementation process begins
- January 1, 2017: Contract starts

Illumination Foundation Award
Thanks to a nomination by CalOptima, Illumination Foundation won the Association for Community Affiliated Plans (ACAP) Supporting the Safety Net Award for its innovative work in recuperative care for homeless Medi-Cal members. In July, Illumination Foundation CEO Paul Leon attended the ACAP CEO Summit in Washington, D.C., where he made a presentation. The award includes a $500 donation to the Irvine-based organization.

Key Meetings
Below are brief summaries of key meetings during the past two months:

- *Hospital Association of Southern California (HASC) Medi-Cal Task Force:* In June and July, I participated in a new group convened by HASC called Medi-Cal Task Force: Promoting Accessibility and Sustainability of Medi-Cal in Local Communities. The meeting gathered

Back to Agenda

nearly 30 key leaders of hospitals, public managed care plans, community health centers and provider organizations from six Southern California counties. I represented Orange County along with Chairman Mark Refowitz, Suzanne Richards, CEO of KPC Health, and Joseph Ruggio, M.D., a cardiologist and former member of CalOptima's Provider Advisory Committee. The task force charter is to seek opportunities to support population health and improve the Medi-Cal delivery system across the state. (A similar group was also convened in Northern California.) Two additional meetings are planned, and the goal is to develop a common policy agenda for collaborative efforts across organizations and forge an advocacy platform for use at the state level.

- *UC Health:* In June, I participated in a regional meeting between leaders of Southern California Medi-Cal plans and executives from UC Health, the organization overseeing UC medical schools and centers statewide. The meeting included UC Health Executive Vice President John Stobo, M.D., L.A. Care CEO John Baackes, Inland Empire Health Plan CEO Brad Gilbert, M.D., along with consultants for UC Health. UC Health requested the meeting to update health plans about UC's Medi-Cal activities and to discuss their strategy to potentially develop a systemwide Medi-Cal agreement across all five medical centers. Historically, UC Health has limited its Medi-Cal line of business, but given the growth of Medi-Cal in California, UC is re-examining its approach. Additional meetings will be planned, which may lead to closer collaboration in the future.
- *Safety Net Summit:* The Coalition of Orange County Community Health Centers and CalOptima organize a quarterly Safety Net Summit to gather Orange County's community health center leaders, CalOptima staff and other stakeholders. The June meeting addressed several topics in which CalOptima is involved, including the WPC pilot, Health Homes Program, IGTs and Medi-Cal auto assignment to community clinics. The meeting was well attended by representatives from seven clinics: AltaMed Health Services, Hurtt Family Health Clinic, KCS Health Center, North Orange County Regional Health Foundation, St. Jude Neighborhood Health Center, Serve the People Community Health Center and Share Our Selves Community Health Center.
- *CMS Medicare Directors Meeting:* In June, I meet with senior Medicare staff at CMS, including Cheri Rice, director of the Medicare Plan Payment Group, and Kathryn Coleman, director of the Medicare Drug and Health Plan Contract Administration Group. I shared updates regarding CalOptima's Medicare programs (OCC, OneCare and PACE) and some of our innovative initiatives, such as the proposed incentive program for physicians serving members in long-term care facilities. The meeting was productive, and the CMS team was pleased to learn about CalOptima's recent successes, such as our quality rankings, membership growth, and increased access for members through new delegated and direct provider networks.
- *Healthy Smiles Meeting:* Healthy Smiles for Kids of Orange County invited me to present a CalOptima overview to its Board members. I shared details about our programs, provider network and employee base as well as our efforts with IGTs. Healthy Smiles received a two-year $400,000 IGT grant to deliver dental services using a school-based model. In the first year, Healthy Smiles held 246 events at 93 schools and performed more than 13,500 dental screenings, which exceeded its goal of 10,000–12,000 screenings.

Back to Agenda

Studies, Reports and Surveys
Orange County and CalOptima are the subject of several recent publications. See summaries of and links to the relevant material below.

- *Regional Market Study:* California Health Care Foundation's California Health Care Almanac examines the health care market in Orange County. I was interviewed on a few occasions for the study, and a fair amount of the material addresses the changes to Medi-Cal since the implementation of the Affordable Care Act. Download the full study here.
- *Community Indicators Report:* Co-sponsored by CalOptima and other agencies, the 2016 Orange County Community Indicators Report is now available on the county's website here. The health section of the report highlights the increase in access and decrease in the uninsured population stemming from the expansion of Medi-Cal. The report also addresses several health trends, including obesity, chronic disease, mental health and substance abuse, as well as care for the elderly.
- *Duals Demonstration Report:* ACAP and the Center for Health Care Strategies released a report identifying innovations brought about by the duals demonstrations nationwide, as well as lessons for integrating care for dual eligible beneficiaries. It features the experiences of 14 ACAP plans, including CalOptima. OCC is favorably mentioned for our proactive enrollment strategy with long-term care facilities, recuperative care for homeless members and value-based purchasing. Read the report here.
- *SCAN/Field Research Survey:* The SCAN Foundation released the third edition of its Field Research survey to measure member satisfaction with CMC plans, including — for the first time — OCC. View a summary here. In general, members report an increasing level of satisfaction with CMC plans across six indicators, including the amount of time their doctor spends with them, information received from their health plan, their choice of doctors and hospitals, the way different health providers work together, and how long they have to wait for appointments.

Back to Agenda

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

June 2, 2016

A Regular Meeting of the CalOptima Board of Directors was held on June 2, 2016, at CalOptima, 505 City Parkway West, Orange, California. Chair Mark Refowitz called the meeting to order at 2:03 p.m. Supervisor Do led the Pledge of Allegiance.

ROLL CALL

Members Present:	Mark Refowitz, Chair; Lee Penrose, Vice Chair; Ellen Ahn; Theresa Boyd; Viet Van Dang, M.D.; Supervisor Andrew Do; Tricia Nguyen; Mike Ryan (non-voting)
Members Absent:	Peter Agarwal; Supervisor Lisa Bartlett; Samara Cardenas, M.D.
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; Javier Sanchez, Chief Network Officer; Chet Uma, Chief Financial Officer; Suzanne Turf, Clerk of the Board

Chair Refowitz announced the following changes to the agenda: Due to a lack of quorum, Item 20, Authorize the Chief Executive Officer to Submit Supplemental Benefit Recommendations to the Centers for Medicare & Medicaid Services and the California Department of Health Care Services for the OneCare Connect Program, and CS 1 are continued to the August 4, 2016 Board meeting; Item 21, Consider Chief Executive Officer and Chief Counsel Performance Reviews and Compensation, and CS 5 through CS 8 are continued to a future Board meeting.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader provided an update on the preliminary Medi-Cal Classic and Medi-Cal Expansion (MCE) rates, and a review of the proposed PACE Modernization Act that is part of a state budget trailer bill which aims to correct issues inherent in the PACE payment methodology. Mr. Schrader reported that the state is increasing CalOptima's Medi-Cal Classic rate by 4% in aggregate for FY 2016-17, and noted that staff will return to the Board in August to request approval of an increase for certain providers for the Medi-Cal Classic population.

Mr. Schrader also reported on the scholarship essay contest launched by CalOptima's Employee Activities Committee (EAC), which awarded three scholarships to CalOptima members that are working toward careers in health care. A short video of the winning members was shared with the Board.

PUBLIC COMMENTS

There were no requests for public comment.

Back to Agenda

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the May 5, 2016 Regular Meeting of the CalOptima Board of Directors; and
   b. Receive and File Minutes of the March 23, 2016 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee, the February 18, 2016 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the November 12, 2015 Meeting of the CalOptima Board of Directors' Member Advisory Committee, the January 21, 2016 Joint Meeting of the Member and Provider Advisory Committee; the March 24, 2016 Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee, and the April 14, 2016 Meeting of the CalOptima Board of Directors' Provider Advisory Committee

3. Authorize Contract Amendments and Revisions of the Current Specialist Medi-Cal Expansion (MCE) Member Rates, with the Exception of Contracts with Ophthalmologists, and Revise Contract Terms to Align with Fiscal Year

4. Authorize Contract Amendments and Revisions of the Current Ophthalmologist Specialist Medi-Cal Expansion (MCE) Member Rates, and Revise Contract Terms to Align with Fiscal Year

5. Consider Appointments to the CalOptima Board of Directors' Member Advisory Committee (MAC); Consider Appointment of MAC Chairperson

6. Consider Appointments to the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC); Consider Appointment of OCC MAC Chairperson

7. Consider Appointments to the CalOptima Board of Directors' Provider Advisory Committee (PAC); Consider Appointment of PAC Chairperson

8. Consider Adoption of Resolution Approving Updated CalOptima Policy GA.8058, Salary Schedule

9. Consider Approval of Proposed Technical Changes to Policy GG.1643: Minimum Physician Standards

10. Consider Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year 2016-17

11. 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

12. Adopt Resolution Authorizing and Directing the Chairman of the Board of Directors to Execute Contract MS-1617-41 with the California Department of Aging for the Multipurpose Senior Service Program for Fiscal Year 2016-17

13. Authorize Extension of Contract with Imagenet

Back to Agenda

14. Authorize Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2015-16 Operating Budget

15. Consider Adoption of Resolution Approving Updated CalOptima Human Resources Policy GA.8055, Retiree Health Benefits

Due to a lack of quorum, Consent Calendar items 3 and 4 were continued. Staff plans to present these items to the Board for ratification at the August 4, 2016 meeting.

Chair Refowitz pulled Consent Calendar items 5, 6 and 7 for discussion.

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

Consider Appointments to the CalOptima Board of Directors' Member Advisory Committee (MAC); Consider Appointment of MAC Chairperson; Consider Appointments to the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC); Consider Appointment of OCC MAC Chairperson; and Consider Appointments to the CalOptima Board of Directors' Provider Advisory Committee (PAC); Consider Appointment of PAC Chairperson

Chair Refowitz commented in support of the recommended appointments/reappointments to the MAC, OCC MAC, and PAC, and suggested extending the terms of the current MAC, OCC MAC, and PAC Chairs until such time as the new Board can consider these appointments at or following the August 4, 2016 Board meeting.

Action: ***On motion of Chair Refowitz, seconded and carried, the Board approved the following: 1) Reappointed the following individuals to their current seats on the MAC for terms ending on June 30, 2018: Christina Sepulveda, Lisa Workman, Gene Howard, Velma Shivers, Sally Molnar, and Sr. Mary Therese Sweeney; appointed Christine Tolbert as the Persons with Special Needs Representative for a term ending June 30, 2018; and extended the term of current MAC Chair Mallory Vega until such time the Board considers this appointment; 2) Reappointed the following individuals to their current seats on the OCC MAC for terms ending on June 30, 2018: Gio Corzo, Patty Mouton, Ted Chigaros, and Christine Chow; appointed John Dupies as the OneCare Connect Member/Family Member Representative for a term ending June 30, 2018; and extended the term of current OCC MAC Chair Patty Mouton until such time the Board considers this appointment; and 3) Reappointed the following individuals to their current seats on the PAC for terms ending on June 30, 2019: Steven Flood, Mary Pham, and Theodore Caliendo, M.D.; appointed Donald Bruhns as the Long Term Services and Support Representative, John Nishimoto, O.D., as the Non-Physician Medical Practitioner Representative, and Anjan Batra, M.D., as the Physician Representative for terms ending June 30, 2019; and extended the term of current PAC Chair Jenna Jensen until such time the Board considers this appointment. (Motion carried 7-0-0; Supervisor Bartlett and Directors Agarwal and Cardenas absent)***

Back to Agenda

REPORTS

Chair Refowitz reordered the agenda to hear Agenda Item 18.

18. Authorize Participation with the Orange County Health Care Agency in the Department of Health Care Services Whole Person Care Pilot Program

Based on his affiliation with the Orange County Health Care Agency, Chair Refowitz did not participate in the discussion or vote on this item.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized participation with the Orange County Health Care Agency (HCA) in the Department of Health Care Services Whole Person Care Pilot program, including providing HCA with a letter of participation for the program. (Motion carried 6-0-0; Chair Refowitz recusing; Supervisor Do and Directors Agarwal and Cardenas absent)***

16. Approve the CalOptima Fiscal Year 2016-17 Operating Budget

Chet Uma, Chief Financial Officer, presented the following recommended actions: 1) Approve the CalOptima Fiscal Year (FY) 2016-17 Operating Budget; 2) Authorize the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002, Purchasing Policy; and 3) Authorize Medi-Cal medical expenditures based on current provider payment rates until the Board approves a final FY 2016-17 Medi-Cal medical budget, and upward or downward adjustments to provider payment rates included in the Board's final FY 2016-17 Medi-Cal budget based on State rate amendments retroactive to the effective date(s) of such rates.

Vice Chair Penrose reported that the Board of Directors' Finance and Audit Committee thoroughly reviewed the proposed operating budget at the May 19, 2016 meeting, and recommended approval of the FY 2016-17 Operating Budget as presented. Mr. Penrose commented that the Board of Directors' Finance and Audit Committee will conduct a comprehensive review of the PACE program at the September meeting and will report back to the Board on the findings.

After discussion of the matter, the Board took the following action.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors approved the CalOptima FY 2016-17 Operating Budget as presented. (Motion carried 6-0-0; Supervisor Bartlett and Directors Agarwal, Boyd, and Cardenas absent)***

17. Approve the CalOptima FY 2016-17 Capital Budget

Mr. Uma presented the recommended action to approve the CalOptima FY 2016-17 Capital Budget for the following asset types: Information Systems, 505 Building Improvements, and PACE.

Vice Chair Penrose commented that the Board of Directors' Finance and Audit Committee reviewed the FY 2016-17 Capital Budget at the May 19, 2016 meeting and recommended Board of Directors approval.

Back to Agenda

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors approved the CalOptima FY 2016-17 Capital Budget as presented. (Motion carried 6-0-0; Supervisor Bartlett and Directors Agarwal, Boyd, and Cardenas absent)***

19. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Events

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized up to $1,500 and staff participation in the 28th Annual Senior Saturday Community Festival on September 10, 2016 at the Pier Plaza in downtown Huntington Beach; made a finding that such expenditures are 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 events and expenditures. (Motion carried 6-0-0; Supervisor Bartlett and Directors Agarwal, Boyd, and Cardenas absent)***

ADVISORY COMMITTEE UPDATES

22. Provider Advisory Committee (PAC) Update

PAC Chair Jenna Jensen reported that at the May 12, 2016 meeting, the PAC approved the FY 2015-16 Accomplishments and FY 2016-17 meeting schedule, and approved a slate of recommended candidates for six appointments expiring on June 30, 2016. Ms. Jensen provided a brief overview of the FY 2015-16 PAC accomplishments.

23. Member Advisory Committee (MAC) Update

Mallory Vega, MAC Chair, reported on MAC activities at the May 12, 2016 meeting, including the review of the slate of candidates for seven seats expiring on June 30, 2016, and recommendations for Board consideration. Ms. Vega presented an overview of the FY 2015-16 accomplishments and the FY 2016-17 Goals and Objectives.

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

Christine Chow, OCC MAC Member Advocate Representative, presented an update on activities at the April 28, 2016 OCC MAC meeting, including recommendations for four seats expiring on June 30, 2016 and one vacant seat, the FY 2015-16 OCC MAC Accomplishments and the FY 2016-17 Objectives. A brief overview of the FY 2015-16 accomplishments was presented.

INFORMATION ITEMS

The following Information Items were accepted as presented:

25. April 2016 Financial Summary
26. Member Experience Update
27. Compliance Report
28. Federal and State Legislative Advocates Reports
29. CalOptima Community Outreach and Program Summary

Back to Agenda

BOARD MEMBER COMMENTS

On behalf of the Board of Directors, Chair Refowitz presented recognition to Directors Ahn, Boyd, Dang, Nguyen, and Ryan in honor of their service on the Board of Directors and their commitment to CalOptima and to Orange County's Medi-Cal beneficiaries. Supervisor Do presented Certificates of Recognition on behalf of himself and Supervisor Bartlett in appreciation of their service on the Board of Directors and to the health and well being of CalOptima's members.

Chief Network Officer Javier Sanchez was also recognized by the Board of Directors for his years of service with CalOptima.

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 3:44 p.m. pursuant to: 1) Government Code Section 54956.9, subdivision (d)(1) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. One Case: Fountain Valley Regional Hospital and Medical Center v. Orange County Health Authority (CalOptima). Orange County Superior Court (OCSC) Case No. 30-2015-00816716-CU-BC-CJC; 2) Government Code Section 54956.9, subdivision (d)(1), CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. (One Case): Kirsten Mayer v. CalOptima Foundation, Inc., Orange County Superior Court (OCSC) Case No. 30-2015-00803243-CU-OE-CJC; and 3) Government Code Section 54956.9, subdivision (d)(4), CONFERENCE WITH LEGAL COUNSEL - ANTICIPATED LITIGATION (One Case).

The Board reconvened to open session at 4:14 p.m. with no reportable actions taken.

ADJOURNMENT

Hearing no further business, the meeting was adjourned at 4:14 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: August 4, 2016

Back to Agenda

MINUTES

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

May 12, 2016

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on May 12, 2016, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Mallory Vega called the meeting to order at 2:40 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Mallory Vega, Chair; Suzanne Butler; Sandy Finestone; Connie Gonzalez; Donna Grubaugh; Gene Howard; Stephanie Martinez; Gregory Mathes; Sally Molnar; Christina Sepulveda; Velma Shivers; Lisa Workman

Members Absent: Victoria Hersey; Patty Mouton; Sr. Mary Therese Sweeney

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Javier Sanchez, Chief Network Officer; Candice Gomez, Executive Director, Program Implementation; Richard Bock, Deputy Chief Medical Officer; Arif Shaikh, Director, Government Affairs; Belinda Abeyta, Director, Customer Service; Becki Melli, Customer Service

MINUTES

Approve the Minutes of the November 12, 2015 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Member Gene Howard, seconded and carried, the MAC approved the minutes as submitted.***

Approve the Minutes of the January 21, 2016 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee and Provider Advisory Committee

Action: ***On motion of Member Sally Molnar, seconded and carried, the MAC approved the minutes as submitted.***

Chair Vega recognized Member Gregory Mathes, whose term expires on June 30, 2016, for his service to the MAC since 2004.

PUBLIC COMMENT
There were no requests for public comment.

Back to Agenda

REPORTS

Consider Approval of Fiscal Year (FY) 2015-2016 MAC Accomplishments

Chair Vega presented the MAC's FY 2015-2016 Accomplishments for approval, which she will present to the CalOptima Board at the June 2, 2016 meeting.

Action: ***On motion of Member Sandy Finestone, seconded and carried, MAC approved the FY 2015-2016 Accomplishments as submitted.***

Consider Approval of FY 2016-2017 MAC Meeting Schedule

Chair Vega presented the FY 2016-2017 meeting schedule for approval.

Action: ***On motion of Member Stephanie Martinez, seconded and carried, MAC approved the FY 2016-2017 MAC Meeting Schedule as submitted.***

Consider Approval of FY 2016-2017 MAC Goals and Objectives (G&O)

Chair Vega reported the MAC G&O Ad Hoc, composed of Connie Gonzalez, Gene Howard and Gregory Mathes, met on April 20, 2016 to review the FY 2016-17 G&O.

Action: ***On motion of Member Sally Molnar, seconded and carried, MAC approved the FY 2016-2017 MAC Goals and Objectives as submitted.***

Recommendation of FY 2016-2017 MAC Slate of Candidates and Chairperson

Chair Vega announced that the Board of Directors has requested additional information on the nominations and recommendations of individuals for appointment to the committee. To that end, a list of all candidates or nominees for each position, a short biography on each candidate or nominee and the Nominations Ad Hoc Subcommittee's recommendation of appointees will be presented to the Board for consideration at the June Board meeting.

Member Sandy Finestone reported on the Nominations Ad Hoc Subcommittee's recommended slate of candidates and Chairperson. The Ad Hoc convened on April 20, 2016 and included Members Connie Gonzalez, Suzanne Butler and Sandy Finestone. After reviewing the applications and selecting a candidate for each seat, the Nominations Ad Hoc recommended the following slate of candidates: 1) Christina Sepulveda as the Children's Representative; 2) Lisa Workman as the Consumer Representative; 3) Gene Howard as the Foster Children Representative; 4) Velma Shivers as the Long-Term Care Representative; 5) Sally Molnar as the Medically Indigent Persons Representative; 6) Sister Mary Therese Sweeney as the Persons with Mental Illness Representative; and 7) Christine Tolbert as the Persons with Special Needs Representative.

Action: ***On motion of Member Sandy Finestone, seconded and carried, MAC approved the recommended slate of candidates as presented .***

Member Finestone reported that the Nomination Ad Hoc recommended the appointment of Mallory Vega as FY 2016-2017 MAC Chair.

Back to Agenda

Action: ***On motion of Member Sally Molnar, seconded and carried, MAC approved the 2016-2017 Chairperson as recommended.***

Consider Recommending Board of Directors' Addition of Vice Chair Position to Member Advisory Committee

Chair Vega reported that the Provider Advisory Committee (PAC) recently voted to recommend to the Board of Directors the addition of a Vice Chair position to the PAC. This request will now go to the Board of Directors for consideration. Chair Vega noted that the Vice Chair would fill in if the Chair were unavailable.

Action: ***On motion of Member Sally Molnar, seconded and carried, MAC recommended Board consideration of the addition of a Vice Chair to MAC.***

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, reported that CalOptima is preparing for a Medi-Cal Expansion (MCE) rate reduction. The proposed rates for the MCE population, about one-fourth of CalOptima's overall Medi-Cal membership, will be a fifteen percent reduction. Mr. Schrader noted that these rates, while lower than the current MCE rates, are based on input from the state. He added that CalOptima would continue to advocate for appropriate MCE and Medi-Cal Classic rates through our associations and our ongoing communications with the Department of Health Care Services (DHCS). If CalOptima is successful in obtaining higher rates, CalOptima will pass these along to our provider partners. Mr. Schrader noted that to ensure CalOptima's provider network is in place on July 1 for the start of FY 2016-17, it is important to send contract amendments now to the health networks, hospitals and specialists rather than wait for final rates. He explained that executing the amendments can take several weeks, and final rates are subject to approval by the Centers for Medicare & Medicaid Services (CMS). He added that the providers have received sufficient communication about this upcoming rate change.

Mr. Schrader reported that the Legacy Awards event was held at the Bowers Museum on April 21, 2016. This event drew the community together to celebrate CalOptima's 20th anniversary and the collective commitment to improving the lives of Orange County's vulnerable residents.

Chief Medical Officer Update

Richard Bock, MD, Deputy Chief Medical Officer, reported on CalOptima's minimum physician standards for all physicians newly credentialed either by CalOptima or its delegated networks. It requires that contracted physicians be board certified in their specialty. Dr. Bock explained the following proposed standards: 1) applicants can have no felony convictions within 10 years prior to applying; 2) physician applicants must not be on probation for any reason; and 3) applicants must not have an accusation pending before their licensing board. He added that an accusation is not a malpractice allegation. An accusation is a legal document from the Medical Board of California (MBC) that begins with a formal disciplinary process after an investigation finds evidence that the

physician has violated disciplinary action. An accusation lists the changes and/or the section of law alleged to have been violated and is served on the physician.

Dr. Bock reported on the rampant growth of opioid use since 2000. This nation-wide problem caused more deaths from opioid overdoses last year than traffic accidents with over 290 million prescriptions written annually. Dr. Bock reported that CalOptima is tracking opioid utilization and working with physicians and pharmacies to track and monitor opioid prescriptions. CalOptima sends any findings to the Medi-Cal investigative unit when someone is prescribed more than 1,000 pills in a 90-day period.

Chief Network Officer Update

Javier Sanchez, Chief Network Officer, reported that CalOptima is working with Dr. Donnelly at the Center for Autism and Neurodevelopmental Disorders to minimize the backlog of children in Orange County that are waiting for an autism screening and diagnosis. Dr. Donnelly and his group developed curriculum to train physicians, primarily pediatricians, to conduct the screening and diagnosis. Mr. Sanchez noted that CalOptima is using Intergovernmental Transfer (IGT) funds to support a provider incentive program that pays physicians as an incentive to take the training. To date, 30 physicians have enrolled for the first six-week session.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, reported that CalOptima mailed over 1,900 application packets to members who have Medicare Part B only to determine if they qualify for the Qualified Member Beneficiary (QMB) program. The QMB program pays premiums, deductibles and co-insurance for Medicare Part A for members who are eligible, but have limited income and resources. Ms. Khamseh noted that CalOptima had a 48% return rate. If a member qualifies, QMB benefits start July 1, 2016. Once members have this additional coverage, they would qualify for OneCare or OneCare Connect programs.

Ms. Khamseh reported that with the passage of Senate Bill 75, children under 19 years of age would become eligible for full-scope Medi-Cal benefits regardless of immigration status, as long as they meet all other eligibility requirements. This population transitions into full-scope Medi-Cal, effective May 16, 2016, and enrolls with CalOptima on June 1, 2016.

Ms. Khamseh reported that CalOptima is working with the Orange County Health Care Agency (HCA) on the transition of California Children Services (CCS) to CalOptima. She noted that CalOptima's transition will begin no earlier than July 1, 2017, and will be contingent upon a readiness review conducted by DHCS.

Ms. Khamseh reminded the committee that only two months remain of passive enrollment for the OneCare Connect program. After July, members will have to enroll voluntarily into OneCare Connect.

INFORMATION ITEMS

Back to Agenda

Medi-Cal Call Center

Hellen Howe, Medi-Cal Program Deputy Director, Social Services Agency (SSA), provided an overview on the SSA Medi-Cal Call Center assistance program. Ms. Howe explained that SSA implemented the Call Center in 2010 to respond to increasing customer volume and to enhance accessibility to services. She noted that Call Center activity has risen 80% in the last five years requiring SSA to transition to an updated platform to increase efficiency and enhance service delivery options. Ms. Howe outlined several strategies to improve customer service, such as monitoring wait times to identify staffing needs, providing callers with a callback option, conducting random supervisory call reviews, and recording calls for quality assurance.

Member Experience Update

Kelly Rex-Kimmet, Director of Quality Analytics, reported on an update on the Member Experience Work Group. The goal of the work group is to implement strategies to raise member experience scores in the Consumer Assessment of Healthcare Providers and Systems (CAHPS), which impacts the National Committee of Quality Assurance (NCQA) accreditation and national ratings. The work group activities include: analyzing CAHPS results and identifying areas for member improvement; conducting a supplemental survey to members; releasing a request for information (RFI) to gather market intelligence on methods to gather further member experience data; conducting customer service post-call surveys; and implementing process improvements at CalOptima and with our health networks. The findings from the supplemental survey identified the following sources of member dissatisfaction: coordination of care; access to specialist care; communication with provider; length of time to get an appointment; and length of time in the waiting room at the appointment. CalOptima will continue member experience initiatives and analysis to identify and reduce member issues.

Federal and State Budget and Legislative Update

Arif Shaikh, Director, Government Affairs, announced that Governor Brown is expected to release his May Revision to the FY 2016-17 State Budget proposal later this week. The May Revise represents the last formal outline of the administration's funding priorities for the next fiscal year, which begins July 1, 2016. Mr. Shaikh reported that the Governor's January budget proposal included the continuation of the Coordinated Care Initiative (CCI), which includes OneCare Connect; however, an extension beyond 2017 would be contingent upon the program achieving greater financial sustainability through increased enrollment. DHCS has proposed CCI program improvements to strengthen Cal MediConnect, including improvement in care coordination, sharing best practices and engaging in outreach to providers in order to reduce opt-out rates. In addition, DHCS is keeping open the possibility of instituting a passive enrollment process in 2017.

Mr. Shaikh announced that the Dental Transformation Initiative (DTI), a program authorized by California's new §1115 Waiver, is designed to increase access to dental care.

ADJOURNMENT

Hearing no further business, Chair Vega adjourned the meeting at 5:00 p.m. The next MAC meeting is scheduled on July 14, 2016 at 2:30 p.m.

Back to Agenda

/s/ Cindi Reichert
Cindi Reichert
Program Assistant

Approved: July 14, 2016

Back to Agenda

MINUTES

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

May 12, 2016

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, May 12, 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 Member Ross led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Theodore Caliendo, M.D.; Alan Edwards, M.D.; Stephen N. Flood; Jena Jensen; Pamela Kahn, R.N.; Teri Miranti; George Orras, Ph.D.; FAAP; Mary Pham, Pharm.D, CHC (arrived at 8:20 AM); Pamela Pimentel, R.N.; Suzanne Richards, RN, MBA, FACHE; Barry Ross, R.N., MPH, MBA; Jacob Sweidan, M.D.
Members Absent:	Camille Fitzpatrick, MSN, ANP-BC, GNP-BC; Cheryl Petterson; Joseph M. Ruggio, M.D., FACP, FACC, FSCAI
Others Present:	Michael Schrader, Chief Executive Officer' Chet Uma, Chief Financial Officer; Gary Crockett, Chief Counsel; Richard Bock, M.D., Deputy Chief Medical Officer; Javier Sanchez, Chief Network Officer; Ladan Khamseh, Chief Operating Officer; Caryn Ireland, Executive Director, Quality Analytics; Phil Tsunoda, Executive Director, Public Affairs; Cheryl Simmons, Staff to the PAC

MINUTES

Approve the Minutes of the April 14, 2016 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Miranti seconded and carried, the Committee approved the minutes of the April 14, 2016 meeting. (Motion carried 11-0-0; Members Fitzpatrick, Petterson, Pham, and Ruggio absent)***

PUBLIC COMMENTS

No requests for public comments were received.

Back to Agenda

REPORTS

Consider Approval of the FY 2016-2017 PAC Meeting Schedule

PAC members reviewed two options for the FY 2016-17 meeting schedule. The first option proposed monthly meetings, and the second option proposed monthly meetings, with the exception of July 2016 and January 2017.

Action: ***On motion of Member Pimentel seconded and carried, the Committee adopted the FY 2016-17 PAC Meeting Schedule reflecting monthly meetings with the exception of July 2016 and January 2017. (Motion carried 11-0-0; Members Fitzpatrick, Petterson, Pham and Ruggio absent)***

Consider Approval of FY 2015-16 PAC Accomplishments

The FY 2015 –16 PAC Accomplishments were presented for approval. The accomplishments will be presented to the CalOptima Board of Directors at the June 2, 2016 meeting.

Action: ***On motion of Member Edwards seconded and carried, the Committee approved the FY 2015-16 PAC Accomplishments. (Motion carried 11-0-0; Members Fitzpatrick, Petterson, Pham and Ruggio absent)***

Consider Recommendation of 2016 PAC Slate of Candidates and PAC Chairperson

Members Edwards, Kahn and Ross reviewed the recommendations of the PAC Nominations Ad Hoc Subcommittee. The subcommittee met on April 28, 2016 to review the applications for the six seats available and to recommend a candidate for the PAC Chair position. The six seats expiring are two (2) Long Term Services and Support Representative, Non-Physician Medical Practitioner Representative, Pharmacy Representative, and two (2) Physician Representatives.

The subcommittee reviewed 15 applications: three (3) for the Long Term Services and Support Representative seats; three (3) for the Non-Physician Medical Practitioner seat; two (2) for the Pharmacy Representative seat; and seven (7) for the Physician Representative seat.

The ad hoc subcommittee recommended the following candidates for the seven expiring seats: Donald Bruhns (new appointment) and Steven Flood (reappointment) for the Long Term Services and Support seats; John Nishimoto, O.D., M.B.A., F.A.A.O (new appointment) for the for the Non-Physician Medical Practitioner seat; Mary Pham, Pharm.D, CHC (reappointment) for the Pharmacy seat; Anjan Batra, M.D. (new appointment) and Theodore Caliendo, M.D. (reappointment) for the two Physician seats; and Jena Jensen for the Traditional/Safety Net seat.

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the recommendations of the PAC Ad Hoc Nominations Subcommittee for the six expiring seats for a two-year term as presented. (Motion carried 8-0-2; Members Caliendo, and Flood, abstained; Members Fitzpatrick, Petterson, Pham and Ruggio absent).***

Back to Agenda

The subcommittee also recommended that Teri Miranti be appointed as PAC Chair for the FY 2016-17 term.

Action: ***On motion of Member Pimentel, seconded and carried, the Committee approved the recommendation of the PAC Ad Hoc Nominations Subcommittee to appoint Teri Miranti, PAC Chair for the FY 2016-17 term. (Motion carried 10-0-1; Member Miranti abstained; Member Fitzpatrick, Petterson, Pham and Ruggio absent).***

CEO AND MANAGEMENT REPORTS

Chief Financial Officer Update

Chet Uma, Chief Financial Officer provided a brief update on the March 2016 Financials that were presented to the Board. Enrollment is at 793,328 for the month of March. Mr. Uma noted that there were two areas not making budget. The Temporary Assistance for Needy Families (TANF) and OneCare Connect (OCC) product lines were lower than the budget projections. Mr. Uma also noted that revenues for the month were lower than expected due to overall lower enrollment and that on a year-to-date basis enrollment is 6.6% higher over last year.

Mr. Uma noted that administrative expenses were running at 31.4% of the budgeted level and that the favorable variance is attributable to lower enrollment compared to budget. He also noted that the balance sheet as of March 31, 2016 showed total assets and outflows of approximately $2.2 billion with total liabilities of $1.5 billion and net assets of $650 million.

Chief Medical Officer Update

Deputy Chief Medical Officer Richard Bock, MD, presented the Minimum Physician Standards (MPS) as requested by Member Miranti at the April PAC meeting. Dr. Bock reviewed the previous standards and the proposed standards with the members. As part of the proposed standards, the new MPS requires that contracted physicians that are under Probation or Accusation by the Medical Board of California are prohibited from providing services to CalOptima members. Dr. Bock will keep the PAC updated once these new standards have been adopted. Dr. Bock, along with Caryn Ireland, Executive Director, Quality Analytics, provided the PAC with an update on Member Experience. After discussion of CalOptima's supplemental survey results, it was decided to reconvene the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Ad Hoc Subcommittee to address the issues identified in a survey that was developed and administered by CalOptima on the member's experience.

Chief Network Officer Update

Javier Sanchez, Chief Network Officer, reported that Dr. Sharps, Medical Director, Behavioral Health, Laura Grigoruk, Director, Provider Relations and himself are working with Dr. Donnelly at the Centers for Autism who has developed a curriculum for a one-week training session on autism to screen and diagnose children with autism. The first session is already at capacity, but future training sessions will be held. CalOptima is providing incentives for attending as

approved by the CalOptima Board of Directors using intergovernmental transfer Funds (IGT). This initiative is intended to help address the backlog for screening children in Orange County.

Mr. Sanchez noted that this would be his last PAC meeting, as he will be leaving CalOptima at the beginning of June 2016.

INFORMATION ITEMS

Federal and State Budget Update

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, noted that the May revise of the Governor's budget was expected on May 13, 2016. Mr. Tsunoda agreed to send a summary of the May budget revise to the PAC members once it was completed.

PAC Member Comments

Member Edwards thanked everyone on the Nominations Ad Hoc Subcommittee and noted the caliber of applicants was very high and reflected the interest from the provider community in participating on this committee and having a voice on behalf of the constituencies they serve.

Member Miranti questioned whether a letter that had recently been sent to CalOptima on behalf of the health networks would receive a formal follow-up response regarding the health network security reserve policy. Staff indicated that a response would be forthcoming.

ADJOURNMENT

There being no further business before the Committee, the Chair adjourned the meeting at 9:11 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: June 9, 2016

Back to Agenda

MINUTES

REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' ONECARE CONNECT CALMEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE

May 26, 2016

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on May 26, 2016, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Patty Mouton called the meeting to order at 3:10 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Ted Chigaros, Christine Chow, Gio Corzo, Josefina Diaz, Sara Lee, Patty Mouton, Lena Berlove (non-voting), Jorge Sole (non-voting), Erin Ulibarri (non-voting)

Members Absent: Donta Harrison, Susie Gordee, Sandy Finestone, George Crits M.D. (non-voting)

Others Present: Ladan Khamseh, Chief Operating Officer; Candice Gomez, Executive Director Program Implementation; Terrie Stanley, Executive Director Clinical Operations; Donald Sharps, M.D., Medical Director; Emily Fonda, M.D., Medical Director; Richard Bock, M.D. , Deputy Chief Medical Officer; Arif Shaikh, Director Government Affairs; Albert Cardenas, Associate Director Customer Service; Becki Melli, Customer Service

MINUTES

Approve the Minutes of the April 28, 2016 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Member Ted Chigaros, seconded and carried, the OCC MAC approved the April 28, 2016 minutes as submitted.***

PUBLIC COMMENT
There were no requests for public comment.

REPORTS

Consider Recommending Board of Directors' Addition of Vice Chair position to the OneCare Connect Member Advisory Committee

Back to Agenda

Chair Mouton announced that the Member Advisory Committee (MAC) voted to recommend to the Board of Directors' adding a Vice Chair position to the MAC. The Vice Chair would fill in at committee meetings or Board meetings if the Chair were unavailable. Chair Mouton reported that nominations for the Vice Chair position would begin at the subsequent OCC MAC meeting following Board approval.

Action: ***On motion of member Ted Chigaros, seconded and carried, the OCC MAC recommended Board consideration of the addition of a Vice Chair position to the OCC MAC.***

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Medical Officer (CMO) Update

Richard Bock, M.D., Deputy Chief Medical Officer, reported on the rampant growth of opioid use since 2000 and the epidemic in Orange County. He noted that Orange County has the highest number of opioid related deaths of any county in California with over 1,000 opioid related deaths during the period of 2009-2013. In addition, this nation-wide problem caused more deaths from opioid overdoses last year than traffic accidents with over 290 million prescriptions written annually. Dr. Bock reported that CalOptima is tracking opioid utilization and working with physicians and pharmacies to track and monitor opioid prescriptions. There are new treatments available for opiod addiction.

Chief Financial Officer (CFO) Update

Nancy Huang, Controller, provided a financial summary for March 2016. Ms. Huang reported that the enrollment summary for March 2016 showed an overall enrollment of close to 800,000 members, including almost 16,000 members in the OneCare Connect program. She added that 98percent of CalOptima's members are in Medi-Cal while the remaining two percent are in OneCare Connect, OneCare and PACE. Ms. Huang reported that the medical loss ratio is approximately 96 percent, which means that 96 cents of every dollar goes to health care.

INFORMATION ITEMS

Behavioral Health Request for Proposal Update

Edwin Poon, Director of Behavioral Health Services, provided a brief background on CalOptima's history with providing a behavioral health benefit. Mr. Poon explained that CalOptima began offering behavioral health benefits to OneCare members in January 2007, through the vendor Windstone Behavioral Health. In January 2014, the Medi-Cal line of business added managed care behavioral health benefits through College Health Independent Physician Association (CHIPA)/Beacon. In addition, CalOptima amended its contract with CHIPA/Beacon to include Autism Spectrum Disorder (ASD) Applied Behavior Analysis/Behavioral Health Treatment (ABA/BHT) benefits when the state transitioned ASD to CalOptima in September 2014. When OneCare Connect (OCC) was implemented in July 2015, Windstone contracted to provide managed behavioral health services to OCC members.

Back to Agenda

Mr. Poon reported that CalOptima is conducting a Request for Proposal (RFP) process to identify a potential behavioral health vendor that could contract for all lines of business. He added that one vendor would be preferable, but not a requirement. Mr. Poon stated that as the field of behavioral health continues to evolve, CalOptima needs a vendor that is on the leading edge of integration, population health, analytics, outcomes and value based reimbursement. CalOptima has an opportunity to enhance the overall health of its members through the effective management of its behavioral health benefits. The RFP selection team would include CalOptima management staff from clinical and operational areas and representatives from outside agencies. Mr. Poon announced that the Board of Directors' Finance and Audit Committee recommended including a member from each of the advisory committees to serve on the RFP selection team. In response, Chair Mouton asked if an OCC MAC member wanted to volunteer for the selection committee. Member Susie Gordee agreed to serve on the RFP selection team with Ted Chigaros as an alternate.

Health Risk Assessment (HRA) - Interdisciplinary Care Team (ICT) - Individual Care Plan (ICP) Update

Terrie Stanley, Executive Director, Clinical Operations, reported that the transition of over 12,000 individuals from OneCare to OneCare Connect in January 2016 generated almost 9,000 HRA bundles for the health networks and over 3,500 for CalOptima. The HRA bundle includes information, such as a completed HRA, initial care plan and recommended interventions for each member. A CalOptima nurse must review the HRA bundles assessing them for various quality measures. Ms. Stanley noted that over 87% of the bundles were returned in a timely manner. Upon review, the HRA scores are recorded in a report card and presented to the ICT and ICP. Ms. Stanley explained that Personal Care Coordinators (PCCs) are an important part of processing the HRA bundles, although they are not clinical staff. The PCCs recently convened for a meeting to discuss the HRA bundles and the process. Additional topics discussed at the meeting included updates on dementia, the nurse advice line, the initial health assessment (IHA) and community resources, such as 2-1-1.

Chair Mouton announced that agenda items VII.B. Federal and State Budget and Legislative Update, VII.C. Member Enrollment Update, and VII.D. OneCare Connect Update would be deferred to the June 23, 2016 meeting.

Post Acute Care

Ted Chigaros, Senior Vice President, Rockport Healthcare Services, explained Rockport is a contracted administrative support services company representing over 80 subacute/skilled nursing facilities (SNFs) in California and Texas. Rockport manages three SNFs in Orange County. Mr. Chigaros explained that nurses and other qualified personnel provide care 24 hours a day managing all the patients' needs from grooming and showering to laundry and meal preparation. Most facilities do not have private rooms. Of the 73 SNFs in Orange County, four do not participate in Medi-Cal and two do not participate in Medicare. Mr. Chigaros explained that SNFs are highly regulated. They must be certified by the Department of Health Care Services (CHCS) with an annual survey process and are monitored by the Office of Statewide

Health Planning and Development (OSHPD). Mr. Chigaros noted that the population residing in skilled nursing facilities is changing. In addition to the elderly, SNFs are now serving younger people, including those with behavioral/mental health problems, those with addiction issues and bariatric patients.

Ombudsman Update

Sara Lee, Supervising Attorney, Health Consumer Action Center (HCAC) Legal Aid Society of Orange County, shared examples of the issues and problems that OCC members experience when they lose Medi-Cal eligibility. She explained if an OCC member loses Medi-Cal, the Medicare premiums continue to be withdrawn from the member's social security check. In addition, the member must pay out of pocket for prescriptions and other necessary medical expenses. She noted that it takes time to resolve the issues for each member, but by working with the Ombudsman and CalOptima, a member has more time to fix the eligibility issue while retaining OCC coverage.

Committee Member Updates

Chair Mouton shared that the recent Town Hall received good reports. There was considerable interest in the OneCare Connect program. Member Jorge Sole noted that over 1,000 people attended the recent Senior Summit held in Laguna Woods. The evaluations indicated that the OneCare Connect presentation received a good response.

Member Sole will present on the Orange County Social Services Agency at the June OCC MAC meeting. Member Erin Ulibarri will present on the Orange County Office on Aging at the July OCC MAC meeting.

The next OneCare Connect MAC meeting is June 23, 2016 at 3:00 p.m.

ADJOURNMENT

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

/s/ Cindi Reichert
Cindi Reichert
Program Assistant

Approved: 6.23.2016

Back to Agenda

MINUTES

REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' ONECARE CONNECT CALMEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE

April 28, 2016

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on April 28, 2016, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Patty Mouton called the meeting to order at 3:10 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Ted Chigaros, Christine Chow, Gio Corzo, Sandy Finestone, Susie Gordee, Sara Lee, Patty Mouton, Lena Berlove (non-voting), Jorge Sole (non-voting), Erin Ulibarri (non-voting)
Members Absent:	Josefina Diaz, Donta Harrison, George Crits, M.D. (non-voting)
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Javier Sanchez, Chief Network Officer; Candice Gomez, Executive Director Program Implementation; Terrie Stanley, Executive Director Clinical Operations; Caryn Ireland, Executive Director, Quality Analytics; Donald Sharps M.D., Medical Director; Arif Shaikh, Director Government Affairs; Belinda Abeyta, Director, Customer Service; Becki Melli, Customer Service

MINUTES

Approve the Minutes of the March 24, 2016 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Member Sandra Finestone, seconded and carried, the OCC MAC approved the minutes as submitted.***

PUBLIC COMMENT
There were no requests for public comment.

REPORTS

Consider Approval of the OCC MAC Accomplishments for the FY 2015-2016
Chair Mouton presented the OCC MAC's FY 2015-2016 Accomplishments for approval and announced she will be presenting the Accomplishments at the June 2, 2016 CalOptima Board meeting.

Action: ***On motion of member Gio Corzo, seconded and carried, the OCC MAC approved the FY 2015-2016 Accomplishments as submitted.***

Back to Agenda

Consider Approval of the FY 2016-2017 OCC MAC Meeting Schedule

Chair Mouton presented the FY 2016-2017 meeting schedule for approval. She noted that the November meeting would be held on the third Thursday of the month instead of the fourth Thursday due to the Thanksgiving holiday.

Action: ***On motion of member Sandy Finestone, seconded and carried, the OCC MAC approved the FY 2016-2017 MAC Meeting Schedule as submitted.***

Consider Approval of the FY 2016-2017 OCC MAC Goals and Objectives (G&O)

Chair Mouton reported that the OCC MAC G&O Ad Hoc, composed of Members Sandy Finestone, Josefina Diaz and Chair Mouton met on April 14, 2016 to review the G&O. She noted that the goals are based on the State's Cal MediConnect goals; however, the Ad Hoc members will review and amend them, if needed, when CalOptima's Strategic Plan is completed.

Action: ***On motion of member Ted Chigaros, seconded and carried the OCC MAC approved the FY 2016-2017 Goals and Objectives as submitted.***

Consider Recommendation of FY 2016-17 OCC MAC Slate of Candidates and Chairperson

Member Erin Ulibarri reported on the recommendation from the OCC MAC Nomination subcommittee for the FY 2016-17 slate of candidates and chairperson. The Ad Hoc convened on April 14, 2016 and included Members Lena Berlove, Sandy Finestone and Erin Ulibarri.

The OCC MAC Nominations Ad Hoc recommended the following slate of candidates: 1) Gio Corzo as the Community-Based Adult Services (CBAS) Provider Representative; 2) Patty Mouton as the Seniors Representative; 3) Ted Chigaros as the Long-Term Care Facility Representative; and 4) Christine Chow as the Member Advocate. In addition, OneCare Connect member John Dupies was selected for the OneCare Connect Member/Family Member seat. The Ad Hoc also recommended the reappointment of Patty Mouton as the Chair.

Action: ***On motion of member Sandy Finestone, seconded and carried, the OCC MAC approved the OneCare Connect slate of candidates and Chair as recommended.***

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer (CEO) Update

Michael Schrader, CEO, provided an update on the annual passive enrollment process. CalOptima's one-year passive enrollment process by birth month and by long- term care facility concludes in July 2016. Mr. Schrader reported that in late March, health plans offering Medicare-Medicaid programs won an extension of the method that automatically enrolls members. The Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS) agreed in concept to allow an annual passive enrollment process for seniors who age into Medicare. Mr. Schrader stated that he would provide additional information as it develops.

INFORMATION ITEMS

Back to Agenda

Street2Home: A Proposed Healthcare Safety Net System for Orange County's Chronically Homeless

Paul Cho, Chief Financial Officer, and Aiko Tan, Executive Director of Healthcare, Illumination Foundation, provided an overview on the Illumination Foundation. Mr. Cho explained that the Illumination Foundation, founded eight years ago, had a vision to provide targeted, interdisciplinary services for the most vulnerable homeless clients to break or prevent the cycle of homelessness and to provide a solution for Orange County's chronic medically fragile homeless that cycle through the emergency rooms, hospitals, justice system and the mental health system. He added that stable housing, medical care, income and community support are factors necessary to the solution.

Ms. Tan explained that recuperative care, introduced in 2008, developed in response to hospitals discharging homeless patients that had nowhere to go. She explained that recuperative care provides care to homeless persons recovering from an acute illness or injury that are unable to sustain recovery if they are living on the street or an unsuitable place. Recuperative care manages the recovery of homeless individuals discharged from hospitals and connects patients to resources and agencies in the client's preferred exit destination.

Mr. Cho reported that recuperative care has led to improved health care, increased access to care and a reduced cost for this population. This population experiences twice as many readmissions and twice as many inpatient days when they are discharged to the street rather than a recuperative care setting. Mr. Cho explained that a future program called "Street 2 Home" would assist the homeless find a stable living environment. This Homeless Health Care Safety Net model could realize tremendous savings by getting the homeless into the program before they need the hospital.

Overview on Mental Health and Substance Abuse Services for OCC

Donald Sharps, M.D., Medical Director, Behavioral Health Integration, presented on mental health and substance abuse services for OneCare Connect members, including a brief overview of the referral process for Medi-Cal and Medicare-Medi-Cal members. Medicare tends to be more streamlined in its processes than Medi-Cal on these issues, as there are multiple entities involved in Medi-Cal, such as the primary care physician (PCP), College Health Independent Physician Association (CHIPA)/Beacon, and Orange County Mental Health Plan, among others. Windstone Behavioral Health is the provider for OneCare Connect. Dr. Sharps added that six percent of OCC beneficiaries use mental health services, which is ten times higher than the Medi-Cal population in general.

Chair Mouton announced that agenda items VII.C.OCC MAC Member Presentation on Post Acute Care and VII.E. Member Enrollment Update, would be deferred to the May 26, 2016 meeting.

OneCare Connect Update

Candice Gomez, Executive Director of Program Implementation, provided an update on the Cal MediConnect program, CalOptima's OneCare Connect program. Ms. Gomez explained that the State is considering changes to the continuity of care requirements (COC), such as the definition of continuity of care and the number of previous provider visits necessary in order to request COC. The State is also considering whether to extend deeming to two months for all plans. Currently, the length of deeming varies from zero, one or two months. Ms. Gomez reported that

Back to Agenda

the State is considering whether to standardize some of the long-term support and services' questions on the Health Risk Assessment (HRA) and making the HRA more consistent across all the plans.

Federal and State Budget and Legislative Update

Arif Shaikh, Director Government Affairs, encouraged the OCC MAC members to send letters of support to DHCS regarding the passive enrollment process. Mr. Shaikh also reported that State budget revisions, known as the May revise, would be announced the second week of May.

Committee Member Updates

Chair Mouton announced that the Provider Advisory Committee (PAC) recently voted to recommend to the Board of Directors' to add a Vice Chair position to the PAC. The Vice Chair would fill in if the Chair were absent. OCC MAC members agreed to add this item to the agenda for the May 26, 2016 meeting.

Chair Mouton announced that Ted Chigaros will present on Post Acute Care and Sara Lee will present her Quarterly Ombudsman report at the May 26, 2016 meeting. Jorge Sole will present his OCC MAC presentation on the Social Services Agency in June.

Member Lena Berlove announced that In Home Supportive Services (IHSS) Public Authority is offering training classes for IHSS providers and recipients. She also announced that there are two vacancies on the IHSS Advisory Committee.

The next OneCare Connect MAC meeting is May 26, 2016 at 3:00 p.m.

ADJOURNMENT

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

/s/ Cindi Reichert
Cindi Reichert
Program Assistant

Approved: 5.26.2016

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Adoption of Resolution Adding Vice Chair Positions to the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee, and Provider Advisory Committee

Contact

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

Recommended Action

Adopt Resolution No. 16-0804-01, adding Vice Chair positions to the Board of Directors' Member Advisory Committee (MAC), OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) and Provider Advisory Committee (PAC), effective upon Board approval.

Background

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of advisory committees. The CalOptima Board established the Member Advisory Committee and Provider Advisory Committee by resolution on February 14, 1995 to serve solely in an advisory capacity providing input and recommendations concerning the CalOptima program. The Board established the OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee by resolution on February 5, 2015 to provide input and recommendations to the CalOptima Board relative to the OneCare Connect program, which is the Cal MediConnect program administered by CalOptima.

The MAC is comprised of fifteen voting members, including two standing members - a representative each from the Health Care Agency and the Social Services Agency. The OCC MAC is comprised of ten voting members, seven of whom represent community seats and three of whom are OneCare Connect members or family of members. There are also four non-voting liaison members representing Orange County agencies. The PAC is comprised of fifteen voting members; the PAC includes one standing member - a representative from the Health Care Agency. The CalOptima Board is responsible for the appointment of all advisory committee members.

Pursuant to the MAC and PAC Resolution No. 95-0214 and the OCC MAC Resolution No. 15-02-05, the CalOptima Board is also responsible for the annual appointment of committee chairs, who may serve two consecutive one-year terms.

Discussion

To ensure consistent committee administration (e.g., such as when a committee chair is unable to attend a committee or Board meeting), representatives from each of the three advisory committees met and recommend the addition of a vice chair position in each committee. As with membership and committee chair appointments, committee vice chairs would be appointed by the Board annually from among the existing MAC, OCC MAC, and PAC members. Adding the vice chair positions would not

Back to Agenda

increase membership on these committees. If the positions are added and filled, the respective committee vice chairs would serve as alternates for the committee chairs when a committee chair is unable to attend a committee meeting or present the committee report at a Board meeting. Consistent with current policy regarding committee chairs, it is proposed that the vice chairs would be eligible to serve up to two consecutive one-year terms, effective upon Board appointment. Terms would typically be tied to the fiscal year, ending on June 30.

If the proposed addition of MAC, OCC MAC, and PAC committee vice chair positions is approved, the following CalOptima policies would be updated accordingly:

- CMC.1007: OneCare Connect Member Advisory Committee;
- AA.1219a: Member Advisory Committee; and
- AA.1219b: Provider Advisory Committee.

Fiscal Impact
There is no fiscal impact for this proposed action.

Rationale for Recommendation
The advisory committee members propose the addition of vice chair positions to the MAC, OCC MAC and PAC advisory committees to assist the respective committee chairs in fulfilling their responsibilities to each respective advisory committee under circumstances when the committee chairs are unavailable to perform their duties.

Concurrence
Member Advisory Committee
OneCare Connect Member Advisory Committee
Provider Advisory Committee
Gary Crockett, Chief Counsel

Attachments
Resolution No. 16-0804-01

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

RESOLUTION NO. 16-0804-01

RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY
d.b.a. Orange Prevention and Treatment Integrated Medical Assistance
d.b.a. CalOptima

APPROVE THE ADDITION OF VICE CHAIR POSITIONS TO THE CALOPTIMA BOARD OF DIRECTORS' MEMBER ADVISORY COMMITTEE, ONECARE CONNECT MEMBER ADVISORY COMMITTEE AND PROVIDER ADVISORY COMMITTEE

WHEREAS, the CalOptima Board of Directors established the Member Advisory Committee (MAC) and the Provider Advisory Committee (PAC) pursuant to Resolution No. 95-0214 to represent the constituencies served by CalOptima and to advise the Board of Directors; and

WHEREAS, the Board established the OneCare Connect Member Advisory Committee (OCC MAC) pursuant to Resolution No. 15-0205 to represent the constituencies served by the OneCare Connect program (the Cal MediConnect program administered by CalOptima), and to advise the Board of Directors; and

WHEREAS, the Resolution No. 95-0214was amended to add a Consumer representative to the MAC pursuant to Resolution No. 11-1103 to provide direct representation of a recipient of CalOptima's services and later amended to modify a seat for a Family Support representative pursuant to Resolution No. 13-0307 to provide representation of families and the interests of children; and again amended to add a position, change the term limits and rename certain seats to the PAC pursuant to Resolution No. 15-0806-02; and

WHEREAS, members of the MAC, OCC MAC and PAC recommend the addition of vice chair positions to each of the three advisory committees to assist the Board-appointed committee chairs in ensuring smooth and streamlined committee administration,.

NOW, THEREFORE, BE IT RESOLVED:

That the Board of Directors hereby approves and adopts the addition of vice chair positions to the MAC, PAC and OCC MAC, with appointments to the vice chair positions to be made by the Board from among advisory committee members, with initial committee vice chairs to be appointed by the Board on or after August 4, 2016.

Back to Agenda

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 4th day of August 2016.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Mark A. Refowitz, Chair, CalOptima Board of Directors

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

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Ratify Agreement 16-93274 with the California Department of Health Care Services (DHCS)

Contact

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

Recommended Action

Ratify Agreement 16-93274 between CalOptima and 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 new five (5) year Primary and Secondary Agreements with DHCS that have been subsequently extended and amended. Amendments to these agreements are summarized in the attached appendix. In August 2014, your Board ratified the execution of Amendment 19 to the Primary Agreement, which 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). The Agreements contain, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

Agreement 16-93274

Since March 2016, CalOptima staff has had numerous discussions and communications with DHCS regarding the status of DHCS' issuance of an amendment to extend the termination date of the Primary Agreement from December 31, 2016 to December 31, 2017. As part of the discussions, CalOptima staff noted the requirement of the Centers for Medicare & Medicaid Services (CMS) that plans renewing their Dual Eligible Special Needs Plan (D-SNP) programs must submit evidence of a **Medicare Improvements for Patients and Providers Act** (MIPPA) - compliant Medicaid contract for the 2017 contract year no later than July 1, 2016.

At the June 2, 2016 meeting, your Board authorized the extension of CalOptima's Primary Agreement with DHCS, in part to meet the CMS filing deadline described above. Based on discussions with DHCS, CalOptima expected to receive a simple extension of the term of the Primary Agreement with DHCS for Medi-Cal for one year, to December 31, 2017. Without prior notice, on June 21, 2016, DHCS took an alternative course of action to enable CalOptima to meet is CMS filing deadline. DHCS deferred its extension of the Primary Agreement to later in the year, and instead chose to extract some language from the Primary Agreement and place it in a standalone contract–Agreement 16-93274–for calendar year 2017.

Back to Agenda

The language in the new Agreement 16-93274 is extracted from Attachment 23 of CalOptima's Primary Agreement. The language was previously approved by your Board in August 2014 in its ratification of Amendment 19 to the Primary Agreement. DHCS has chosen to make this language stand alone as its own contract for the term January 1, 2017 to December 31, 2017. This language incorporates provisions related to MIPPA-compliant contracts, and as such the submission of Agreement 16-93274 allowed CalOptima to meet its CMS filing deadline, a necessary filing to be able to operate CalOptima's D-SNP, OneCare.

In summary, DHCS' decision to extract the language from Attachment 23 of the Primary Agreement and place it in Agreement 16-93274 for calendar year 2017 simply reorganizes the location of the language that was previously approved by your Board, and does not include substantial changes.

Fiscal Impact
The recommended action to ratify Agreement 16-93274 between CalOptima and DHCS is projected to be budget neutral to CalOptima.

Rationale for Recommendation
The signing of Agreement 16-93274 was necessary to ensure CalOptima met the CMS requirements in order for CalOptima to operate the OneCare and OneCare Connect programs in calendar year 2017. The ratification of the Agreement will ensure compliance with CalOptima's obligations as a public agency.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix Summary of Amendments to Primary and Secondary Agreements with DHCS

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 4

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.	December 9, 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

Back to Agenda

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
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015

Back to Agenda

A-26 . adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 incorporates the Hospital Quality Assurance Fee (QAF) into CalOptima's Optional Expansion rates for the period January 1, 2014 to June 30, 2014.	May 7, 2015

Back to Agenda

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)
A-05 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 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) April 7, 2016 (Ratification)

Back to Agenda

CalOptima Board Action Agenda Referral

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Revising the Membership of the CalOptima Board of Directors' Finance and Audit Committee and the Board of Directors' Quality Assurance Committee

Contact

Michael Schrader, Chief Executive Officer, (714) 246-8400

Recommended Actions

Reduce the size of the CalOptima Board of Directors':

1. Finance and Audit Committee from four to three seats; and
2. Quality Assurance Committee from five to four seats.

Background/Discussion

On March 12, 1996, the Board of Directors established the Finance and Quality Assurance Committees consisting of three Board members appointed by the CalOptima Board Chair. The Finance Committee was charged with oversight responsibilities for all financial matters affecting CalOptima. In November 2009, the Board changed the Finance Committee title to the Board of Directors' Finance and Audit Committee (FAC) and expanded the scope of responsibilities to include audit oversight. In April 2010, the Board expanded the size of the FAC to four Board members.

The Board of Directors' Quality Assurance Committee (QAC) membership is charged with oversight responsibilities related to the overall quality of CalOptima's healthcare programs. In June 2012, the Board expanded the membership of the Committee to four (4) members due to increasing regulatory quality requirements that require review by this Committee. In light of CalOptima's growth and business requirements, the Board approved the expansion of this Committee to five (5) members.

These changes were implemented as a result of changes to the composition/size of the CalOptima Board of Directors. Based on the reduction in the size of the CalOptima Board from 11 to nine voting members effective August 4, 2016, it is recommended that the size of the FAC be reduced to three seats, and the QAC to four seats, with each committee comprised of members of the Board of Directors.

Fiscal Impact

None

Rationale for Recommendation

The recommended action will bring the Finance and Audit Committee and Quality Assurance Committee into alignment with the current Board membership.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments
None

/s/ Michael Schrader *07/29/2016*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Authorize Issuance of a Request for Proposal for Consulting Services to Conduct a Compensation Study

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400
Katia Taylor, Interim Director, Human Resources, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO) to issue a Request for Proposal (RFP) for consulting services to conduct a compensation study and accept proposals from qualified firms.

Background/Discussion

At its April 4, 2013, meeting the CalOptima Board of Directors approved the recommended compensation survey consultant, Pearl Meyer & Partners, and authorized the CEO to execute a contract to assist in the development of CalOptima's compensation program. The total cost to update and implement the compensation program was estimated at $180,000. In addition, a Board ad hoc committee was formed to oversee the compensation study.

The contract included three specific deliverables:

- Compensation Philosophy: A statement which reflects a balanced approach that is fair and equitable to employees, recognizes CalOptima's public agency status, and can be administered by the CEO on a consistent basis. At the August 1, 2013, meeting, the Board adopted the CalOptima Compensation Philosophy;

- Total Rewards Review: An independent review and survey of CalOptima's current compensation structure and comparison to labor market benchmarks and peer organizations. At the December 5, 2013, meeting, the Board received a progress report on the Total Rewards Review, and approved proposed revisions to the Paid Time Off (PTO) Policy; and

- Compensation Administration Guidelines: A document that defines the principles upon which CalOptima's compensation practices are to be managed, the procedural aspects of how compensation is to be administered, and how the overall compensation administration function will respond to changing market conditions and business demands to compete for and retain talent, including conducting follow up salary surveys on a regular basis in the future to ensure that CalOptima remains current and competitive with its compensation practices. At its March 6, 2014, meeting, the Board received the report on the Total Rewards Review, and approved the proposed Compensation Administration Guidelines.

Back to Agenda

Since the last compensation study was completed in 2013-2014, market demand for skilled and competent employees in health care has grown increasingly competitive. In order to ensure that CalOptima remains competitive with other organizations for human capital, Management recommends conducting an updated compensation study, including both salary and benefits.

Consistent with the Pearl Myer guidelines, staff plans to develop an RFP for consulting services to conduct a compensation study in August 2016, with a target selection of a consultant in mid-September 2016. As proposed, the RFP evaluation team will make a recommendation to the CEO on which vendor to select based on the evaluation results.

Fiscal Impact
There are no costs associated with the recommended action to authorize the CEO to issue an RFP for consulting services to conduct a salary and benefits survey and accept proposals from qualified firms. Once a review and evaluation of all proposals have been completed and a suitable firm is selected, Staff will return to the Board upon the completion of the RFP process to approve the selected firm and request funding for the contract.

Rationale for Recommendation
Results from the compensation study will enable CalOptima to update and revise its compensation structure to increase operational efficiencies, simplify administrative procedures, ensure equitability by job classification, and facilitate employee career growth.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Appoint Directors to the CalOptima Foundation Board of Directors

Contact

Michael Schrader, Chief Executive Officer, (714) 246-8400

Recommended Actions

1. Appoint the following members to the Foundation Board of Directors of the CalOptima Foundation:
    - Ria Berger
    - Ron DiLuigi
    - Dr. Nikan Khatibi
    - Alexander Nguyen, M.D.
    - J. Scott Schoeffel
    - Paul Yost, M.D.

2. The following members shall continue to serve on the Board of Directors of the CalOptima Foundation:
    - Mark Refowitz, Chairperson
    - Lee Penrose, Vice Chairperson
    - Supervisor Lisa Bartlett
    - Supervisor Andrew Do

Background and Discussion

The Bylaws of the CalOptima Foundation provide that the initial members of the Board of Directors of CalOptima Foundation are the Board of Directors of CalOptima until their successors have been elected and seated. The Foundation Bylaws also provide that the CalOptima Foundation Board of Directors shall be elected by the Foundation's Sole Statutory Member, which is CalOptima. To date, members of the CalOptima Board have served as members of the Foundation Board. Until such time as the CalOptima Board of Directors establishes a different structure for the Foundation Board, it is recommended that the Foundation Board continue to be comprised of the members of the CalOptima Board of Directors.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

Pursuant to the Bylaws of the Foundation, CalOptima as the Sole Statutory Member of the CalOptima Foundation elects the members of the Board of Directors of the Foundation.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Ratification of Medi-Cal Expansion (MCE) Member Rate Change for CalOptima Community Network Specialist Physicians and Contract Amendments Implementing the Rate Change and Aligning Contract Expiration Dates with CalOptima's Fiscal Year End

Contact

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

Recommended Actions

1. Ratify change of the reimbursement rates for CalOptima Community Network Specialists for services rendered to Medi-Cal Expansion (MCE) member to 156% of the CalOptima Medi-Cal fee schedule, effective July 1, 2016; and
2. Ratify contact amendments with existing Community Network Specialists and contracts with new Community Network Specialists to implement the rate change and align contract expiration dates with CalOptima's fiscal year end.

Background/Discussion

In support of MCE, the Board on November 7, 2013, approved the distribution of enhanced federal funding received from the California Department of Health Care Services (DHCS), to contracted Specialists. CalOptima, in order to maintain the higher funding level for Expansion Members, was obligated to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014, and DHCS gradually reduced the level of MCE monies to CalOptima. The Board subsequently approved a reduction in Specialist rates on September 3, 2015.

Until June 30, 2016, contracted Specialists were compensated at 38% over the Community Network Medi-Cal Specialist physician contracted fee-for-service (FFS) rate. As a result of draft MCE rates provided by DHCS, staff is seeking Board ratification of a rate change reflected in contract amendments executed with the specialist contracted to provide services for MCE members to reflect the rates approved by the Board at its May 5, 2016 meeting. The revised rate is equal to 156% of the CalOptima Medi-Cal fee schedule and is a 15% reduction from the prior rate and is based on rates provided to CalOptima by DHCS. The change was reflected in the Fiscal Year (FY) 2016-17 Operating which was approved by the CalOptima Board on June 2, 2016.

The current contracts with Specialists specify that contracts become effective when fully executed, and remain in effect for a one-year term, with renewal for additional one-year terms effective upon approval by the CalOptima Board of Directors. This structure results in variable effective and expiration dates throughout the year, and variable timeframes under which amendments are effective.

To enhance consistency and streamline processes, staff proposes to align all CCN Specialist contracts with CalOptima's fiscal year, with terms of up to one year for newly contracted providers from the

Back to Agenda

effective date until the following June 30. Renewals will then be effective based on Board approval, for July 1 through June 30 terms. Existing contracts were amended to include the revised term language when they were amended for the modification in the MCE rates.

Fiscal Impact
Management has included the impact of adjustments associated with the revised specialist rates in the CalOptima FY 2016-17 Operating Budget approved by the Board on June 2, 2016. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the recommended actions.

Rationale for Recommendation
The amendment to the Specialist contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Rate Increase for CalOptima Community Network Primary Care Physicians (PCPs), except for St. Joseph Health Entities and Affiliates, for Services Provided to Medi-Cal Members and Contract Amendments Implementing the Rate Increase and Aligning Contract Expiration Dates with CalOptima's Fiscal Year End

Contact

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

Recommended Actions

1. Authorize increase of the reimbursement rates for CalOptima Community Network Primary Care Physicians (PCP) except for St. Joseph Health entities and affiliates, for services rendered to Medi-Cal Members to 129% of the CalOptima Medi-Cal fee schedule, effective July 1, 2016; and
2. Authorize contract amendments with existing Community Network PCPs, except for St. Joseph Health entities and affiliates, and contracts with new Community Network PCPs to implement the rate increase and align contract expiration dates with CalOptima's fiscal year end.

Background/Discussion

On January 1, 2011, CalOptima launched a direct network called the CalOptima Care Network. This network contracted directly with providers to serve members – a departure from CalOptima's previous strategy of assigning members to delegated Health Networks. In 2013, the CalOptima Care Network was renamed the CalOptima Community Network (CCN).

Since the inception of the program, PCPs have been compensated at 123% of the CalOptima Medi-Cal fee schedule. In addition, CCN providers have received a $1.00 per member per month (PMPM) case management fee paid semi-annually for each member assigned to the PCP.

Staff is requesting Board approval to increase the percent paid based on the CalOptima Medi-Cal fee schedule PCPs receive effective July 1, 2016, which is funded by the trend increase accounted for in the FY 2016-17 Operating Budget. Staff also proposes to incorporate the $1.00 PMPM case management fee into the overall PCP fee schedule and include it as part of the proposed percentage change.

The Fiscal Year (FY) 2016-17 Operating Budget approved by the Board on June 2, 2016, includes a 4% increase in PCP reimbursement for Medi-Cal Classic (i.e., non-Expansion Medi-Cal) members. The FY 2016-17 budget does not include an increase related to the Medi-Cal Expansion (MCE) population. To avoid a situation in which PCPs are paid a different (i.e., lower) rate for Expansion members than for Classic members, staff is proposing to maintain a uniform reimbursement rate for both Medi-Cal Classic and Expansion members. To achieve this result, staff is proposing to apply the budgeted increase across both Medi-Cal Classic and Expansion populations, which results in a blended increase to PCPs of 2.85% for both populations. In addition, the $1.00 PMPM case management fee is

Back to Agenda

equivalent to an increase of approximately 2.0% to the current PCP fee schedule rate. Combining both the budgeted rate increase and the case management fee, staff is proposing an increase in compensation to PCPs to 129% of the CalOptima Medi-Cal fee schedule.

The current contracts with CCN PCPs specify that the contracts become effective when fully executed, and remain in effect for a one-year term, with renewal for additional one-year terms effective upon approval by the CalOptima Board of Directors. This structure results in having effective and expiration dates throughout the year, and variable timeframes under which providers contracts are effective as well as variable terms under which amendments may become effective. To enhance consistency and streamline processes, staff proposes to align all CCN PCP contracts with CalOptima's fiscal year, with terms of up to one year for newly contracted providers from the effective date until the following June 30. Renewals will then be effective based on Board approval, for July 1 through June 30 terms. Existing contracts will be amended to include the revised term language when they are amended for other contractual revisions in the ordinary course of business.

Fiscal Impact
The recommended action of increasing rates for CalOptima Community Network Primary Care Physicians for services rendered to Medi-Cal Members is in line with rates included in the CalOptima FY 2016-17 Operating Budget. The total annual increase to fee-for-service PCP expenses is budgeted to be $1.0 million.

The planned inclusion of the $1.00 PMPM case management fee as part of the overall PCP fee schedule is projected to be budget neutral to CalOptima. This is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The value of the 2% increase to the PCP fee schedule was calculated to be equivalent to the annual funding for the case management fee, which was approximately $715,000 in the prior applicable year.

Rationale for Recommendation
The proposed amendments to the PCPs contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *07/29/2016*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing Rate Increase for CalOptima Community Network St. Joseph Health Entities and Affiliates, Primary Care Physicians (PCPs), for Services Provided to Medi-Cal Members and Contract Amendments Implementing the Rate Increase and Aligning Contract Expiration Dates with CalOptima's Fiscal Year End

Contact

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

Recommended Actions

1. Authorize increase of the reimbursement rates for CalOptima Community Network St. Joseph Health entities and affiliates, Primary Care Physicians (PCP), for services rendered to Medi-Cal Members to 129% of the CalOptima Medi-Cal fee schedule, effective July 1, 2016; and
2. Authorize contract amendments with existing Community Network, St. Joseph Health entities and affiliates PCPs, and contracts with new Community Network PCPs to implement the rate increase and align contract expiration dates with CalOptima's fiscal year end.

Background/Discussion

On January 1, 2011, CalOptima launched a direct network called the CalOptima Care Network. This network contracted directly with providers to serve members – a departure from CalOptima's previous strategy of assigning members to delegated Health Networks. In 2013, the CalOptima Care Network was renamed the CalOptima Community Network (CCN).

Since the inception of the program, PCPs have been compensated at 123% of the CalOptima Medi-Cal fee schedule. In addition, CCN providers have received a $1.00 per member per month (PMPM) case management fee paid semi-annually for each member assigned to the PCP.

Staff is requesting Board approval to increase the percent paid based on the CalOptima Medi-Cal fee schedule PCPs receive effective July 1, 2016 which is funded by the trend increase accounted for in the FY 2016-17 Operating Budget. Staff also proposes to incorporate the $1.00 PMPM case management fee into the overall PCP fee schedule and include it as part of the proposed percentage change.

The Fiscal Year (FY) 2016-17 Operating Budget approved by the Board on June 2, 2016, includes a 4% increase in PCP reimbursement for Medi-Cal Classic (i.e., non-Expansion Medi-Cal) members. The FY 2016-17 budget does not include an increase related to the Medi-Cal Expansion (MCE) population. To avoid a situation in which PCPs are paid a different (i.e., lower) rate for Expansion members than for Classic members, staff is proposing to maintain a uniform reimbursement rate for both Medi-Cal Classic and Expansion members. To achieve this result, staff is proposing to apply the budgeted increase across both Medi-Cal Classic and Expansion populations, which results in a blended increase to PCPs of 2.85% for both populations. In addition, the $1.00 PMPM case management fee is equivalent to an increase of approximately 2.0% to the current PCP fee schedule rate. Combining both

Back to Agenda

the budgeted rate increase and the case management fee, staff is proposing an increase in compensation to PCPs to 129% of the CalOptima Medi-Cal fee schedule.

The current contracts with CCN PCPs specify that the contracts become effective when fully executed, and remain in effect for a one-year term, with renewal for additional one-year terms effective upon approval by the CalOptima Board of Directors. This structure results in having effective and expiration dates throughout the year, and variable timeframes under which providers contracts are effective as well as variable terms under which amendments may become effective. To enhance consistency and streamline processes, staff proposes to align all CCN PCP contracts with CalOptima's fiscal year, with terms of up to one year for newly contracted providers from the effective date until the following June 30. Renewals will then be effective based on Board approval, for July 1 through June 30 terms. Existing contracts will be amended to include the revised term language when they are amended for other contractual revisions in the ordinary course of business.

Fiscal Impact
The recommended action of increasing rates for CalOptima Community Network Primary Care Physicians for services rendered to Medi-Cal Members is in line with rates included in the CalOptima FY 2016-17 Operating Budget. The total annual increase to fee-for-service PCP expenses is budgeted to be $1.0 million.

The planned inclusion of the $1.00 PMPM case management fee as part of the overall PCP fee schedule is projected to be budget neutral to CalOptima. This is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The value of the 2% increase to the PCP fee schedule was calculated to be equivalent to the annual funding for the case management fee, which was approximately $715,000 in the prior applicable year.

Rationale for Recommendation
The proposed amendments to the PCPs contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Ratification of Rate Adjustments to Medi-Cal Fee-For-Service Hospital Inpatient Rates, Except for the Entities and Affiliates of Kindred Hospitals, St. Joseph Health, and UC Irvine Medical Center, for Classic (Non-Expansion) Medi-Cal Members; Rate Adjustments for Hospitals Reimbursed using the All Patient Refined Diagnosis Related Group (APR-DRG) Methodology for Medi-Cal Expansion Members; and Contract Amendments Implementing these Rate Changes

Contact

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

Recommended Actions

Ratify:

1. An increase of 4% to the inpatient rates for hospital fee-for-service Classic (non-Expansion) Medi-Cal member rates except for the entities and affiliates of Kindred Hospitals, St. Joseph Health, and UC Irvine Medical Center, effective July 1, 2016;
2. Effective July 1, 2016, revision of Medi-Cal Expansion rates to hospitals reimbursed based using the APR-DRG methodology to 2% above their pre July 1, 2016 levels; and
3. Contract amendments to implement these rate changes.

Background/Discussion

The FY 2016-2017 CalOptima Operating budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in hospital medical costs.

As part of the 2014 implementation of Medi-Cal Expansion (MCE), the California Department of Health Care Services (DHCS) provided increased funding to health plans, including CalOptima, for members who were newly eligible for Medi-Cal (also known as "MCE" members).

Since 2014, CalOptima has received separate Medi-Cal per-member-per-month (PMPM) funding amounts from DHCS for MCE members, which were different than the capitation rates received for Classic or non-MCE members.

Over time, based on actual enrollment and utilization data, DHCS has reduced the PMPM funding for MCE members in order to more accurately reflect the actual costs experienced by health plans for services rendered to MCE members.

As a result of these PMPM reductions, CalOptima has made a series of adjustments to the rates paid to its contracted health networks, hospitals, and specialists for services rendered to MCE members. The MCE rates paid to hospitals were set to expire on June 30, 2016. At its May 5, 2016, meeting, the CalOptima Board approved a revision to these expiring rates.

Back to Agenda

Over the same time period that CalOptima made adjustments to MCE rates paid to contracted hospitals, several hospitals began transitioning from per diem payments to an APR-DRG-based methodology. This overlap resulted in the following:

- The shift in reimbursement methodology resulted in varying rate increases due to factors, such as each hospital's specific case mix.
- Based on draft and final MCE rates received from DHCS, CalOptima made corresponding adjustments to both per diem and APR-DRG rates to ensure that appropriate payment adjustments were made to all contracted hospitals.
- Initial MCE rate adjustments were derived from base data that was in existence prior to the implementation of APR-DRG rates for some hospitals. Had the increased hospital expenses resulting from the change to APR-DRG rates been included in the base data, the resulting MCE adjustment would have been effectively smaller.

With these considerations in mind, CalOptima attempted to ensure that adjustments applied to hospital MCE rates would impact all contracted hospitals equitably.

Based on continuing rate reductions for the MCE population from the state, the Board authorized reductions in payment rates to all hospitals for MCE members by 15% at its May 5, 2016 meeting, effective July 1, 2016. On further review, management now recommends revising the MCE rates for hospitals contracted for MCE members that are reimbursed using the APR-DRG methodology to their levels immediately prior to implementation the referenced May 5, 2016 Board action, and increasing the MCE payment rates by 2% above these levels, effective July 1, 2016. This action will keep MCE payment rate adjustments in line with those received by non-APR-DRG contracted hospitals, and will result in all contracted hospitals receiving comparable MCE rate adjustments.

Fiscal Impact

The recommended action to increase the current FFS hospital inpatient Medi-Cal rates by 4% for services to non-MCE members is projected to be $6.8 million. The recommended action to implement a 2% increase to MCE rates for hospitals contracted for MCE members that are reimbursed on an APR-DRG methodology, and suspend the 15% rate decrease is projected to be $7.8 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the recommended actions.

Rationale for Recommendation

The proposed amendment to the hospital contracts will support the stability of CalOptima's contracted provider delivery system that continues to grow significantly. Contract language allows CalOptima and the providers to terminate the contracts with or without cause.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Ratification of Rate Adjustments to Medi-Cal Fee-For-Service Hospital Inpatient Rates for UC Irvine Medical Center, for Classic (Non-Expansion) Medi-Cal Members; Rate Adjustments for Hospitals Reimbursed using the All Patient Refined Diagnosis Related Group (APR-DRG) Methodology for Medi-Cal Expansion Members as applicable; and Contract Amendments Implementing These Rate Changes

Contact

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

Recommended Actions

Ratify:

1. An increase of 4% to the inpatient rates for hospital fee-for-service Classic (non-Expansion) Medi-Cal member rates for UC Irvine Medical Center effective July 1, 2016;
2. Effective July 1, 2016, revision of Medi-Cal Expansion rates to hospitals reimbursed based using the APR-DRG methodology to 2% above their pre July 1, 2016 levels as applicable; and
3. Contract amendments to implement these rate changes.

Background/Discussion

The FY 2016-2017 CalOptima Operating budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in hospital medical costs.

As part of the 2014 implementation of Medi-Cal Expansion (MCE), the California Department of Health Care Services (DHCS) provided increased funding to health plans, including CalOptima, for members who were newly eligible for Medi-Cal (also known as "MCE" members).

Since 2014, CalOptima has received separate Medi-Cal per-member-per-month (PMPM) funding amounts from DHCS for MCE members, which were different than the capitation rates received for Classic or non-MCE members.

Over time, based on actual enrollment and utilization data, DHCS has reduced the PMPM funding for MCE members in order to more accurately reflect the actual costs experienced by health plans for services rendered to MCE members.

As a result of these PMPM reductions, CalOptima has made a series of adjustments to the rates paid to its contracted health networks, hospitals, and specialists for services rendered to MCE members. The MCE rates paid to hospitals were set to expire on June 30, 2016. At its May 5, 2016, meeting, the CalOptima Board approved a revision to these expiring rates.

Back to Agenda

Over the same time period that CalOptima made adjustments to MCE rates paid to contracted hospitals, several hospitals began transitioning from per diem payments to an APR-DRG-based methodology. This overlap resulted in the following:

- The shift in reimbursement methodology resulted in varying rate increases due to factors, such as each hospital's specific case mix.
- Based on draft and final MCE rates received from DHCS, CalOptima made corresponding adjustments to both per diem and APR-DRG rates to ensure that appropriate payment adjustments were made to all contracted hospitals.
- Initial MCE rate adjustments were derived from base data that was in existence prior to the implementation of APR-DRG rates for some hospitals. Had the increased hospital expenses resulting from the change to APR-DRG rates been included in the base data, the resulting MCE adjustment would have been effectively smaller.

With these considerations in mind, CalOptima attempted to ensure that adjustments applied to hospital MCE rates would impact all contracted hospitals equitably.

Based on continuing rate reductions for the MCE population from the state, the Board authorized reductions in payment rates to all hospitals for MCE members by 15% at its May 5, 2016 meeting, effective July 1, 2016. On further review, management now recommends revising the MCE rates for hospitals contracted for MCE members that are reimbursed using the APR-DRG methodology to their levels immediately prior to implementation the referenced May 5, 2016 Board action, and increasing the MCE payment rates by 2% above these levels, effective July 1, 2016. This action will keep MCE payment rate adjustments in line with those received by non-APR-DRG contracted hospitals, and will result in all contracted hospitals receiving comparable MCE rate adjustments.

Fiscal Impact

The recommended action to increase the current FFS hospital inpatient Medi-Cal rates by 4% for services to non-MCE members is projected to be $6.8 million. The recommended action to implement a 2% increase to MCE rates for hospitals contracted for MCE members that are reimbursed on an APR-DRG methodology, and suspend the 15% rate decrease is projected to be $7.8 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the recommended actions.

Rationale for Recommendation

The proposed amendment to the hospital contracts will support the stability of CalOptima's contracted provider delivery system that continues to grow significantly. Contract language allows CalOptima and the providers to terminate the contracts with or without cause.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

13. Consider Ratification of Rate Adjustments to Medi-Cal Fee-For-Service Hospital Inpatient Rates for St. Joseph Health Entities and Affiliates, for Classic (Non-Expansion) Medi-Cal Members; Rate Adjustments for Hospitals Reimbursed using the All Patient Refined Diagnosis Related Group (APR-DRG) Methodology for Medi-Cal Expansion Members; and Contract Amendments Implementing These Rate Changes

Contact

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

Recommended Actions

Ratify:

1. An increase of 4% to the inpatient rates for hospital fee-for-service Classic (non-Expansion) Medi-Cal member rates for the St. Joseph Health entities and affiliates, effective July 1, 2016;
2. Effective July 1, 2016, revision of Medi-Cal Expansion rates to hospitals reimbursed based using the APR-DRG methodology to 2% above their pre July 1, 2016 levels; and
3. Contract amendments to implement these rate changes.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in hospital medical costs.

As part of the 2014 implementation of Medi-Cal Expansion (MCE), the California Department of Health Care Services (DHCS) provided increased funding to health plans, including CalOptima, for members who were newly eligible for Medi-Cal (also known as "MCE" members).

Since 2014, CalOptima has received separate Medi-Cal per-member-per-month (PMPM) funding amounts from DHCS for MCE members, which were different than the capitation rates received for Classic or non-MCE members.

Over time, based on actual enrollment and utilization data, DHCS has reduced the PMPM funding for MCE members in order to more accurately reflect the actual costs experienced by health plans for services rendered to MCE members.

As a result of these PMPM reductions, CalOptima has made a series of adjustments to the rates paid to its contracted health networks, hospitals, and specialists for services rendered to MCE members. The MCE rates paid to hospitals were set to expire on June 30, 2016. At its May 5, 2016, meeting, the CalOptima Board approved a revision to these expiring rates.

Back to Agenda

Over the same time period that CalOptima made adjustments to MCE rates paid to contracted hospitals, several hospitals began transitioning from per diem payments to an APR-DRG-based methodology. This overlap resulted in the following:

- The shift in reimbursement methodology resulted in varying rate increases due to factors, such as each hospital's specific case mix.
- Based on draft and final MCE rates received from DHCS, CalOptima made corresponding adjustments to both per diem and APR-DRG rates to ensure that appropriate payment adjustments were made to all contracted hospitals.
- Initial MCE rate adjustments were derived from base data that was in existence prior to the implementation of APR-DRG rates for some hospitals. Had the increased hospital expenses resulting from the change to APR-DRG rates been included in the base data, the resulting MCE adjustment would have been effectively smaller.

With these considerations in mind, CalOptima attempted to ensure that adjustments applied to hospital MCE rates would impact all contracted hospitals equitably.

Based on continuing rate reductions for the MCE population from the state, the Board authorized reductions in payment rates to all hospitals for MCE members by 15% at its May 5, 2016 meeting, effective July 1, 2016. On further review, management now recommends revising the MCE rates for hospitals contracted for MCE members that are reimbursed using the APR-DRG methodology to their levels immediately prior to implementation the referenced May 5, 2016 Board action, and increasing the MCE payment rates by 2% above these levels, effective July 1, 2016. This action will keep MCE payment rate adjustments in line with those received by non-APR-DRG contracted hospitals, and will result in all contracted hospitals receiving comparable MCE rate adjustments.

Fiscal Impact
The recommended action to increase the current FFS hospital inpatient Medi-Cal rates by 4% for services to non-MCE members is projected to be $6.8 million. The recommended action to implement a 2% increase to MCE rates for hospitals contracted for MCE members that are reimbursed on an APR-DRG methodology, and suspend the 15% rate decrease is projected to be $7.8 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the recommended actions.

Rationale for Recommendation
The proposed amendment to the hospital contracts will support the stability of CalOptima's contracted provider delivery system that continues to grow significantly. Contract language allows CalOptima and the providers to terminate the contracts with or without cause.

Concurrence
Gary Crockett, Chief Counsel

Back to Agenda

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

Continued to Future Board of Directors Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
14. Consider Authorizing Policy Modifications to Eliminate Specialist Physician Aggregate Reimbursement Rate Requirement for Health Networks

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

Recommended Action
Authorize the Chief Executive Officer (CEO) to amend policies to eliminate the requirement for health networks to reimburse specialist physicians at a specific rate in aggregate.

Background
Since July 30, 1997, the CalOptima Board of Directors (Board) established policy to reimburse specialist physicians above the standard Medi-Cal rates in order to ensure access to specialty care. CalOptima funds its contracted Medi-Cal health networks accordingly and expects the health networks to reimburse its specialist physicians at rates higher than the Medi-Cal fee schedule. Throughout the years, the Board has made modifications to this health network requirement in order to accommodate access needs, industry changes in physician reimbursement trends, and changes in CalOptima member demographics. Currently, the health networks are required to reimburse specialist physicians, in the aggregate, at least 156% of the Medi-Cal fee schedule for services rendered to CalOptima Medi-Cal members identified with a Medi-Cal Expansion aid code. Health networks are required to reimburse specialist physicians, in the aggregate, at an amount equal or greater than 133% of the Medi-Cal fee schedule for all other CalOptima Medi-Cal members.

CalOptima's health networks are comprised of three different delivery models: Physician-Hospital Consortia (PHC), Share Risk Group (SRG) and Health Care Services Plans (Health Plans). Each health network receives capitation on a monthly basis. The capitation payment is paid to the health network for the delivery of covered services, including specialty services, and is adjusted for member aid code, age, and gender. Currently, the health networks maintain different minimum compensation levels for their specialist physicians for their members who qualify for Medi-Cal through Medi-Cal Expansion and traditional Medi-Cal. In subsequent discussions, the health networks have raised concerns about the current reimbursement methodology for specialist physicians as these services are no longer reimbursed solely on a fee-for-service basis. Many health networks are converting from a pay-for-volume to a pay-for-value reimbursement system. As a result, administering the different reimbursement methodologies has become administratively burdensome and restrictive

Discussion
CalOptima currently contracts with 14 Medi-Cal health networks. Each network has developed its own network of specialist physicians. Reimbursement to these physicians has become more complex as the health care industry, as a whole, has migrated away from the traditional fee-for-service system. The Centers for Medicare & Medicaid Services (CMS) is encouraging the health care industry to move

Back to Agenda

away from volume-based fee-for-service payments towards value-based payment models. For example, CMS has launched alternative payment models for certain specialties, including oncology, end stage renal disease, and cardiovascular disease. These new payment models incorporate bundled payment systems and performance based incentives. Similarly, many health networks have developed uniquely different reimbursement structures that can include fee-for-service, bundled payments, case rates, and specialty capitation.

Consequently, CalOptima's current reimbursement criteria for specialist physicians is no longer in-line with industry trends, are cumbersome to administer, and does not provide the health networks flexibility to implement pay-for-value programs. Therefore, effective July 1, 2016, Management proposes to eliminate the health network requirement for specialist physician reimbursement at a specific rate in aggregate. This requirement no longer reflects the initial premise for ensuring appropriate access to specialty care services as health networks have moved away from an exclusive fee-for-service payment methodology. While the removal of this requirement allows health networks more flexibility to develop varying reimbursement arrangements, the current capitation rate paid by CalOptima for Medi-Cal expansion members is in line with the funding of the CalOptima Care Network (CCN) and is anticipated to be sufficient to support reimbursement of specialist physicians at 156% of the Medi-Cal fee schedule assuming current utilization levels. CalOptima will monitor the health networks through the medical loss ratio (MLR) audits. MLR is a common financial metric used throughout the managed health care industry to define the ratio of medical costs incurred to premium/capitation revenue received. During the MLR audits, health network medical costs will be evaluated to ensure the appropriateness of provider payments and medical expense allocations based on CMS MLR guidelines.

Fiscal Impact
There is no anticipated fiscal impact. The recommended action to eliminate the health network requirement to reimburse specialist physicians at a specific rate, in aggregate is not expected to result in a change to the current Medi-Cal Expansion health network capitation expenses.

Rationale for Recommendation
Eliminating the current specific reimbursement requirement for specialty physicians will allow the health networks to move towards value-based contracting and reimbursement and be more in-line with industry practice and pay-for-value concepts.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, AltaMed Health Services Corporation, for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Contact

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

Recommended Actions

1. Ratify 4% rate increase for the professional component of capitation rates for contracted Medi-Cal Shared Risk Group (SRG) AltaMed Health Services Corporation for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016;
2. Ratify contract amendment to implement the rate increase; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in professional health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendment reflecting a 4% increase to the professional component of the capitation rates for Medi-Cal SRG networks, for Classic Medi-Cal (non-expansion) members and contract amendments implementing the rate increase effective July 1, 2016.

This increase in the professional component of capitation is calculated to be comparable to the funding level for professional services in the CalOptima Community Care Network (CCN), and to allow for comparable primary care physician (PCP) reimbursement by the Health Networks as is provided by CCN.

In a separate agenda item, the Board is considering modifications to the requirement that Health Networks reimburse specialist physicians, in the aggregate, at an amount equal or greater than 133% of the Medi-Cal fee schedule. As that item indicates, due to changes in industry trends and concerns raised by a number of the Health Networks, removing the requirement is recommended to allow health networks more flexibility to develop varying reimbursement arrangements. The current capitation rate paid by CalOptima for Medi-Cal expansion members is in line with the funding of the CalOptima Care Network (CCN) and is anticipated to be sufficient to support reimbursement of specialist physicians at 156% of the Medi-Cal fee schedule assuming current utilization levels.

Back to Agenda

CalOptima will monitor the health networks through the medical loss ratio (MLR) audits. MLR is a common financial metric used throughout the managed health care industry to define the ratio of medical costs incurred to premium/capitation revenue received. During the MLR audits, health network medical costs will be evaluated to ensure the appropriateness of provider payments and medical expense allocations based on CMS MLR guidelines.

Fiscal Impact
As indicated, the recommended action to ratify Medi-Cal contract amendments for SRG professional rates for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $10.15 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation
The proposed amendment to the Medi-Cal SRG contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, AMVI Health Network for Classic (Non-Expansion) Medi-Cal members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Contact

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

Recommended Actions

1. Ratify 4% rate increase for the professional component of capitation rates for contracted Medi-Cal Physician-Hospital Consortia (PHC) AMVI Health Network for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016;
2. Ratify contract amendment to implement the rate increase; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in professional health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendment reflecting a 4% increase to the professional component of the capitation rates for Medi-Cal PHC networks, for Classic Medi-Cal (non-expansion) members and contract amendments implementing the rate increase effective July 1, 2016.

This increase in the professional component of capitation is calculated to be comparable to the funding level for professional services in the CalOptima Community Care Network (CCN), and to allow for comparable primary care physician (PCP) reimbursement by the Health Networks as is provided by CCN.

In a separate agenda item, the Board is considering modifications to the requirement that Health Networks reimburse specialist physicians, in the aggregate, at an amount equal or greater than 133% of the Medi-Cal fee schedule. As that item indicates, due to changes in industry trends and concerns raised by a number of the Health Networks, removing the requirement is recommended to allow health networks more flexibility to develop varying reimbursement arrangements. The current capitation rate paid by CalOptima for Medi-Cal expansion members is in line with the funding of the CalOptima Care Network (CCN) and is anticipated to be sufficient to support reimbursement of specialist physicians at 156% of the Medi-Cal fee schedule assuming current utilization levels.

Back to Agenda

CalOptima will monitor the health networks through the medical loss ratio (MLR) audits. MLR is a common financial metric used throughout the managed health care industry to define the ratio of medical costs incurred to premium/capitation revenue received. During the MLR audits, health network medical costs will be evaluated to ensure the appropriateness of provider payments and medical expense allocations based on CMS MLR guidelines.

Fiscal Impact

As indicated, the recommended action to ratify Medi-Cal contract amendments for PHC professional rates for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $10.15 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation

The proposed amendment to the Medi-Cal PHC contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

17. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Arta Western Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Contact

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

Recommended Actions

1. Ratify 4% rate increase for the professional component of capitation rates for contracted Medi-Cal Shared Risk Group (SRG) Arta Western Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016;
2. Ratify contract amendment to implement the rate increase; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in professional health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendments reflecting a 4% increase to the professional component of the capitation rates for Medi-Cal SRG networks, for Classic Medi-Cal (non-expansion) members and contract amendments implementing the rate increase effective July 1, 2016.

This increase in the professional component of capitation is calculated to be comparable to the funding level for professional services in the CalOptima Community Care Network (CCN), and to allow for comparable primary care physician (PCP) reimbursement by the Health Networks as is provided by CCN.

In a separate agenda item, the Board is considering modifications to the requirement that Health Networks reimburse specialist physicians, in the aggregate, at an amount equal or greater than 133% of the Medi-Cal fee schedule. As that item indicates, due to changes in industry trends and concerns raised by a number of the Health Networks, removing the requirement is recommended to allow health networks more flexibility to develop varying reimbursement arrangements. The current capitation rate paid by CalOptima for Medi-Cal expansion members is in line with the funding of the CalOptima Care Network (CCN) and is anticipated to be sufficient to support reimbursement of specialist physicians at 156% of the Medi-Cal fee schedule assuming current utilization levels.

Back to Agenda

CalOptima will monitor the health networks through the medical loss ratio (MLR) audits. MLR is a common financial metric used throughout the managed health care industry to define the ratio of medical costs incurred to premium/capitation revenue received. During the MLR audits, health network medical costs will be evaluated to ensure the appropriateness of provider payments and medical expense allocations based on CMS MLR guidelines.

Fiscal Impact
As indicated, the recommended action to ratify Medi-Cal contract amendments for SRG professional rates for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $10.15 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation
The proposed amendment to the Medi-Cal SRG contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, CHOC Physicians Network for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Contact

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

Recommended Actions

1. Ratify 4% rate increase for the professional component of capitation rates for contracted Medi-Cal Physician-Hospital Consortia (PHC) CHOC Physicians Network for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016;
2. Ratify contract amendment to implement the rate increase; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in professional health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendments reflecting a 4% increase to the professional component of the capitation rates for Medi-Cal PHC networks, for Classic Medi-Cal (non-expansion) members and contract amendments implementing the rate increase effective July 1, 2016.

This increase in the professional component of capitation is calculated to be comparable to the funding level for professional services in the CalOptima Community Care Network (CCN), and to allow for comparable primary care physician (PCP) reimbursement by the Health Networks as is provided by CCN.

In a separate agenda item, the Board is considering modifications to the requirement that Health Networks reimburse specialist physicians, in the aggregate, at an amount equal or greater than 133% of the Medi-Cal fee schedule. As that item indicates, due to changes in industry trends and concerns raised by a number of the Health Networks, removing the requirement is recommended to allow health networks more flexibility to develop varying reimbursement arrangements. The current capitation rate paid by CalOptima for Medi-Cal expansion members is in line with the funding of the CalOptima Care Network (CCN) and is anticipated to be sufficient to support reimbursement of specialist physicians at 156% of the Medi-Cal fee schedule assuming current utilization levels.

Back to Agenda

CalOptima will monitor the health networks through the medical loss ratio (MLR) audits. MLR is a common financial metric used throughout the managed health care industry to define the ratio of medical costs incurred to premium/capitation revenue received. During the MLR audits, health network medical costs will be evaluated to ensure the appropriateness of provider payments and medical expense allocations based on CMS MLR guidelines.

Fiscal Impact
As indicated, the recommended action to ratify Medi-Cal contract amendments for PHC professional rates for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $10.15 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation
The proposed amendment to the Medi-Cal PHC contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

19. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, Family Choice Medical Group, Inc. for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Contact

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

Recommended Actions

1. Ratify 4% rate increase for the professional component of capitation rates for contracted Medi-Cal Physician-Hospital Consortia (PHC) Family Choice Medical Group, Inc. for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016;
2. Ratify contract amendment to implement the rate increase; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in professional health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendments reflecting a 4% increase to the professional component of the capitation rates for Medi-Cal PHC networks, for Classic Medi-Cal (non-expansion) members and contract amendments implementing the rate increase effective July 1, 2016.

This increase in the professional component of capitation is calculated to be comparable to the funding level for professional services in the CalOptima Community Care Network (CCN), and to allow for comparable primary care physician (PCP) reimbursement by the Health Networks as is provided by CCN.

In a separate agenda item, the Board is considering modifications to the requirement that Health Networks reimburse specialist physicians, in the aggregate, at an amount equal or greater than 133% of the Medi-Cal fee schedule. As that item indicates, due to changes in industry trends and concerns raised by a number of the Health Networks, removing the requirement is recommended to allow health networks more flexibility to develop varying reimbursement arrangements. The current capitation rate paid by CalOptima for Medi-Cal expansion members is in line with the funding of the CalOptima Care Network (CCN) and is anticipated to be sufficient to support reimbursement of specialist physicians at 156% of the Medi-Cal fee schedule assuming current utilization levels.

Back to Agenda

CalOptima will monitor the health networks through the medical loss ratio (MLR) audits. MLR is a common financial metric used throughout the managed health care industry to define the ratio of medical costs incurred to premium/capitation revenue received. During the MLR audits, health network medical costs will be evaluated to ensure the appropriateness of provider payments and medical expense allocations based on CMS MLR guidelines.

Fiscal Impact

As indicated, the recommended action to ratify Medi-Cal contract amendments for PHC professional rates for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $10.15 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation

The proposed amendment to the Medi-Cal PHC contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

20. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Health Maintenance Organization, Heritage Provider Network, Inc. for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Contact

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

Recommended Actions

1. Ratify 4% rate increase for the professional component of capitation rates for contracted Medi-Cal Health Maintenance Organization (HMO) Heritage Provider Network, Inc. for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016;
2. Ratify contract amendment to implement the rate increase; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in professional health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendments reflecting a 4% increase to the professional component of the capitation rates for Medi-Cal HMO networks, (excluding Kaiser), for Classic Medi-Cal (non-expansion) members and contract amendments implementing the rate increase effective July 1, 2016.

This increase in the professional component of capitation is calculated to be comparable to the funding level for professional services in the CalOptima Community Care Network (CCN), and to allow for comparable primary care physician (PCP) reimbursement by the Health Networks as is provided by CCN.

In a separate agenda item, the Board is considering modifications to the requirement that Health Networks reimburse specialist physicians, in the aggregate, at an amount equal or greater than 133% of the Medi-Cal fee schedule. As that item indicates, due to changes in industry trends and concerns raised by a number of the Health Networks, removing the requirement is recommended to allow health networks more flexibility to develop varying reimbursement arrangements. The current capitation rate paid by CalOptima for Medi-Cal expansion members is in line with the funding of the CalOptima Care Network (CCN) and is anticipated to be sufficient to support reimbursement of specialist physicians at 156% of the Medi-Cal fee schedule assuming current utilization levels.

Back to Agenda

CalOptima will monitor the health networks through the medical loss ratio (MLR) audits. MLR is a common financial metric used throughout the managed health care industry to define the ratio of medical costs incurred to premium/capitation revenue received. During the MLR audits, health network medical costs will be evaluated to ensure the appropriateness of provider payments and medical expense allocations based on CMS MLR guidelines.

Fiscal Impact
As indicated, the recommended action to ratify Medi-Cal contract amendments for HMO professional rates, (excluding Kaiser) for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $10.15 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation
The proposed amendment to the Medi-Cal HMO contracts, (excluding Kaiser), will support the stability of CalOptima's contracted provider delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

21. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Monarch HealthCare, A Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Contact

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

Recommended Actions

1. Ratify 4% rate increase for the professional component of capitation rates for contracted Medi-Cal Shared Risk Group (SRG) Monarch HealthCare, A Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016;
2. Ratify contract amendment to implement the rate increase; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in professional health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendments reflecting a 4% increase to the professional component of the capitation rates for Medi-Cal SRG networks, for Classic Medi-Cal (non-expansion) members and contract amendments implementing the rate increase effective July 1, 2016.

This increase in the professional component of capitation is calculated to be comparable to the funding level for professional services in the CalOptima Community Care Network (CCN), and to allow for comparable primary care physician (PCP) reimbursement by the Health Networks as is provided by CCN.

In a separate agenda item, the Board is considering modifications to the requirement that Health Networks reimburse specialist physicians, in the aggregate, at an amount equal or greater than 133% of the Medi-Cal fee schedule. As that item indicates, due to changes in industry trends and concerns raised by a number of the Health Networks, removing the requirement is recommended to allow health networks more flexibility to develop varying reimbursement arrangements. The current capitation rate paid by CalOptima for Medi-Cal expansion members is in line with the funding of the CalOptima Care Network (CCN) and is anticipated to be sufficient to support reimbursement of specialist physicians at 156% of the Medi-Cal fee schedule assuming current utilization levels.

Back to Agenda

CalOptima will monitor the health networks through the medical loss ratio (MLR) audits. MLR is a common financial metric used throughout the managed health care industry to define the ratio of medical costs incurred to premium/capitation revenue received. During the MLR audits, health network medical costs will be evaluated to ensure the appropriateness of provider payments and medical expense allocations based on CMS MLR guidelines.

Fiscal Impact
As indicated, the recommended action to ratify Medi-Cal contract amendments for SRG professional rates for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $10.15 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation
The proposed amendment to the Medi-Cal SRG contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

22. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Orange County Physicians IPA Medical Group, Inc., dba Noble Community Medical Associates, Inc. of Mid-Orange County for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Contact

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

Recommended Actions

1. Ratify 4% rate increase for the professional component of capitation rates for contracted Medi-Cal Shared Risk Group (SRG) Orange County Physicians IPA Medical Group, Inc., dba Noble Community Medical Associates, Inc. of Mid-Orange County , for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016;
2. Ratify contract amendment to implement the rate increase; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in professional health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendments reflecting a 4% increase to the professional component of the capitation rates for Medi-Cal SRG networks, for Classic Medi-Cal (non-expansion) members and contract amendments implementing the rate increase effective July 1, 2016.

This increase in the professional component of capitation is calculated to be comparable to the funding level for professional services in the CalOptima Community Care Network (CCN), and to allow for comparable primary care physician (PCP) reimbursement by the Health Networks as is provided by CCN.

In a separate agenda item, the Board is considering modifications to the requirement that Health Networks reimburse specialist physicians, in the aggregate, at an amount equal or greater than 133% of the Medi-Cal fee schedule. As that item indicates, due to changes in industry trends and concerns raised by a number of the Health Networks, removing the requirement is recommended to allow health networks more flexibility to develop varying reimbursement arrangements. The current capitation rate paid by CalOptima for Medi-Cal expansion members is in line with the funding of the CalOptima Care

Back to Agenda

Network (CCN) and is anticipated to be sufficient to support reimbursement of specialist physicians at 156% of the Medi-Cal fee schedule assuming current utilization levels.

CalOptima will monitor the health networks through the medical loss ratio (MLR) audits. MLR is a common financial metric used throughout the managed health care industry to define the ratio of medical costs incurred to premium/capitation revenue received. During the MLR audits, health network medical costs will be evaluated to ensure the appropriateness of provider payments and medical expense allocations based on CMS MLR guidelines.

Fiscal Impact
As indicated, the recommended action to ratify Medi-Cal contract amendments for SRG professional rates for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $10.15 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation
The proposed amendment to the Medi-Cal SRG contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, Orange County Advantage Medical Group, Inc. for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Contact

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

Recommended Actions

1. Ratify 4% rate increase for the professional component of capitation rates for contracted Medi-Cal Physician-Hospital Consortia (PHC) Orange County Advantage Medical Group, Inc. for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016;
2. Ratify contract amendment to implement the rate increase; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in professional health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendments reflecting a 4% increase to the professional component of the capitation rates for Medi-Cal PHC networks, for Classic Medi-Cal (non-expansion) members and contract amendments implementing the rate increase effective July 1, 2016.

This increase in the professional component of capitation is calculated to be comparable to the funding level for professional services in the CalOptima Community Care Network (CCN), and to allow for comparable primary care physician (PCP) reimbursement by the Health Networks as is provided by CCN.

In a separate agenda item, the Board is considering modifications to the requirement that Health Networks reimburse specialist physicians, in the aggregate, at an amount equal or greater than 133% of the Medi-Cal fee schedule. As that item indicates, due to changes in industry trends and concerns raised by a number of the Health Networks, removing the requirement is recommended to allow health networks more flexibility to develop varying reimbursement arrangements. The current capitation rate paid by CalOptima for Medi-Cal expansion members is in line with the funding of the CalOptima Care Network (CCN) and is anticipated to be sufficient to support reimbursement of specialist physicians at 156% of the Medi-Cal fee schedule assuming current utilization levels.

Back to Agenda

CalOptima will monitor the health networks through the medical loss ratio (MLR) audits. MLR is a common financial metric used throughout the managed health care industry to define the ratio of medical costs incurred to premium/capitation revenue received. During the MLR audits, health network medical costs will be evaluated to ensure the appropriateness of provider payments and medical expense allocations based on CMS MLR guidelines.

Fiscal Impact
As indicated, the recommended action to ratify Medi-Cal contract amendments for PHC professional rates for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $10.15 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation
The proposed amendment to the Medi-Cal PHC contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

24. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Prospect Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Contact

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

Recommended Actions

1. Ratify 4% rate increase for the professional component of capitation rates for contracted Medi-Cal Shared Risk Group (SRG) Prospect Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016;
2. Ratify contract amendment to implement the rate increase; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in professional health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendments reflecting a 4% increase to the professional component of the capitation rates for Medi-Cal SRG, for Classic Medi-Cal (non-expansion) members and contract amendments implementing the rate increase effective July 1, 2016.

This increase in the professional component of capitation is calculated to be comparable to the funding level for professional services in the CalOptima Community Care Network (CCN), and to allow for comparable primary care physician (PCP) reimbursement by the Health Networks as is provided by CCN.

In a separate agenda item, the Board is considering modifications to the requirement that Health Networks reimburse specialist physicians, in the aggregate, at an amount equal or greater than 133% of the Medi-Cal fee schedule. As that item indicates, due to changes in industry trends and concerns raised by a number of the Health Networks, removing the requirement is recommended to allow health networks more flexibility to develop varying reimbursement arrangements. The current capitation rate paid by CalOptima for Medi-Cal expansion members is in line with the funding of the CalOptima Care Network (CCN) and is anticipated to be sufficient to support reimbursement of specialist physicians at 156% of the Medi-Cal fee schedule assuming current utilization levels.

Back to Agenda

CalOptima will monitor the health networks through the medical loss ratio (MLR) audits. MLR is a common financial metric used throughout the managed health care industry to define the ratio of medical costs incurred to premium/capitation revenue received. During the MLR audits, health network medical costs will be evaluated to ensure the appropriateness of provider payments and medical expense allocations based on CMS MLR guidelines.

Fiscal Impact
As indicated, the recommended action to ratify Medi-Cal contract amendments for SRG professional rates for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $10.15 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation
The proposed amendment to the Medi-Cal SRG contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

25. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Talbert Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Contact

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

Recommended Actions

1. Ratify 4% rate increase for the professional component of capitation rates for contracted Medi-Cal Shared Risk Group (SRG) Talbert Medical Group, Inc. , for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016;
2. Ratify contract amendment to implement the rate increase; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in professional health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendments reflecting a 4% increase to the professional component of the capitation rates for Medi-Cal SRG networks, for Classic Medi-Cal (non-expansion) members and contract amendments implementing the rate increase effective July 1, 2016.

This increase in the professional component of capitation is calculated to be comparable to the funding level for professional services in the CalOptima Community Care Network (CCN), and to allow for comparable primary care physician (PCP) reimbursement by the Health Networks as is provided by CCN.

In a separate agenda item, the Board is considering modifications to the requirement that Health Networks reimburse specialist physicians, in the aggregate, at an amount equal or greater than 133% of the Medi-Cal fee schedule. As that item indicates, due to changes in industry trends and concerns raised by a number of the Health Networks, removing the requirement is recommended to allow health networks more flexibility to develop varying reimbursement arrangements. The current capitation rate paid by CalOptima for Medi-Cal expansion members is in line with the funding of the CalOptima Care Network (CCN) and is anticipated to be sufficient to support reimbursement of specialist physicians at 156% of the Medi-Cal fee schedule assuming current utilization levels.

Back to Agenda

CalOptima will monitor the health networks through the medical loss ratio (MLR) audits. MLR is a common financial metric used throughout the managed health care industry to define the ratio of medical costs incurred to premium/capitation revenue received. During the MLR audits, health network medical costs will be evaluated to ensure the appropriateness of provider payments and medical expense allocations based on CMS MLR guidelines.

Fiscal Impact
As indicated, the recommended action to ratify Medi-Cal contract amendments for SRG professional rates for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $10.15 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation
The proposed amendment to the Medi-Cal SRG contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

26. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, United Care Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Contact

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

Recommended Actions

1. Ratify 4% rate increase for the professional component of capitation rates for contracted Medi-Cal Shared Risk Group (SRG) United Care Medical Group, Inc. , for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016;
2. Ratify contract amendment to implement the rate increase; and
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016 includes a 4% trend increase in professional health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendments reflecting a 4% increase to the professional component of the capitation rates for Medi-Cal SRG networks, for Classic Medi-Cal (non-expansion) members and contract amendments implementing the rate increase effective July 1, 2016.

This increase in the professional component of capitation is calculated to be comparable to the funding level for professional services in the CalOptima Community Care Network (CCN), and to allow for comparable primary care physician (PCP) reimbursement by the Health Networks as is provided by CCN.

In a separate agenda item, the Board is considering modifications to the requirement that Health Networks reimburse specialist physicians, in the aggregate, at an amount equal or greater than 133% of the Medi-Cal fee schedule. As that item indicates, due to changes in industry trends and concerns raised by a number of the Health Networks, removing the requirement is recommended to allow health networks more flexibility to develop varying reimbursement arrangements. The current capitation rate paid by CalOptima for Medi-Cal expansion members is in line with the funding of the CalOptima Care Network (CCN) and is anticipated to be sufficient to support reimbursement of specialist physicians at 156% of the Medi-Cal fee schedule assuming current utilization levels.

Back to Agenda

CalOptima will monitor the health networks through the medical loss ratio (MLR) audits. MLR is a common financial metric used throughout the managed health care industry to define the ratio of medical costs incurred to premium/capitation revenue received. During the MLR audits, health network medical costs will be evaluated to ensure the appropriateness of provider payments and medical expense allocations based on CMS MLR guidelines.

Fiscal Impact
As indicated, the recommended action to ratify Medi-Cal contract amendments for SRG professional rates for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $10.15 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation
The proposed amendment to the Medi-Cal SRG contracts will support the stability of CalOptima's contracted provider delivery system.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

27. Consider Ratification of Rate Increase for Facility Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, Children's Hospital of Orange County for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase

Contact

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

Recommended Actions

1. Ratify 4% rate increase for the facility component of capitation rates for contracted Medi-Cal Physician-Hospital Consortia (PHC) Children's Hospital of Orange County for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016; and
2. Ratify contract amendment to implement the rate increase.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016, includes a 4% trend increase in hospital health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendments reflecting a 4% increase to the facility component of the capitation rates for Medi-Cal Physician-Hospital Consortia for Classic (Non-Expansion) Medi-Cal Members and contract amendment implementing the rate increase effective July 1, 2016.

Fiscal Impact

As indicated, the recommended action to ratify Medi-Cal contract amendments for PHC facility rates for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $2.76 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation

The proposed amendment to the Medi-Cal PHC network will support the stability of CalOptima's contracted provider delivery system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

28. Consider Ratification of Rate Increase for Facility Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, Fountain Valley Regional Hospital and Medical Center, for Classic (Non-Expansion) Medi-Cal Members and Contract Amendments Implementing the Rate Increase

Contact

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

Recommended Action

1. Ratify 4% rate increase for the facility component of capitation rates for contracted Medi-Cal Physician-Hospital Consortia (PHC) Fountain Valley Regional Hospital and Medical Center for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016; and
2. Ratify contract amendments to implement the rate increase.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016, includes a 4% trend increase in hospital health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendments reflecting a 4% increase to the facility component of the capitation rates for Medi-Cal Physician-Hospital Consortia for Classic (Non-Expansion) Medi-Cal Members and contract amendment implementing the rate increase effective July 1, 2016.

Fiscal Impact

As indicated, the recommended action to ratify Medi-Cal contract amendments for PHC facility rates, for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $2.76 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation

The proposed amendment to the Medi-Cal PHC network will support the stability of CalOptima's contracted provider delivery system.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments
None

/s/ Michael Schrader *07/29/2016*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

29. Consider Ratification of Rate Increase for Facility Component of Capitation Rates for Contracted Medi-Cal Health Maintenance Organization, Heritage Provider Network, Inc. for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase

Contact

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

Recommended Action

1. Ratify 4% rate increase for the facility component of capitation rates for contracted Medi-Cal Health Maintenance Organization (HMO) Heritage Provider Network, Inc. for Classic (Non-Expansion) Medi-Cal members effective July 1, 2016; and
2. Ratify contract amendment to implement the rate increase.

Background/Discussion

The FY 2016-2017 CalOptima Operating Budget approved by the Board of Directors in June of 2016, includes a 4% trend increase in hospital health network capitation costs.

Staff is requesting ratification of the rate increase and the implementing contract amendment reflecting a 4% increase to the facility component of the capitation rates for Medi-Cal Health Maintenance Organization for Classic (Non-Expansion) Medi-Cal Members and contract amendment implementing the rate increase effective July 1, 2016.

Fiscal Impact

As indicated, the recommended action to ratify Medi-Cal contract amendment for HMO facility rates for Classic (non-MCE) Medi-Cal members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The anticipated total annual increase for the proposed increase is budgeted to be $2.76 million. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the increased expense.

Rationale for Recommendation

The proposed amendment to the Medi-Cal HMO network will support the stability of CalOptima's contracted provider delivery system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

30. Consider Approval of Rate Increase for Contracted Community Based Adult Services (CBAS) Centers Serving Medi-Cal and OneCare Connect Members; Authorize Contract Amendments to Implement the Increase

Contact

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

Recommended Actions

1. Approve 4% reimbursement rate increase for CalOptima CBAS centers for Medi-Cal and OneCare Connect members effective July 1, 2016; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend CBAS contracts to implement the increase.

Background/Discussion

The CalOptima FY 2016-17 Operating Budget was approved by the Board on June 2, 2016. The budget included projected cost trends for CBAS services, which was sufficient to support a moderate rate change to CalOptima's contracted CBAS centers.

On July 12, 2012, the Board authorized the Board Chair to execute an amendment to the Primary Agreement between the California Department of Health Care Services (DHCS) and CalOptima adding CBAS benefits to managed care plans. The Board also authorized CalOptima staff to contract with DHCS-approved CBAS centers.

Contracted CBAS centers are crucial network partners for CalOptima. The care the CBAS centers provide allows members to live in their homes by providing a safe, stimulating environment for members during the day. This care also results in avoiding premature skilled nursing facility placement.

Since 2012, CBAS centers have been reimbursed at the DHCS mandated rates, with no rate increases for three years. CalOptima has received repeated requests for contract rate increases from various CBAS centers citing increased costs related to providing care to members with higher acuity.

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Staff recommends increasing rates for CBAS centers by 4% and is requesting authorization to amend contracts to reflect the increase effective July 1, 2016.

Fiscal Impact

The recommended action to increase CBAS center rates and amend CBAS center contracted rates for Medi-Cal and OneCare Connect members is a budgeted item in the CalOptima FY 2016-17 Operating Budget. The annual fiscal impact is projected at $1 million. Staff anticipates Medi-Cal revenue for FY 2016-17 to be sufficient to cover the costs of the increased CBAS center rates.

Back to Agenda

Rationale for Recommendation

The proposed rate increase and CBAS center contract amendments will support the stability of CalOptima's contracted provider delivery system.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

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

07/29/2016 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

31. Consider Proposed Changes to Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment Requirements

Contact

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

Recommended Actions

1. Authorize proposed modifications to Policy EE.1106, Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment, to extend the timeframe for health networks to meet the minimum member enrollment requirement from 12 to a maximum of 36 months.~~30 months; and~~
2. ~~Delegate authority to the Chief Executive Officer (CEO) to extend the timeframe up to an additional six (6) months for new health networks to meet the minimum member enrollment requirements (for a maximum of 36 months).~~

Revised 8/4/16

Background

Since inception, CalOptima has prioritized the integrity of its provider network and delivery system. In its Contract for Health Care Services with health networks, CalOptima requires health networks to maintain a minimum member enrollment in order to participate in the program.

On September 1, 1998, the Board authorized the CEO to execute contracts with health networks, which incorporated a minimum member enrollment threshold. On January 5, 1999, the Board approved a Health Network Minimum and Maximum Member Enrollment policy to ensure adherence to minimum enrollment requirement in health network contracts. This policy states in part that, starting 12 months after initial member enrollment date, a health network shall maintain enrollment of at least 5,000 members throughout the term of its contract, and if a health network fails to maintain an average enrollment of at least 5,000 members over three consecutive months, CalOptima may terminate its contract.

CalOptima's long standing policy of requiring delegated health networks to maintain a minimum member enrollment is designed to ensure the viability of health networks, support administrative efficiencies, and stabilize the delivery system. It also allows CalOptima to manage the delivery of health care services in a cost effective and efficient manner. However, in the past, the Board has recognized limited circumstances in which modifications to the minimum member enrollment requirement was appropriate in order to accommodate changes to member health care needs or unique circumstances impacting the delivery system.

Discussion

At the Board's direction and to meet the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services (DHCS) regulatory requirements, staff continually monitors and

evaluates CalOptima's delivery system and provider network to ensure member access to care and to the providers of their choice. In February 2013, the Board authorized the CEO to explore options to expand CalOptima's delivery system by adding additional health networks through a Request for Proposal (RFP) process.

The RFP process resulted in the addition of new health networks that support CalOptima's mission to enhance geographic access and availability, add new provider choices within a member's ethnic or local community, and address potentially unmet member language and cultural needs. While new health networks allow CalOptima to expand the make-up and breadth of its provider network, it now appears that the networks added through the most recent RFP process may need more to time to meet CalOptima's minimum member enrollment requirements.

New health networks, especially during their first years in operation, encounter factors that may result in slower membership growth. A key contributing factor is CalOptima's member auto assignment allocation methodology, which is structured to encourage improved health network performance and member health outcomes by measuring health networks' administrative and clinical quality scores. While new health networks may receive members through active selection and scoring on some administrative measures, they must wait until a full one-year cycle of data collection before their quality scores are reflected in their auto assignment ranking. In addition, new health networks may not have the name recognition or market footing if they are newly established or new to Orange County. Larger or more well-established health networks have a market advantage in that they have several years of quality scores to positively impact their auto assignment ranking, more experience serving CalOptima members, and may have better name recognition.

As indicated in the CalOptima Fiscal Year 2016-17 Operating Budget, member enrollment for Medi-Cal is anticipated to grow by 1.8% in the next fiscal year, whereas in previous years health networks experienced more rapid enrollment growth due to the Affordable Care Act (ACA) and Medi-Cal expansion. New health networks coming on board after the ACA and Medi-Cal expansion efforts would not benefit from such rapid membership growth. Other Medi-Cal transitions, such as Medi-Cal for All Children, are not anticipated to have as significant an impact on member enrollment. Based on analysis of current enrollment trends, auto assignment outcomes and estimated growth projections, staff anticipates that new health networks may need extra time, up to 26 to 28 months, to meet the minimum member enrollment requirement.

The Board's Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) have both discussed the minimum enrollment requirement for new health networks, most recently at the July 14, 2016 and June 9, 2016 meetings, respectively. The MAC and PAC expressed concerns that new health networks may not meet the minimum member enrollment requirement in the current timeframe required by CalOptima's policy.

In order to facilitate CalOptima's efforts to expand its delivery system, based on the recommendation from the PAC and with concurrence from the MAC, staff proposes that the timeframe for new health networks to meet the minimum member enrollment requirement be extended from 12 to 30 months and authority be delegated to the CEO to extend the timeframe an additional six (6) months, if necessary,

for a total of 36 months after the initial member enrollment date. The CEO shall report to the Board when an extension is granted.

Fiscal Impact

There is no fiscal impact anticipated from the recommended action. CalOptima does not expect to incur any additional medical expenses for members who are impacted by this recommended action, since health network capitation and fee-for-service reimbursement rates are based on the same unit cost levels.

Rationale for Recommendation

Amending Policy EE.1106, Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment, to extend the timeframe for new health networks to meet the minimum member enrollment requirement from 12 to 30 months and to grant the CEO the authority to extend the timeframe by an additional six (6) months, if necessary, will provide flexibility in health network management that would help facilitate CalOptima's effort to expand its delivery system in preparation for future membership growth.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Policy EE.1106, Health Network Minimum and Maximum Member Enrollment, (redline and clean copies)
2. September 1, 1998 CalOptima Board Action Agenda Referral, VIII.A., Authorize CEO to Execute Health Network Contracts
3. January 5, 1999 CalOptima Board Action Agenda Referral, VIII.C., Approve Elements to Implement Minimum Enrollment Threshold
4. February 7, 2013 CalOptima Board Action Agenda Referral, VII.C., Consider Options for Developing a Provider Delivery System in Preparation for Implementation of the Duals Demonstration, Including Related Financial Modeling and Contract Template Development

/s/ Michael Schrader *07/29/2016*

Authorized Signature **Date**

Medi-Cal CalOptima A Public Agency Better. Together.

Policy #: EE.1106
Title: **Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment**
Department: Network Management
Section: Not Applicable

CEO Approval: _____Michael Schrader_____

Effective Date: 03/01/96
Last Review Date: 082/041/16
Last Revised Date: 082/041/16

I. PURPOSE

~~To~~ This policy establishes minimum and maximum Member enrollment for a Health Network, Primary Hospital, Primary Physician Group, and CalOptima Community Network (CCN).

~~II. DEFINITIONS~~

~~III.~~II. POLICY

A. Minimum enrollment

1. The minimum enrollment requirement shall apply to a Health Network and CCN ~~twelve (12)~~thirty (30) months after initial Member enrollment date.

~~1.~~a. The Chief Executive Officer (CEO) may extend the timeframe by an additional six (6) months, if necessary, to provide flexibility in Health Network management or to accommodate changes to Member health care needs or unique circumstances impacting the delivery system for new Health Networks to meet the minimum Member enrollment requirements (for a maximum of thirty-six (36) months).

2. After the initial ~~twelve (12~~thirty (30) months, or thirty-six (36) months if an extension is granted by the CEO, of Member enrollment, a Health Network shall maintain a Member enrollment of at least five-thousand (5,000) Members for the remainder of the term of the Contract for Health Care Services.

3. If a Health Network fails to maintain an average Member enrollment over three (3) consecutive months of at least five-thousand (5,000) Members, CalOptima may terminate the Contract for Health Care Services in accordance with the terms of that contract.

B. Maximum enrollment

1. Except as otherwise provided in Section I~~I~~I.B.3. of this policy:

a. Combined Member enrollment in a Primary Hospital or Primary Physician Group shall not exceed one-~~-~~third (1/3) of all Members eligible for Health Network enrollment.

b. Member enrollment in a Health Network shall not exceed one third (1/3) of all Members eligible for Health Network enrollment.

c. Combined Member enrollment in CCN shall not exceed ten percent (10%) of all Members eligible for Health Network enrollment.

2. If a Health Network, Primary Hospital, or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, such Health Network, Primary Hospital, or Primary Physician Group shall not be eligible to contract with CalOptima as part of an additional Health Network.

3. Subject to the provisions of this policy, CalOptima shall continue to enroll Members in a Health Network, or CCN, until the Health Network, CCN, Primary Hospital, or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months.

a. If a Health Network reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, CalOptima shall cease all auto assignment of Members to the Health Network effective the first (1st) calendar day of the immediately following month.

b. If a Primary Hospital or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, CalOptima shall cease all auto assignment of Members to each Health Network comprised of such Primary Hospital or Primary Physician Group effective the first (1st) calendar day of the immediately following month.

c. If CCN reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, CalOptima shall cease all auto assignment of Members to CCN effective the first (1st) calendar day of the immediately following month.

d. Notwithstanding the provision of this section, CalOptima shall continue to enroll a Member in a Health Network, or CCN, if:

i. The Member selects the Health Network or CCN in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process;

ii. The Member has Family Linked Members currently enrolled in the Health Network or CCN;

iii. The Member is re-enrolled in the Health Network, or CCN, after experiencing a lapse of Medi-Cal eligibility less than three-hundred-sixty-five (365) calendar days in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process;

iv. The Member is re-enrolled in the Health Network pursuant to the Bone Marrow Transplant or Solid Organ Transplant process as set forth in CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct;

v. CalOptima auto assigns the Member to the Health Network or CCN based on auto assignment allocation to a Community Clinic as set forth in CalOptima Policy AA.1207a: CalOptima Auto Assignment Process; or

vi. CalOptima's Chief Medical Officer (CMO), or their Dedesignee, determines that it is in the Member's best interest to enroll in the Health Network, or CCN.

C. Health Network Enrollment Changes

1. CCN and a Health Network, and its Ccontracted Pproviders, shall not advise, urge, or otherwise encourage Members to change Health Networks as a direct result from the Member's medical history or health status.

2. CCN and a Health Network shall be responsible for all Members who either select or are otherwise auto-assigned to the Health Network and are strictly prohibited from discriminating against Members based on:

a. Diagnosis;

b. Medical or claims history;

c. Age;

d. Mental or physical disability;

e. Genetic information;

f. Source of payment;

g. Sexual orientation;

h. Marital status;

i. Creed;

j. Religion;

k. Sex/Gender;

l. Race;

m. Color;

n. Ancestry; and

o. National origin.

3. CalOptima shall process alleged acts of discrimination in accordance with CalOptima Policy GGHH.1104: Complaints of Discrimination.

D. CalOptima's Board of Directors shall have the right to selectively waive a Health Network's or CCN's minimum and maximum enrollment or limit a Health Network's or CCN's enrollment if it determines that such action is in the best interest of Members.

~~IV.~~III. PROCEDURE

A. Minimum and Maximum Enrollment

1. CalOptima's ~~Provider~~ Network Management Department shall monitor a Health Network, CCN Primary Hospital, and Primary Physician Group enrollment for compliance with the minimum and maximum enrollments set forth in this policy.

2. If a Health Network fails to maintain an average enrollment over three (3) consecutive months of at least five-thousand (5,000) Members after the initial ~~twelve (12)~~thirty (30) months, or thirty-six (36) months if an extension is granted by the CEO, ~~months~~ of Member enrollment:

a. CalOptima's ~~Provider~~ Network Management Department shall notify the CalOptima's Compliance Committee; and

b. Upon approval from CalOptima's Compliance Committee, CalOptima's Regulatory Affairs & Compliance Department will review the Health Network's non-compliance and issue a notice in accordance with CalOptima Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions.

3. If a Health Network, CCN, Primary Hospital, or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months:

a. CalOptima's ~~Provider~~ Network Management Department shall notify CalOptima's Compliance Committee;

b. Upon approval from CalOptima's Compliance Committee, CalOptima's ~~Provider~~ Network Management Department shall notify the Health Network, CCN, Primary Hospital, or Primary Physician Group that such Health Network, CCN, Primary Hospital, or Primary Physician Group is not eligible to contract with CalOptima for any other Health Network;

c. Upon approval from CalOptima's Compliance Committee, and except as provided in Section II~~I~~.B.3.c. of this policy, CalOptima shall cease Member auto assignment to the Health Network and shall make appropriate adjustments to the auto assignment allocation as set forth in CalOptima Policy AA.1207a: CalOptima Auto Assignment ~~Process~~; and

d. CalOptima's Provider Network Department shall notify the Health Network, Primary Hospital, Primary Physician Group, or CCN of the enrollment limit.

4. If Member enrollment in a Health Network, CCN, Primary Hospital, or Primary Physician Group falls below the maximum enrollment limit for three (3) consecutive months, CalOptima shall reinstate Member auto assignment to the Health Network.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy AA.1000: Glossary of Terms
C. CalOptima Policy AA.1207a: CalOptima Auto Assignment ~~Process~~
D. CalOptima Policy DD.2006: Enrollment I~~i~~n/Eligibility with CalOptima Direct
E. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
F. CalOptima Policy ~~GG~~HH.1104: Complaints of Discrimination
G. CalOptima Policy HH.2002: ~~Health Network~~ Sanctions
H. CalOptima Policy HH.2005: Corrective Action Plan

~~VII.~~VI. REGULATORY AGENCY APPROVALS

A. 03/29/16: Department of Health Care Services
B. 01/23/15: Department of Health Care Services

~~VIII.~~VII. BOARD ACTIONS

A. 08/04/16: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 03/06/14: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 08/30/06: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 05/07/02: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 01/05/99: Regular Meeting of the CalOptima Board of Directors

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

Version	~~Version~~ Date	Policy Number	Policy Title
~~Original Date~~Effective	03/01/1996	EE.1106	Health Network Minimum and Maximum Member Enrollment
Revised ~~Revision Date 1~~	03/07/1996	EE.1106	Health Network Minimum and Maximum Member Enrollment
Revised ~~Revision Date 2~~	01/01/2007	EE.1106	Health Network Minimum and Maximum Member Enrollment
Revised ~~Revision Date 3~~	12/01/2011	EE.1106	Health Network Minimum and Maximum Member Enrollment
Revised ~~Revision Date 4~~	09/01/2014	EE.1106	Health Network Minimum and Maximum Member Enrollment
~~Revision Date 5~~Revised	02/01/2016	EE.1106	Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment
Revised	08/04/2016	EE.1106	Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment

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

Term	Definition
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
Community Health Center	Also known as Community Clinic—a health center that meets all of the following criteria: 1. Recognized by the Department of Public Health as a licensed Community Clinic or is a Federally Qualified Health Center (FQHC) or FQHC Look-Alike; 2. Affiliated with a Health Network; and 3. Ability to function as a Primary Care Provider (PCP).
Contracted Provider	A Provider who is obligated by written contract to provide Covered Services to Members on behalf of CalOptima, its contracted Health Networks or Physician Medical Groups.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Family Linked Member	A Member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another Member who is in his or her family and who resides in the same household.
Health Network	A Physician Hospital Consortium (PHC), Pphysician Medical Ggroup (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A Member who is eligible to choose a CalOptima Health Network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Hospital	A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).

Policy #: EE.1106
Title: **Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment**
Department: Network Management
Section: Not Applicable

CEO Approval: Michael Schrader_____

Effective Date: 03/01/96
Last Review Date: 08/04/16
Last Revised Date: 08/04/16

I. PURPOSE

This policy establishes minimum and maximum Member enrollment for a Health Network, Primary Hospital, Primary Physician Group, and CalOptima Community Network (CCN).

II. POLICY

A. Minimum enrollment

1. The minimum enrollment requirement shall apply to a Health Network and CCN thirty (30) months after initial Member enrollment date.

    a. The Chief Executive Officer (CEO) may extend the timeframe by an additional six (6) months, if necessary, to provide flexibility in Health Network management or to accommodate changes to Member health care needs or unique circumstances impacting the delivery system for new Health Networks to meet the minimum Member enrollment requirements (for a maximum of thirty-six (36) months).

2. After the initial thirty (30) months, or thirty-six (36) months if an extension is granted by the CEO, of Member enrollment, a Health Network shall maintain a Member enrollment of at least five-thousand (5,000) Members for the remainder of the term of the Contract for Health Care Services.

3. If a Health Network fails to maintain an average Member enrollment over three (3) consecutive months of at least five-thousand (5,000) Members, CalOptima may terminate the Contract for Health Care Services in accordance with the terms of that contract.

B. Maximum enrollment

1. Except as otherwise provided in Section II.B.3. of this policy:

    a. Combined Member enrollment in a Primary Hospital or Primary Physician Group shall not exceed one-third (1/3) of all Members eligible for Health Network enrollment.

    b. Member enrollment in a Health Network shall not exceed one third (1/3) of all Members eligible for Health Network enrollment.

c. Combined Member enrollment in CCN shall not exceed ten percent (10%) of all Members eligible for Health Network enrollment.

2. If a Health Network, Primary Hospital, or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, such Health Network, Primary Hospital, or Primary Physician Group shall not be eligible to contract with CalOptima as part of an additional Health Network.

3. Subject to the provisions of this policy, CalOptima shall continue to enroll Members in a Health Network, or CCN, until the Health Network, CCN, Primary Hospital, or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months.

a. If a Health Network reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, CalOptima shall cease all auto assignment of Members to the Health Network effective the first (1st) calendar day of the immediately following month.

b. If a Primary Hospital or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, CalOptima shall cease all auto assignment of Members to each Health Network comprised of such Primary Hospital or Primary Physician Group effective the first (1st) calendar day of the immediately following month.

c. If CCN reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months, CalOptima shall cease all auto assignment of Members to CCN effective the first (1st) calendar day of the immediately following month.

d. Notwithstanding the provision of this section, CalOptima shall continue to enroll a Member in a Health Network, or CCN, if:

i. The Member selects the Health Network or CCN in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process;

ii. The Member has Family Linked Members currently enrolled in the Health Network or CCN;

iii. The Member is re-enrolled in the Health Network, or CCN, after experiencing a lapse of Medi-Cal eligibility less than three-hundred-sixty-five (365) calendar days in accordance with CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process;

iv. The Member is re-enrolled in the Health Network pursuant to the Bone Marrow Transplant or Solid Organ Transplant process as set forth in CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct;

v. CalOptima auto assigns the Member to the Health Network or CCN based on auto assignment allocation to a Community Clinic as set forth in CalOptima Policy AA.1207a: CalOptima Auto Assignment; or

vi. CalOptima's Chief Medical Officer (CMO), or their Designee, determines that it is in the Member's best interest to enroll in the Health Network, or CCN.

C. Health Network Enrollment Changes

1. CCN and a Health Network, and its Contracted Providers, shall not advise, urge, or otherwise encourage Members to change Health Networks as a direct result from the Member's medical history or health status.

2. CCN and a Health Network shall be responsible for all Members who either select or are otherwise auto-assigned to the Health Network and are strictly prohibited from discriminating against Members based on:

   a. Diagnosis;

   b. Medical or claims history;

   c. Age;

   d. Mental or physical disability;

   e. Genetic information;

   f. Source of payment;

   g. Sexual orientation;

   h. Marital status;

   i. Creed;

   j. Religion;

   k. Sex/Gender;

   l. Race;

   m. Color;

   n. Ancestry; and

   o. National origin.

3. CalOptima shall process alleged acts of discrimination in accordance with CalOptima Policy HH.1104: Complaints of Discrimination.

D. CalOptima's Board of Directors shall have the right to selectively waive a Health Network's or CCN's minimum and maximum enrollment or limit a Health Network's or CCN's enrollment if it determines that such action is in the best interest of Members.

III. PROCEDURE

A. Minimum and Maximum Enrollment

1. CalOptima's Network Management Department shall monitor a Health Network, CCN Primary Hospital, and Primary Physician Group enrollment for compliance with the minimum and maximum enrollments set forth in this policy.

2. If a Health Network fails to maintain an average enrollment over three (3) consecutive months of at least five-thousand (5,000) Members after the initial thirty (30) months, or thirty-six (36) months if an extension is granted by the CEO, of Member enrollment:

a. CalOptima's Network Management Department shall notify the CalOptima's Compliance Committee; and

b. Upon approval from CalOptima's Compliance Committee, CalOptima's Regulatory Affairs & Compliance Department will review the Health Network's non-compliance and issue a notice in accordance with CalOptima Policies HH.2005: Corrective Action Plan and HH.2002: Sanctions.

3. If a Health Network, CCN, Primary Hospital, or Primary Physician Group reaches one-hundred percent (100%) of the maximum enrollment limit for three (3) consecutive months:

a. CalOptima's Network Management Department shall notify CalOptima's Compliance Committee;

b. Upon approval from CalOptima's Compliance Committee, CalOptima's Network Management Department shall notify the Health Network, CCN, Primary Hospital, or Primary Physician Group that such Health Network, CCN, Primary Hospital, or Primary Physician Group is not eligible to contract with CalOptima for any other Health Network;

c. Upon approval from CalOptima's Compliance Committee, and except as provided in Section II.B.3.c. of this policy, CalOptima shall cease Member auto assignment to the Health Network and shall make appropriate adjustments to the auto assignment allocation as set forth in CalOptima Policy AA.1207a: CalOptima Auto Assignment; and

d. CalOptima's Provider Network Department shall notify the Health Network, Primary Hospital, Primary Physician Group, or CCN of the enrollment limit.

4. If Member enrollment in a Health Network, CCN, Primary Hospital, or Primary Physician Group falls below the maximum enrollment limit for three (3) consecutive months, CalOptima shall reinstate Member auto assignment to the Health Network.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract for Health Care Services
B. CalOptima Policy AA.1000: Glossary of Terms
C. CalOptima Policy AA.1207a: CalOptima Auto Assignment
D. CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct
E. CalOptima Policy DD.2008: Health Network and CalOptima Community Network Selection Process
F. CalOptima Policy HH.1104: Complaints of Discrimination
G. CalOptima Policy HH.2002: Sanctions
H. CalOptima Policy HH.2005: Corrective Action Plan

VI. REGULATORY AGENCY APPROVALS

A. 03/29/16: Department of Health Care Services
B. 01/23/15: Department of Health Care Services

VII. BOARD ACTIONS

A. 08/04/16: Regular Meeting of the CalOptima Board of Directors
B. 03/06/14: Regular Meeting of the CalOptima Board of Directors
C. 08/30/06: Regular Meeting of the CalOptima Board of Directors
D. 05/07/02: Regular Meeting of the CalOptima Board of Directors
E. 01/05/99: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title
Effective	03/01/1996	EE.1106	Health Network Minimum and Maximum Member Enrollment
Revised	03/07/1996	EE.1106	Health Network Minimum and Maximum Member Enrollment
Revised	01/01/2007	EE.1106	Health Network Minimum and Maximum Member Enrollment
Revised	12/01/2011	EE.1106	Health Network Minimum and Maximum Member Enrollment
Revised	09/01/2014	EE.1106	Health Network Minimum and Maximum Member Enrollment
Revised	02/01/2016	EE.1106	Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment
Revised	08/04/2016	EE.1106	Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment

IX. GLOSSARY

Term	Definition
CalOptima Community Network	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
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Contracted Provider	A Provider who is obligated by written contract to provide Covered Services to Members on behalf of CalOptima, its contracted Health Networks or Physician Medical Groups.
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Family Linked Member	A Member who shares a county case number, as assigned by the County of Orange Social Services Agency, with another Member who is in his or her family and who resides in the same household.
Health Network	A Physician Hospital Consortium (PHC), Physician Medical Group (PMG) under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Health Network Eligible Member	A Member who is eligible to choose a CalOptima Health Network or CalOptima Community Network (CCN).
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Primary Hospital	A hospital contracted with CalOptima on a capitated and delegated basis as the hospital partner of a Physician Hospital Consortium (PHC).
Primary Physician Group	A physician group contracted with CalOptima on a capitated and delegated basis as the physician partner of a Physician Hospital Consortium (PHC).

CalOPTIMA Board Action Agenda Referral

Action to Be Taken September 1, 1998
Regular Meeting of the CalOPTIMA Board of Directors'

Report
VIII. A. Authorize Chief Executive Officer to Execute Health Network Contracts

Contact
Mary Dewane, CalOPTIMA Chief Executive Officer, (714) 246-8400

Recommended Action
Authorize CalOPTIMA Chief Executive Officer (CEO) to execute and deliver the Health Network contracts, and all other documents contemplated thereby, on behalf of CalOPTIMA, with such revisions and amendments deemed necessary and appropriate by CalOPTIMA staff upon advice of counsel.

Background
On October 1, 1995, CalOPTIMA entered into contracts with Health Plans (now referred to as "Health Networks"). These contracts were established for a three-year period and will terminate on September 30, 1998. During the contract period, CalOPTIMA and its Health Networks have undergone a number of consolidations and terminations. As a result, CalOPTIMA presently contracts with 17 Health Networks, including five health maintenance organizations (HMOs) and 12 physician hospital consortia (PHCs).

On April 7, 1998, the CalOPTIMA Board of Directors authorized CalOPTIMA staff to: (a) initiate and complete a contracting process for a three year contract with CalOPTIMA's existing Health Networks for the period October 1, 1998 through September 30, 2001 and (b) forego use of a Request for Proposal (RFP) process for additional Health Networks. Since that date, CalOPTIMA staff has worked intensely to complete the contracts, which will be extended to the 17 Health Networks currently contracting with CalOPTIMA. The contracts will have a start date of October 1, 1998.

Discussion
During the past five months, CalOPTIMA staff have worked closely with legal counsel to assure the legal propriety of the contracts and to ensure that the contracts conform to any applicable federal, state, or county laws and regulations. CalOPTIMA staff has also worked closely with DHS staff to ensure that the Department's concerns were appropriately addressed. In addition, CalOPTIMA staff has met with and sought input from representatives of the member and provider communities, including representatives of the Member Advisory Committee and Provider Advisory Committee.

Additionally, CalOPTIMA staff worked closely with the CalOPTIMA Board of Directors Contract Ad Hoc Workgroup. The Board of Directors' Contract Ad Hoc Workgroup's comments were integrated into the final version of the contract.

SEPARATE CONTRACTS

As with the 1995 contracts, CalOPTIMA staff used separate contracting instruments for the various types of Health Networks that contract with CalOPTIMA. Because HMOs are permitted, under California law, to act as a single entity, CalOPTIMA has developed a single contract for Knox-Keene licensed HMOs.

Because PHCs are comprised of distinct legal entities, a physician component and a hospital component, CalOPTIMA will continue to use separate contracts for PHCs, one for each component. However, all physician contracts will be identical to all other physician contracts and all hospital contracts will be identical to other hospital contracts. The PHC contracts have been modified since the last contracting period. Specifically, the physician and hospital are no longer identical but instead have been tailored to reflect the responsibilities of each entity under the contract. The modifications and the existence of two separate contracts does not, however, change the fact that the contracts bind both parties to the global requirements placed on the Health Networks at large. In fact, the Recital Section of the contract now provides that the PHC must agree to operate in a manner that is mutually beneficial to both entities and "to cooperate and coordinate with each other and CalOPTIMA in arranging and/or and providing Covered Services to Members." Additionally, under the new contract, as set forth in Article II, the PHCs will be required to submit a statement of operations. This statement will be attested to by both parties and will help ensure an understanding of the global requirements placed on the PHC as a Health Network.

CONTRACT STRUCTURE/ CHANGES

The structure of the three contracts is the same. Additionally, all three contracts remain very close to the 1995 contracts in both content and form. In reviewing the need for modifications to the 1995 contract, CalOPTIMA staff determined that contract changes should fall into one of two broad categories: (1) contract modifications required by state and federal regulations and agencies, and (2) contract modifications that would clarify and refine CalOPTIMA's expectations of its Health Networks. After the initial draft was shared with interested parties, CalOPTIMA staff made additional changes based upon input received from the member and provider communities and the Contract Ad Hoc Workgroup.

Many of the modifications in the new contract stem from the Federal Balanced Budget Act of 1997 (BBA). In that regard, CalOPTIMA was instructed by DHS to include specific language which either paraphrased or interpreted the BBA. For example, in Article I, the section which lists defined terms, the definition of Emergency Medical Condition and Emergency Services have been altered to mirror the BBA language. Other examples of BBA requirements submitted to CalOPTIMA by the state are evident throughout Article II, the Section that addresses the functions and duties of the Health Network. For instance, the language requiring the reporting of Fraud and Abuse Investigations and cooperation of the Health Networks in the Tobacco Litigation Lawsuit.

The state also asked that CalOPTIMA revise its contract in a number of other areas. For example, the inclusion of the definition of Family Planning Covered Services is a state requirement, as is the language holding the state harmless and prohibiting providers from billing the state for provision of Covered Services. Another example of new contract provisions required by the state is the section addressing the provision of Member Records to other treating providers upon a Member's request at no cost to the member.

A significant change in the contract stems from the state's change in payment of capitation to CalOPTIMA. As of June 1998, CalOPTIMA was placed on one hundred percent (100%) post payment of its capitation from the state. That means CalOPTIMA receives capitation from the state a month after the services are rendered. When CalOPTIMA staff reviewed what impact this change would have on the Health Networks, CalOPTIMA staff determined that it would be in the best interest of Health Networks to minimize the amount of capitation paid on post-payment basis. Accordingly, CalOPTIMA staff determined that CalOPTIMA should continue to pre-pay the Health Networks the majority of their monthly capitation payments. Specifically, as set forth in Article IV, seventy-five percent (75%) of capitation will continue being paid prior to services being rendered, only the remaining twenty-five percent (25%) of the capitation will be post-paid, thereby minimizing the impact of this change in state operations on the Health Networks.

In addition, several modifications were made to contracts to clarify CalOPTIMA's expectations of the Health Networks as well as the existing obligations of the Health Networks under the contract. For example, the contract clarifies CalOPTIMA's expectations in the areas of payment to specialists, both in and out of network, timely clean claim payment, delegation and oversight and data reporting, particularly the reporting of encounter data.

Modifications were also made to the contract based upon the suggestions of the Health Networks. For example, the addition of a Notice provision in Article XI, the modification of the Indemnity Clause in Article XI and several modifications made to the subcontracting references and payment sections of the Contract were suggested by the Health Networks.

Finally, modifications were made to the contract based on specific recommendations of the Contracting Ad Hoc Workgroup. Significantly, the Contract Ad Hoc Workgroup recommend that the minimum enrollment threshold be raised from 2,500 to 5,000 members effective March 31, 1999. The Workgroup determined that incorporating increased threshold requirements into the contract would provide the Health Networks with an opportunity to fully understand CalOPTIMA's enrollment expectations prior to executing the contract. Pursuant to the Workgroup's recommendations, this modification was incorporated into Article VIII, the Section of the contract referencing Sanctions and Terminations.

Another significant contractual modification recommended by the Workgroup is the inclusion of the requirement in PHC, Physician and Hospital contracts, that both components submit a mutual statement of operations. The statement is to be signed by both the Physician and Hospital entities comprising the PHC.

CONCLUSION/ RECOMMENDATION

CalOPTIMA staff believes that the contracts clarify and refine its expectations of its Health Networks. The contracts reflect the policies and goals of CalOPTIMA as it enters its second contracting period. Most importantly, the contracts protect the best interest of CalOPTIMA members, its Health Networks and the organization.

CalOPTIMA staff recommends that the Board authorize CalOPTIMA Chief Executive Officer to execute and deliver the provider agreements, and all other documents contemplated thereby, on behalf of CalOPTIMA, with such revisions and amendments deemed necessary and appropriate by CalOPTIMA staff upon advice of counsel.

Fiscal Impact

The provider contracts with HMOs and Physician Hospital Consortia have a collective value approximating $153 million in direct capitation payments at an annualized rate based upon activity levels as of the end of CalOPTIMA's current fiscal year.

Rationale for Recommendation

CalOPTIMA staff believes that the contracts developed in coordination with legal counsel and Ad Hoc Workgroup clarify and refine CalOPTIMA's expectations of its networks. Staff is confident that the contracts meet the legal requirements faced by CalOPTIMA and that the contracts reflect the policies and goals of CalOPTIMA. Moreover, the contracts protect the best interest of CalOPTIMA members, its Health Networks, and the organization.

Concurrence

CalOPTIMA Contract Ad Hoc Workgroup
Foley & Lardner

Attachments

None

/s/ Mary Dewane — *8/26/1998*
Authorized Signature — **Date**

CalOPTIMA Board Action Agenda Referral

Action to Be Taken January 5, 1999
Regular Meeting of the CalOPTIMA Board of Directors

Report Item
VIII. C. Approve Elements to Implement Minimum Enrollment Threshold

Contact
Ray Jankowski, CalOPTIMA Chief Operating Officer, (714) 246-8400

Recommended Action

A. Approve the methodology of measurement for the minimum enrollment threshold; and,

B. Authorize CalOPTIMA staff to develop health network consolidation/termination policies and procedures for presentation to the February 2, 1999, CalOPTIMA Board of Directors.

Background
On September 1, 1998, the CalOPTIMA Board of Directors authorized the Chief Executive Officer to execute and deliver the 1998 Contract for Health Care Services ("Contracts"). Significantly, the contracts contained a clause increasing the minimum member enrollment threshold from 2,500 to 5,000.

CalOPTIMA has notified the health networks of its intent to exercise its right to terminate those networks with an enrollment of less than 5,000 Medi-Cal members on or after March 31, 1999, pursuant to Article VII, Section B of the Contract.

Discussion
Presently, five (5) of CalOPTIMA's health networks have been identified as having an enrollment of less than 5,000 Medi-Cal members. An analysis of health network enrollment reveals that CalOPTIMA has experienced a downward enrollment trend over the past year. This trend may be compounded over the next several months by the State mandated re-determination process. This process affects approximately 30,000 members with aid codes 38 or 3C and could result in membership loss to CalOPTIMA and its health networks. Accordingly, it is foreseeable that additional health networks may fall below 5,000, particularly those networks that have less than 5,500 Medi-Cal members. Currently, there are three (3) additional networks with enrollment below 5,500.

\010599\enrollment2

Back to Agenda

CalOPTIMA staff recommends approval of its proposed measurement methodology. Specifically, staff proposes to measure the actual Medi-Cal membership of each network during the month of April 1999 and every April annually thereafter for the term of the Contract.* There is a predictable decrease in enrollment at different points in the month due to the fact that some members may lose eligibility on the first of the month only to regain it during the same month. Recognizing that, CalOPTIMA staff proposes that each health network's actual member enrollment should be measured daily during the month of April. If a health network reaches 5,000 Medi-Cal members on any day during April, the health network would not be terminated. Conversely, those health networks that fail to meet the minimum enrollment on any day during the month would be terminated unless have they have submitted and CalOPTIMA has approved a consolidation plan. This measurement methodology should allow those networks that have consistently maintained a level of enrollment of 5,000 members an opportunity to remain in the CalOPTIMA Program without being subject to the effects of temporary enrollment fluctuations, while still allowing CalOPTIMA the ability to enforce the enrollment threshold contract provision.

CalOPTIMA staff recognizes as part of this process, an overriding goal to maintain the integrity of the CalOPTMA provider network. Accordingly, staff must develop policies and procedures for a termination/consolidation process that will allow CalOPTIMA to achieve this goal and simultaneously ensure the ongoing financial viability and success of the CalOPTIMA program. CalOPTIMA staff anticipates presenting the final draft to of the policies and procedures for approval at the February 2, 1999 meeting of the CalOPTIMA Board of Directors.

Fiscal Impact

No immediate fiscal impact is anticipated. However, the final approval and implementation of the measurement methodology and CalOPTIMA's consolidation/termination policies and procedures should assist CalOPTIMA and its health networks in maintaining administrative expenses at a cost effective level.

Rationale for Recommendation

A. CalOPTIMA staff recommends approval of the proposed measurement methodology

The measurement methodology as proposed by CalOPTIMA staff will allow health networks achieving the minimum enrollment threshold during the month of April the opportunity to remain in the CalOPTIMA program without subjecting those networks to termination due to fluctuations in member enrollment during the measurement period. The measurement will also allow CalOPTIMA the opportunity to terminate those health networks that are unable to meet the minimum enrollment threshold of 5,000.

*Health Networks must have a minimum of 5,000 members enrolled in CalOPTIMA's Medi-Cal program. Accordingly, members enrolled with a network under CalOPTIMA's Healthy Families Program will not be counted in the measurement process.

B. Authorizing CalOPTIMA staff to develop consolidation and termination policies and procedures will allow CalOPTIMA the opportunity to preserve integrity of its provider network and ensure the continuing financial success and strength of the CalOPTIMA program.

Concurrence
Foley & Lardner

Attachments
None

/s/ Mary Dewane — *12/16/1998*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

VII. C. Consider Options for Developing a Provider Delivery System in Preparation for Implementation of the Duals Demonstration, Including Related Financial Modeling and Contract Template Development

Contact

Michael Schrader, Chief Executive Officer, (714) 246-8400
Javier Sanchez, Executive Director, CalOptima Care Network, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to expand the provider delivery system for the purpose of preparing for the implementation of the Duals Demonstration, including conducting related financial modeling, developing contract templates with the assistance of legal counsel, and the following:
    a. Leverage existing health networks (Board-approved January 3, 2013); and
    b. Explore the option of adding ~~Add~~ additional health networks selected through a Request for Proposal (RFP) process; and
    c. To maintain provider-patient relationships, explore the option of contracting ~~contract~~ directly with independent providers through CalOptima Care Network (CCN). These CCN contracts will:
        i. Offer no more than Medicare rates; and
        ii. Be available only with independent providers unaffiliated with CalOptima health networks who serve Dual Eligibles in Fee-For-Service (FFS) Medicare
    d. After six months, staff will evaluate access gaps, reimbursement rates and network coverage; and
2. Authorize the CEO, with the assistance of legal counsel, to enter into Letters of Intent (LOI) with RFP responders selected to participate memorializing the intent to participate in the Duals Demonstration. LOIs will only be necessary if CalOptima has not received the final contract terms and rates. The final contract terms are subject to future Board approval, as well as state and federal approval, as required.

Background

CalOptima currently serves approximately 75,000 members who are dually eligible for both Medicare and Medi-Cal ("Dual Eligibles"). The CalOptima Board previously approved CalOptima's intention to partner with both the federal and state governments to establish a Duals Demonstration for Dual Eligibles in Orange County. As a Duals Demonstration plan, CalOptima would coordinate the full array of health care benefits for Dual Eligible individuals, including both Medicare covered benefits, Medi-Cal covered wrap-around services and Medi-Cal Long-Term Services and Supports.

Back to Agenda

At its May 2012 meeting, the CalOptima Board authorized the CEO to complete and submit an application to CMS and DHCS to obtain designation as a Duals Demonstration. At that time, the Board also authorized the CEO to spend pre-implementation startup costs of not-to-exceed $373,994 to secure the necessary resources to meet regulatory requirements for the development of the Duals Demonstration. The initial application requirements were submitted and staff continues to respond to additional inquiries regarding the application. On January 3, 2013, the CalOptima Board approved additional funding of $615,000 for the balance of FY 2012–13 to continue the implementation efforts. Additionally, during the January meeting, the CalOptima Board authorized staff to leverage existing OneCare delegated health network contracts for participation in the Duals Demonstration.

While Duals Demonstration details are in the process of being finalized by the Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS), management's understanding is that the proposed method of enrollment of members into the Demonstration is through a passive enrollment process with an opt-out option. This is similar to the approach used at the start of CalOptima's OneCare program in 2005. At that time, there were approximately 55,000 dual eligible members in Orange County. Most of these individuals were passively enrolled into OneCare. However, within several months of OneCare's startup, approximately 75% of these individuals actively disenrolled from the program. While OneCare has experienced steady and consistent growth since inception, it continues to experience the disenrollment of members who are unable to access providers not contracted with OneCare.

Discussion

The potential enrollment for the first year of the Duals Demonstration is projected to be approximately 50,000 Orange County dual eligible members currently in fee-for-service (FFS) Medicare. Enrollment is scheduled to begin in September 2013 and will continue for 12 months.

While the start date has been moved to September, members will start receiving notices in June 2013. Therefore, CalOptima must have a complete network ready to accept enrollment by June. Recognizing that the state has put forth a very aggressive timeline, it is important for CalOptima to begin preparations for expansion.

To ensure maintenance of existing patient-provider relationships to the fullest extent feasible under the Demonstration, CalOptima staff desires to engage providers who already serve dual eligible members in FFS Medicare but have not participated in OneCare to their fullest capacity, do not contract with any of CalOptima's contracted health networks or Participating Medical Groups (PMGs) under the OneCare program, or do not currently contract with CalOptima at all. Inclusion of providers who currently serve members in FFS Medicare would ensure adequate network capacity, geographic coverage and cultural competence, and would support member engagement and retention in the Demonstration.

Back to Agenda

Stakeholder Vetting Process

The Board's Provider Advisory Committee (PAC) recently undertook an input and vetting process that included formation of an ad hoc workgroup to consider options for the Duals Demonstration provider delivery system and offer guidance regarding provider engagement. The workgroup's recommendations regarding delivery system expansion and options for provider participation were approved by the PAC at its June 14, 2012, meeting. The recommendations have been considered and incorporated into this proposed Board action.

The ad hoc workgroup, which includes representatives from hospitals, trade associations, CalOptima's contracted health networks, HMOs, some ancillary and DME providers as well as individual medical providers and other stakeholders, continues to meet regularly to discuss maximizing provider participation in the Duals Demonstration.

Building on CalOptima's OneCare Provider Network

In preparation for the joint CMS and DHCS plan readiness review, staff will leverage existing OneCare contracts, as approved during the January 2013 CalOptima Board meeting. While the final readiness requirements have not been released, staff anticipates that both CMS and DHCS will require plans to provide signed contracts to demonstrate a provider network.

Through the stakeholder engagement process, three options have emerged to further expand the Duals delivery system. The options available for this expansion include:

Option 1:

a. Leverage existing contracted OneCare health networks as approved by the Board on January 3, 2013.
b. After six months, staff will evaluate access gaps, reimbursement rates and network coverage.

Option 2:

a. Leverage existing contracted OneCare health networks as approved by the Board on January 3, 2013; and
b. Add additional health networks through an RFP process. This process would seek proposals from health care entities, such as organized medical groups and health plans that desire to contract with CalOptima to provide services as part of the Duals Demonstration through alternative financial/risk delegation models; and authorize staff to use certain criteria to evaluate providers' delegation readiness, as applicable, and subject to refinement based on final Duals Demonstration requirements;
c. After six months, staff will evaluate access gaps, reimbursement rates and network coverage; and
d. Authorize the CEO, with the assistance of legal counsel, to enter into Letters of Intent (LOI) with RFP responders selected to participate memorializing the

intent to participate in the Duals Demonstration. LOIs will only be necessary if CalOptima has not received the final contract terms and rates. The final contract terms are subject to future Board approval, as well as state and federal approval, as required.

Option 3:

a. Leveraging existing contracted OneCare health networks as approved by the Board on January 3, 2013; and
b. Add additional health networks through an RFP process as described in Option 2, above;
c. To maintain provider-patient relationships, contract directly with independent providers through the CalOptima Care Network (CCN). These CCN contracts will: (i) offer no more than Medicare rates; and, (ii) be available only with independent providers unaffiliated with CalOptima health networks who serve Dual Eligibles in Fee-for-Service (FFS) Medicare;
d. After six months, staff will evaluate access gaps, reimbursement rates and network coverage; and
e. Authorize the CEO, with the assistance of legal counsel, to enter into Letters of Intent (LOI) with RFP responders selected to participate memorializing the intent to participate in the Duals Demonstration. LOIs will only be necessary if CalOptima has not received the final contract terms and rates. The final contract terms are subject to future Board approval, as well as state and federal approval, as required.

After careful consideration, staff recommends Option 3.

Provider Delivery System Expansion

Staff recommends providing alternatives to the existing OneCare delivery system to execute a successful Duals Demonstration that includes as many provider choice options for the 50,000 dual eligibles currently in FFS Medicare as possible. To achieve one of the important the goals of the Demonstration to maintain continuity of care and member/provider relationships for Duals who choose or are passively enrolled in the Demonstration, it is important that the CalOptima Board consider allowing flexible options to participate in the Duals Demonstration for providers who currently provide services to Duals outside of CalOptima in Medicare FFS. CalOptima's experience from the OneCare startup indicates that if members are not able to maintain access to providers of their choice, members will exercise their right to disenroll from the Demonstration. The RFP process would allow providers to express their preferred means of participating in the Duals Demonstration:

- Full Delegation/Full Risk (available only in Medi-Cal currently)
- Partial Delegation/Partial Risk – includes Shared Risk Groups (SRGs) or Physician Hospital Consortia (PHC) (available in Medi-Cal and OneCare)

- Direct Contract/No Delegation (available only in Medi-Cal currently for limited diagnoses) or
- Minimal Delegation (professional or PCP capitation not available currently)

Currently participating delegated medical groups would also have an opportunity to propose new ways to participate in the CalOptima delivery system. For example, current SRGs may propose future participation as Full Risk medical groups. Review criteria for such proposals would include evaluation of whether the requesting provider(s) meet the appropriate regulatory risk-bearing organization and CalOptima criteria.

This process would also include the development of a contract template for each contracting option to be provided to interested providers. By offering additional contracting options, CalOptima staff anticipates engaging providers who have not traditionally participated with CalOptima (e.g., Medicare FFS providers), as well as expanding opportunities for currently contracted providers. As an example, two HMOs and three health networks currently contracted in CalOptima's Medi-Cal program are not OneCare providers.

CalOptima would enter into LOIs with providers interested in participating in the Duals Demonstration. Once rates are provided, CalOptima staff intends to develop a provider payment methodology that is based on Medicare rates, subject to final negotiations with DHCS and CMS. The final financial aspects of the Duals Demonstration will be provided to the Board for final approval in conjunction with proposed provider contract terms associated with all contracting options and a proposed agreement with DHCS and CMS.

CalOptima would negotiate appropriate market-based rates with providers opting to contract directly with CCN. Such rates would not exceed 100% of the Medicare Fee Schedule for Orange County. However, after six months, CalOptima would evaluate the needs of the Duals provider network and may consider paying providers rates higher than Medicare rates for some selected providers to fill gaps in the network and to guarantee continuity of care. This policy would be consistent with CalOptima's Medi-Cal Policy EE.1130 and would be subject to future Board approval.

<u>RFP and Evaluation Process</u>
CalOptima would request proposals (RFP) from medical groups and health plans interested in participating as Full Delegation/Full Risk and Minimal Delegation providers. CalOptima intends to evaluate providers and groups based on their ability to meet the minimum quality, administrative and financial participation criteria. Staff is in the process of developing the formal scoring criteria that will be used to evaluate the RFP responses with the assistance of a M.D. Medical Management consultant specializing in network structure. Such criteria would be approved by the Board and would include, but would not be limited to the following:

1. Medi-Cal/Medicare managed care experience
2. A requirement to participate in CalOptima's Medi-Cal and Medicare programs

3. A requirement to serve all CalOptima member categories and ages eligible for health network enrollment
4. Applicants must demonstrate the ability to add new providers not currently participating in the CalOptima system
5. Capacity to service seniors and persons with disabilities
6. Necessary licensing and/or accreditation (hospitals must be Joint Commission accredited)
7. Administrative capacity to perform:
    a. Utilization management
    b. Medical management
    c. Credentialing
    d. Quality management
    e. Claims processing and adjudication
    f. Member services and customer service functions
    g. Electronic data interchange
8. SB 260 compliance
9. Financial solvency
10. Financial reserve requirements
11. Cultural and linguistic services
12. Coordination with Long-Term Services and Supports and carve-out agencies
13. Demonstrated capacity to provide, or written subcontracts for the provision of, all covered services, as defined in the Division of Financial Responsibility (DOFR) provided by CalOptima
14. A history of quality patient care and member satisfaction as demonstrated through HEDIS or other approved measures

Recognizing the different strengths and weaknesses among the various groups and the need to maintain as many qualified participating providers as possible, CalOptima staff plans to work with health networks and providers independently in an effort to determine the optimal relationship for all parties involved.

Letters of Intent

To secure a robust delivery system and provider network that offers the best opportunity for a successful Duals Demonstration, it is necessary for CalOptima to secure LOIs with providers ahead of the start date of the Demonstration. Due to the lack of rates and final contractual terms associated with the Demonstration, the only option available to CalOptima is to enter into Letters of Intent (LOI) with down-stream providers selected according to the proposed process described above. With assistance of legal counsel, CalOptima staff would draft and execute LOI with providers subject to the final contract terms are to be negotiated and subject to future Board approval. If CalOptima receives capitation rates and final terms of the Demonstration from DHCS, the execution of LOIs with providers may not be necessary.

Back to Agenda

Fiscal Impact
Significant financial analysis will be performed once the rates for the Duals Demonstration are determined. The Board will have the opportunity to assess CalOptima's participation in the Duals Demonstration and the associated delivery system once rates are received. The rates paid to CalOptima are expected to be based on the current medical costs for Duals Demonstration eligibles, with reductions to generate savings to the State and CMS from the program. The rates paid to providers will be based on the rates paid to CalOptima. CalOptima's best opportunity to mitigate financial risks is to achieve the broadest network of providers and largest number of members possible. The more CalOptima's Duals Demonstration membership is reflective of the Orange County duals population as a whole, then the more likely the payment rates provided under the program will be adequate. CalOptima will be fully financially responsible for duals that may be served in CCN and will implement a coordinated model of care consistent with prevailing managed care principles in Orange County.

Rationale for Recommendation
The recommended action honors and fulfills the goals of the Duals Demonstration and provides networks an opportunity to secure greater participation among providers already in the CalOptima provider network. The Duals delivery system strategy captures new providers to ensure continuity of care and gives providers choice to participate in a way that best suits their business model. Staff's recommended approach applies a standard used by California public plans, including but not limited to LA Care, Inland Empire Health Plan, Health Plan of San Mateo, Gold Coast Health Plan, Central Coast Alliance for Health and CenCal Health.

In addition, successful implementation of the Duals Demonstration is predicated in large part on the establishment of a network that includes providers who may not have fully participated with CalOptima or have not contracted with CalOptima previously and are currently providing services for CalOptima dual eligible members in FFS Medicare. To engage these providers, CalOptima recommends the Board consider expanding the Duals Demonstration delivery system to offer a flexible participation model that aligns providers' organizational capacity with their level of desired risk.

Concurrence
Michael H. Ewing, Chief Financial Officer
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *2/1/13*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

32. Consider Extension of Contract with National Committee for Quality Assurance (NCQA)-Certified Vendor Inovalon which Provides Healthcare Effectiveness Data and Information Set (HEDIS) Reporting Support

Contact

Len Rosignoli, Chief Information Officer, (714) 246-8400
Caryn Ireland, Executive Director, Quality, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to:

1. Extend the Inovalon contract through October 31, 2019; and
2. Authorize payment of maintenance and support fees under the Inovalon contract through October 31, 2019.

Background

For Medicare-related products, HEDIS is a required method of reporting "healthcare effectiveness" using established and standard measurement criteria in a variety of areas. HEDIS helps to determine the Medicare Stars Rating, and HEDIS reporting is required for health plans (including CalOptima) that offer any Medicare products, for the California Department of Health Care Services (DHCS) regulatory quality reporting, and for NCQA accreditation.

Medicare uses a Star Rating System to measure how well Medicare Advantage and prescription drug (Part D) plans perform. Ratings range from one to five stars, with five being highest. Medicare scores how well plans performed in over 90 measurement areas within categories including:

- Staying Healthy – includes screenings, tests, vaccines, and other check-ups that help members stay healthy.
- Managing chronic (long-term) conditions – includes how often members in this category get certain necessary tests and treatments that help them manage their condition.
- Member experience with health plan and drug coverage – includes ratings of member satisfaction with the health plan.
- Member complaints and changes in the health plan's performance – includes how often Medicare found problems with the plan and how often members had problems with the plan. Includes how much the plan's performance has improved (if at all) over time.
- Health Plan customer service – includes how well the plan handles member appeals.
- Drug safety and accuracy of drug pricing – includes how accurate the plan's pricing information is and how often members with certain medical conditions are prescribed drugs in a way that is safer and clinically recommended for their condition.

HEDIS reporting is complex and requires the support of a NCQA certified HEDIS reporting vendor to adequately comply with regulations and to ensure accurate and timely reporting as well as auditability.

CalOptima contracted with Inovalon as the vendor of choice for HEDIS reporting.

In 2006, a request for proposal (RFP) was issued to find and select a HEDIS reporting vendor. Inovalon (named MedAssurant at the time) was selected and a contract effective November 1, 2006, was executed for a five-year term, ending on October 31, 2011. This was approved by the CalOptima Board of Directors as part of the Capital budget for Fiscal Year (FY) 2006-07.

On June 2, 2011, the Board approved an extension of the Inovalon agreement (then named Catalyst) through October 31, 2016. The current agreement allows for the option to extend for three (3) additional one-year terms, the latest ending October 31, 2019.

In the summer of 2014, staff evaluated the HEDIS reporting marketplace through a request for information (RFI) process to solicit input from HEDIS reporting vendors. Nine vendors responded to CalOptima's RFI. Five of the responding vendors were either not NCQA certified or only partially certified and were disqualified. The remaining four were evaluated based on cost and functionality. Based on this process, staff supported the continuation of the Inovalon agreement based on three primary factors remaining true: lowest cost, full functionality, and existing relationship.

Discussion
As a result of the recent market evaluation completed in 2014, and very limited shift in this industry segment since that time, staff recommends extending the agreement through October 31, 2019. The results of the RFI also showed no cost savings or improvements in process to justify the investment to change vendors.

HEDIS reporting has become somewhat of a commodity among the vendors in the marketplace. The differentiators are cost and relationship. CalOptima has a favorable pricing structure with Inovalon and a strong relationship that has enabled consistently positive HEDIS reporting and audit results. Additionally, changing vendors requires significant information services and operational investment and can be disruptive during the transition process.

Fiscal Impact
The CalOptima FY 2016-17 Operating Budget includes the annual fees for the existing HEDIS reporting vendor. Management will include expenses for the period of July 1, 2017, through October 31, 2019, related to proposed contract extension in the CalOptima FY 2017-18 and FY2018-19 Operating Budget when presented for Board consideration.

Rationale for Recommendation
The recommendation will enable continuity of HEDIS reporting and maintenance of a successful vendor relationship.

Concurrence
Gary Crockett, Chief Counsel

Attachments

1. June 2, 2011 CalOptima Board Action Agenda Referral, V. E., Authorize Extension of the Contract for Certified HEDIS Software
2. June 6, 2006 CalOptima Board Action Agenda Referral, VI. B., Approve the CalOptima Fiscal Year 2006-07 Capital Budget

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2011
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
V. E. Authorize Extension of the Contract for Certified HEDIS Software

Contact
Gertrude Carter, M.D., Chief Medical Officer, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to extend CalOptima's contract with MedAssurant for certified HEDIS software, Catalyst, through October 31, 2014, and to add two additional one-year extension options, exercisable at CalOptima's sole and absolute discretion.

Background
In 2006, the Board of Directors granted authority to issue a Request for Proposal (RFP) to procure and contract with a vendor for certified HEDIS software. Prior to using a certified vendor, CalOptima staff created source code for HEDIS reporting. However, with the inception of OneCare, HEDIS reporting requirements expanded significantly since the Centers for Medicare & Medicaid Services (CMS) requires full HEDIS reporting for Medicare Advantage Plans. CalOptima now reports over 40 measures across all programs: Medi-Cal, Healthy Families, and OneCare.

The use of a certified vendor reduces internal staffing burden, reduces NCQA HEDIS compliance audit risk (since the vendor is already certified by NCQA), and increases efficiencies.

As a result of the RFP process in 2006, CalOptima entered into an agreement on November 1, 2006 with MedAssurant for a term of five years. The contract currently expires on October 31, 2011.

Discussion
A contract extension would allow CalOptima to continue to use certified HEDIS software while recognizing efficiencies. CalOptima staff spends over 1000 work hours to build data tables and run the HEDIS software. While this work load is large, staff estimates that conversion to a new software application would require work hours in excess of 2000 hours.

In addition, the current software has become part of core business operations for medical data management. Catalyst is used for creating monthly registries of members with clinical gaps. These registries support the following business requirements:

- OneCare Model of Care
- HEDIS improvement initiatives

- DHCS-required Quality Improvement Projects
- MRMIB-required quality improvement initiatives
- Pay for Performance programs

Fiscal Impact
The cost of HEDIS software is a budgeted item for Fiscal Year (FY) 2010-11. The budgeted amount is $115,200. Annual costs are based on software license fees. For FY 2011-12, the estimated cost will be $110,400, which reflects changes in reporting requirements. In subsequent years, the costs will be built into the budget.

Rationale for Recommendation
This Board action will enable CalOptima to continue to use certified HEDIS software for required HEDIS reporting for the Medi-Cal, Healthy Families, and OneCare programs.

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

Attachments
None

/s/ Richard Chambers — *5/24/11*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2006
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. B. Approve the CalOptima Fiscal Year 2006-07 Capital Budget

Contact
Keith Quinlivan, Chief Financial Officer (714) 246-8400

Recommended Action
Approve the CalOptima Fiscal Year 2006-07 Capital Budget.

Background
From the time of its start up through February 28, 2006, CalOptima has invested $14,700,000 in furniture, equipment and tenant improvements. Such fixed assets wear out over time, with the result that accumulated depreciation totaling $10,600,000 has been charged against the value of these purchases. The resulting net value of CalOptima's fixed assets was $4,100,000 as of February 28, 2006, reflecting a seventy-two percent (72%) rate of depreciation of such value over time.

Discussion
CalOptima staff is proposing a capital budget of $3,037,560 for FY 2006-07 in order to make needed improvements in the following three areas:

Computer Hardware	$1,004,560
Computer Software	1,507,000
Tenant Improvements	526,000
	$3,037,560

This budget will fund, among other things, upgrades to computer hardware and software to enhance operational decision-making and allow staff to better monitor HEDIS scores.

Fiscal Impact
Investment in the capital budget will reduce CalOptima's investment principal by $3,037,560. At a three percent (3%) return rate, this will reduce annual interest income by $90,000.

Rationale for Recommendation
The proposed FY 06-07 Capital Budget will enhance operational efficiencies by making an investment in CalOptima's infrastructure as proposed.

Concurrence
Foley & Lardner LLP
Board of Directors' Finance Committee

Attachments
Attachment A: CalOptima Fiscal Year 2006-07 Proposed Capital Budget

/s/ Richard Chambers *5/31/2006*
Authorized Signature **Date**

Proposed CalOptima Fiscal Year 2006-2007 Capital Budget

Budget Items	Budget Amount	
Hardware Retirement / Replacements	$208,000	
HP RISS System (data archiving & retrieval)	$160,000	
Facets Production Cluster Upgrade (Hardware)	$150,000	
UPS Power Distribution System	$150,000	
Backup Data Storage Appliance	$100,000	
HEDIS Server	$50,000	
Network Based Fax Tool	$40,000	
Networked Color Printer Replacement	$27,200	
Mailing Machine	$27,000	
6 Laptops w/ Docking Stations	$25,860	
Laptop Pool Replacements	$20,000	
Remote Authentication Security (RAS)	$20,000	
CareLink Server	$19,500	
Replace HP Cabinets	$13,000	
Spare Enterasys Blade	$12,000	
InFocus LitePro Projectors	$9,000	
Total Computer Hardware		**$1,004,560**
HEDIS Software	$600,000	
Fraud Detection Software Pharmacy	$300,000	
Pre Payment Claims Audit Software	$150,000	
Facets Production Cluster Upgrade (Software)	$110,000	
Contract Management Software System	$75,000	
Batch Scheduler Software	$65,000	
Symposium Software Upgrade	$60,000	
Upgrade PBX to New Version	$40,000	
Call Monitoring System	$33,000	
BRS Upgrade/SQL Upgrade	$25,000	
W2K3 Server Software	$20,000	
Antigen for MS Exchange	$10,000	
Calendaring/File Tracking SW	$10,000	
AutoCad 2006 Software	$6,800	
Reader Board Software	$2,200	
Software		**$1,507,000**
Remodel Common Areas	$413,000	
A/V Equipment for Meeting Rooms	$78,000	
Building Monument Sign	$35,000	
Tenant Improvements		**$526,000**
	Grand Total	**$3,037,560**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
33. Authorize Submission of Proposal to the U.S. Department of Health and Human Services for a Quality Improvement Technical Assistance Grant

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

Recommended Actions
1. Authorize the Chief Executive Officer (CEO) to submit an application for a direct technical assistance grant to the Department of Health and Human Services Centers for Medicare and Medicaid Services under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA); and
2. Direct staff to return to the Board with specific deliverables and a proposed spending plan.

Background
In late June 2016, it was announced that federal grant funding would be available for technical assistance to assist clinicians in optimizing the use of health information technology in their practices. To capitalize on this opportunity and bring additional dollars into Orange County, staff submitted a non-binding letter of intent to submit a proposal by the July 6, 2016 deadline, with the formal grant application due no later than August 8, 2016.

MACRA was enacted "to amend title XVIII of the Social Security Act to repeal the Medicare sustainable growth rate and strengthen Medicare access by improving physician payments and making other improvements, to reauthorize the Children's Health Insurance Program, and for other purposes."

The MACRA makes three important changes to how Medicare pays those who give care to Medicare beneficiaries. These changes create a Quality Payment Program (QPP)[1]:
1. Ending the Sustainable Growth Rate formula for determining Medicare payments for health

2. Making a new framework for rewarding health care providers for giving better care not just more care
3. Combining existing quality reporting programs into one new system.

The MACRA QPP has two paths[1]:
1. Merit-Based Incentive Payment System (MIPS)
2. Alternative Payment Models (APMs)

The MIPS program will measure Eligible Professionals on quality, resource use, clinical practice management, and meaningful use of certified electronic health record (EHR) technology.[1]

APMs establish new ways for Medicare to pay health care providers for the care given to Medicare beneficiaries. Examples include paying some participating health care providers a lump-sum incentive

[1]From https://www.cms.gov. Medicare>Value-Based Programs>MACRA MIPS & APMs>MACRA: MIPS& APMs

payment (from 2019-2024), increasing transparency of physician-focused payment models, and, starting in 2026, offering some participating health care providers higher annual payments. Accountable Care Organizations, Patient Centered Medical Homes, and bundled payment models are some examples of APMs.[1]

Discussion

The Federal Department of Health and Human Services (HHS) via the Centers for Medicare and Medicaid Services (CMS) is offering a grant opportunity entitled "MACRA Quality Improvement Direct Technical Assistance (MQIDTA)" through the Office of Acquisition and Grants Management.

As indicated, the purpose of this program/contract is to provide direct technical assistance and support services tailored to clinician needs to ensure successful participation of MIPS eligible clinicians. Technical assistance is defined as clinician outreach, education, practice readiness, practice facilitation, Health Information Technology (HIT) optimization, practice workflow redesign, change management, strategic planning, assisting with full transition to APM, and enabling partnerships with local stakeholders.[2]

This is a cost-plus-fixed-fee contract. The estimated period of performance is five years, from November 30, 2016 through November 29, 2021. The Contractor shall be paid on a monthly basis upon its submission of complete and acceptable voucher/invoices. The fixed fee portion of the effort shall be divided equally between each of the 12 months of the base year.[2]

Payment of withholding (15% or $100,000 whichever is less) to be made in the final invoice, upon completion of close-out audit.[2]

If the Government elects to exercise its options (refer to Section I, FAR 52-217-9) option periods shall be funded by modification(s) to this contract signed by the Contracting Officer.[2]

The total award of the MQIDTA Program nationwide is currently $100 million for assisting 200,000 providers (exclusive of operating expenses such as software, hardware, and staffing).

This opportunity is a natural extension of the duties of the former CalOptima Regional Extension Center (COREC) and the current CalOptima TechAssist Program (COTAP) as well as the work of the CalOptima Quality department. Some additional background on those programs follows.

On February 17, 2009, the President signed the American Recovery and Reinvestment Act of 2009 (ARRA). Title XIII of Division A and Title IV of Division B of ARRA, together cited as the Health Information Technology for Economic and Clinical Health Act (HITECH Act), include provisions to promote meaningful use of health information technology to improve the quality and value of American health care. The HITECH Act authorizes incentive payments to eligible Medicare and Medicaid providers for meaningful use of certified EHR technology. In 2015, providers were expected to have adopted and be actively utilizing an EHR in compliance with the meaningful use

[1]From https://www.cms.gov. Medicare>Value-Based Programs>MACRA MIPS & APMs>MACRA: MIPS& APMs

[2]From the HHSM-500-2016-RFP-0021 MACRA Quality Improvement Direct Technical Assistance Request For Proposal

definition or be subject to financial penalties under Medicare (per Sections 4101(b) and 4102(b) of ARRA).

To help providers address these challenges, the Office of the National Coordinator for Health IT (ONC) funded the establishment of Regional Extension Centers (RECs). Four RECs were funded in California, including COREC, the CalOptima Regional Extension Center, which was part of the CalOptima Foundation. Since program inception, the four California RECs have provided assistance to over 10,000 providers. COREC has recently completed and assisted 1,010 primary care providers in Orange County.

COTAP is operating under a grant from the California Department of Health Services (DHCS) for technical assistance similar to COREC, but for eligible professionals beyond only primary care providers (e.g. specialists, physician assistants, nurse practitioners, etc.). DHCS refers to this program as the California Technical Assistance Program, or CTAP. The application for this grant was approved by the CalOptima Board of Directors in June of 2014 and awarded later that same month in the amount of $4.3 million.

Timing
Although it was generally known within the industry that this new grant opportunity may become available in 2016, the details of the timing were not publicized until a teleconference conducted on June 30, 2016. CalOptima staff submitted a non-binding letter of intent ahead of the July 6, 2016 due date. CMS updated the submission schedule again on July 21, 2016, and completed applications are due to CMS by 8:00 a.m. PDT on Monday, August 8, 2016. If approved, staff plans to submit CalOptima's proposal on Friday, August 5, 2016. If grant funds are awarded to CalOptima, staff will return to the Board with details on specific deliverables and a proposed spending plan.

Fiscal Impact
The financial impact of this application and program is budget neutral. Only currently budgeted positions will be used to support the requirements of this program, unless funds for staffing are included in the award. More details will be provided as part of the specific proposed spending plan.

Rationale for Recommendation
Staff felt this funding opportunity should not be missed, in order to potentially receive additional monies to support work that is already somewhat in progress, and to support the provider community as the industry transitions to continue to increase the focus on quality of care for members.

However, at this time, staff is still in the process of gathering details on the program as they are being developed. Reflecting the early stages of the program and its deliverables, the RFP indicates in part:

> Successful MQIDTA contractors will need to commit to and meet quantifiable outcomes that must align with the overall aims of the MACRA requirements, many of which are yet to be defined. Provide 2 (two) examples of corporate experience that required you to be agile with delivering services.[2]

[1]From https://www.cms.gov. Medicare>Value-Based Programs>MACRA MIPS & APMs>MACRA: MIPS& APMs

[2]From the HHSM-500-2016-RFP-0021 MACRA Quality Improvement Direct Technical Assistance Request For Proposal

Concurrence
Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer

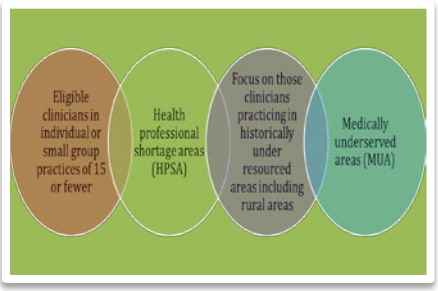
Attachment
Presentation: MACRA Quality Improvement Direct Technical Assistance Quality Payment Program – Small, Underserved and Rural Support, dated June 30, 2016

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

[1]From https://www.cms.gov. Medicare>Value-Based Programs>MACRA MIPS & APMs>MACRA: MIPS& APMs
[2]From the HHSM-500-2016-RFP-0021 MACRA Quality Improvement Direct Technical Assistance Request For Proposal

Centers for Medicare & Medicaid Services

MACRA Quality Improvement Direct Technical Assistance Quality Payment Program – Small, Underserved and Rural Support



MQIDTA (QPP_SURS) Pre Proposal Conference
Quality Improvement & Innovation Group
Thursday, June 30, 2016

Agenda

- Program Overview
- Contract Overview
- Break
- Discussion with Partners
  - Health Resources and Services Administration (HRSA)
  - Office of the National Coordinator (ONC)
- OAGM Procurement Timelines
- Questions and Answers

MQIDTA (QPP_SURS) Program Team

Quality Improvement and Innovations Group

- Dennis Wagner, Quality Improvement & Innovation Group(QIIG) Director
- Jeneen Iwugo, QIIG Deputy Director
- Traci Archibald, ESRD, Population and Community Health (EPCH) Division Director
- Brenda Gentles, SME
- Christina Goatee, SME
- Ann Turner, SME

Office of Acquisitions and Grants Management

- Kim Tatum, Contracting Officer
- Jonathan Chattler, Contract Specialist
- Irina Perl, Contract Specialist

Partnerships

- Laura Rosas, ONC
- Dr. Thomas Mason, ONC
- Paul Moore, HRSA
- Wakina Scott , HRSA

MQIDTA (QPP_SURS) Program Overview

What is MACRA ?

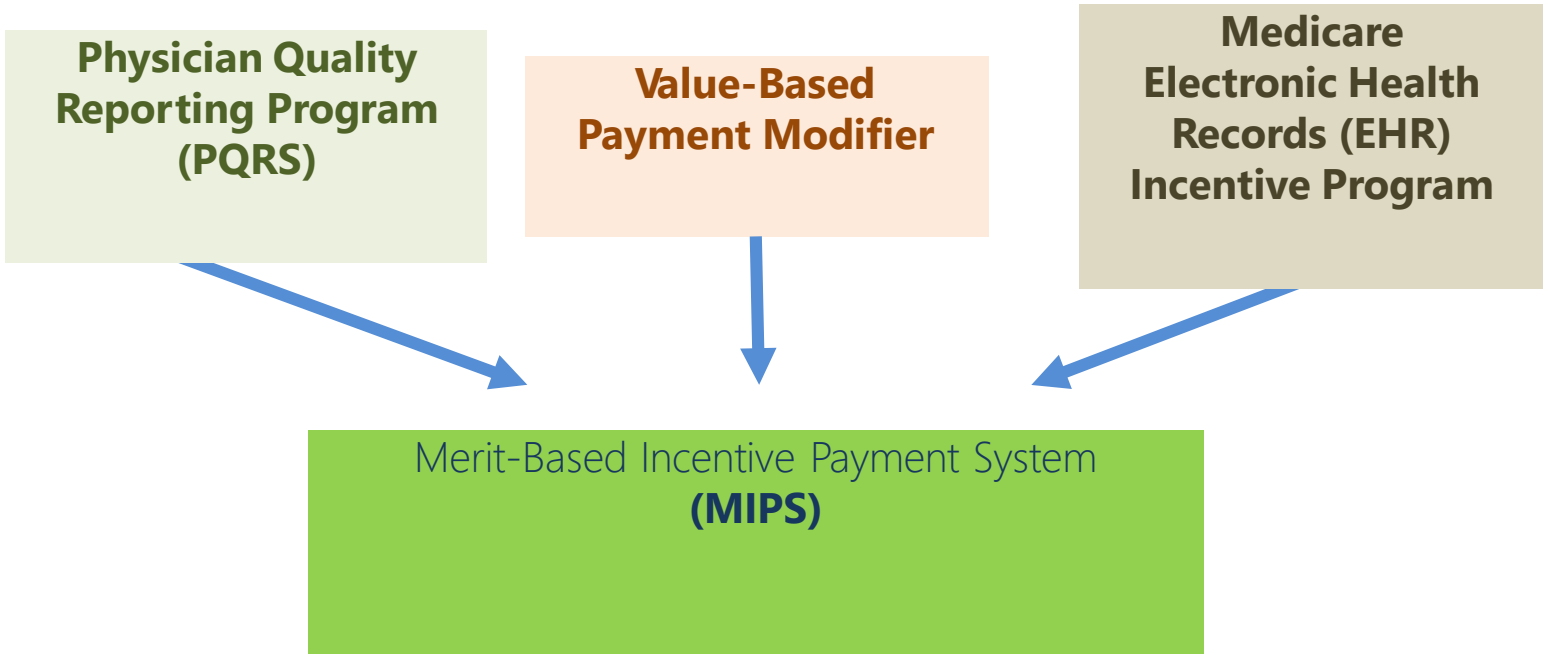
MACRA stands for the **Medicare Access and CHIP Reauthorization Act of 2015,** bipartisan legislation signed into law on April 16, 2015**.**

What does it do ?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for **value** over volume
- **Streamlines** multiple quality reporting programs into 1 new system **Merit based Incentive Payment System** (MIPS)
- **Provides bonus payments** for participation in ***eligible*** **alternative payment models (APMs)**

MQIDTA (QPP_SURS) Program Overview

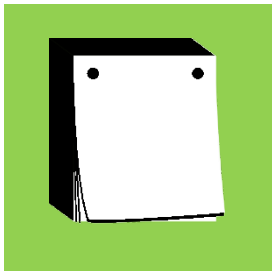
MACRA streamlines these programs into **MIPS**



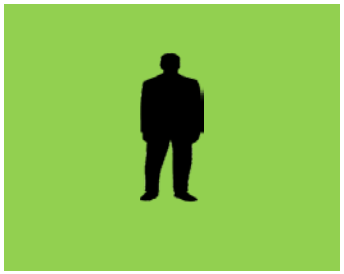
MQIDTA (QPP_SURS) Program Overview

Are there any exceptions to participation in MIPS?

There are **3 groups** of clinicians who will NOT be subject to MIPS:



FIRST year of Medicare Part B participation



Below low patient volume threshold
Low volume is <=$10,000 in allowed charges and <=100 beneficiaries seen.

Certain participants in ELIGIBLE Alternative Payment Models

Note: MIPS **does not** apply to hospitals or facilities

MQIDTA (QPP_SURS) Program Overview

What will determine an EPs MIPS score?

The MIPS composite performance **score** will factor in performance in **4 weighted categories**:

Quality

Quality measures wil be published in an **annual list** *and clinicians will be* **able to choose** *the measures on which they'l be evaluated*

Resource use

Will compare resources used to treat similar **care episodes** *and* **clinical condition groups** *across practices and can be* **risk-adjusted** *to reflect external factors*

Clinical practice improvement activities

Examples include care coordination, shared decision-making, safety checklists, expanding practice access

Use of certified EHR technology

% weight of this **may decrease** *as more users adopt EHR*

MQIDTA (QPP_SURS) Program Overview

MIPS: Clinical Practice Improvement Activities (CPIA)

The Secretary is required to specify clinical practice improvement activities. Subcategories of activities are also specified in the statute, some of which are:

Expanded Practice Access	Population Management	Care Coordination	Beneficiary Engagement	Patient Safety Practice Assessment	Alternative Payment Models
•Same day appointments for urgent needs •After hours clinician advice	•Monitoring health conditions & providing timely intervention •Participation in a qualified clinical data registry	•Timely communication of test results •Timely exchange of clinical information with patients AND providers •Use of remote monitoring •Use of telehealth	•Establishing care plans for complex patients •Beneficiary self-management assessment & training •Employing shared decision making	•Use of clinical checklists •Use of surgical checklists •Assessments related to maintaining of certification	•Participation in an APM will also count for CPIA

MQIDTA (QPP_SURS) Program Overview

PARTICIPANTS CHECK IN

MQIDTA (QPP_SURS): Technical Assistance

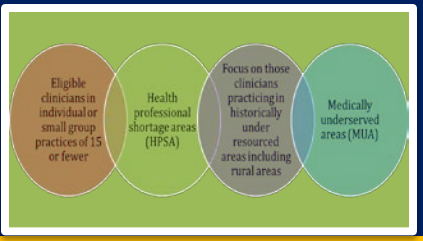
MQIDTA (QPP_SURS): Technical Assistance

The purpose of this contract is to provide a ***flexible*** and ***agile*** approach to **customized direct technical assistance** and support services tailored to clinician needs to ensure success for participating in the Merit-based Incentive Payment System (MIPS) and easing eligible clinicians into the transition of Medicare payments from a fee-for-service system to one that is based on performance and patient outcomes.

CMS on behalf of the Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers …or regional health collaboratives and others experienced and interested in assisting small, underserved and rural clinicians) to offer guidance and assistance to MIPS eligible clinicians in practices of 15 or fewer professionals.

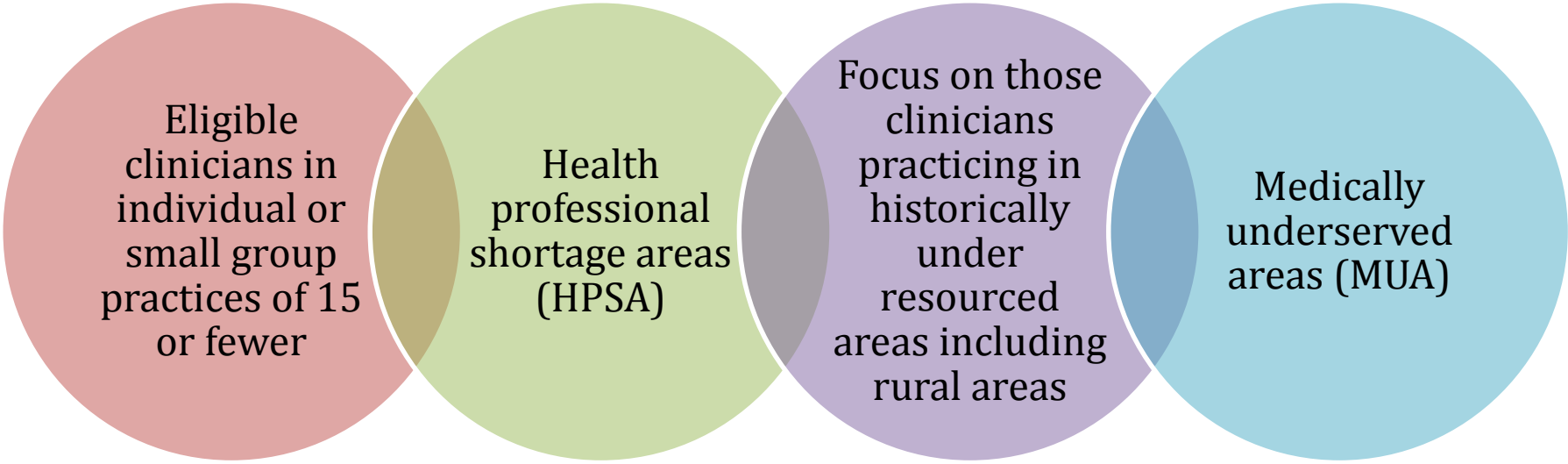
https://www.congress.gov/bill/114th-congress/house-bill/2/text)

(*"The Secretary shall enter into contracts or agreements with appropriate entities (such as quality improvement organizations, regional extension centers (as described in section 3012(c) of the Public Health Service Act), or regional health collaboratives) to offer guidance and assistance to MIPS eligible professionals in practices of 15 or fewer professionals (with priority given to such practices located in rural areas, health professional shortage areas (as designated under in section 332(a)(1)(A) of such Act), and medically underserved areas, and practices with low composite scores) with respect to— "(i) the performance categories described in clauses (i) through (iv) of paragraph (2)(A); or '(ii) how to transition to the implementation of and participation in an alternative payment model as described in section 1833(z)(3)(C)."*



MQIDTA (QPP_SURS): Technical Assistance

The Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS) intends to solicit and award multiple contracts to qualified contractors for Medicare Access and CHIP Reauthorization Act (MACRA) Quality Improvement Direct Technical Assistance Quality Payment Program – Small, Underserved and Rural Support. Technical assistance through this program will target:



MQIDTA (QPP_SURS): Technical Assistance

CMS expects to cover all eligible clinicians meeting the target population requirements designated in the statute that need assistance across the country.

The target population includes practices with ***15 or fewer clinicians***, with preference given to practices in medically underserved and rural areas.

MQIDTA (QPP_SURS): Technical Assistance

What

- Clinician Outreach and Education
- Practice Readiness
- Practice Facilitation

is

- Health Information Technology (HIT) optimization
- Practice workflow redesign

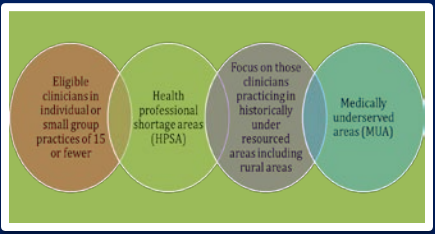
Technical

- Change Management
- Strategic Planning
- Clinician Satisfaction

Assistance?

- Assisting clinicians in fully transitioning to Alternative Payment Models (APM)
- Enabling partnerships

The contractor must ***identify, assess, and enroll*** clinicians into the program, ***assist*** with the implementation of a quality improvement program, provide a flexible and agile approach to customized direct technical assistance tailored to clinician needs, and enable Peer-to-Peer learning in order to heighten customer satisfaction.



MQIDTA (QPP_SURS): Technical Assistance

L.12 Technical Approach/Targeted Outcomes (VOL I)

Offerors shall propose an approach to provide customized direct technical assistance tailored to clinician needs to help **ALL** eligible clinicians within a contiguous state boundary and successfully ease the transition of Medicare payments from a fee for service system to one based on performance and patient outcomes for MIPS eligible clinicians. Clinician needs are defined as education, outreach and technical support.

The Technical Proposal should include how you will identify % of eligible clinicians within the following categories and provide target numbers:

- Individual and small practice clinicians
- Clinicians located in primary care HPSAs
- Clinicians in practices located in rural counties
- Clinicians serving large underserved populations

The contractor must ***identify, assess, and enroll*** clinicians into the program, ***assist*** with the implementation of a quality improvement program, provide a flexible and agile approach to customized direct technical assistance tailored to clinician needs, and enable Peer-to-Peer learning in order to heighten customer satisfaction.

MQIDTA (QPP_SURS): Technical Assistance

L.12 Technical Approach/Targeted Outcomes (VOL I) Sec E

Offerors' approach will describe the methodology in which direct customized technical assistance will be determined at the level of need at the right time and with the least amount of intervention and expenditure of resources need for the following categories:

(1) Individual and small practice clinicians
(2) Clinicians located in primary care HPSAs
(3) Clinicians in practices located in rural counties
(4) Clinicians serving large underserved populations
(5) Clinicians with the greatest need of technical assistance

These categories are **not mutually exclusive**; clinicians who fall in more than one of these categories should be prioritized in the provision of customized direct technical assistance.

The contractor must ***identify, assess, and enroll*** clinicians into the program, ***assist*** with the implementation of a quality improvement program, provide a flexible and agile approach to customized direct technical assistance tailored to clinician needs, and enable Peer-to-Peer learning in order to heighten customer satisfaction.

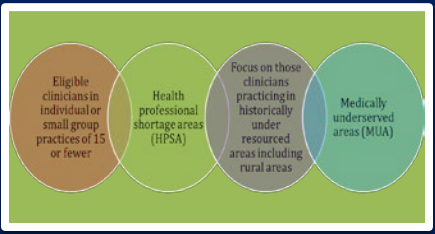
MQIDTA (QPP_SURS): Technical Assistance

L.12 Technical Approach/Targeted Outcomes (VOL I) Sec F

MQIDTA (QPP_SURS) is an active process by which the contractor will assist clinicians with participating in MIPS and assisting clinicians with transitioning into APMs as appropriate, by customizing an approach to meet individual clinician needs.

Note: This plan shall be further developed as a deliverable upon contract award.

The contractor must ***identify, assess, and enroll*** clinicians into the program, ***assist*** with the implementation of a quality improvement program, provide a flexible and agile approach to customized direct technical assistance tailored to clinician needs, and enable Peer-to-Peer learning in order to heighten customer satisfaction.



MQIDTA (QPP_SURS): Technical Assistance

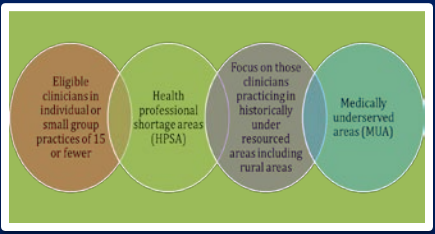
L.13 Corporate Experience, Operational Capacity and Key Personnel (VOL II) Sec A (1-4), B

It is vital to leverage previous clinician relationships (i.e. those developed by Quality Improvement Organizations (QIOs), Quality Improvement Networks (QINs), Regional Extension Centers (RECs) Transforming Clinical Practice Initiative and other technical assistance programs).

Offerors's technical assistance will include Peer-to-Peer learning through collaboration and engagement with Learning and Action Networks (LANs).

- Proposals should include evidence of local presence through prime and inclusive of subcontractor teaming arrangements for all proposed states/territories in order to have efficient approach to reach local clinicians.
- Describe pre-existing Networks, Partnerships and/or Collaborations that include a diverse spectrum of community stakeholders and/or plan to expand and build new clinician relationships.
- Describe methodology for a tailored technical assistance strategy to serve ALL Eligible clinicians based on customer segments (i.e. rural, HPSA, specialty clinicians, office managers, etc.) and the ability to provide and/or facilitate efficient and effective technical assistance at the level of clinician need administered at the right time with the least amount of intervention and expenditure of resources.

The contractor must ***identify, assess, and enroll*** clinicians into the program, ***assist*** with the implementation of a quality improvement program, provide a flexible and agile approach to customized direct technical assistance tailored to clinician needs, and enable Peer-to-Peer learning in order to heighten customer satisfaction.



MQIDTA (QPP_SURS): Technical Assistance

Quality Innovation Network-Quality Improvement Organizations (QIN-QIO) TA

- ~400,000 eligible clinicians
- Larger practices (>15 EPs)
- Non-rural
- Focus on user experience and customer service.
- Technical assistance provided via:
  - LANs
  - Educational modules aligned with QPP content that provide CME/CEU credit
  - Direct TA (as requested) that is individualized to the customer

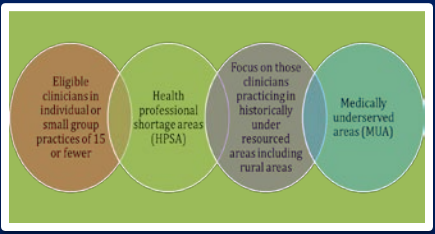
Transforming Clinical Practice Initiative (TCPI)

- Covers 140,000+ Practices
- Four year model test
- Large Scale Practice Transformation Improvement efforts
- Leveraging existing collaboration to create comprehensive Community of Practice
- Open Door Forums
- Aims to assist clinicians in progressing through the five phases of practice transformation in order to help more clinicians become a part of APMs

MQIDTA (QPP_SURS)

- 200,000+ clinicians
- Small Practices(<=15 ECs)
- Practices in rural & HPSA Areas/medically underserved populations
- Support maximizing existing REC/QIO /RHC network infrastructure

Organizations funded under MACRA and the organizations within the TCPI will be aligned and work closely together without duplicating clinicians and activities, to help practices successfully transform their care, while also preparing for the new Quality Payment Program.



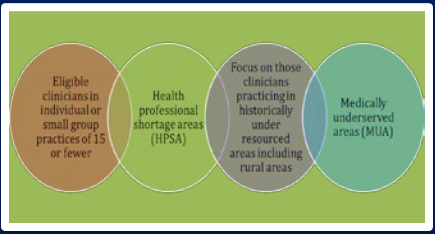
MQIDTA (QPP_SURS): Technical Assistance

L.13 Corporate Experience, Operational Capacity and Key Personnel (VOL II) A (1-4)

Successful MQIDTA contractors will need to commit to and meet quantifiable outcomes that must align with the overall aims of the MACRA requirements, many of which are yet to be defined. Provide 2 (two) examples of corporate experience that required you to be agile with delivering services. In addition, Offerors should provide the following:

- Experience and measurable success in providing customized and local direct technical assistance to Medicare and Medicaid healthcare clinicians (especially those in small, underserved, and rural practices) to adopt and optimize the use of certified HIT, improve clinical quality and manage resource use.
- Experience supporting methodologies for success with multiple clinicians in small, rural and underserved areas at different levels of need/technical assistance
- Corporate experience that indicates service delivery processes that successfully used interventions to assist clinicians in addressing quality improvement interventions for Medicare beneficiaries and quality measurement reporting in Medicare programs.
- A plan to manage multiple partners which, includes but is not limited to administrative and management structure of teaming arrangements, effective lines of communication, resource and subcontractor management and also identify potential risks.

The contractor must ***identify, assess, and enroll*** clinicians into the program, ***assist*** with the implementation of a quality improvement program, provide **a flexible and agile approach** to customized direct technical assistance tailored to clinician needs, and enable Peer-to-Peer learning in order to heighten customer satisfaction.



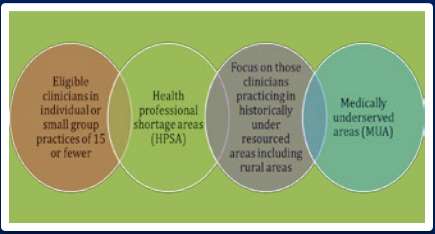
MQIDTA (QPP_SURS): Technical Assistance

SOW C.2 Eligibility Requirements

In accordance with the MACRA legislation, MQIDTA (QPP-SURS) contractors may include entities such as Quality Improvement Organizations (QIOs), Regional Extension Centers (RECs) or Regional Health Collaborative (RHCs). Contractors are encouraged to collaborate in order to strengthen the application, reach, and scope of services being provided to MIPS eligible clinicians.

It is required that the MQIDTA (QPP-SURS) contractor meet the eligibility criteria for the contract goals in providing a comprehensive direct technical assistance approach. The approach will assist in mitigating the challenges faced by small and individual clinicians in rural and other under resourced areas.

The contractor must ***identify, assess, and enroll*** clinicians into the program, ***assist*** with the implementation of a quality improvement program, provide a flexible and agile approach to customized direct technical assistance tailored to clinician needs, and enable **Peer-to-Peer learning** in order to heighten customer satisfaction.



MQIDTA (QPP_SURS): Technical Assistance

SOW C.2 Eligibility Requirements

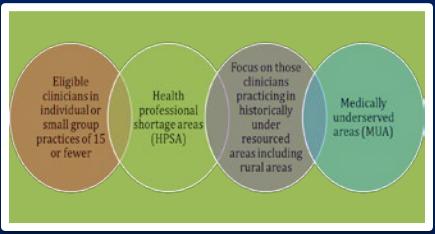
The MQIDTA (QPP-SURS) contractor is required to bring unique, extensive expertise and experience in order to strengthen the overall strategy in the provision of direct technical assistance. These multi-dimensional challenges will be addressed in tandem by the three types of organizational requirements:

- **Requirement 1 -** Comprehensive experience and measurable success in providing customized and local direct technical assistance to Medicare and Medicaid health care clinicians (especially those in small, underserved, and rural practices) to adopt and optimize the use of certified HIT

- **Requirement 2 -** Comprehensive experience and history in working with key stakeholders to implement innovative tools and successful interventions to assist clinicians in addressing quality improvement interventions for Medicare beneficiaries and quality measurement reporting

- **Requirement 3 -** Multi-stakeholder organization that implements initiatives to improve the quality and affordability of health care services. This organization should be governed by stakeholders that represent clinicians groups, hospitals and health systems; healthcare payers; healthcare purchasers and consumers and entities representing consumers.

The contractor must ***identify, assess, and enroll*** clinicians into the program, ***assist*** with the implementation of a quality improvement program, provide a flexible and agile approach to customized direct technical assistance tailored to clinician needs, and enable **Peer-to-Peer learning** in order to heighten customer satisfaction.



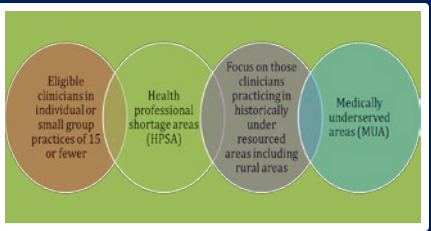
MQIDTA (QPP_SURS): Technical Assistance

L.13 Corporate Experience, Operational Capacity and Key Personnel (VOL II)

A key goal is to provide the right level of technical assistance at the right time in a way that provides the best possible value to the government. MQIDTA (QPP_SURS) contractors should:

- Demonstrate how they will assess needs and provide customized support to previously under or unsupported clinicians.
- Develop and use technical assistance approaches that will aid clinicians to effectively solve their challenges most efficiently. In extreme cases, technical assistance including a physical "boots on the ground" presence in practices may be required.
- Describe methodology to determine the right level of technical assistance at the right time with the least amount of intervention and expenditure of resources, progressing if necessary.
- Provide approach and measures to continuously monitor eligible clinicians' satisfaction with technical assistance which includes timeliness of touch, support, and useful resources.

The contractor must ***identify, assess, and enroll*** clinicians into the program, ***assist*** with the implementation of a quality improvement program, provide a flexible and agile approach to customized direct technical assistance tailored to clinician needs, and enable Peer-to-Peer learning in order to **heighten customer satisfaction**.



MQIDTA (QPP_SURS): Technical Assistance

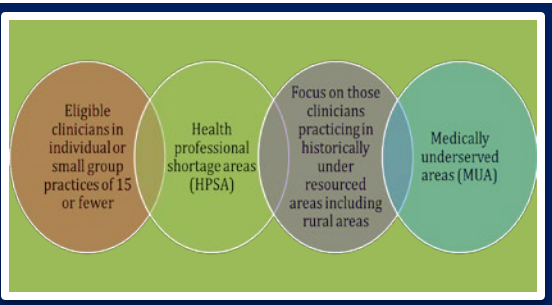
Desired Outcomes

SOW C.3.3

- ✓ **Serve** ALL clinicians in your defined contiguous area that meet the criteria for small, rural, health professional underserved and medically underserved areas
- ✓ **Provide** customized technical assistance to clinician at the level in which they need and that provides the greatest value
- ✓ **Ensure** eligible clinician's satisfaction with technical assistance which includes timeliness of touch, support, and useful resources
- ✓ **Increase** the number of eligible MIPS eligible clinicians participating in MIPS and APM programs
- ✓ **Transform** clinical practices by educating clinicians on successful techniques related to the four MIPS performance categories

MQIDTA (QPP_SURS): Technical Assistance

PARTICIPANTS CHECK IN

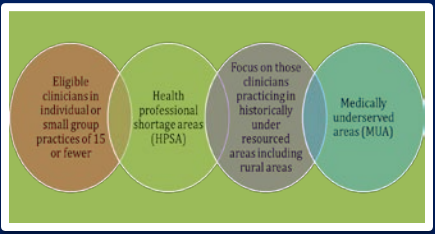


MQIDTA (QPP_SURS): BREAK

We will resume in 20 minutes

MQIDTA (QPP_SURS): BREAK
WE WILL RESUME IN 20 MINUTES

Question	Response
Q: What is the CPIA requirement for rural providers and those in Health Professional Shortage Areas (HPSAs)?	A: Clinicians in small, rural, HPSAs, or non-patient-facing professionals may receive the highest score of 100% by reporting two CPIAs (either medium or high). For clinicians that are small, rural, health professional shortage areas practices or non-patient facing professionals, in order to achieve a 50% score, one CPIA is required (either medium or high). CMS will monitor this category closely to determine if other considerations are warranted for rural clinicians.
Q: How will CMS determine whether a clinician has met the participation requirements?	A: The proposal in the NPRM accounts for participation in multiple Advanced APMs where appropriate. We propose that, for instances in which an individual clinician does not become a Qualifying APM Participant through any single Advanced APM Entity, CMS will assess the Advanced APM participation of the clinician individually.
Q: MACRA requires special consideration for small and rural providers, as well as those practicing in HPSAs. How is CMS implementing these considerations in the proposed rule?	A: These eligible clinicians are given special consideration under the performance categories.
Q: When will the MACRA Quality Improvement Direct Technical Assistance (MQIDTA) Program, Quality Payment Program – Small, Underserved and Rural Support (QPP-SURS) begin?	A: The program will begin on or about November 30, 2016. We anticipate our QPP-SURS providers to begin outreach efforts and begin notifying clinicians about resources available through this program.
Q: Will the MQIDTA, (QPP-SURS) contractor also work with stakeholders outside of the Quality Payment Program?	A: The MQIDTA (QPP-SURS) support contractor will have the ability to coordinate the much needed activities with various stakeholders, organizations and clinical communities that are working to support QPP implementation and effectiveness. This coordination should be both proactive and ongoing, adjusting to changing needs as the program evolves. CMS partners with national organizations and key stakeholders, and relies on those relationships to create awareness and educate their members at state and local levels. CMS is working with over 150 national organizations including: Specialties, Family Medicine, Nurses, Physician Assistants , Hospitals , Long Term Care/Rehab/Home Care/Hospice, Advocacy , Health Care Administration and other Health Providers
Q:How is the TCPI funding you announced different than the technical assistance funding in the MACRA legislation you're announcing today?	A: TCPI has been in existence prior to the MACRA legislation. The initiative promotes peer-based learning networks designed to coach, mentor and assist clinicians in developing core competencies specific to practice transformation. The TCPI aims to assist clinicians in progressing through the five phases of practice transformation in order to help more clinicians become a part of Alternative Payment Models, which is a core part of the Quality Payment Program. The MACRA technical assistance will go to organizations in targeted geographic regions to provide hands-on training about the Quality Payment Program. The education will be tailored to the individual concerns of small practices, especially those that practice in historically under-resourced areas including rural areas, health professional shortage areas, and medically underserved areas. The organizations funded under MACRA and the organizations within the TCPI will be aligned and work closely together to help practices successfully transform their care, while also preparing for the new Quality Payment Program.



MQIDTA (QPP_SURS): Implementation Schedule

Offerors Technical Approach should demonstrate the ability to begin outreaching efforts immediately upon award.

THE TIME

Finalize the MACRA regulation-FALL 2016

TO START

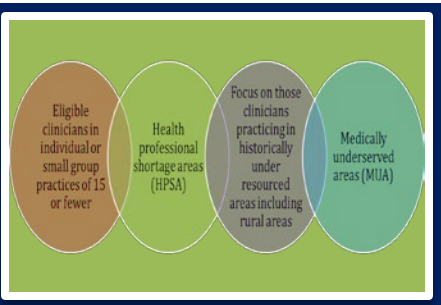
First performance period MIPS

Jan 1, 2017 thru December 31, 2017

IS NOW!

Last performance period for separate programs Jan 1, 2016 thru December 31, 2016.

First payment year for MIPS 2019, based on first performance period of 2017.



MQIDTA (QPP_SURS): Contract Overview (OAGM)

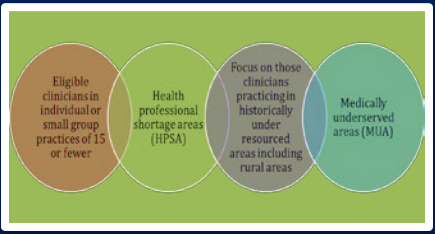
MQIDTA (QPP_SURS): Contract Overview (OAGM)

Contract Specialists
Jonathan Chattler
Irina Perl

Contracting Officer
Kimberly Tatum

Contractor Compliance Officer
Greg Gesterling

Additional questions and correspondence should be submitted electronically to MQIDTA@cms.hhs.gov by July 6, 2016



MQIDTA (QPP_SURS): Contract Overview (OAGM)

- Information provided during this conference shall not qualify the terms of the solicitation
- Terms of the solicitation and specifications remain unchanged unless the solicitation is amended in writing
- Attendance at this pre-proposal conference is not a prerequisite for proposal submission and will not be considered a factor in proposal evaluation
- CMS will post a summary response to questions discussed at today's conference under the Federal Business Opportunities (FedBizOpps) database

Conflict of Interest

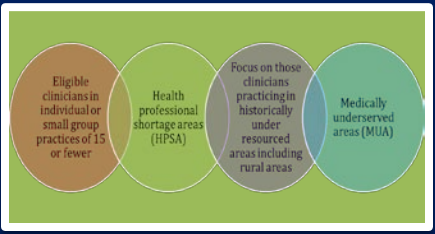
Greg Gesterling

Contractor Compliance Officer

Organizational Conflict of Interest Language

J.6 CONTRACTOR BUSINESS ETHICS, CONFLICT OF INTEREST AND COMPLIANCE PROGRAM REQUIREMENTS

J.7 Contract personal COI Financial Disclosure Template



MQIDTA (QPP_SURS): Contract Overview (OAGM)

- Cost Plus Fixed Fee Multiple Award Contracts
- Best Value Award Decision – Greatest overall benefit in response to the solicitation
- Full and Open Competition
  - -All vendors, large and small, are eligible to compete
- Period of Performance
  - -Base Year plus 4 option years
- Multiple Awards
- Subcontracting goals

MQIDTA (QPP_SURS): Contract Overview (OAGM)

Technical Proposal Evaluation; listed in order of importance

A. Evaluation of Technical Approach and Targeted Outcomes

B. Evaluation of Corporate Experience, Operational Capacity and Key Personnel

C. Evaluation of 508 Compliance

D. Evaluation of Past Performance

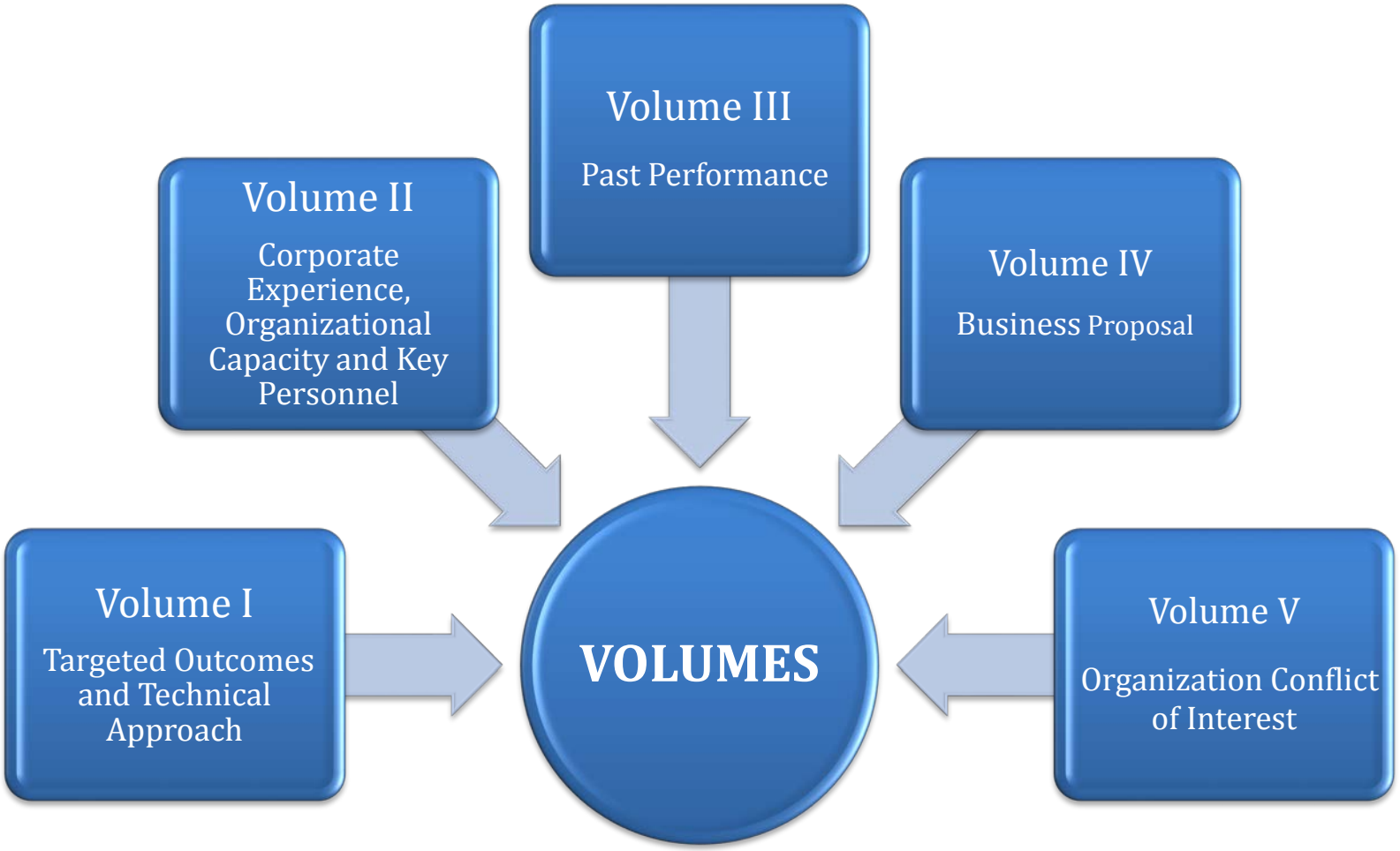
Business Proposal Evaluation

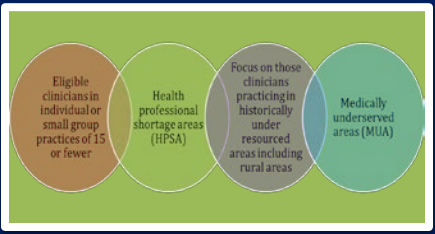
Evaluation to determine the cost reasonableness

Conflict of Interest Evaluation

Evaluation in accordance with FAR 9.5 that prescribers responsibilities, general rules, and procedures for identifying, evaluating, and resolving organizational conflicts of interest

MQIDTA (QPP_SURS): Contract Overview (OAGM)





MQIDTA (QPP_SURS): Contract Overview (OAGM)

Procurement Timeline	
RFP Release Date	June 20, 2016
Pre-proposal Webinar	June 30, 2016
Questions Due	July 6, 2016
Notice of Intent Due	July 6, 2016
Proposal Due Date	July 28, 2016
Est. Competitive Range Determination	September 2016
Est. Request for Final Proposals Revisions	October 2016
Est. Final Revised Proposals Due	November 2016
Est. Multiple Awards	November 2016

MQIDTA (QPP_SURS): Discussion with Partners

PARTICIPANTS CHECK IN

MQIDTA (QPP_SURS): Discussion with Partners

MQIDTA (QPP_SURS): Partner HRSA

- Agency of the U.S. Department of Health and Human Services
- Primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable
- Comprised of five bureaus and ten offices providing leadership and financial support to health care providers in every state and US territory

HRSA
Health Resources & Services Administration

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

MQIDTA (QPP_SURS): Partner HRSA

- HRSA funds organizations that work with the specific provider types identified in the MQIDTA solicitation
  - Access to and familiarity with providers practicing in rural areas, HPSAs, and MUAs
  - Experience providing TA on quality reporting and improvement, health IT, and other operational issues

HRSA
Health Resources & Services Administration

MQIDTA (QPP_SURS): Partner HRSA

- State Offices of Rural Health
  - Funded by HRSA's Federal Office of Rural Health Policy since 1991
  - 50 state offices and 1 national organization (nosorh.org)
  - General purpose of each SORH is to help their individual rural communities build health care delivery systems
- Rural Health Resource Center
  - Since 1999, the Technical Assistance and Services Center (TASC) has provided information, tools, and education to critical access hospitals (CAHs) and state Flex Programs (ruralcenter.org/tasc)

MQIDTA (QPP_SURS): Partner Health Resources & Services Administration (HRSA)

- Primary Care Associations
  - State or regional non-profit organizations providing training and TA to safety-net providers
- Health Center Controlled Networks
  - Networks to assist Federally Qualified Health Centers (FQHCs) and the safety-net community to address operational and clinical challenges related to the use of health IT (http://bphc.hrsa.gov/qualityimprovement/strategicpartnerships/)

HRSA
Health Resources & Services Administration

MQIDTA (QPP_SURS): Discussion with Partners

PARTICIPANTS CHECK IN

MQIDTA (QPP_SURS): Partner ONC

★Better ★Smarter ★Healthier

continue to work across sectors and across the aisle for the goals we share: ***better care, smarter spending, and healthier people***.

HITECH Act	EHRs & HIE	Payment Reform
2009	2014	2014+
Gives ONC authority to launch REC, HIE, Beacon & Workforce programs	Widespread adoption & meaningful use of EHRs	Health IT Enabled Reform Models & ID Path FFS to PFP

Back to Agenda

MQIDTA (QPP_SURS): Partner Office of National Coordinators

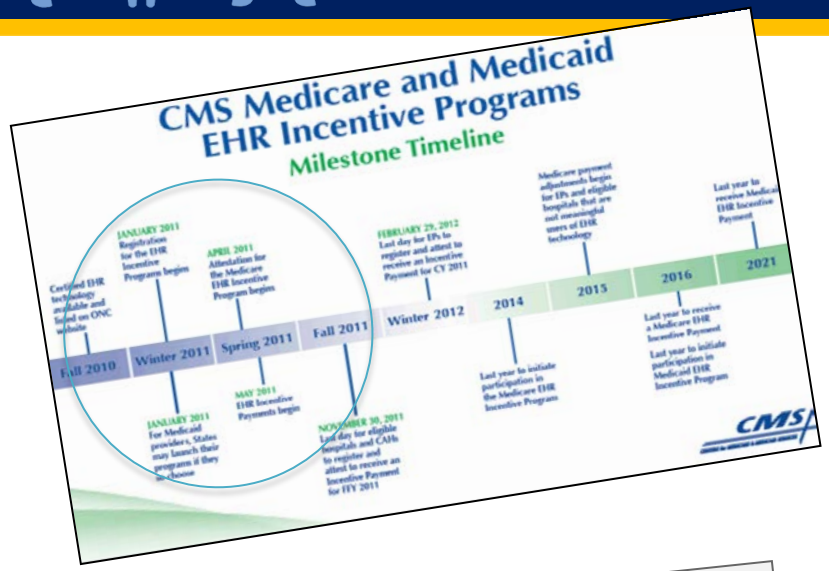
ONC's Office of Programs and Engagement (OPro)

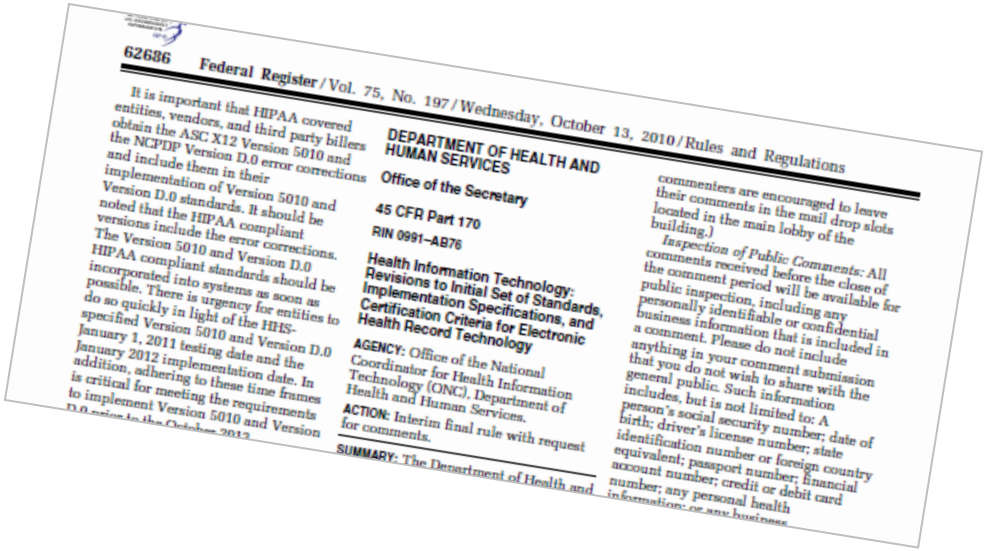
- OPRO is responsible for implementing and overseeing grant programs and other initiatives that advance the nation toward universal adoption and meaningful use of interoperable health information technology in support of health care and population health.

- OPRO supports care providers in the adoption, implementation and optimization of health information technology and adaptation to new care and payment models.

- OPRO supports consumer use of electronic personal health information and activities for certification of health information technology.

MQIDTA (QPP_SURS): Partner ONC





62686 Federal Register / Vol. 75, No. 197 / Wednesday, October 13, 2010 / Rules and Regulations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of the Secretary

45 CFR Part 170

RIN 0991–AB76

Health Information Technology: Revisions to Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology

AGENCY: Office of the National Coordinator for Health Information Technology (ONC), Department of Health and Human Services.

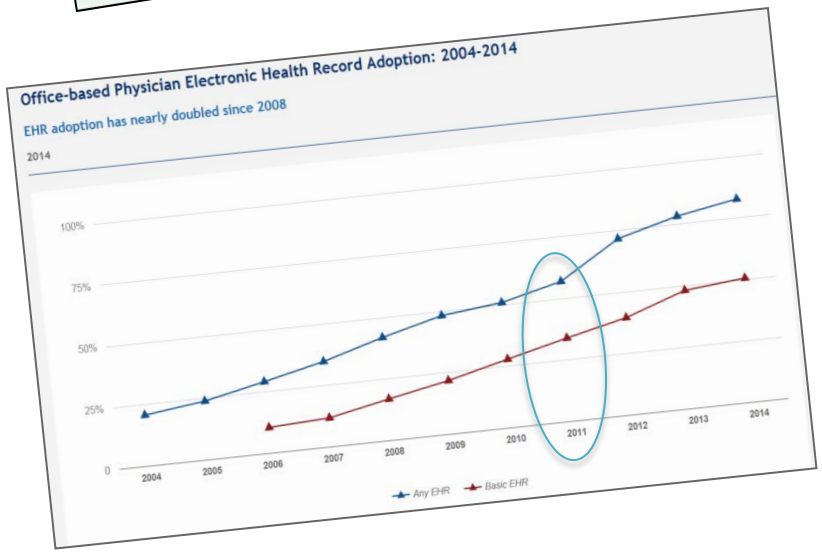
ACTION: Interim final rule with request for comments.

SUMMARY: The Department of Health and

It is important that HIPAA covered entities, vendors, and third party billers obtain the ASC X12 Version 5010 and the NCPDP Version D.0 error corrections and include them in their implementation of Version 5010 and Version D.0 standards. It should be noted that the HIPAA compliant versions include the error corrections. The Version 5010 and Version D.0 HIPAA compliant standards should be incorporated into systems as soon as possible. There is urgency for entities to do so quickly in light of the HHS-specified Version 5010 and Version D.0 testing date and the January 1, 2011 testing date and the January 2012 implementation date. In addition, adhering to these time frames is critical for meeting the requirements to implement Version 5010 and Version

commenters are encouraged to leave their comments in the mail drop slots located in the main lobby of the building.)

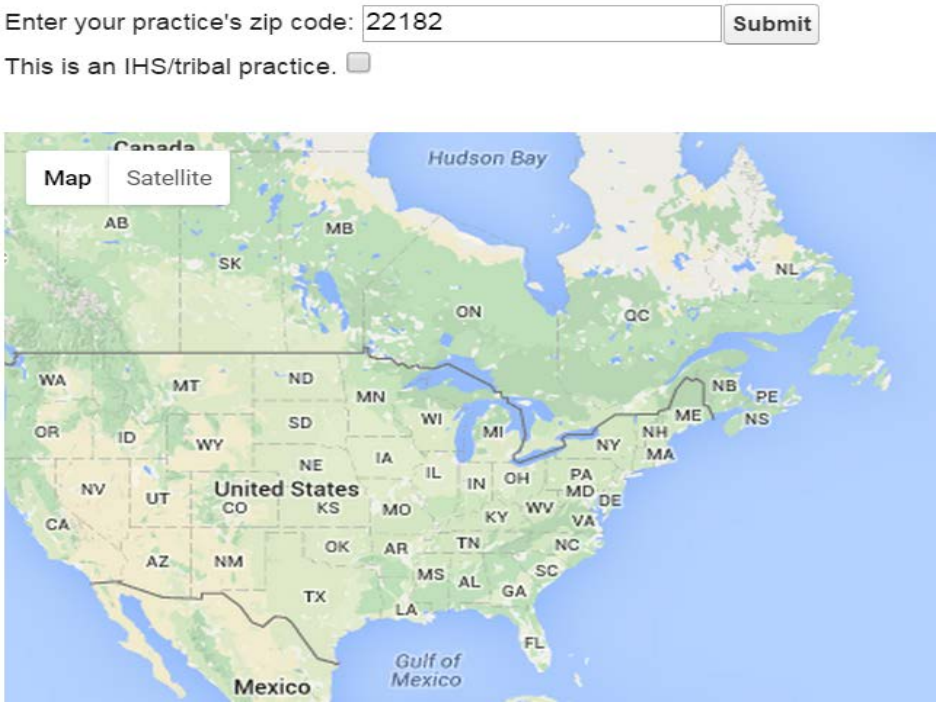
Inspection of Public Comments: All comments received before the close of the comment period will be available for public inspection, including any personally identifiable or confidential business information that is included in a comment. Please do not include anything in your comment submission that you do not wish to share with the general public. Such information includes, but is not limited to: A person's social security number; date of birth; driver's license number; state identification number or foreign country equivalent; passport number; financial account number; credit or debit card number; any personal health information; or any business



Hospital EHR Adoption	Percent of Hospitals with EHR						
	2008	2009	2010	2011	2012	2013	2014
All Hospitals with a Basic EHR with Clinician Notes	9%	12%	16%	28%	44%	59%	76%
All Small Hospitals with a Basic EHR with Clinician Notes	6%	8%	11%	22%	39%	53%	70%
All Rural Hospitals with a Basic EHR with Clinician Notes	6%	8%	11%	22%	36%	53%	70%
All Critical Access Hospitals with a Basic EHR with Clinician Notes	4%	7%	10%	20%	35%	54%	68%
All Hospitals with a Certified EHR	--	--	--	72%	85%	94%	97%

Regional Extension Center Program

- 62 Regional Extension Centers across the U.S.
- About 90% will continue to operate after the period of performance has ended (6/16 for most awardees)
- The REC program assisted over 144,000 providers in adopting and meaningfully using an EHR by focusing on:
  - **EHR implementation and project management**
  - **Health IT education and training**
  - **Vendor selection and financial consultation**
  - **Practice/workflow redesign**
  - **Privacy and Security**
  - **Partnering with Health Information Exchanges**
  - **Ongoing technical assistance**



https://www.healthit.gov/providers-professionals/listing-regional-extension-centers

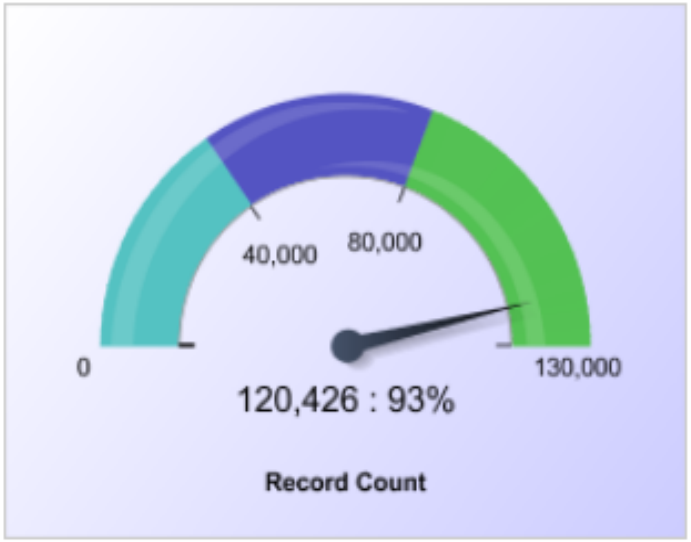
For a list of RECs see Listing of Regional Extension Centers

MQIDTA (QPP_SURS): Partner ONC

A History of Programmatic Success: *Regional Extension Center Program*

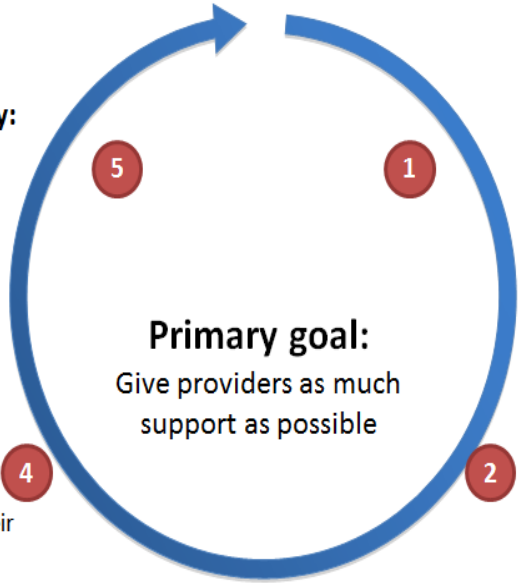
REC Success

All Providers at Meaningful Use (M3)



This includes providers currently marked "participating" only.

REC Services



Improve Care Quality:
- Assess ACO, PCMH, other Alternative Payment Models
- Prepare for future pay for performance
- Coordinate care across the continuum

Plan:
- Conduct readiness assessment
- Identify tools needed for change (i.e. EHR system, workflow changes, etc.)

Primary goal:
Give providers as much support as possible

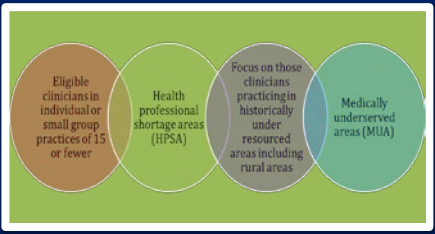
Operate & Maintain:
- Continuous quality improvement
- Empower patients in their health care
- MU Stages 1,2,3

Transition:
- Redesign practice workflow
- Perform HIT education & training

Implement:
- Provide technical assistance
- Partner with local stakeholders, HIEs

MQIDTA (QPP_SURS): Discussion with Partners

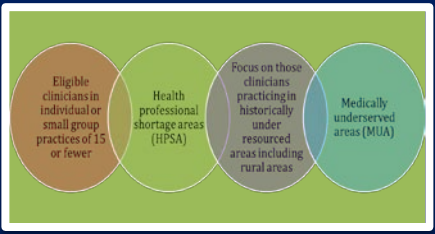
PARTICIPANTS CHECK IN



MQIDTA (QPP_SURS): Q & A

Questions and Answers

Time: 20 Minutes



MQIDTA (QPP_SURS)

THANK YOU

MQIDTA (QPP_SURS): Additional Information

- HHS Press Office
  http://www.hhs.gov/about/news/2016/06/20/hhs-announces-major-initiative-help-small-practices-prepare-quality-payment-program.html

- FedBizOpps.gov-solicitation
  https://www.fbo.gov/index?s=opportunity&mode=form&id=57766996f8ecd4749cd4b18e60f63a8e&tab=core&_cview=1

- Quality Payment Program
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program.html

- Quality Innovation Networks – Quality Improvement Organizations Directory
  http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228774346757

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
34. Authorize Extension of Contract with Healthcare Insight, a Division of Verisk Health, Inc.

Contact
Ladan Khamseh, Chief Operating Officer, (714)246-8400
Silver Ho, Executive Director, Compliance, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to negotiate an amendment to extend the existing Amended and Restated Contract (Contract) with Verisk Health, Inc. (Verisk) through December 31, 2017.

Background
CalOptima currently contracts with Verisk to provide three separate and distinct functions: 1) pre-payment claims clinical edits; 2) forensic claims review; and 3) identification of potential fraud, waste, and abuse (FWA) cases. CalOptima initially contracted with Verisk on October 1, 2008, following a competitive bidding process, to provide professional claims review and FWA reporting services. CalOptima amended the contract, effective September 1, 2010, to include catastrophic claim pre-payment forensic review services and to clarify several other contractual requirements, which amendments were ratified and approved by the Board on July 7, 2011. At that time, the contract was also extended to December 31, 2014 with two, one year extension options. CalOptima has subsequently exercised both of the extension options such that the contract now expires on December 31, 2016.

A summary of the Verisk contracted services is as follows:

1. Pre-Payment Claims Edits: During the pre-payment claims review, Verisk applies the National Correct Coding Initiative (NCCI) standards for Medicare and Medi-Cal outpatient claims as well as other pre-payment clinical claims edits to identify irregular claims billing practices. These edits are conducted in addition to the edits currently embedded in CalOptima's core operating system, Facets. The largest volume of data is processed during the pre-payment claims review.

2. Catastrophic Forensic Claims Review: Verisk provides clinical forensic review of large dollar claims with total billed charges in excess of $100,000 or $50,000 in reimbursement payments per claim. The reviews generally focus on claims that include services paid based on a charge reimbursement methodology. During the clinical forensic review process, charges will not be allowed if determined to be coded/billed inappropriately. The clean portion of the claim is paid and disallowed charges are pended if additional medical justification is required to support the disallowed charges. Verisk conducts a medical record review to verify accuracy of billed charges. The disallowed charges are denied if additional information is not received within the required time limits. CalOptima has final determination on whether to deny charges based on Verisk recommendation. Verisk is reimbursed for the forensic reviews based on a percent of savings realized by CalOptima.

3. Identification of Potential FWA Cases: Medicare Advantage and Medicaid managed care regulations require that the plan sponsor or managed care organization performs effective monitoring in order to prevent and detect FWA. Verisk analyzes historical and current claims data to identify potential FWA cases. Potential FWA cases are referred to CalOptima's Special Investigations Unit (SIU) for further consideration.

CalOptima contracted with a new pre-payment claims edit vendor, Optum, which was selected through a Request for Proposal (RFP) process. When fully implemented in November 2016, the Optum process will include new clinical editing protocols integrated into Facets; this will eliminate the need for outside vendor review, leading to a more robust and timely clinical edit processing of claims in-house.

Due to the complexity, cost consideration and specialized skill set required for the forensic review of high dollar claims as well as FWA reporting, staff plans to conduct separate RFP processes to consider vendors for these two services currently performed by Verisk.

Discussion

During the past year, CalOptima staff has made efforts to improve efficiencies in identifying inappropriate coding/claims billing practices and potential FWA cases. As such, an RFP was issued for the purposes of developing more comprehensive editing capabilities and incorporating pre-payment claims edits into the core business system, Facets, rather than sending data to an external vendor for review. Implementation efforts with its new vendor, Optum, began in early 2016 with an expected go-live in November 2016. Additionally, dedicated staff with technical experience (clinical as well as hospital coding) will be resourced to oversee this function.

While CalOptima has contracted with Optum to begin pre-payment claim editing in-house as the first step, CalOptima will continue to rely on Verisk for two of its claims review functions—forensic claims review and FWA reporting services—until an RFP process is completed and contract(s) are entered into with appropriate vendor(s). Staff is currently in the process of issuing RFPs for these services.

During the past year, savings of over $2.8 million, after payment of contingency fees, have been realized by CalOptima under this contract based on the forensic review of claims. To ensure best practices and effective management of these functions, staff has evaluated how these services can be best provided. To date, CalOptima has implemented strategies intended to reduce the number of disputes related to high dollar claims while meeting applicable requirements to ensure the appropriate payments, as well as identify and report potential fraud, waste and abuse trending.

CalOptima staff seeks authority to extend the current Verisk contract as it relates to forensic claims review and FWA reporting services through December 31, 2017. Extension of the contract through this period will provide sufficient time for CalOptima staff to conduct the RFPs, complete the contracting process and, as applicable, implement these services with qualified vendors.

Fiscal Impact

Funding for this recommended action is included in the CalOptima FY 2016-17 Operating Budget approved by the Board on June 2, 2016. Management will budget expenses related to the proposed contract extension in the CalOptima FY 2017-18 Operating Budget accordingly.

Rationale for Recommendation
Staff recommends that the Board authorize an extension and amendment of the Verisk contract through December 2017 to allow sufficient time to complete competitive bidding processes for forensic claims review and FWA reporting services.

Concurrence
Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer

Attachment
July 7, 2011 CalOptima Board Action Agenda Referral, VI. B., Authorize the Chief Executive Officer (CEO) to Execute a Contract with One or More Vendors for Credit Balance Recovery Services; Ratify and Authorize the Chief Executive Officer to Amend an Existing Vendor Claims Contract with HealthCare Insight to Add Catastrophic Claims Post-Payment Review

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken July 7, 2011
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. B. Authorize the Chief Executive Officer (CEO) to Execute a Contract with One or More Vendors for Credit Balance Recovery Services; Ratify and Authorize the Chief Executive Officer to Amend an Existing Vendor Claims Contract with HealthCare Insight to Add Catastrophic Claims Post-Payment Review

Contact

Ruth Watson, Executive Director - Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into a three-year contingency-based contract with two separate one-year extension options, with one or more vendors, for the provision of Credit Balance Recovery (CBR) Services; and,

2. Ratify amendment to HealthCare Insight contract for prepayment recovery services to add catastrophic claims post-payment review, and authorize the Chief Executive Officer, with the assistance of legal counsel, to further amend the contract regarding those services.

Background

CalOptima currently processes approximately 1.5 million claims per year for CalOptima Direct and OneCare members, with payments associated with these claims exceeding $660 million dollars annually. Since 2008, as part of CalOptima's program integrity strategy, staff has sought and received Board approval to contract with several vendors to ensure claim payment accuracy. These include the following:

- In 2008, the Board authorized staff to enter into a contract with a vendor to provide coordination of benefits (COB) identification and overpayment recovery services for claims when it is determined that CalOptima is not the primary payer. Under this authority, staff contracted with Health Management Services, which has identified and recovered more than $5 million on behalf of CalOptima using a data mining process.

- In 2008, the Board also authorized staff to contract with a vendor for claims pre-payment code review, fraud, waste, and abuse prevention services. Based on this authority, staff contracted with HealthCare Insight (HCI). CalOptima has recognized pre-payment savings in excess of $3.5 million since the inception of the HCI contract.

- In 2010, staff received approval to enter into a contract with Socrates to pursue third party liability (TPL) subrogation recovery services for the OneCare and Healthy Families lines of business.

Discussion

Program integrity activities are key to ensuring that public funds are appropriately spent. As indicated, CalOptima has successfully implemented a variety of cost containment initiatives in support of that goal. Medi-Cal's size and diversity make it vulnerable to improper payments that can result from fraud, waste, abuse, or clerical errors. CalOptima staff continues to look for additional program integrity activities that can prevent, detect, and recover improper payments, and has identified two additional programs designed to prevent and/or recover claim overpayments as a result of fraud, waste, abuse or clerical errors.

1) Credit Balance Recovery. Credit balances are improper or excess payments made to a provider. Such payments can occur on patient accounts when the reimbursement received by the provider exceeds the appropriate or expected reimbursement for services rendered, for example, as a result of multiple reimbursements from different payers (by both CalOptima and the primary payer), adjustments to previously-paid claims, computer-generated billing errors, or mis-postings to accounts (e.g., where no refund is due to the patient or payer). Some of the amounts may be considered "overpayments" due to the Medicaid program. When such "credit balances" occur, they appear in the provider's records as a credit on the patient account that is carried forward month to month in the provider's books. Under Federal law, providers are obligated to disclose and refund known overpayments. In addition, having such credit balances on their books distorts the liabilities in a provider's patient accounting system. Providers work with CBR vendors to identify and address credit balances that are the result of billing and/or payment errors made by both hospitals and payers. Credit Balance Recovery Services involve a financial review of the provider's patient accounts; it is not a hospital bill audit. The vendor works collaboratively with the provider's staff to reconcile accounts to resolve the outstanding credit balance and refund the overpayment to the appropriate payor. Implementing CBR services can translate into a $1-$5 per member per year in overpayment recovery opportunity.

   Earlier this year, CalOptima staff issued a Request for Proposal (RFP) soliciting vendors that had a well-established presence in the Credit Balance Recovery arena in Orange County. Staff is currently evaluating RFP responses to identify the vendor or vendors whose service offerings best meet CalOptima's needs. Specific criteria to be included in the vendor contract include an agreed upon approval process to ensure that CalOptima will make the final determination regarding all overpayment recovery activities in compliance with CalOptima's policies and procedures, as well as all applicable regulatory requirements.

As proposed, vendors for CBR services are paid a percentage of the recovery on a contingency basis after CalOptima recovers credit balances it is owed. While the provider has an independent obligation to reimburse CalOptima for such amounts involving its members, contracting with a CBR vendor is expected to result in greater recoveries.

2) Catastrophic Claim Post-Payment Review. In unique situations such as when services needed by a CalOptima member are not available at a contracted facility, CalOptima staff negotiates with non-contracted facilities. With non-contracted providers, reimbursement for each admission is typically negotiated separately and a Letter of Agreement (LOA) is signed by the facility and CalOptima. The Assist Group (TAG), a strategic partner of HCI, provides pre-payment and post-payment review of large dollar claims to ensure billed services are supported by corresponding medical records. TAG performs a pre-screen review and makes a recommendation on whether a detailed forensic review is warranted. Non-contested charges would be paid at the agreed upon LOA rate, while any contested charges would be reviewed against medical records to determine whether the charges are substantiated. The provider has the right to appeal this determination by submitting additional information to TAG as part of CalOptima's standard Provider Dispute Resolution (PDR) process for first level appeals. If a provider is not satisfied with the outcome of this first level review, it would have the ability to submit a second level appeal through CalOptima's standard processes to CalOptima's Grievance and Appeals Services (GARS) department. Additional payment would be made to the facility if the forensic review, PDR process or GARS process determines that some portion of the contested charges are supported.

As indicated above, CalOptima entered into a contract with HCI for pre-payment claims review in 2008. This contract was amended twice in 2010, first to reflect a change in vendor ownership status, and second to extend the agreement through September 2013 and to incorporate a number of changes to the scope of work, including the addition of post payment forensic review services. Ratification of these changes is now being sought, along with authority to further amend the HCI agreement consistent with regulatory requirements, and to clarify issues including PDR review responsibilities, settling authority, and criteria for vendor reimbursement.

Fiscal Impact

1. CBR Services - As proposed, the contract with the selected vendor will be structured with a negotiated contingency payment scale related to a percentage of savings. It is anticipated that net recovery over the proposed three-year term of the agreement may be as much as $1million.

2. Catastrophic Claim Post-Payment Review - The HCI contract contains a contingency payment scale related to a percentage of savings. The estimated annual savings/ recoupments from post payment review services could potentially reach $1 million.

Rationale for Recommendation

By contracting with a Credit Balance Recovery vendor, CalOptima will have the ability to identify and recover overpayments due to other insurance coverage, misapplied payments and contractual issues that remain un-reimbursed on a provider's accounts receivables.

Ratifying and further amending the HCI contract for Catastrophic Claim Post-Payment Review better ensures that CalOptima will reimburse facilities for only those charges that are substantiated through a detailed review of large dollar hospital bills.

Successful implementation of these services will enable CalOptima to better meet its obligations to insure program integrity and identify potential instances of fraud, waste and abuse.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Richard Chambers — *7/5/11*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

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

Recommended Actions
1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background
In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder
NO FEE
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2014000535189 9:23 am 12/11/14
93 413 A17 35
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(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

TABLE OF CONTENTS

Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the "**CEQA Guidelines**"), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Cal.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq.*, all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By: _____
Wayne W. Winthers, City Attorney

DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

(SEAL)

Suzanne M. Turf
Notary Public in and for said State

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies)~~, and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

(SEAL)

Michele E. Day
Notary Public in and for said State

EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

36. Consider Authorization of License Agreement with the County of Orange for Usage of Space at the County Community Service Center

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a one year license agreement with the County of Orange for non-exclusive use of approximately 362 square feet of space at the County Community Service Center (CCSC), located at 15496 Magnolia Street, Westminster, CA 92683; and
2. Approve allocation of $22,538 from existing reserves to fund the license agreement through June 30, 2017.

Background

The current County Community Service Center (CCSC) facility provides a variety of health and human services to local residents, including referrals for mental and public health, resources for the homeless, legal assistance, marriage licenses and passport services. The current CCSC also offers residents help to apply for Medi-Cal and Medicare. Representatives from the Health Care Agency, Social Services Agency, Office on Aging, Department of Housing, and County Clerk-Recorder Department are available on designated days.

As a public and community health plan that serves the low-income Medi-Cal population in Orange County, CalOptima has been committed to member outreach, health education and engagement since its inception. By actively engaging our members in efforts with our community-based organization partners and through health education workshops, health fairs and seminars, we increase opportunities for our members to receive information regarding our programs, learn about their benefits and be more proactive participants in their own health care.

Since 2008, CalOptima has utilized available space at the current CCSC offer health education seminars. At the current CCSC location, CalOptima currently hosts one health education seminar per month to assist members about health care programs. Topics at some of the recent health education seminars have included:

- Program for All-Inclusive Care for the Elderly (PACE)
- OneCare Connect
- Medicare 2016: New Policy and Changes
- Memory Loss, Dementia, and Alzheimer's Disease
- Understanding Social Security Programs and Benefits
- Consult with Three Cardiologists: Learn about Stroke and Peripheral Arterial Disease

While CalOptima members reside throughout Orange County, a large percentage reside in the central portion of the county. Residents in the cities of Santa Ana, Garden Grove, and Westminster comprise over 30% of CalOptima's total membership.

The current CCSC, located in the City of Westminster, has proven to be a centrally-located space for CalOptima members to attend health education seminars, and obtain information about programs and services. In conjunction with services offered by various county departments, the County of Orange provided CalOptima with use of the CCSC at no cost as a service to community residents.

Due to CalOptima's growth in membership and programs, and the resulting increase in interest in CalOptima's health education seminars at CCSC, additional space would better accommodate the needs of CalOptima members. At recent seminars, members have been turned away due to lack of space. While staff has addressed this issue in the short term by hosting multiple seminar sessions on the same day, the current space presents logistical challenges.

Earlier this year, the County of Orange informed CalOptima of its decision to expand capacity at the CCSC by leasing additional space located across the parking lot from the existing facility effective July 1, 2016 for use by the Orange County Social Services Agency. The leased space would provide the County with expanded space for its programs and also provide CalOptima with the opportunity to enter into a license agreement with the County that would provide CalOptima with a dedicated office, as well as shared use of a conference room space in order to offer more health education seminars and other community events each month.

Discussion

Staff recommends authorization of the license agreement with the County of Orange, which would allow CalOptima to have one dedicated office, along with shared use of a conference room. The County's recently added CCSC space has a conference room (which is 253 square feet in size) that is adjacent to the entryway of the suite. Additionally, the County of Orange is proposing to remove the wall between the conference room and the entryway (at CalOptima's expense), which would create a larger space for community events, such as the health education seminars. While the original CCSC has a maximum capacity to hold events with 20 participants, the new CCSC space will have the capacity to hold events with approximately 50 participants.

The County's newly leased CCSC space is comprised of 2,080 square feet total. The County's primary lease agreement with the property owner is for $5,000 per month (approximately $2.40 per square foot) and includes seven offices as well as a conference room. As proposed, CalOptima would have access to the conference room for 50% of the time, one dedicated office, and the common area of the leased space.

Based on estimates provided by the County of Orange, the monthly expenses to CalOptima for its portion of the space is $1,453.02. This cost estimate is based on: 253 square footage of conference room space, 109 square foot dedicated CalOptima office, and prorated 21% of total common area. The County of Orange estimates the improvement costs to remove the wall between the conference room and the entryway at $7,646 in one-time costs to CalOptima.

Staff has conducted a review of the County of Orange's sub-lease agreement. Based on current commercial real estate trends, the proposed license is well within market pricing.

	Total Amount
License Fee (August 2016 - June 2017) • Fee includes leased space, IT services, telephone services, janitorial services, and electrical/utilities	$14,892
Improvement costs (Removal of wall)	$7,646
Total	**$22,538**

The County of Orange's primary lease agreement for the annexed CCSC is for the period of July 1, 2016 through June 30, 2017. Staff is proposing CalOptima's license for the CCSC annex to be for the period of August 5, 2016 through June 30, 2017.

Fiscal Impact
The recommended action to execute a license agreement with the County of Orange through June 30, 2017, for usage of space at the CCSC will be funded through an allocation of $22,538 from existing reserves.

Rationale for Recommendation
As part of CalOptima's mission, staff works towards providing access to health care services for our members. In the past eight years, CalOptima's participation at the CCSC has proved extremely valuable, as we have helped provide access to information about programs and benefits, as well as critical health education to members. Due to CalOptima's new programs and substantial increase in overall membership, the current CCSC location no longer meets the needs of our members. The opportunity to partner with the County of Orange and sub-lease additional space, provides a low-cost solution to not only meet the existing logistical challenges of the health education seminars, but also provides an opportunity for CalOptima to expand its services to members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Draft County of Orange CCSC Annex Proposed License Agreement with CalOptima for new CCSC location
2. CCSC Cost Apply
3. County of Orange Primary Lease Agreement for new CCSC location
4. Quotation for Tenant Improvements

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

LICENSE AGREEMENT

This LICENSE AGREEMENT (**"License"**) is made and entered into _____ , 2016 (**"Effective Date"**), by and between, CALOPTIMA, (hereinafter referred to as **"LICENSEE"**) and COUNTY OF ORANGE, a political subdivision of the State of California (hereinafter referred to as **"COUNTY"**) without regard to number and gender. LICENSEE and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**."

RECITALS

I. COUNTY leases that certain real property located at 15496 Magnolia in the City of Westminster, (**"County Property"**) pursuant to a lease dated July 1, 2016 for COUNTY's Social Services Agency's (**"SSA"**) Orange County Community Service Center Annex (**"OCCSCA"**).

II. The Services provided by LICENSEE will include a convenient on-site source while SSA clients are at the SSA Office.

III. COUNTY agrees to provide LICENSEE sufficient office space within the SSA Office for LICENSEE to provide the Services.

NOW THEREFORE, in consideration of the Recitals above, incorporated herein by reference, COUNTY and LICENSEE do hereby agree as follows:

1. DEFINITIONS (AMLC-2.1 S)

The following words in this License have the significance attached to them in this clause, unless otherwise apparent from context:

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"Chief Real Estate Officer" means the Chief Real Estate Officer, County Executive Office, County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Board of Supervisors.

"**Facilities Services Manager**" means the Manager of the Social Services Agency, Facilities Services, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the Director of Social Services Agency.

"Risk Manager" means the Manager of County Executive Office, Risk Management, for the County of Orange, or upon written notice to LICENSEE, such entity as shall be designated by the County Executive Officer.

"SSA Director" means the Director of Social Services Agency, County of Orange, or designee, or upon written notice to LICENSEE, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. TERM (AMLC-3.1 N)

The term of this License shall commence on the Effective Date and terminate on June 30, 2017, unless terminated as provided in Clause 3 (TERMINATION) of this License.

3. TERMINATION (AMLC-3.3 S)

This License shall be revocable by either COUNTY's SSA Director or LICENSEE at any time; however, as a courtesy the Parties will attempt to give thirty (30) days written notice to the other Party upon revocation.

4. LICENSE AREA (AMLC-4.2 N)

COUNTY grants to LICENSEE the non-exclusive right to use that certain property hereinafter referred to as **"License Area,"** shown on Exhibit A, attached hereto and by reference made a part hereof, for the purposes set forth in Clause 6 (USE) of this License together with non-exclusive, in common use of COUNTY's elevators, stairways, washrooms, hallways, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to LICENSEE's License Area created by this License.

During the term of this License, the dates and times for use of the License Area will be determined by the Facilities Services Manager, and the location of the License Area is subject to relocation at the sole discretion of the Facilities Operations Manager.

5. PARKING (AMLC-4.4 S)

Throughout the term of this License COUNTY shall provide one (1) parking space for LICENSEE's free and non-exclusive use.

6. USE (AMLC-5.1 N)

LICENSEE's use of the License Area shall be limited to general office to provide clients with health related workshops and information regarding their Medi-Cal benefits.

LICENSEE agrees not to use the License Area for any other purpose nor to engage in or permit any other activity within or from the License Area without prior written permission from the Facilities Services Manager. LICENSEE further agrees not to conduct or permit to be conducted any public or private nuisance in, on, or from the License Area, not to commit or permit to be committed waste on the License Area, and to comply with all governmental laws and regulations in connection with its use of the License Area.

NO ALCOHOLIC BEVERAGES OR TOBACCO PRODUCTS SHALL BE SOLD OR CONSUMED WITHIN THE LICENSE AREA.

7. LICENSE FEE (AMLC-6.1 S)

LICENSEE agrees to pay COUNTY from and after the effective date of this License according to the following schedule:

MONTH	MONTHLY LICENSE FEE
1	$0.00
2	$361.73
3	$1,453.02
4	$1,453.02
5	$1,453.02
6	$1,453.02
7	$1,453.02
8	$1,453.02
9	$1,453.02
10	$1,453.02
11	$1,453.02
12	$1,453.02

The monthly License Fee shall be payable in advance, without prior notice or demand on the first day of each calendar month while this License is in effect without deduction or offset in lawful money of the United States.

In the event the obligation to pay the License Fee begins or terminates on some day other than the first day or last day of the month, the License Fee shall be prorated to reflect the actual period of use on the basis of a thirty (30) day month. The fee for any partial calendar month during which this License becomes effective will be payable on such effective date.

8. PAYMENT PROCEDURE (AMLC-7.1 N)

All payments shall be delivered to the County of Orange, Office of the Auditor-Controller, P. O. Box 567 (630 N. Broadway), Santa Ana, California 92702. The designated place of payment may be changed at any time by COUNTY upon ten (10) days written notice to LICENSEE. License Fee payments may be made by check payable to the County of Orange. Said License Fee payment shall include a payment voucher indicating that the payment is for the monthly License Fee for office space at the Orange County Community Service Center Annex in Westminster, California. A duplicate copy of the payment voucher shall be mailed to the County of Orange, Social Services Agency, 500 N. State College Boulevard, Orange, California,

92868, Attention: Facilities Services Manager. LICENSEE assumes all risk of loss if payments are made by mail.

No payment by LICENSEE or receipt by COUNTY of a lesser amount than the payment due shall be deemed to be other than on account of the payment due, nor shall any endorsement or statement on any check or any letter accompanying any check or payment as payment be deemed an accord and satisfaction, and COUNTY shall accept such check or payment without prejudice to COUNTY's right to recover the balance of said payment or pursue any other remedy in this License.

9. CHARGE FOR LATE PAYMENT (AMLC-7.2 S)

LICENSEE hereby acknowledges that late payment of sums due hereunder will cause COUNTY to incur costs not contemplated by this License, the exact amount of which will be extremely difficult to ascertain. Such costs include but are not limited to costs such as administrative processing of delinquent notices, increased accounting costs, etc.

Accordingly, if any payment pursuant to this license is not received by COUNTY by the due date, a late charge of one and one-half percent (1.5%) of the payment due and unpaid plus $100 shall be added to the payment, and the total sum shall become immediately due and payable to the COUNTY. An additional charge of one and one-half percent (1.5%) of said payment, excluding late charges, shall be added for each additional month that said payment remains unpaid.

LICENSEE and COUNTY hereby agree that such late charges represent a fair and reasonable estimate of the costs that COUNTY will incur by reason of LICENSEE's late payment.

Acceptance of such late charges (and/or any portion of the overdue payment) by COUNTY shall in no event constitute a waiver of LICENSEE's default with respect to such overdue payment, or prevent COUNTY from exercising any of the other rights and remedies granted hereunder.

10. UTILITIES, JANITORIAL, MAINTENANCE AND REPAIR (AMLC-9.3 N)

COUNTY shall be responsible for all charges for all utilities (water, gas and sewer),. County shall be responsible for all maintenance and repairs (including but not limited to: fire alarm, fire extinguisher, HVAC system, elevator maintenance, landscaping, pest control, and trash). COUNTY shall be responsible for telephone service, internet service and janitorial service. All charges for services provided by COUNTY pursuant to this Clause shall be included in LICENSEE's "MONTHLY LICENSE FEE" pursuant to Clause 7. (LICENSE FEE) of the License.

11. CONSTRUCTION AND/OR ALTERATION BY LICENSEE (AMD2.1 S)

COUNTY's Consent. No structures, improvements, or facilities shall be constructed, erected, altered, or made by LICENSEE within the License Area without prior written consent of the Facilities Services Manager. Any conditions relating to the manner, method, design, and construction of said structures, improvements, or facilities fixed by the Facilities Services Manager as a condition to granting such consent, shall be conditions hereof as though originally stated herein. LICENSEE may, at any time and at its sole expense, install and place business fixtures and equipment within License Area.

Strict Compliance with Plans and Specifications. All improvements constructed by LICENSEE within the

License Area shall be constructed in strict compliance with detailed plans and specifications approved by the Facilities Services Manager.

COUNTY shall contract with a licensed contractor to remove the existing wall between the "Reception Area" and "Room #1" as depicted in Exhibit B, to replace existing carpet, and repair any areas resulting from removing said wall. LICENSEE shall reimburse COUNTY in the amount not to exceed Seven Thousand six hundred forty-five dollars and fifty-five cents ($7,645.55) within twenty (20) business days of COUNTY's submittal to LICENSEE of an invoice from COUNTY.

12. MECHANICS LIENS OR STOP-NOTICES (AMD4.1 S)

LICENSEE shall at all times indemnify, defend with counsel approved in writing by COUNTY and save COUNTY harmless from all claims, losses, demands, damages, cost, expenses, or liability costs for labor or materials in connection with construction, repair, alteration, or installation of structures, improvements, equipment, or facilities within the License Area, and from the cost of defending against such claims, including attorney fees and costs.

In the event a lien or stop-notice is imposed upon the License Area as a result of such construction, repair, alteration, or installation, LICENSEE shall either:

A. Record a valid Release of Lien, or

B. Procure and record a bond in accordance with Section 3143 of the Civil Code, which frees the License Area from the claim of the lien or stop-notice and from any action brought to foreclose the lien.

Should LICENSEE fail to accomplish either of the two optional actions above within fifteen (15) days after the filing of such a lien or stop-notice, the License shall be in default and shall be subject to immediate termination.

13. OWNERSHIP OF IMPROVEMENTS (AMD6.1 N)

All improvements, exclusive of trade fixtures, constructed or placed within the License Area by LICENSEE must, upon completion, be free and clear all liens, claims, or liability for labor or material and at COUNTY's option shall be the property of COUNTY's at the expiration of this License or upon earlier termination hereof. COUNTY retains the right to require LICENSEE, at LICENSEE's cost, to remove all LICENSEE's improvements located on the License Area at the expiration or termination hereof.

14. INSURANCE (AML10.1 N)

LICENSEE agrees to purchase all required insurance at LICENSEE's expense and to deposit with COUNTY certificates of insurance, including all endorsements required herein, necessary to satisfy COUNTY that the insurance provisions of this License have been complied with and to keep such insurance coverage and the certificates and endorsements therefore on deposit with COUNTY during the entire term of this License. This License shall automatically terminate at the same time LICENSEE's insurance coverage is terminated. If within ten (10) business days after termination under this Clause LICENSEE obtains and provides evidence of the required insurance coverage acceptable to Facilities Services Manager, this License may be reinstated at the sole discretion of Facilities Services Manager.

LICENSEE agrees that LICENSEE shall not operate on the License Area at any time the required insurance is not in full force and effect as evidenced by a certificate of insurance and necessary endorsements or, in the interim, an official binder being in the possession of Facilities Services Manager. In no cases shall assurances by LICENSEE, its employees, agents, including any insurance agent, be construed as adequate evidence of insurance. Facilities Services Manager will only accept valid certificates of insurance and

endorsements, or in the interim, an insurance binder as adequate evidence of insurance. LICENSEE also agrees that upon cancellation, termination, or expiration of LICENSEE's insurance, COUNTY may take whatever steps are necessary to interrupt any operation from or on the License Area until such time as the Facilities Services Manager reinstates the License.

If LICENSEE fails to provide Facilities Services Manager with a valid certificate of insurance and endorsements, or binder at any time during the term of the License, COUNTY and LICENSEE agree that this shall constitute a material breach of the License. Whether or not a notice of default has or has not been sent to LICENSEE, said material breach shall permit COUNTY to take whatever steps necessary to interrupt any operation from or on the License Area, and to prevent any persons, including, but not limited to, members of the general public, and LICENSEE's employees and agents, from entering the License Area until such time as Facilities Services Manager is provided with adequate evidence of insurance required herein. LICENSEE further agrees to hold COUNTY harmless for any damages resulting from such interruption of business and possession, including, but not limited to, damages resulting from any loss of income or business resulting from the COUNTY's action.

All contractors performing work on behalf of LICENSEE pursuant to this License shall obtain insurance subject to the same terms and conditions as set forth herein for LICENSEE. LICENSEE shall not allow contractors or subcontractors to work if contractors have less than the level of coverage required by COUNTY from LICENSEE under this License. It is the obligation of LICENSEE to provide written notice of the insurance requirements to every contractor and to receive proof of insurance prior to allowing any contractor to begin work within the License Area. Such proof of insurance must be maintained by LICENSEE through the entirety of this License and be available for inspection by a COUNTY representative at any reasonable time.
All self-insured retentions (**"SIRs"**) and deductibles shall be clearly stated on the Certificate of Insurance. If no SIRs or deductibles apply, indicate this on the Certificate of Insurance with a "0" by the appropriate line of coverage. Any **SIR** or deductible in excess of $25,000 ($5,000 for automobile liability), shall specifically be approved by COUNTY's Risk Manager.

If LICENSEE fails to maintain insurance acceptable to COUNTY for the full term of this License, COUNTY may terminate this License.

Qualified Insurer

The policy or policies of insurance must be issued by an insurer licensed to do business in the state of California (California Admitted Carrier) or have a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category) as determined by the most current edition of the **Best's key Rating Guide/Property-Casualty/United States or ambest.com**.

If the insurance carrier is not an admitted carrier in the state of California and does not have an A.M. Best rating of A-/VIII, COUNTY's Risk Manager retains the right to approve or reject a carrier after a review of the company's performance and financial ratings.

The policy or policies of insurance maintained by LICENSEE shall provide the minimum limits and coverage as set forth below:

Coverages	Minimum Limits

Coverages	Minimum Limits
Commercial General Liability	$1,000,000 per occurrence $2,000,000 aggregate
Automobile Liability including coverage for owned, non-owned and hired vehicles	$1,000,000 limit per occurrence
Workers' Compensation	Statutory
Employers' Liability Insurance	$1,000,000 per occurrence

Required Coverage Forms

The Commercial General Liability coverage shall be written on Insurance Services Office (**"ISO"**) form CG 00 01, or a substitute form providing liability coverage at least as broad.
The Business Auto Liability coverage shall be written on ISO form CA 00 01, CA 00 05, CA 00 12, CA 00 20, or a substitute form providing liability coverage as broad.

Required Endorsements

The following endorsements must be submitted with the Certificate of Insurance:

a) The Commercial General Liability policy shall contain an Additional Insured endorsement using ISO form CG 2010 or CG 2033 or a form at least as broad naming the COUNTY, its elected and appointed officials, officers, employees, and agents as Additional Insureds.

b) The Commercial General Liability policy shall contain a primary non-contributing endorsement evidencing that the LESSEE's insurance is primary and any insurance or self-insurance maintained by the COUNTY shall be excess and non-contributing.

c) The Workers' Compensation policy shall contain a waiver of subrogation endorsement waiving all rights of subrogation against the COUNTY, and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees.

d) The Commercial Property policy shall contain a Loss Payee endorsement naming the COUNTY as respects the COUNTY's financial interest when applicable.

All insurance policies required by this contract shall waive all rights of subrogation against the COUNTY and members of the Board of Supervisors, its elected and appointed officials, officers, agents and employees when acting within the scope of their appointment or employment.

All insurance policies required by this contract shall give COUNTY thirty (30) days notice in the event of cancellation and ten (10) days for non-payment of premium. This shall be evidenced by policy provisions or an endorsement separate from the Certificate of Insurance.

The Commercial General Liability policy shall contain a severability of interests' clause, also known as a "separation of insureds" clause (standard in the ISO CG 001 policy).

Insurance certificates should be forwarded to COUNTY's address provided in Clause 17 (NOTICES) below or to an address provided by SSA/Facilities Services Manager. LICENSEE has ten (10) business days to provide adequate evidence of insurance or this License may be cancelled.

COUNTY expressly retains the right to require LICENSEE to increase or decrease insurance of any of the above insurance types throughout the term of this License. Any increase or decrease in insurance will be as deemed by COUNTY's Risk Manager as appropriate to adequately protect COUNTY.

COUNTY shall notify LICENSEE in writing of changes in the insurance requirements. If LICENSEE does not deposit copies of acceptable certificates of insurance and endorsements with COUNTY incorporating such changes within thirty (30) days of receipt of such notice, this License may be in breach without further notice to LICENSEE, and COUNTY shall be entitled to all legal remedies.

The procuring of such required policy or policies of insurance shall not be construed to limit LICENSEE's liability hereunder nor to fulfill the indemnification provisions and requirements of this License, nor in any way to reduce the policy coverage and limits available from the insurer.

15. OPERATIONS (AMLC-11.1 N)

LICENSEE shall keep and maintain the License Area and all improvements of any kind in good condition and in substantial repair. COUNTY will, on LICENSEE's behalf, provide all maintenance and repairs to the License Area during the term of the License. LICENSEE is required to notify COUNTY of any and all necessary maintenance and repairs to the License Area on a timely basis.

LICENSEE expressly agrees to maintain the License Area in a safe, clean, wholesome, and sanitary condition, to the complete satisfaction of COUNTY and in compliance with all applicable laws. LICENSEE further agrees to keep the License Area free and clear of rubbish and litter. COUNTY shall have the right to enter upon and inspect the License Area at any time for cleanliness and safety.

LICENSEE shall designate in writing to COUNTY an on-site representative who shall be responsible for the day to day operation and level of maintenance, cleanliness, and general order.

16. LIMITATION OF THE LICENSE (AMLC-13.1 S)

This License and the rights and privileges granted LICENSEE in and to the License Area are subject to all covenants, conditions, restrictions, and exceptions of record or apparent from a physical inspection of the License Area. Nothing contained in this License or in any document related hereto shall be construed to imply the conveyance to LICENSEE of rights in the License Area, which exceed those owned by COUNTY.

17. HIPAA NOTICE (N)

LICENSEE acknowledges that the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) requires COUNTY to safeguard and maintain the confidentiality of any Protected Health Information (PHI). LICENSEE hereby agrees not to access, remove, destroy, or relocate any property used by COUNTY to safeguard and store PHI. LICENSEE further agrees to use appropriate safeguards and to

take all reasonable steps to prevent access to any PHI stored on the premises, including informing its workforce, contractors and vendors of the confidential nature of the records maintained by COUNTY. LICENSEE agrees to report to COUNTY within ten (10) calendar days any unauthorized use or any disclosure of PHI, which LICENSEE becomes aware. Upon COUNTY's knowledge of any breach, disclosure, or unauthorized use of PHI by LICENSEE, COUNTY shall:

a. Provide an opportunity for LICENSEE to cure the breach or end the violation. If LICENSEE does not cure the breach or end the violation within thirty (30) days or shorter period as required by COUNTY, COUNTY shall terminate this Agreement; or

b. Immediately terminate this Agreement if cure is not possible.

18. HAZARDOUS MATERIALS (AMLC-16.1 S)

A. Definition of Hazardous Materials. For purposes of this License, the term **"Hazardous Material"** or "Hazardous Materials" shall mean any hazardous or toxic substance, material, product, byproduct, or waste which is or shall become regulated by any governmental entity, including, without limitation, the COUNTY acting in its governmental capacity, the State of California or the United States government.

B. Use of Hazardous Materials. LICENSEE or LICENSEE's employees, agents, independent contractors or invitees (collectively **"LICENSEE Parties"**) shall not cause or permit any Hazardous Materials to be brought upon, stored, kept, used, generated, released into the environment or disposed of on, under, from or about the License Area (which for purposes of this clause shall include the subsurface soil and ground water). Notwithstanding the foregoing, LICENSEE may keep on or about the License Area small quantities of Hazardous Materials that are used in the ordinary, customary and lawful cleaning of and business operations on the License Area.

C. LICENSEE Obligations. If the presence of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties results in (i) injury to any person, (ii) injury to or contamination of the License Area (or a portion thereof), or (iii) injury to or contamination or any real or personal property wherever situated, LICENSEE, at its sole cost and expense, shall promptly take all actions necessary or appropriate to return the License Area to the condition existing prior to the introduction of such Hazardous Materials to the License Area and to remedy or repair any such injury or contamination. Without limiting any other rights or remedies of COUNTY under this License, LICENSEE shall pay the cost of any cleanup or remedial work performed on, under, or about the License Area as required by this License or by applicable laws in connection with the removal, disposal, neutralization or other treatment of such Hazardous Materials caused or permitted by LICENSEE or LICENSEE Parties. Notwithstanding the foregoing, LICENSEE shall not take any remedial action in response to the presence, discharge or release, of any Hazardous Materials on, under or about the License Area caused or permitted by LICENSEE or LICENSEE Parties, or enter into any settlement agreement, consent decree or other compromise with any governmental or quasigovernmental entity without first obtaining the prior written consent of the COUNTY. All work performed or caused to be performed by LICENSEE as provided for above shall be done in good and workmanlike manner and in compliance with plans, specifications, permits and other requirements for such work approved by COUNTY.

D. Indemnification for Hazardous Materials. To the fullest extent permitted by law, LICENSEE hereby agrees to indemnify, hold harmless, protect and defend (with attorneys acceptable to COUNTY) COUNTY, its elected officials, officers, employees, agents and independent contractors and the

License Area, from and against any and all liabilities, losses, damages (including, but not limited, damages for the loss or restriction on use of rentable or usable space or any amenity of the License Area or damages arising from any adverse impact on marketing of the License Area), diminution in the value of the License Area, judgments, fines, demands, claims, recoveries, deficiencies, costs and expenses (including, but not limited to, reasonable attorneys' fees, disbursements and court costs and all other professional or consultant's expenses), whether foreseeable or unforeseeable, arising directly or indirectly out of the presence, use, generation, storage, treatment, on or off-site disposal or transportation of Hazardous Materials on, into, from, under or about the License Area by LICENSEE or LICENSEE's Parties. The foregoing indemnity shall also specifically include the cost of any required or necessary repair, restoration, clean-up or detoxification of the License Area and the preparation of any closure or other required plans.

19. NOTICES (AMLC-14.1 S)

All notices pursuant to this License shall be addressed as set forth below or as either Party may hereafter designate by written notice and shall be sent through the United States mail in the State of California duly registered or certified with postage prepaid. If any notice is sent by registered or certified mail, as aforesaid, the same shall be deemed served or delivered twenty-four (24) hours after mailing thereof as above provided. Notwithstanding the above, COUNTY may also provide notices to LICENSEE by personal delivery, by regular mail, or by electric mail and any such notice so given shall be deemed to have been given upon receipt.

TO: COUNTY

County of Orange
Social Services Agency
Facilities Services
500 N. State College Boulevard
Orange, CA 92868

With a copy to:

County Executive Office
Attention: Chief Real Estate Officer
333 W. Santa Ana Boulevard, 3rd Floor
Santa Ana, CA 92701

TO: LICENSEE

CalOptima
15496 Magnolia, #111
Westminster, CA 92806
Phil Tsunoda, Executive Director,
Public Policy & Public Affairs
ptsunoda@caloptima.org

20. ATTACHMENTS TO LICENSE (AMLC-15.1 S)

This License includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
Exhibit A - License Description
Exhibit B – Floor Plan

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WITNESS WHEREOF, the parties have executed this License the day and year first above written.

APPROVED AS TO FORM:
OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By_____
Deputy County Counsel

Date:_____

LICENSEE
CalOptima

By_____

Name:_____
Title:_____

RECOMMENDED FOR APPROVAL

Social Services Agency

By_____
Carol Wiseman, Chief Deputy Director

CEO Real Estate Services

By_____
John Beck, Administrative Manager

COUNTY

COUNTY OF ORANGE

By _____
Scott Mayer, Chief Real Estate Officer
County Executive Office
Per Resolution No. 14-014 of the Board of Supervisors and Minute Order dated January 28, 2014

Date:_____

GENERAL CONDITIONS (AMLC-GC l-17 S)

1. PERMITS AND LICENSES (AMLC - GC2 S)

LICENSEE shall be required to obtain any and all permits and/or licenses which may be required in connection with the operation of the License Area as set out herein. No permit, approval, or consent given hereunder by COUNTY, in its governmental capacity, shall affect or limit LICENSEE's obligations hereunder, nor shall any approvals or consents given by COUNTY, as a Party to this License, be deemed approval as to compliance or conformance with applicable governmental codes, laws, rules, or regulations.

2. SIGNS (AMLC-GC3 S)

LICENSEE agrees not to construct, maintain, or allow any signs, banners, flags, etc., upon License Area except as approved by Facilities Operations Manager unapproved signs, banners, flags, etc., may be removed.

3. LICENSE ORGANIZATION (AMLC-GC4 S)

The various headings and numbers herein, the grouping of provisions of this License into separate clauses and paragraphs, and the organization hereof, are for the purpose of convenience only and shall not be considered otherwise.

4. AMENDMENTS (AMLC-GC5 S)

This License is the sole and only agreement between the Parties regarding the subject matter hereof; other agreements, either oral or written, are void. Any changes to this License shall be in writing and shall be properly executed by both Parties.

5. UNLAWFUL USE (AMLC-GC6 S)

LICENSEE agrees no improvements shall be erected, placed upon, operated, nor maintained on the License Area, nor any business conducted or carried on therein or there from, in violation of the terms of this License, or of any regulation, order of law, statute, bylaw, or ordinance of a governmental agency having jurisdiction.

6. INSPECTION (AMLC-GC7 S)

COUNTY or its authorized representative shall have the right at all reasonable times to inspect the operation to determine if the provisions of this License are being complied with.

7. INDEMNIFICATION (AMLC-GC8 S)

LICENSEE hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of persons or property arising from, growing out of, or in any way connected with or related to this License except claims arising from the concurrent active or sole negligence of COUNTY, its officers, agents, and employees. LICENSEE hereby agrees to indemnify, hold harmless, and defend with counsel acceptable to COUNTY, its officers, agents, and employees against any and all claims, loss, demands, damages, cost, expenses, or liability costs arising out of the operation, use, or maintenance of the property

described herein, and/or LICENSEE's exercise of the rights under this License, except for liability arising out of the concurrent active or sole negligence of COUNTY, its officers, agents, or employees, including the cost of defense of any lawsuit arising there from.

In the event COUNTY is named as co-defendant, LICENSEE shall notify COUNTY of such fact and shall represent COUNTY with counsel acceptable to COUNTY in such legal action unless COUNTY undertakes to represent itself as co-defendant in such legal action, in which event LICENSEE shall pay to COUNTY its litigation costs, expenses, and attorney's fees. In the event judgment is entered against COUNTY and LICENSEE because of the concurrent active negligence of COUNTY and LICENSEE, their officers, agents, or employees, an apportionment of liability to pay such judgment shall be made by a court of competent jurisdiction. Neither Party shall request a jury apportionment.

8. TAXES AND ASSESSMENTS (AMLC-GC9 S)

Although not anticipated, should this License create a possessory interest which is subject to the payment of taxes levied on such interest, it is understood and agreed that all taxes and assessments (including but not limited to said possessory interest tax) which become due and payable in connection with this License or upon fixtures, equipment, or other property used in connection with this License, shall be the full responsibility of LICENSEE, and LICENSEE shall cause said taxes and assessments to be paid promptly.

9. PARTIAL INVALIDITY (AMLC-GC10 S)

If any term, covenant, condition, or provision of this License is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

10. WAIVER OF RIGHTS (AMLC-GC11 S)

The failure of COUNTY to insist upon strict performance of any of the terms, covenants, or conditions of this License shall not be deemed a waiver of any right or remedy that COUNTY may have, and shall not be deemed a waiver of the right to require strict performance of all the terms, covenants, and conditions of the License thereafter, nor a waiver of any remedy for the subsequent breach or default of any term, covenant, or condition of the License. Any waiver, in order to be effective, must be signed by the Party whose right or remedy is being waived.

11. CONDITION OF LICENSE AREA UPON TERMINATION (AMLC-GC12 S)

Except as otherwise agreed to herein, upon termination of this License, LICENSEE shall redeliver possession of said License Area to COUNTY in substantially the same condition that existed immediately prior to LICENSEE’s entry thereon, reasonable wear and tear, flood, earthquakes, and any act of war excepted.

12. DISPOSITION OF ABANDONED PERSONAL PROPERTY (AMLC-GC13 S)

If LICENSEE abandons the License Area or is dispossessed thereof by process of law or otherwise, title to any personal property belonging to LICENSEE and left on the License Area ten (10) days after such event shall be deemed, at COUNTY’s option, to have been transferred to COUNTY. COUNTY shall have the

right to remove and to dispose of such property without liability there from to LICENSEE or to any person claiming under LICENSEE, and shall have no need to account therefore.

13. TIME OF ESSENCE (AMLC-GC14 S)

Time is of the essence of this License. Failure to comply with any time requirements of this License shall constitute a material breach of this License.

14. NO ASSIGNMENT (AMLC-G15 S)

The License granted hereby is personal to LICENSEE and any assignment of said license by LICENSEE, voluntarily or by operation of law, shall automatically terminate the License granted hereby.

15. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (AMLC-GC16 S)

In order to comply with child support requirements of the County of Orange, LICENSEE hereby furnishes COUNTY's Facilities Operations Manager, COUNTY's standard form, Child Support Enforcement Certification Requirements. COUNTY acknowledges receipt of the aforementioned form, which contains the following information:

a) In the case where LICENSEE is doing business as an individual, LICENSEE's name, date of birth, Social Security number, and residence address;

b) In the case where LICENSEE is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;

c) A certification that LICENSEE has fully complied with all applicable federal and state reporting requirements regarding its employees; and

d) A certification that LICENSEE has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment and will continue to so comply.

Failure of LICENSEE to continuously comply with all federal and state reporting requirements for child support enforcement or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment shall constitute a material breach of this License. Failure to cure such breach within sixty (60) calendar days of notice from COUNTY's shall constitute grounds for termination of this License.

It is expressly understood that this data will be transmitted to governmental agencies charged with the establishment and enforcement of child support orders and will not be used for any other purpose.

16. RIGHT TO WORK AND MINIMUM WAGE LAWS (AMLC-GC17 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LICENSEE shall require its employees that directly or indirectly service the License Area or terms and conditions of this License, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LICENSEE shall also require and verify that its contractors or any other persons servicing the License Area

or terms and conditions of this License, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LICENSEE shall pay no less than the greater of the Federal or California Minimum Wage to all its employees that directly or indirectly service the License Area, in any manner whatsoever. LICENSEE shall require and verify that all its contractors or other persons servicing the License Area on behalf of LICENSEE also pay their employees no less than the greater of the Federal or California Minimum Wage.

LICENSEE shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the License Area or terms and conditions of this License.

Notwithstanding the minimum wage requirements provided for in this clause, LICENSEE, where applicable, shall comply with the prevailing wage and related requirements pursuant to the provisions of Section 1773 of the Labor Code of the State of California.

17. BEST MANAGEMENT PRACTICES (AMLC 15.1 S)

LICENSEE and all of LICENSEE's, agents, employees and contractors shall conduct operations under this License so as to assure that pollutants do not enter municipal storm drain systems which systems are comprised of, but are not limited to curbs and gutters that are part of the street systems ("**Stormwater Drainage System**"), and to ensure that pollutants do not directly impact "**Receiving Waters**" (as used herein, Receiving Waters include, but are not limited to, rivers, creeks, streams, estuaries, lakes, harbors, bays and oceans).

The Santa Ana and San Diego Regional Water Quality Control Boards have issued National Pollutant Discharge Elimination System ("**NPDES**") permits ("**Stormwater Permits**") to the County of Orange, and to the Orange County Flood Control District and cities within Orange County, as co-permittees (hereinafter collectively referred to as "**County Parties**") which regulate the discharge of urban runoff from areas within the County of Orange, including the License Area. The County Parties have enacted water quality ordinances that prohibit conditions and activities that may result in polluted runoff being discharged into the Stormwater Drainage System.

To assure compliance with the Stormwater Permits and water quality ordinances, the County Parties have developed a Drainage Area Management Plan ("**DAMP**") which includes a Local Implementation Plan ("**LIP**") for each jurisdiction that contains Best Management Practices ("**BMP(s)**") that parties using properties within Orange County must adhere to. As used herein, a BMP is defined as a technique, measure, or structural control that is used for a given set of conditions to manage the quantity and improve the quality of stormwater runoff in a cost effective manner. These BMPs are found within the COUNTY's LIP in the form of Model Maintenance Procedures and BMP Fact Sheets (the Model Maintenance Procedures and BMP Fact Sheets contained in the DAMP/LIP shall be referred to hereinafter collectively as "**BMP Fact Sheets**") and contain pollution prevention and source control techniques to eliminate non-stormwater discharges and minimize the impact of pollutants on stormwater runoff.

The use under this License does not require BMP Fact Sheets.

18. PAYMENT CARD COMPLIANCE (AMLC-G15 S)

Should LICENSEE conduct credit/debit card transactions in conjunction with their business with the COUNTY, on behalf of the COUNTY, or as part of the business that they conduct, LICENSEE covenants and warrants that it is currently Payment Card Industry Data Security Standard (**"PCI DSS"**) and Payment Application Data Security Standards (**"PA DSS"**) compliant and will remain compliant during the entire duration of this License. LICENSEE agrees to immediately notify COUNTY in the event LICENSEE should ever become non-compliant, and will take all necessary steps to return to compliance and shall be compliant within ten (10) days of the commencement of any such interruption.

Upon demand by COUNTY, LICENSEE shall provide to COUNTY written certification of LICENSEE's PCI DSS and/or PA DSS compliance.

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LICENSE DESCRIPTION (10.1 S)

PROJECT NO: GA 1213-236 DATE: 6/29/16

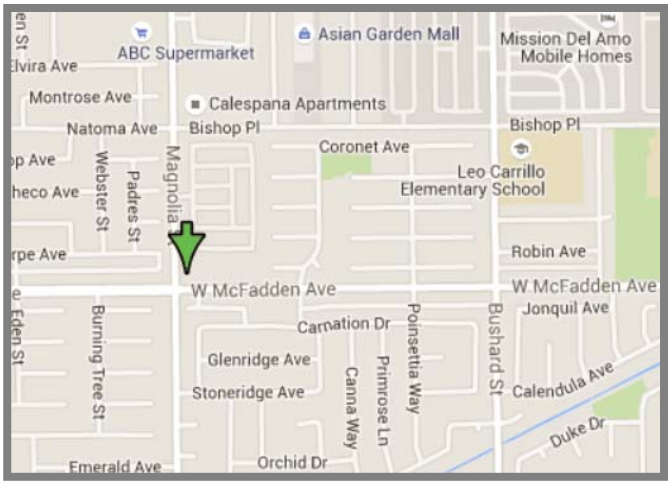
PROJECT: CalOptima
15496 Magnolia, #111
Westminster, CA 92806

WRITTEN BY: EAS

All the License Area referenced on a Floor Plan marked Exhibit B, attached hereto and made a part hereof, being approximately Three Hundred Sixty Two (362) rentable square feet of COUNTY-designated space for LICENSEE's non-exclusive use, which space may vary from time-to-time based on COUNTY's pre-approval in writing, and being a portion of the Orange County Community Service Center Annex building located at 15496 Magnolia, Suite 111, Rooms 1 and 2 in the City of Westminster, County of Orange, State of California, together with appurtenant right to use common areas located thereon, and the non-exclusive use of one parking space in the adjacent parking lot.

NOT TO BE RECORDED

EXHIBIT A



Location Map

License Area:
Rooms 1 & 2

EXHIBIT B

Reception Area

CCSC COST APPLY - 15496 Magnolia Street, Westminster

FY 2016-17 MONTHLY INVOICE CODING SUMMARY

Invoice Coding and Job Number Allocation.

	Fund/Dept/Budget Control Unit/Object/Job No.	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency/Partners	100/063/063 2211/2200/ S34000	$ 656.94	$ 295.21	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	$ 1,116.57	**$ 12,117.85**
Clerk-Recorder	100/063/063 2211/2200/ S34006	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Health Care Agency	100/063/063 2211/2200/ S34007	$ 1,278.26	$ 1,278.26	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	$ 4,365.61	**$ 46,212.65**
OC Community Resources	100/063/063 2211/2200/ S34008	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
CalOptima	100/063/063 2211/2200/S34009	$ -	$ 361.73	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	$ 1,453.02	**$ 14,891.90**
		$ 1,935.20	**$ 1,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 6,935.20**	**$ 73,222.40**

LEASED SPACE

	sq ft	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency	**177.25**	**16.43%**	**$ 251.40**	**$ 107.96**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 929.32**	**$ 9,652.58**
Health Care Agency - Total	**666.25**	**61.75%**	**$ 405.80**	**$ 405.80**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 3,493.15**	**$ 35,743.11**
- Environmental Health	379.05	35.13%	$ 230.87	$ 230.87	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	$ 1,987.36	20,335.35
- AMHS	232.7	21.57%	$ 141.73	$ 141.73	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	$ 1,220.05	12,483.93
- Public Health Nursing	54.5	5.05%	$ 33.19	$ 33.19	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	$ 285.74	2,923.83
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**235.5**	**21.83%**	**$ -**	**$ 143.44**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 1,234.73**	**$ 12,490.71**
					$ -										
TOTAL	**1079**	**100%**	**$ 657.20**	**$ 657.20**	**$ 5,000.00**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 5,657.20**	**$ 57,886.40**

Total leased space: 2080 sq. ft.

Lease rates:		Monthly	Fiscal Year total:
Rent: September 1, 2016 - September 30, 2017	$	5,000.00	$ 50,000.00
Operating Expenses: July 1 2016- June 30, 2017	$	657.20	$ 7,886.40

IT SERVICES

	# computers	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency	**1**	**12.50%**	**$ 96.25**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 625.63**
Health Care Agency - Total	**6**	**75.00%**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 288.75**	**$ 3,465.00**
- Environmental Health	5	$ 0.63	$ 240.63	$ 240.63	240.625	240.625	240.625	240.625	240.625	240.625	240.625	240.625	240.625	240.625	$ 2,887.50
- AMHS	0.5	$ 0.06	$ 24.06	$ 24.06	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	$ 288.75
- Public Health Nursing	0.5	$ 0.06	$ 24.06	$ 24.06	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	24.0625	$ 288.75
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**1**	**12.50%**	**$ -**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 48.13**	**$ 529.38**
TOTAL	**8**	**100%**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 385.00**	**$ 4,620.00**

Monthly IT rates $ 385.00
Annual Telephone Service Costs $ 4,620.00

TELEPHONE SERVICES

	# phones	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total
Social Services Agency	**1**	**16.67%**	**$ 39.33**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 255.67**
Health Care Agency - Total	**4**	**66.67%**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 78.67**	**$ 944.00**
- Environmental Health	3	50.00%	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 59.00	$ 708.00
- AMHS	0.5	8.33%	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 118.00
- Public Health Nursing	0.5	8.33%	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 9.83	$ 118.00
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**1**	**16.67%**	**$ -**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 19.67**	**$ 216.33**
TOTAL	**6**	**100%**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 118.00**	**$ 1,416.00**

Monthly Telephone Service Costs $ 118.00
Annual Telephone Service Costs $ 1,416.00

JANITORIAL SERVICES

	sq ft	Allocation %	July 2016	August 2016	September 2016	October 2016	November 2016	December 2016	January 2017	February 2017	March 2017	April 2017	May 2017	June 2017	Annual Total

Social Services Agency	**177.25**	**16.43%**	**$**	**219.95**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**94.46**	**$**	**1,258.98**
Health Care Agency - Total	**666.25**	**61.75%**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**355.05**	**$**	**4,260.54**
- Environmental Health	379.05	35.13%	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	202.00	$	2,423.95
- AMHS	232.7	21.57%	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	124.01	$	1,488.07
- Public Health Nursing	54.5	5.05%	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	29.04	$	348.52
Clerk-Recorder	**0**	**0.00%**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**
OC Community Resources - Total	**0**	**0.00%**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**	**$**	**-**
Cal Optima	**235.5**	**21.83%**	**$**	**-**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**125.50**	**$**	**1,380.48**
TOTAL	**1079**	**100%**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**575.00**	**$**	**6,900.00**

Total leased space: 2080 sq. ft.

Monthly Janitorial Costs $ 575.00
12 mo. Annual Janitorial Costs $ 6,900.00

ELECTRICAL/UTILITIES

	sq ft	Allocation %	219.9548193	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	94.45667285	Annual Total
Social Services Agency	**1**	**12.50%**	**$ 50.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 325.00**
Health Care Agency - Total	**6**	**75.00%**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 150.00**	**$ 1,800.00**
- Environmental Health	5	62.50%	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 125.00	$ 1,500.00
- AMHS	0.5	6.25%	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 150.00
- Public Health Nursing	0.5	6.25%	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 12.50	$ 150.00
Clerk-Recorder	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
OC Community Resources - Total	**0**	**0.00%**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**
Cal Optima	**1**	**12.50%**	**$ -**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 25.00**	**$ 275.00**
TOTAL	**8**	**100%**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 200.00**	**$ 2,400.00**

Total leased space: 2080 sq. ft.

Estimated Utility Costs $ 200.00
12 mo. Annual Janitorial Costs $ 2,400.00

Annex - 15496 Magnolia Ave, CCSC

Previous site amount	Variance
$ 11,476.51	$34,736.14

Total Annual Charges - check

$ 70,822.40

CODING

SSA INVOICE				Cost Apply - Other Agency			
Fund/Dept/Budget Control	Unit	Object	Job #	Fund/Dept/Budget Control	Unit	Object	Job #
100/063/063	2211	2200	S34000	--	--	--	--
100/063/063	2211	2200	S34007	See below			
See above				100/042/042	6600	2200	H4046800
See above				100/042/042	2100	2200	H2407N70
See above				100/042/042	1520	2200	H1120800
100/063/063	2211	2200	S34006	100/059/059	--	2200	PCW002
100/063/063	2211	2200	S34008	See below			
	2211	2200	S34009	NA - will be invoiced			
Default SSA coding	--	--	--	--	--	--	--
100/063/063	2211	2200	S34000	--	--	--	--

Lease, Janitorial & Utility Allocation	sq ft	Allocation %
Social Services Agency	177.25	16.427%
Health Care Agency	666.25	61.747%
- Environmental	379.05	35.130%
- AMHS	232.7	21.566%
- Public Health	54.5	5.051%
Clerk-Recorder	0	0.000%
OC Community Resources	0	0.000%
CalOptima	235.5	21.826%
TOTAL	1079	161.7%

West Annex Community Customer Service Center
15496 Magnolia Street
Westminster, CA 92683

LEASE

THIS IS A LEASE (hereinafter referred to as "**Lease**"), made July 1, 2016, ("**Effective Date**") by and between CHARLES H. MANH and ANH MANH, Co-Trustees of the MANH FAMILY TRUST, under declaration of trust dated August 15, 2006 ("**LESSOR**") and the COUNTY OF ORANGE, a political subdivision of the State of California ("**COUNTY**"), without regard to number and gender. The LESSOR and COUNTY may individually be referred to herein as a "**Party**," or collectively as the "**Parties**.

1. DEFINITIONS (1.2 S)

"Board of Supervisors" means the Board of Supervisors of the County of Orange, a political subdivision of the State of California.

"County Executive Officer" means the County Executive Officer, County Executive Office, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

"CEO Real Estate"" means the County Executive Office's Real Estate team, or upon written notice to LESSOR, such other person or entity as shall be designated by the Chief Real Estate Officer, County of Orange, or designee.

"Chief Real Estate Officer" means the Chief Real Estate Officer for the County of Orange, or designee or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or r the Board of Supervisors.

"County Counsel" means the County Counsel, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the Board of Supervisors.

"Risk Manager" means the Risk Manager, County Executive Office, Risk Management, County of Orange, or designee, or upon written notice to LESSOR, such other person or entity as shall be designated by the County Executive Officer or the Board of Supervisors.

2. PREMISES (1.3 S)

LESSOR leases to COUNTY that certain property consisting of 2,120 square feet, located at 15496 Magnolia Street, Suite 111, Westminster, CA and described in Exhibit A and shown on Exhibit B, which exhibits are attached hereto and by reference made a part hereof (hereinafter referred to as "**Premises**"),, together with non-exclusive, in common use of LESSOR's elevators, stairways, washrooms, hallways, parking areas, driveways for vehicle ingress and egress, pedestrian walkways, other facilities and common areas appurtenant to the Premises created by this Lease.

3. PARKING (1.4 S)

LESSOR, throughout the term of this Lease, shall provide a total of thirteen (13) parking spaces for COUNTY's free and non-exclusive use. Said parking spaces are to be located in the parking areas adjacent to the Premises. LESSOR shall designate three (3) parking spaces adjacent to the Premises to be reserved for use by COUNTY clients. Said parking spaces shall contain signs above the space indicating that the spaces are reserved for COUNTY use.

In addition to said parking spaces, LESSOR shall also provide parking for disabled persons in accordance with the Americans with Disabilities Act, Section 7102 of the California Uniform Building Code and the applicable codes and/or ordinances relating to parking for disabled persons as established by the local jurisdiction in which the Premises is located where the provisions of such local codes and/or ordinances exceed or supersede the State requirements.

4. TERM (2.2 N)

The term of this Lease shall be one (1) year ("**Term**"), commencing upon the first of the next month following execution of this Lease by the COUNTY Chief Real Estate Officer or upon LESSOR's delivery and COUNTY's acceptance of the Premises, whichever is later ("**Commencement Date**").
Parties agree that the Commencement Date of this Lease will be confirmed in writing by either Party upon demand by the other.

5. RENT (3.1 N)

COUNTY agrees to pay LESSOR as rent for the Premises the sum of Five Thousand Dollars ($5,000.00) per month pursuant to the following rent payment schedule ("**Rent**").

MONTH	MONTHLY RENT	MONTH	MONTHLY RENT
1	$0.00	7	$5,000.00
2	$0.00	8	$5,000.00
3	$5,000.00	9	$5,000.00
4	$5,000.00	10	$5,000.00
5	$5,000.00	11	$5,000.00
6	$5,000.00	12	$5,000.00

To obtain rent payments LESSOR (or LESSOR's designee) shall submit to the COUNTY, in a form acceptable to said COUNTY, a written claim for payment of applicable Rent and COUNTY's share of the NNN Expenses, as defined in Section 6, below.
Payment shall be due and payable by direct deposit into a bank account specified by LESSOR within twenty (20) days after the later of the following:

A. The first day of the month following the month earned; or
B. Receipt of LESSOR's written claim by COUNTY.

Should COUNTY occupy the Premises before the Commencement Date, LESSOR shall be entitled to pro rata Rent for the period of occupancy occupied prior to the Commencement Date based upon the monthly Rent above. Said Rent shall be included in the rent claim submitted by LESSOR for the first full month of the Term and shall be paid by COUNTY at the time of payment for said month.

6. REIMBURSEMENT OF LESSOR'S OPERATING EXPENSES (6.0 N)

LESSOR and COUNTY agree pursuant to Section 5, above, that COUNTY shall pay the fixed amount of $657.20 ($.31/sf/mo.) per month for the term of the lease, as reimbursement for COUNTY's pro rata share of LESSOR's expenses related to the items described in Section 6A, 6B, 6C and 6D of this Lease for the property in which the Premises is located ("**NNN Expenses**"). LESSOR shall submit to COUNTY a separate monthly invoice .in addition to the monthly Rent invoice.

The pro rata share of LESSOR's NNN Expenses as defined above is determined according to the gross leasable area of the Premises as it relates to the total gross leasable area of the building that contains the Premises. The percent of COUNTY's occupancy which LESSOR and COUNTY agree is 12.47% (the "**pro rata share**"): the Premises is 2,120 gross square feet; and the total building area is 17,000 gross square feet.

COUNTY shall reimburse LESSOR for COUNTY's pro rata share of the NNN Expenses only for the items in Section 6A, 6B and 6C and 6D below:

A. Property Taxes and Property Tax Assessments pursuant to Section 13 of this Lease.
B. Maintenance and repair, and janitorial services for the common area restrooms in the building in which the Premises is located pursuant to Section 9 of this Lease.
C. Common area maintenance and repair of the building, parking lots, landscaping, lighting, and other common area maintenance and repair costs pursuant to Section 9 of this Lease.
D. Commercial Property Insurance and Commercial General Liability Insurance pursuant to Section 11 of this Lease.

7. ALTERATIONS (4.4 S)

COUNTY may make improvements and changes in the Premises, including but not limited to the installation of fixtures, partitions, counters, shelving, and equipment as deemed necessary or appropriate. It is agreed that any such fixtures, partitions, counters, shelving, or equipment attached to or placed upon the Premises by COUNTY shall be considered as personal property of COUNTY, who shall have the right to remove same. COUNTY agrees that the Premises shall be left in as good condition as when received, reasonable wear and tear excepted.

8. ORANGE COUNTY INFROMATION TECHNOLOGY SYSTEM S (OCIT) (4.5 N)

LESSOR agrees that COUNTY may install, at COUNTY's sole cost and expense, computer and telecommunication devices in, on, or around the Premises and LESSOR's building in accordance with COUNTY's plans and specifications provided that the provisions of the Clause entitled ALTERATIONS, of this Lease, shall be applicable to such work. It shall be COUNTY's responsibility to obtain all governmental permits and/or approvals required for such installation; however, LESSOR shall reasonably cooperate with COUNTY as necessary or appropriate, to obtain said permits and/or approvals.

9. REPAIR, MAINTENANCE, AND JANITORIAL SERVICES (5.1 N)

LESSOR shall keep, maintain, and repair the building and other improvements upon the Premises in good and sanitary order and condition (except as otherwise provided in this Lease) including without limitation, the maintenance and repair of the roof, parking lot, sidewalks, common area restrooms including janitorial supplies and services, landscaping, store front, doors, window casements, glazing, plumbing, pipes, electrical wiring, and conduits, and the heating and air conditioning system including the maintenance of a service contract with a heating and air conditioning contractor, as necessary to maintain the property in

which the Premises is located in good and sanitary order, condition, and repair. COUNTY shall reimburse LESSOR for the County's pro rata share of said expenses in accordance with Section 6 of the Lease. Notwithstanding the language in the paragraph above, COUNTY shall provide at its own cost and expense all repair and maintenance and services to the interior of the Premises.

A. Heating, Ventilation and Air Conditioning System (HVAC)

During all operating hours the HVAC system serving the Premises, to be repaired and maintained by the LESSOR, shall be capable of maintaining the Premises at 78º Dry Bulb at a maximum range of 40% to 60% Relative humidity during the summer when the outdoor temperature is 95º Dry Bulb, and at 68º Dry Bulb in the winter when the outside temperature is 35º Dry Bulb.

In order for the COUNTY to comply with the California Code of Regulations, Title 8, Section 5142, and as it may be subsequently amended, LESSOR shall inspect the HVAC system at least once annually or on a schedule agreed to in writing by LESSOR and COUNTY, and provide repair and maintenance accordingly. LESSOR's inspections and maintenance of the HVAC system shall be documented in writing. The LESSOR shall at a minimum, maintain a record of: (a) the name of the individual(s) inspecting and/or maintaining the system, (b) the date of the inspection and/or maintenance, and (c) the specific findings and actions taken. The LESSOR shall ensure that such records are retained for at least five (5) years. The LESSOR shall make all HVAC records required by this section available to COUNTY for examination and copying, within forty-eight (48) hours of a written request from COUNTY. LESSOR acknowledges that COUNTY may be subject to fines and/or penalties for failure to provide said records to regulatory agencies within the given timeframes. Should COUNTY incur fines and/or penalties as a direct result of LESSOR's failure to provide said records to COUNTY, LESSOR shall reimburse COUNTY for said fines and/or penalties within thirty (30) days upon written notice. Should LESSOR fail to reimburse COUNTY within thirty (30) days, COUNTY may deduct the amount of the fine and/or penalty from any rent payable.

B. Janitorial Supplies and Services

LESSOR shall provide janitorial supplies and services on a five-day-per-week basis (Monday through Friday) to the common areas and common area restrooms in accordance with Exhibit D (JANITORIAL SPECIFICATIONS) attached hereto and by reference made a part hereof.

If LESSOR fails to provide satisfactory janitorial supplies to Premises, the Chief Real Estate Officer, or designee may notify LESSOR either verbally or in writing; and if LESSOR does not provide janitorial supplies within twenty-four (24) hours after LESSOR has received such written notice from COUNTY, COUNTY may provide the janitorial supplies necessary or have others do

so, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

If LESSOR or its representative cannot be contacted by COUNTY for emergency repairs and/or services the same day any emergency repairs and/or services are necessary to remedy the emergency condition, or if LESSOR following such contact by COUNTY is unable or refuses to make the necessary repairs within a reasonable time or provide the necessary services, as determined by the Chief Real Estate Officer, COUNTY may at its option have the necessary repairs made and/or provide services to remedy the emergency condition, and deduct the cost thereof, including labor, materials and COUNTY's administrative costs from any rent payable.

10. ELECTRIC UTILITIES (5.2 N)

COUNTY shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the interior of the Premises directly to the utility company.

LESSOR shall be responsible for and pay, prior to the delinquency date, all charges for electric utilities supplied to the exterior of the Premises and to the common areas of the property in which the Premises is located.

INSURANCE (5.3 S)

Commercial Property Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial property insurance with all risk or special form coverage, covering the loss or damage to the Premises to the full insurable value of the improvements located on the Premises (including the full value of all improvements and fixtures owned by LESSOR) at least in the amount of the full replacement cost thereof, and in no event less than the total amount required by any lender holding a security interest.

LESSOR agrees to and shall include in the policy or policies of commercial property insurance a standard waiver of the right of subrogation against COUNTY by the insurance company issuing said policy or policies. LESSOR shall provide COUNTY with a Certificate of Insurance as evidence of compliance with these requirements.

Commercial General Liability Insurance: LESSOR shall obtain and keep in force during the term of this Lease a policy or policies of commercial general liability insurance covering all injuries occurring

within the building and the Premises. The policy or policies evidencing such insurance shall provide the following:

a. Name COUNTY as an additional insured;
b. Shall be primary, and any insurance or self-insurance maintained by COUNTY shall be excess and non-contributing;
c. LESSOR shall notify County in writing within thirty (30) days of any policy cancellation and ten (10) days for non-payment of premium and provide a copy of the cancellation notice to County. Failure to provide written notice of cancellation may constitute a material breach of the Lease, upon which the County may suspend or terminate this Lease.
d. Shall provide a limit of One Million Dollars ($1,000,000) per occurrence; and
e. The policy or policies of insurance must be issued by an insurer with a minimum rating of A- (Secure A.M. Best's Rating) and VIII (Financial Size Category as determined by the most current edition of the **Best's Key Rating Guide/Property-Casualty/United States or ambest.com).** It is preferred, but not mandatory, that the insurer be licensed to do business in the state of California (California Admitted Carrier).

If the insurance carrier does not have an A.M. Best Rating of A-/VIII, the CEO/Office of Risk Management retains the right to approve or reject a carrier after a review of the company's performance and financial ratings. Prior to the Commencement Date of this Lease and upon renewal of such policies, LESSOR shall submit to COUNTY a Certificate of Insurance and required endorsements as evidence that the foregoing policy or policies are in effect.

If LESSOR fails to procure and maintain the insurance required to be procured by LESSOR under this Lease, COUNTY may, but shall not be required to, order such insurance and deduct the cost thereof plus any COUNTY administrative charges from the rent thereafter payable.

11. INDEMNIFICATION (5.5 A S)

LESSOR shall defend, indemnify and save harmless COUNTY and COUNTY Parties from and against any and all claims, demands, losses, or liabilities of any kind or nature which COUNTY or the COUNTY Parties may sustain or incur or which may be imposed upon them for injury to or death of persons, or damage to property as a result of, or arising out of, the negligence or intentional misconduct of LESSOR or the LESSOR Parties, in connection with the maintenance or use of the Premises by LESSOR or the LESSOR Parties.

12. TAXES AND ASSESSMENTS (5.6 N)

All taxes and assessments which become due and payable upon the Premises shall be the full responsibility of LESSOR, and LESSOR shall cause said taxes and assessments to be paid prior to the due date.

COUNTY shall reimburse LESSOR for its proportionate share of Taxes and Assessments pursuant to Section 5 of this Lease.

13. BUILDING AND SAFETY REQUIREMENTS (5.7 S)

During the full term of this Lease, LESSOR, at LESSOR's sole cost, agrees to maintain the Premises in compliance with all applicable laws, rules, regulations, building codes, statutes, and orders as they are applicable on the date of this Lease, and as they may be subsequently amended.

Included in this provision is compliance with the Americans with Disabilities Act ("**ADA**") and all other federal, state, and local codes, statutes, and orders relating to disabled access as they are applicable on the dates of this Lease, and as they may be subsequently amended.

LESSOR further agrees to maintain the Premises as a "safe place of employment," as defined in the California Occupational Safety and Health Act (California Labor Code, Division 5, Part 1, Chapter 3, beginning with Section 6400) and the Federal Occupational Safety and Health Act, where the provisions of such Act exceed, or supersede, the California Act, as the provisions of such Act are applicable on the date of this Lease, and as they may be subsequently amended.

In the event LESSOR neglects, fails, or refuses to maintain said Premises as aforesaid, COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY's sole option, cure any such default by performance of any act, including payment of money, and subtract the cost thereof plus reasonable administrative costs from the rent.

14. TOXIC MATERIALS (5.9 S)

COUNTY hereby warrants and represents that COUNTY will comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "**Toxic Materials**"). COUNTY shall be responsible for and shall defend, indemnify and hold LESSOR, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the storage, use, and disposal of Toxic Materials on the Premises by COUNTY. If the storage, use, and disposal of Toxic Materials on the Premises by COUNTY results in contamination or

deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, COUNTY shall promptly take any and all action necessary to clean up such contamination.

Likewise, LESSOR hereby warrants and represents that LESSOR has in the past and will hereafter comply with all laws and regulations relating to the storage, use and disposal of hydrocarbon substances and hazardous, toxic or radioactive matter, including, but not limited to, those materials identified in Title 26 of the California Code of Regulations (collectively "Toxic Materials"). LESSOR shall be responsible for and shall defend, indemnify and hold COUNTY, its officers, directors, employees, agents, and representatives, harmless from and against all claims, costs and liabilities, including attorneys' fees and costs arising out of or in connection with the previous, current and future storage, use and disposal of Toxic Materials on the Premises (or building if the Premises comprises only a portion of said building) by LESSOR. If the previous, current and future storage, use, and disposal of Toxic Materials on the Premises by LESSOR results in contamination or deterioration of water or soil resulting in a level of contamination greater than maximum allowable levels established by any governmental agency having jurisdiction over such contamination, LESSOR shall promptly take any and all action necessary to clean up such contamination.

15. SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE (6.4 S)

This Lease and all rights of the COUNTY hereunder are subject and subordinate to any mortgage or deed of trust which does now or may hereafter cover the Premises or any interest of LESSOR therein, and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions of any such mortgage or deed of trust; except, insofar as COUNTY is meeting its obligations under this Lease, any foreclosure of any mortgage or deed of trust shall not result in the termination of this Lease or the displacement of COUNTY.

In the event of transfer of title to the Premises, including any proceedings brought for foreclosure or in the event of the exercise of the power of sale under any mortgage or deed of trust or by any other transfer of title covering the Premises, COUNTY shall attorn to and recognize any subsequent title holder as the LESSOR under all terms, covenants and conditions of this Lease. COUNTY's possession of the Premises shall not be disturbed by the LESSOR or its successors in interest, and this Lease shall remain in full force and effect. Said attornment shall be effective and self-operative immediately upon succession of the current title holder, or its successors in interest, to the interest of LESSOR under this Lease.

Notwithstanding the above, this Lease is contingent upon LESSOR's obtaining a Subordination, Attornment and Non-Disturbance Agreement from LESSOR’s lender, within thirty (30) days of

LESSOR's execution of this Lease. LESSOR shall require all future lenders on the Premises upon initiation of their interest in the Premises, to enter into a Subordination, Attornment and Non-Disturbance Agreement with COUNTY thereby insuring COUNTY of its leasehold interests in the Premises. Said Subordination, Attornment and Non-Disturbance Agreement shall be in the form of COUNTY's standard form Subordination, Attornment and Non-Disturbance Agreement shown on Exhibit E, attached hereto and by reference made a part hereof, or in a form approved by the Chief Real Estate Officer, and County Counsel.

Foreclosure shall not extinguish this Lease, and any lender or any third party purchasing the Premises at foreclosure sale shall do so subject to this Lease and shall thereafter perform all obligations and be responsible for all liabilities of the LESSOR under the terms of this Lease.

Upon default by LESSOR of any note or deed of trust, COUNTY may, at its option, make all lease payments directly to the lender, and same shall be applied to the payment of any and all delinquent or future installments due under such note or deed of trust.

16. ESTOPPEL CERTIFICATE (6.5 S)

COUNTY agrees that the County Executive Officer shall furnish from time to time upon receipt of a written request from LESSOR or the holder of any deed of trust or mortgage covering the Premises or any interest of LESSOR therein, COUNTY's standard form Estoppel Certificate containing information as to the current status of the Lease. The Estoppel Certificate shall be approved by the Chief Real Estate Officer, and County Counsel.

17. DEFAULTS AND REMEDIES (6.8 S)

The occurrence of any of the following shall constitute an event of default:

- Failure to pay any installment of any monetary amount due and payable hereunder;
- Failure to perform any obligation, agreement or covenant under this Lease.

In the event of any non-monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to initiate action to cure said breach.

In the event of any non-monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach and LESSOR shall have fifteen (15) days in which to initiate action to cure said

breach.

In the event of any monetary breach of this Lease by COUNTY, LESSOR shall notify COUNTY in writing of such breach, and COUNTY shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

In the event of any monetary breach of this Lease by LESSOR, COUNTY shall notify LESSOR in writing of such breach, and LESSOR shall have fifteen (15) days in which to cure said breach, unless specified otherwise within this Lease.

18. DEBT LIMIT (6.9 S)

LESSOR acknowledges and agrees that the obligation of the COUNTY to pay rent under this Lease is contingent upon the availability of COUNTY funds which are appropriated or allocated by the COUNTY's Board of Supervisors for the payment of rent hereunder. In this regard, in the event that this Lease is terminated due to an uncured default of the COUNTY hereunder, LESSOR may declare all rent payments to the end of COUNTY's current fiscal year to be due, including any delinquent rent from prior budget years. In no event shall LESSOR be entitled to a remedy of acceleration of the total rent payments due over the term of the Lease. The Parties acknowledge and agree that the limitations set forth above are required by Article 16, section 18, of the California Constitution. LESSOR acknowledges and agrees that said Article 16, section 18, of the California Constitution supersedes any law, rule, regulation or statute, which conflicts with the provisions of this paragraph. Notwithstanding the foregoing, LESSOR may have other rights or civil remedies to seek relief due to the COUNTY's default under the Lease. Such rights or remedies may include a right to continue the COUNTY's right of possession under the Lease and sue for the rent as it becomes past due.

19. LABOR CODE COMPLIANCE (6.10 S)

LESSOR acknowledges and agrees that all improvements or modifications required to be performed as a condition precedent to the commencement of the term of this Lease or any such future improvements or modifications performed by LESSOR at the request of COUNTY shall be governed by, and performed in accordance with, the provisions of Article 2 of Chapter 1, Part 7, Division 2 of the Labor Code of the State of California (Sections 1770, et seq.). These provisions are applicable to improvements or modifications costing more than $1,000.

Pursuant to the provisions of Section 1773 of the Labor Code of the State of California, the Orange County Board of Supervisors has obtained the general prevailing rate of per diem wages and the general prevailing

rate for holiday and overtime work in the locality applicable to this Lease for each craft, classification, or type of workman needed to execute the aforesaid improvements or modifications from the Director of the State Department of Industrial Relations. Copies of said prevailing wage rates may be obtained from the State of California, Department of Industrial Relations, or the County Executive Officer.

LESSOR hereby agrees to pay or cause its contractors and/or subcontractors to pay said prevailing wage rates at all times for all improvements or modifications to be completed for COUNTY within the premises, and LESSOR herein agrees that LESSOR shall post, or cause to be posted, a copy of the most current, applicable prevailing wage rates at the site where the improvements or modifications are performed.

Prior to commencement of any improvements or modifications, LESSOR shall provide the County Executive Officer with the applicable certified payroll records for all workers that will be assigned to the improvements or modifications. Said payroll records shall contain, but not be limited to, the complete name, address, telephone number, social security number, job classification, and prevailing wage rate for each worker. LESSOR shall provide, the County Executive Officer bi-weekly updated, certified payroll records for all workers that include, but not be limited to, the weekly hours worked, prevailing hourly wage rates, and total wages paid.

If LESSOR neglects, fails, or refuses to provide said payroll records to the County Executive Officer, such occurrence shall constitute an event of default of this lease and COUNTY may, notwithstanding any other termination provisions contained herein:

A. Terminate this Lease; or

B. At COUNTY's sole option, COUNTY may deduct future rent payable to LESSOR by COUNTY as a penalty for such non-compliance of paying prevailing wage, which rent deduction would be COUNTY's estimate, in its sole discretion, or such prevailing wage rates not paid by LESSOR.

Except as expressly set forth in this Lease, nothing herein is intended to grant authority for LESSOR to perform improvements or modifications on space currently leased by COUNTY or for which COUNTY has entered into a lease or lease amendment.

20. CHILD SUPPORT ENFORCEMENT REQUIREMENTS (6.12 S)

In order to comply with child support enforcement requirements of the County of Orange, within thirty (30) days after COUNTY's execution of this Lease agreement, LESSOR agrees to furnish the County Executive Officer, COUNTY's standard form, *Child Support Enforcement Certification Requirements*, which includes the following information:

A. In the case where LESSOR is doing business as an individual, LESSOR's name, date of birth, Social Security number, and residence address;

B. In the case where LESSOR is doing business in a form other than as an individual, the name, date of birth, Social Security number, and residence address of each individual who owns an interest of ten (10) percent or more in the contracting entity;

C. A certification that the LESSOR has fully complied with all applicable federal and state reporting requirements regarding its employees; and

D. A certification that the LESSOR has fully complied with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, and will continue to so comply.

Failure of LESSOR to timely submit the data and/or certifications required above or to comply with all federal and state reporting requirements for child support enforcement, or to comply with all lawfully served Wage and Earnings Assignment Orders and Notices of Assignment, shall constitute a material breach of this Lease. Failure to cure such breach within sixty (60) calendar days of notice from the County Executive Officer shall constitute grounds for termination of this Lease.

Notwithstanding any other provisions of this Lease, LESSOR shall be given an opportunity to cure as follows:

A. A notice of any claimed failure to comply shall be given to LESSOR, in writing, by personal delivery, or facsimile transmission, from the County Executive Officer. The written notice shall state the specific data or certification required, the specific federal or state reporting requirements for child support enforcement that has not been complied with or the specific Wage and Earnings Assignment Order and Notice of Assignment that has not been complied with; and

B. LESSOR shall have sixty (60) days from the actual receipt of the written notice to cure the failure to comply specified in the notice, provided that LESSOR's performance to cure within sixty (60) days is not hindered, impaired or prevented by federal, state or local agencies. If the claimed failure as set forth in the written notice is failure to perform an act by a certain time, the failure of performance of said certain act by said certain time shall be deemed cured for purposes of this Lease if it is timely performed in accordance with the provisions of this paragraph.

It is expressly understood that this data will be transmitted to governmental agencies charged with the

establishment and enforcement of child support orders and will not be used for any other purpose.

21. RIGHT TO WORK AND MINIMUM WAGE LAWS (6.13 S)

In accordance with the United States Immigration Reform and Control Act of 1986, LESSOR shall require its employees that directly or indirectly service the Premises or terms and conditions of this Lease, in any manner whatsoever, to verify their identity and eligibility for employment in the United States. LESSOR shall also require and verify that its contractors or any other persons servicing the Premises or terms and conditions of this Lease, in any manner whatsoever, verify the identity of their employees and their eligibility for employment in the United States.

Pursuant to the United States of America Fair Labor Standard Act of 1938, as amended, and State of California Labor Code, Section 1178.5, LESSOR shall pay no less than the greater of the Federal or California minimum wage to all its employees that directly or indirectly service the Premises, in any manner whatsoever. LESSOR shall require and verify that all its contractors or other persons servicing the Premises on behalf of the LESSOR also pay their employees no less than the greater of the Federal or California minimum wage.

LESSOR shall comply and verify that its contractors comply with all other Federal and State of California laws for minimum wage, overtime pay, record keeping, and child labor standards pursuant to the servicing of the Premises or terms and conditions of this Lease.

Notwithstanding the minimum wage requirements provided for in this clause, LESSOR, where applicable, shall comply with the prevailing wage and related requirements, as provided for in the Clause entitled LABOR CODE COMPLIANCE of this Lease.

22. AUTHORITY (N)

The Parties to this Lease represent and warrant that this Lease has been duly authorized and executed and constitutes the legally binding obligation of their respective organization or entity, enforceable in accordance with its terms.

23. NOTICES (8.1 S)

All written notices pursuant to this Lease shall be addressed as set forth below or as either party may hereafter designate by written notice and shall be deemed delivered upon personal delivery, delivery by facsimile machine, or seventy-two (72) hours after deposit in the United States Mail.

TO: LESSOR Charles H. Manh and Anh Manh Manh Family Trust 8990 Westminster Blvd., Second Floor Westminster, CA 92683	TO: COUNTY County of Orange 333 Santa Ana Blvd., 3rd Floor Santa Ana, CA 92701 Attention: Scott Mayer, Chief Real Estate Officer Email: Scott.Mayer@ocgov.com Phone: (714) 834-3046

24. ATTACHMENTS (8.2 S)

This Lease includes the following, which are attached hereto and made a part hereof:

I. GENERAL CONDITIONS
II. EXHIBITS
   A. Description - Premises
   B. Plot Plan - Premises
   C. Performance Specifications
   D. Janitorial Specifications
   E. Subordination, Attornment, and Non-Disturbance Agreement

25. MISCELLANEOUS (N)

COUNTY may remove and dispose, and in a manner best suited for such removal and disposition, of any item(s) of furniture ("**Furniture Items**") off the Premises, which is (are) personal property of the LESSOR, as COUNTY deems appropriate or is of no use for COUNTY. LESSOR hereby waives all claims and recourse against COUNTY including the right of contribution for loss or damage of property arising from, growing out of or in any way connected with or related to the removal and disposition of the Furniture Items except claims arising from the concurrent active negligence of COUNTY, its officers, agents, and employees.

//

IN WITNESS WHEREOF, the parties have executed this Agreement the day and year first above written.

LESSOR

CHARLES H. MANH and ANH MANH,
Co-Trustees of the MANH FAMILY TRUST, dated August 15, 2006

By: _____ May 25th, 2016
CHARLES H. MANH, Co-Trustee

By: _____ May 25th, 2016
ANH MANH, Co-Trustee

APPROVED AS TO FORM:

OFFICE OF COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By _____
Deputy County Counsel

COUNTY

COUNTY OF ORANGE
Chief Real Estate Officer

_____
By: Scott D. Mayer Per Ordinance No. 15-009 of the Board of Supervisors and Minute Order dated June 9, 2015

GENERAL CONDITIONS (9.1-9.17 S)

1. LEASE ORGANIZATION (9.1 S)

The various headings in this Lease, the numbers thereof, and the organization of the Lease into separate sections and paragraphs are for purposes of convenience only and shall not be considered otherwise.

2. INSPECTION (9.2 N)

LESSOR or his authorized representative shall have the right at all reasonable times and upon reasonable advance notice to COUNTY, which authorization shall not be unreasonably withheld, to inspect the Premises to determine, if COUNTY is complying with all the provisions of this Lease.

3. SUCCESSORS IN INTEREST (9.3 S)

Unless otherwise provided in this Lease, the terms, covenants, and conditions contained herein shall apply to and bind the heirs, successors, executors, administrators, and assigns of all the parties hereto, all of whom shall be jointly and severally liable hereunder.

4. DESTRUCTION OF OR DAMAGE TO PREMISES (9.4 S)

"Partial Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is less than 25% of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

"Total Destruction" of the Premises shall mean damage or destruction to the Premises, for which the repair cost is 25% or more of the then replacement cost of the Premises (including tenant improvements), excluding the value of the land.

In the event of a Partial Destruction of the Premises, LESSOR shall immediately pursue completion of all repairs necessary to restore the Premises to the condition which existed immediately prior to said Partial Destruction. Said restoration work (including any demolition required) shall be completed by LESSOR, at LESSOR's sole cost, within sixty (60) days of the occurrence of said Partial Destruction or within an extended time frame as may be authorized, in writing, by COUNTY. The Partial Destruction of the Premises shall in no way render this Lease and/or any option to purchase null and void; however, rent payable by COUNTY under the Lease shall be abated in proportion to the extent COUNTY's use and occupancy of the Premises is adversely affected by said Partial Destruction, demolition, or repair work

required thereby. Should LESSOR fail to complete necessary repairs, for any reason, within sixty (60) days, or other time frame as may be authorized by COUNTY, COUNTY may, at COUNTY's sole option, terminate the Lease or complete necessary repair work and deduct the cost thereof, including labor, materials, and overhead from any rent thereafter payable.

In the event of Total Destruction of the Premises or the Premises being legally declared unsafe or unfit for occupancy, this Lease and/or any option shall in no way be rendered null and void and LESSOR shall immediately instigate action to rebuild or make repairs, as necessary, to restore the Premises (including replacement of all tenant improvements) to the condition which existed immediately prior to the destruction. All rent payable by COUNTY shall be abated until complete restoration of the Premises is accepted by COUNTY. In the event LESSOR refuses to diligently pursue or is unable to restore the Premises to an occupiable condition (including replacement of all tenant improvements) within 180 days of the occurrence of said destruction or within an extended time frame as may be authorized, in writing, by COUNTY, COUNTY may, at COUNTY's sole option, terminate this Lease or complete the restoration and deduct the entire cost thereof, including labor, materials, and overhead from any rent payable thereafter.

Further, LESSOR, at COUNTY's request, shall provide a suitable, COUNTY-approved temporary facility ("**Facility**") for COUNTY's use during the restoration period for the Premises. The Facility may be leased, at market rate, under a short term lease, for which the COUNTY will reimburse LESSOR the cost thereof, on a monthly basis.

5. AMENDMENT (9.5 S)

This Lease sets forth the entire agreement between LESSOR and COUNTY and any modification must be in the form of a written amendment.

6. PARTIAL INVALIDITY (9.6 S)

If any term, covenant, condition, or provision of this Lease is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remainder of the provisions hereof shall remain in full force and effect and shall in no way be affected, impaired, or invalidated thereby.

7. CIRCUMSTANCES WHICH EXCUSE PERFORMANCE (9.7 S)

If either Party hereto shall be delayed or prevented from the performance of any act required hereunder by reason of acts of God, performance of such act shall be excused for the period of the delay; and the period for the performance of any such act shall be extended for a period equivalent to the period of such

delay. Financial inability shall not be considered a circumstance excusing performance under this Lease.

8. WAIVER OF RIGHTS (9.9 S)

The failure of LESSOR or COUNTY to insist upon strict performance of any of the terms, conditions, and covenants in this Lease shall not be deemed a waiver of any right or remedy that LESSOR or COUNTY may have, and shall not be deemed a waiver of any right or remedy for a subsequent breach or default of the terms, conditions, and covenants herein contained.

9. HOLDING OVER (9.10 S)

In the event COUNTY shall continue in possession of the Premises after the term of this Lease, such possession shall not be considered a renewal of this Lease but a tenancy from month to month and shall be governed by the conditions and covenants contained in this Lease.

10. HAZARDOUS MATERIALS (9.11 S)

LESSOR warrants that the Premises is free and clear of all hazardous materials or substances.

11. EARTHQUAKE SAFETY (9.12 N)

LESSOR is informed and believes that the Premises is not in violation of any applicable seismic safety regulations and building codes.

12. QUIET ENJOYMENT (9.13 S)

LESSOR agrees that, subject to the terms, covenants and conditions of this Lease, COUNTY may, upon observing and complying with all terms, covenants and conditions of this Lease, peaceably and quietly occupy the Premises.

13. WAIVER OF JURY TRIAL (9.15 S)

Each Party acknowledges that it is aware of and has had the advice of Counsel of its choice with respect to its rights to trial by jury, and each party, for itself and its successors and assigns, does hereby expressly and knowingly waive and release all such rights to trial by jury in any action, proceeding or counterclaim brought by any party hereto against the other (and/or against its officers, directors, employees, agents, or subsidiary or affiliated entities) on or with regard to any matters whatsoever arising out of or in any way

connected with this agreement and/or any claim of injury or damage.

14. GOVERNING LAW AND VENUE. (9.16 S)

This agreement has been negotiated and executed in the State of California and shall be governed by and construed under the laws of the State of California. In the event of any legal action to enforce or interpret this agreement, the sole and exclusive venue shall be a court of competent jurisdiction located in Orange County, California, and the parties hereto agree to and do hereby submit to the jurisdiction of such court, notwithstanding Code of Civil Procedure section 394.

15. TIME (9.17 S)

Time is of the essence of this Lease.

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EXHIBIT A

DESCRIPTION OF PREMISES (10.1 N)

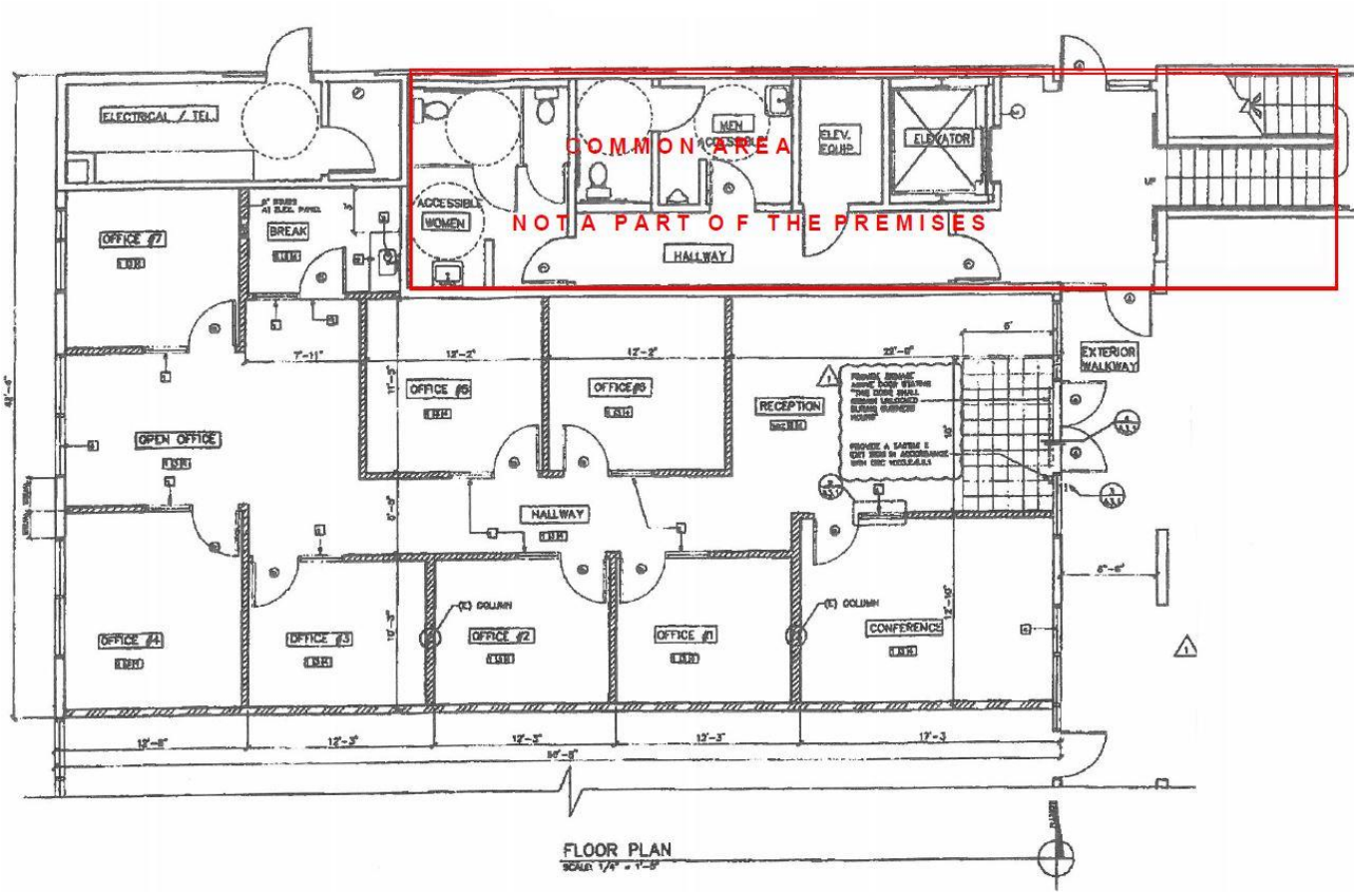
PROJECT: Community Customer Service Annex

All the Premises shown as the floor plan marked Exhibit B, attached hereto and made a part hereof, being a portion of the first floor of that certain two (2) story building located at 15496 Magnolia Street, Suite 111, in the City of Westminster, County of Orange, State of California, together with non-exclusive use of common area restrooms and thirteen (13) parking spaces in the parking areas shown on Exhibit B.

NOT TO BE RECORDED

EXHIBIT B
FLOOR PLAN OF PREMISES

15496 MAGNOLIA STREET, SUITE 111,
WESTMINSTER, CA



Gross Leasable Area: 2,120 Square Feet

EXHIBIT C

PERFORMANCE SPECIFICATIONS (10.3N) LESSOR shall perform the following Work prior to the Commencement Date of this Lease and according to the Tenant Improvement Performance Specifications that follow:

Specific locations to be identified by COUNTY prior to lease execution

1. Repair or replace door closer.
2. Replace stained ceiling tiles.
3. Repair or replace door closer.
4. Remove any signage from previous tenant that exists inside or outside of the Premises
5. Re-key front door and any internal door locks.
6. Provide the security code for existing alarm system.
7. Deliver the Premises with all electrical, plumbing and HVAC systems in proper working order.
8. Repair or replace any HVAC components resulting from findings of COUNTY's inspection of the HVAC system.

1. HEAT, VENT & AIR CONDITION ("HVAC")

A. Heating & air conditioning equipment shall have the capability of maintaining all occupied indoor areas at the room temperatures shown when outdoor temperatures are as follows:

OUTDOORS	*MAINTAIN INDOORS*
Summer – 95° Dry Bulb	78° Dry Bulb at a maximum range of 40% to 60% Relative humidity
Winter – 35° Dry Bulb	68° Dry Bulb

B. All HVAC controls pertinent to the Premises are to be located within the Premises.

C. All HVAC thermostats shall be concealed by a clear plastic tamper proof lock box.

2. ELECTRICAL & COMMUNICATIONS

A. Provide and install fluorescent lighting at all interior spaces that meet code and provide the following minimum lighting intensities at desk level:

LOCATION	*MINIMUM FOOT CANDLES:*
General Offices/Utility Rooms	60
Public Areas	30
General Corridors	20
LOCATION	*MINIMUM FOOT CANDLES:*
Other interior areas	I.E.S. Recommended Levels
Parking Lot	1

B. All Lighting controls pertinent to the Premises shall be located within the Premises.

COMPLIANCE WITH AMERICANS WITH DISABILITIES ACT ("ADA")

LESSOR shall assure that the Premises and Property are in compliance with current standards of the Americans with Disabilities Act for ingress and egress to the Premises and Property.

EXHIBIT D

JANITORIALSPECIFICATIONS (10.4 N)

It is the intent of this Exhibit to provide general guidelines for minimum janitorial service. Any absence of a specific janitorial service from this Exhibit does not relieve LESSOR of the obligation to provide such service should it become necessary.

Janitorial service as required in the clause entitled (REPAIR, MAINTENANCE AND JANITORIAL SERVICE) of this Lease, shall be inclusive of, but not limited to, the services as detailed below:

RESTROOMS

A. **NIGHTLY**:

1. Clean and damp-mop floors;
2. Wash all mirrors, bright work and enameled surfaces;
3. Wash and sanitize all basins, bowls, urinals, and toilet seats;
4. Dust, clean, and wash where necessary, all partitions, tile walls, dispensers, and receptacles;
5. Empty and sanitize all receptacles and sanitary napkin disposals;
6. Provide materials and fill all toilet tissue, towel, seat cover, sanitary napkin, and soap dispensers.

B. **MONTHLY**:

1. Machine strip restroom floors and apply finish/sealer where applicable;
2. Wash all partitions, tile walls, and enamel surfaces;
3. Vacuum all louvers, vents, and dust light fixtures.

MISCELLANEOUS SERVICES

1. Maintain building common/shared areas, corridors, and other public areas in a clean condition;
2. Surface parking lot is to be cleaned on a monthly or more frequent basis;
3. All interior and exterior windows of the building are to be cleaned quarterly.

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EXHIBIT E

SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT

THIS IS A SUBORDINATION, ATTORNMENT AND NON-DISTURBANCE AGREEMENT, made _____, 20__, by and between the County of Orange ("COUNTY") and _____ ("LENDER").

A. By lease dated _____, ("Lease"), _____ ("LESSOR") leased to COUNTY and COUNTY leased from LESSOR those certain Premises described as: _____.

B. LENDER is the holder or about to become the holder of a mortgage or Deed of Trust ("Note") which constitutes or will constitute a lien against the Premises leased by COUNTY pursuant to the aforesaid Lease.

C. LENDER has requested that _____ execute a Subordination, Attornment and Non-Disturbance Agreement in accordance with the terms of the Lease.

NOW, THEREFORE, the parties hereto do hereby agree as follows:

1. Subject to the terms and conditions of the Lease, all rights of COUNTY thereunder are or shall become subordinate to the Note and to any and all advances made on the security thereof, and to any and all increases, renewals, modifications, consolidations, replacements and extensions thereof.

2. In the event that LENDER succeeds to the interest of LESSOR under the Lease, by reason of foreclosure of the Note, by other proceedings brought to enforce any rights of LENDER under the Note, by deed in lieu of foreclosure, or by any other method, COUNTY shall promptly attorn to LENDER under all of the terms, covenants, and conditions of the Lease for the balance of the then-current term (and any extension or renewals thereof which may be effective in accordance with any option therefore contained in the Lease), with the same force and effect as if LENDER were the Lessor under the Lease. So long as COUNTY is not in default under the Lease, LENDER or its successors in interest shall not disturb the interests of COUNTY under said Lease, but shall allow said interests to continue in full force and effect for the balance of the then-current term and any extension available to COUNTY which may be provided in accordance with the Lease. Said attornment shall be effective and self-operative immediately upon LENDER'S succession to the interest of LESSOR under the Lease.

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3. This agreement may not be modified orally or in any manner other than by written agreement signed by the parties hereto or their respective successors or assigns. All of the terms, covenants, and conditions herein shall run with the land and shall be binding upon and inure to the benefit of the parties hereto and their respective successors and assigns.

COUNTY:

COUNTY OF ORANGE

By:_____

County Chief Real Estate Officer

LENDER:

By:_____

Print Name:_____

Title:_____

APPROVAL AS TO FORM:
OFFICE OF THE COUNTY COUNSEL
ORANGE COUNTY, CALIFORNIA

By:_____

Deputy County Counsel

Date:_____

H.L. MILLER incorporated

A General Construction Company

PROPOSAL

Date	Proposal #
7/27/2016	3827

Name / Address
SOCIAL SERVICES AGENCY 500 N. State College Blvd. Orange, CA 92868 ATTN: AL PASILLAS E: Al.Pasillas@ssa.ocgov.com

Description	Total
JOB SITE: 15946 Magnolia, Suite 111 - Wall Removal REF: MA-063-16011114	
1. Remove 18' x 9' of wall with one window and one door and haul away. 2. Finish corner and replace any ceiling tiles damaged from the wall removal. Remove switches in conference room and tie lighting in both rooms to one set of switches. CARPENTER: 17 Hours at $85/Hr = $1,445.00 DRYWALL: 6 Hours at $90/Hr = $540.00 PAINTING: 4 Hours at $80/Hr = $320.00 ELECTRICAL: 9 Hours at $75/Hr = $675.00 ELECTRICAL HELPER: 9 Hours at $50/Hr = $450.00 ESTIMATED MATERIAL: $350.00 + 10% = $385.00	3,815.00
3. Remove carpet in both rooms and haul away. Prep floor and install 65.5 Sq. Yds. of level loop light to medium beige carpet. FLOORING: 18 Hours at $61/Hr - $1,098.00 ESTIMATED MATERIAL: $1,902.41 + 10% = $2,091.55	3,189.55
4. Repair carpet with similar color where wall was removed. (4" x 15'). FLOORING: 6 Hours at $61/Hr = $366.00 ESTIMATED MATERIAL: $250.00 + 10% = $275.00	641.00
Howard L. Miller, President JA QUOTE IS GOOD FOR 60 DAYS.	

Please make checks payable to:H.L. Miller, Inc. CA State Contractors Lic. #385912 Tax ID 56-2399764	**Total** $7,645.55

PURSUANT TO CALIFORNIA PUBLIC CONTRACT CODE, SECTION 20104.50, INTEREST IS DUE IF NOT PAID WITHIN 30 DAYS OF THE ABOVE DATE, AT THE RATE ALLOWED IN THE CODE OF CIVIL PROCEDURE SECTION 685.101.

2201 E. Winston Road, Unit I, Anaheim, CA 92806-5537
Phone: (714) 998-8699 • Fax: (714) 998-8698 • Email: hlmcinc@aol.com

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

37. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Activities

Contact

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

Recommended Actions

1. Authorize expenditures in support of CalOptima's participation in the following community activities:
    a. Up to $5,250 and staff participation at the Vietnamese Cultural Center 2016 Mid-Autumn Festival in Fountain Valley;
    b. Up to $5,000 and staff participation for Preferred Community Partner membership with the Orange County Medical Association (OCMA);
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

Staff recommends the authorization of the expenditure for participation in the 2016 Mid- Autumn Festival scheduled in Orange County (Fountain Valley) to highlight all CalOptima programs in the community as well as participation in OCMA Preferred Community partner activities to reach out to OCMA physicians who provide care to CalOptima members. Details on these activities and CalOptima's proposed participation are summarized below:

- CalOptima's proposed participation in the Vietnamese Cultural Center's 2016 Mid-Autumn Festival in Fountain Valley includes a $5,250 financial commitment for the following: participation, one 10x10 exhibitor space, CalOptima's logo on promotional flyers and the 1,500 lanterns to be distributed at the event, and one CalOptima banner on the stage at the festival. The festival takes place locally near the largest Vietnamese community in Orange County and draw from communities throughout the county. The anticipated number of attendees is more than 3,000 throughout the day. CalOptima previously participated in this event on September 27, 2015 at Mile Square Park in Fountain Valley. CalOptima provided staff participation, 700 lanterns, and 700 mooncakes with CalOptima's logo. Additionally, staff provided information the CalOptima program. CalOptima's participation in this event will provide information and resources to a substantial number of members and potential members. This event is expected to create positive visibility for CalOptima and will provide an opportunity to provide outreach to the Vietnamese community.

- Staff also recommends authorization for expenditures of up to $5,000 and staff participation for an OCMA Preferred Community Partner membership with access to outreach, educational and other OCMA activities. OCMA will also recognize CalOptima's partnership and provide advertising space on its website. CalOptima maintains a strong relationship with the OCMA and its many physician members who provide services to CalOptima members. OCMA membership includes over 2,000 physician members and is one of the largest medical associations in the United States. CalOptima has been a member of OCMA since December 2006. Maintaining membership will allow CalOptima to continue fostering a collaborative relationship with OCMA and accessing educational and outreach opportunities that enhance the services provided to CalOptima members. Continued membership will provide opportunities to strengthen our relationship with CalOptima providers while creating positive visibility in the medical community. CalOptima staff has reviewed the requests and believes they meet the criteria for consideration for participation, which include the following:

    1. The number of people the activities /events will reach;
    2. The marketing benefits accrued to CalOptima;
    3. The strength of the partnership or level of involvement with the requesting entities;
    4. Past participation;
    5. Staff availability; and
    6. Available budget.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended actions of up to $10,250 is included as part of the Public Activities 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 actions in order to support community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, promote health and wellness as well as provide opportunities to participate in outreach, educational and other activities with OCMA physicians serving CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. 2016 Mid-Autumn Festival Request Letter
2. 2016 OCMA Request Letter and Preferred Community Partner Invoice

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

TRUNG TÂM VĂN HÓA VIỆT NAM

Trường Việt Ngữ

14171 Newland St., Westminster, CA 92683 * PO Box 65, Midway City, CA 92655 * Tel: 714-894-6319 * www.TTVHVN.com
Office: 8732 Westminster Blvd., Suite # 1, Westminster, CA. 92683

Vietnamese Cultural Center - Vietnamese Language School

July 20, 2016

Mr. Phil Tsunoda
Executive Director, Public Policy and Public Affairs
CalOptima
505 City Parkway West
Orange, CA 92868

Re: Sponsorship for the 2016 Mid-Autumn Festival – Saturday, September 17, 2016

Dear Mr. Tsunoda,

On behalf of the Vietnamese Cultural Center, we would like to thank you for your support and participation in last year's Mid-Autumn Festival held at Mile Square Park in Fountain Valley. As you might remember the 2015 event had approximately 3,000 attendees throughout the day and was a great success.

The Mid-Autumn Festival is a traditional festival for the Vietnamese community also known as "Children's Day." The Mid-Autumn Festival celebrates three fundamental concepts: Gathering, Thanksgiving and Praying. During this time various activities are held to celebrate, such as harvesting rice before the 15th of the eight lunar month, provide offerings to the God of Earth, setting up platforms with light lanterns during the evening. The Mid-Autumn Festival is a day where families gather and enjoy time with their children. The tradition of brightly lit lanterns lends to the legend that Cuoi floated to the moon on a banyan tree and was stranded there. Children light lanterns and participate in a procession to show Cuoi the way back to Earth.

This year, the 2016 Mid-Autumn Festival event will take place on Saturday, September 17 at Mile Square Park in Fountain Valley from 3 – 8 p.m. We anticipate a greater attendance at the event this year, of which will consist of families with children and older adults.

We ask for your participation and sponsorship in the amount of $5,250 for the 2016 Mid-Autumn Festival. As an event sponsor you will receive a 10x10 exhibitor booth/space in a prime location at the event, your logo will appear on all promotional flyers produced for the event and on 1,500 lanterns that will be distributed to attendees at the event, and your banner will be displayed on the stage.

I also look forward to your CEO, Michael Schrader to be a part of the event program on stage. Should you have any questions regarding the event, please contact me at (714) 548-4845 or by e-mail at promath10@yahoo.com. The Vietnamese Cultural Center appreciates CalOptima's support.

Sincerely,

TRUNG TÂM VĂN HÓA VIỆT NAM • TRƯỜNG VIỆT NGỮ •

Pho Huynh

Chairman/Founder
Board of Directors

ORANGE COUNTY
medical association
HELPING YOU NAVIGATE CHANGE

17322 Murphy Avenue Irvine, CA • 92614
Phone: 949.398.8100 • Fax: 949.398.8120

July 12, 2016

Michael Schrader, CEO
CalOptima
505 City Parkway West
Orange, CA 92868

Dear Michael –

On behalf of the Orange County Medical Association, a renewal of your annual Preferred Community Partner status is requested.

CalOptima's support is exceptionally meaningful to OCMA and is essential in the pursuit of our common goals. We will continue to coordinate seminars and other outreach activities to Orange County physicians regarding CalOptima programs and initiatives emphasizing the most efficient and high quality care for CalOptima members.

OCMA will be happy to discuss any specific Community Partner plans and initiatives to increase your level of satisfaction. We are most grateful for your commitment of collaboration with and direct support of OCMA.

Enclosed is a renewal invoice for your convenience. Please contact us with any questions.

We look forward to actively working alongside you over the next year!

Sincerely,

Jim Peterson
Chief Executive Officer

ORANGE COUNTY
medical association
HELPING YOU NAVIGATE CHANGE

17322 Murphy Avenue Irvine, CA • 92614
Phone: 949.398.8100 • Fax: 949.398.8120

PREFERRED COMMUNITY PARTNER INVOICE

Date: July 12, 2016

CalOptima

Attn: Michael Schrader, CEO

Thank You! We appreciate your partnership!

Item	Description	Price	Total
Silver Annual Preferred Community Partnership	**August, 2016 thru July, 2017**	**$5,000.00**	**$5,000.00**
		Total Due:	**$5,000.00**

Payment: Credit Card or check made payable to OCMA accepted.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
38. Consider Authorization of Expenditures for Full Board Membership in the National Association of Corporate Directors

Contact
Michael Schrader, Chief Executive Officer, (714) 246-8400
Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions
Authorize expenditures of $11,050 for full board membership in the National Association of Corporate Directors (NACD)

Background
For more than thirty-five (35) years, NACD has worked with corporate directors to advance exemplary board leadership. It is the recognized authority on leading boardroom practices and currently helps more than 17,000 corporate directors nationwide. NACD enables corporate directors to anticipate risks and opportunities and equip them to make sound decisions based on leading practices and insights from recognized experts. Beginning in July 2015, the CalOptima board of directors signed up for full membership in NACD, with some board members participating in NACD events. .

Discussion
NACD recommends that members of the board of directors, members of executive management, and corporate secretaries participate in NACD activities. CalOptima's membership renewal fee of $11,050 includes membership for thirteen (13) individuals. The effective dates of membership are July 1, 2016, through June 30, 2017. Additional costs are associated with participation in NACD events.

Fiscal Impact
The recommended action is a budgeted item under the CalOptima Fiscal Year 2016-17 Operating Budget approved by the Board on June 2, 2016.

Rationale for Recommendation
CalOptima's continued membership with NACD will assist board members in remaining current on best practices in board leadership and governance.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

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

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

Recommended Actions
1. Consider adoption of Resolution Approving CalOptima's Updated Human Resources Policy GA.8058: Salary Schedule; and
2. Consider approving 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 an existing Human Resources policy that has been updated and is being presented for review and approval.

	Policy No./Name	Summary of Changes	Reason for Change
1.	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	- 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 5

	Policy No./Name	Summary of Changes	Reason for Change
		positions. A summary of the changes to the Salary Schedule is included for reference.	positions indicated on the attached revised Salary Schedule. A change to 1 position is related to a change in wage grade to reflect market changes. New Position: Creation of a new Job Title typically due to a change in the scope of a current position or the addition of a new level in a job family. 1 position at Executive Director level; downgraded from Chief. (2 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. 1 position at Chief level. (2 positions)

In addition, also included as an attachment is a summary of changes to Executive compensation, which is provided as information to the Board consistent with the requirements under the Compensation Administration Guidelines adopted by the Board as part of CalOptima Policy GA. 8057: Compensation Program.

Fiscal Impact

The fiscal impact of this recommended action is budget neutral. Unspent budgeted funds for salaries and benefits approved in the CalOptima FY 2016-17 Operating Budget on June 2, 2016, will fund the total cost of $174,842.19. This estimate includes salary grade increases and market adjustments effective on or after the pay period ending August 6, 2016.

Rationale for Recommendation

Salary Grade Increase for Director Health Education & Disease Management
A market study was conducted by the Human Resources Department resulting in a recommendation to increase target compensation to a grade higher due to increased subject matter complexity and job responsibility.

Market Adjustments
Staff recommends salary adjustments for forty-seven (47) positions effective on or after the pay period ending August 6, 2016. This impacts employees in the following departments: forty-six (46) in Claims; and one (1) in Government Affairs. The recommended increase is to attract and retain well qualified staff. Pursuant to the Compensation Administration Guidelines adopted as part of CalOptima Policy GA. 8057: Compensation Program, approval by the Board of Directors is required as part of the process for market adjustments, which are not part of the regular merit process. Recommendations are made based on extensive review by CalOptima's Resources Workgroup consistent with the market adjustment process to ensure that CalOptima remains competitive with market trends and meets its ongoing obligation to provide structure and clarity on employment matters, consistent with applicable federal, state, and local laws and regulations.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 16-0804-02, Approve Updated Human Resources Policies
2. Revised CalOptima Policy GA.8058: Salary Schedule (redlined and clean versions) – with revised Attachment
3. Summary of Changes to the Salary Schedule, Market Adjustments and Executive Salary

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

RESOLUTION NO. 16-0804-02

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

APPROVE UPDATED HUMAN RESOURCES POLICY

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policy GA.8058: Salary Schedule.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 4th day of August, 2016.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Mark A. Refowitz, Chair, CalOptima Board of Directors

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

Policy #: GA.8058
Title: **Salary Schedule**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader

Effective Date: 05/01/14
Last Review Date: 08~~6~~/04~~2~~/16
Last Revised Date: 08~~6~~/04~~2~~/16

~~*Board Approved Policy*~~

I. PURPOSE

A. ~~To~~ 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~~e~~ ensures the salary schedule is publicly available pursuant to the requirements of California Code of Regulations (CCR) section 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. DEFINITIONS~~

~~Not Applicable~~

~~III.~~II. POLICY

A. Pursuant to the requirements under Title 2, California Code of Regulations (CCR) ~~Section~~ §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.

~~IV.~~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.

~~V.~~IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of 086/042/16)

~~VI.~~V. REFERENCES

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

~~VII.~~VI. REGULATORY AGENCY APPROVALS

Not Applicable

~~VIII.~~VII. BOARD ACTIONS

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

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

Version	~~Version~~ Date	Policy Number	Policy Title
~~Original Date~~Effective	05/01/14	GA.8057	Compensation Program and Salary Schedule
Revised~~Revision Date 1~~	08/07/14	GA.8057	Compensation Program and Salary Schedule
Revised~~Revision Date 2~~	11/06/14	GA.8057	Compensation Program and Salary Schedule
Revised~~Revision Date 3~~	12/04/14	GA.8057	Compensation Program and Salary Schedule
Revised~~Revision Date 4~~	03/05/15	GA.8057	Compensation Program and Salary Schedule
Revised~~Revision Date 5~~	06/04/15	GA.8058	Salary Schedule
Revised~~Revision Date 6~~	10/01/15	GA.8058	Salary Schedule
Revised~~Revision Date 7~~	12/03/15	GA.8058	Salary Schedule
Revised~~Revision Date 8~~	03/03/16	GA.8058	Salary Schedule
Revised~~Revision Date 9~~	06/02/16	GA.8058	Salary Schedule
Revised	08/04/16	GA.8058	Salary Schedule

~~X.~~IX. ~~DEFINITIONS~~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:	08/04/16
Last Revised Date:	08/04/16

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 California Code of Regulations (CCR) section 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.

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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:

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

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

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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 08/04/16)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

Not Applicable

VII. BOARD ACTIONS

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Revised	03/05/15	GA.8057	Compensation Program and Salary Schedule

Version	Date	Policy Number	Policy Title
Revised	06/04/15	GA.8058	Salary Schedule
Revised	10/01/15	GA.8058	Salary Schedule
Revised	12/03/15	GA.8058	Salary Schedule
Revised	03/03/16	GA.8058	Salary Schedule
Revised	06/02/16	GA.8058	Salary Schedule
Revised	08/04/16	GA.8058	Salary Schedule

1

IX. GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised August 4, 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 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 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	
	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 Network Officer~~	~~T~~	~~478~~	~~$197,704~~	~~$266,968~~	~~$336,024~~	Remove position
**	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	
	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	

CalOptima - Annual Base Salary Schedule - Revised August 4, 2016
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	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	
*	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	

CalOptima - Annual Base Salary Schedule - Revised August 4, 2016
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
*	Director Configuration & Coding	Q	596	$114,400	$154,440	$194,480	
*	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~~	~~P~~	~~484~~	~~$95,264~~	~~$128,752~~	~~$162,032~~	Remove position
*	Director Health Education & Disease Management	Q	150	$114,400	$154,440	$194,480	Pay grade increase
*	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	
*	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	TBD	$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	494	$164,736	$222,352	$280,072	New position

CalOptima - Annual Base Salary Schedule - Revised August 4, 2016
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
** 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	511	$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	
HCC Coding Specialist Sr	L	615	$54,288	$70,512	$86,736	
Health Coach	M	556	$62,400	$81,120	$99,840	
Health Educator	K	47	$47,112	$61,360	$75,504	
Health Educator Sr	L	355	$54,288	$70,512	$86,736	
Health Network Liaison Specialist (RN)	N	524	$71,760	$93,184	$114,712	
Health Network Oversight Specialist	M	323	$62,400	$81,120	$99,840	
HEDIS Case Manager	N	443	$71,760	$93,184	$114,712	
HEDIS Case Manager (LVN)	M	552	$62,400	$81,120	$99,840	
Help Desk Technician	J	571	$40,976	$53,352	$65,624	
Help Desk Technician Sr	K	573	$47,112	$61,360	$75,504	
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	
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	

CalOptima - Annual Base Salary Schedule - Revised August 4, 2016
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
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	TBD	$82,576	$107,328	$131,976	New Position
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 Concurrent Review	O	320	$82,576	$107,328	$131,976	
Manager Contracting	O	329	$82,576	$107,328	$131,976	
Manager Creative Branding	N	430	$71,760	$93,184	$114,712	
Manager Cultural & Linguistic	N	349	$71,760	$93,184	$114,712	
Manager Customer Service	N	94	$71,760	$93,184	$114,712	
Manager Decision Support	O	454	$82,576	$107,328	$131,976	
Manager Disease Management	O	372	$82,576	$107,328	$131,976	
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	

CalOptima - Annual Base Salary Schedule - Revised August 4, 2016
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	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 Prior Authorizations	O	269	$82,576	$107,328	$131,976	
	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	TBD	$82,576	$107,328	$131,976	
	Manager Reporting & Financial Compliance	O	572	$82,576	$107,328	$131,976	
	Manager Strategic Development	O	603	$82,576	$107,328	$131,976	
	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	
	Occupational Therapist	N	531	$71,760	$93,184	$114,712	
	Occupational Therapist Assistant	M	TBD	$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	
	Payroll/HRIS Analyst	K	286	$47,112	$61,360	$75,504	
	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	

CalOptima - Annual Base Salary Schedule - Revised August 4, 2016
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
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	TBD	$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	
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	TBD	$47,112	$61,360	$75,504	
Regulatory Affairs and Compliance Analyst Sr	L	TBD	$54,288	$70,512	$86,736	

CalOptima - Annual Base Salary Schedule - Revised August 4, 2016
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Regulatory Affairs and Compliance Lead	M	TBD	$62,400	$81,120	$99,840	
	RN (PACE)	N	480	$71,760	$93,184	$114,712	
	Security Analyst Int	N	534	$71,760	$93,184	$114,712	
	Security Analyst Sr	O	474	$82,576	$107,328	$131,976	
	Security Officer	F	311	$27,872	$34,840	$41,808	
	SharePoint Developer/Administrator Sr	O	397	$82,576	$107,328	$131,976	
	Social Worker	K	463	$47,112	$61,360	$75,504	
*	Special Counsel	R	317	$137,280	$185,328	$233,376	
	Sr Manager 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 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	TBD	$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 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	
	Technical Writer Sr	M	470	$62,400	$81,120	$99,840	

CalOptima - Annual Base Salary Schedule - Revised August 4, 2016
Effective as of May 1, 2014

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

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

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

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

Summary of Changes to Salary Schedule

For August 2016 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Chief Network Officer	T	N/A	Remove title from salary schedule. Position is being eliminated.	N/A	August 2016
Director Health Education	P	N/A	Remove title from salary schedule. Position is being eliminated.	N/A	August 2016
Director Health Education & Disease Management	P	Q	Based on changes in the duties and responsibilities of this position, HR reviewed the updated job description and determined that the salary grade should be adjusted one level up to align with current market rates.	1 Director will receive a 5% adjustment. The total impact for the current fiscal year is $6,171.36.	August 2016
Executive Director Network Operations	N/A- new position	TBD / S	The "Chief Network Officer" position is being downgraded to "Executive Director Network Operations."	N/A	August 2016
Manager Behavioral Health	N/A- new position	TBD / O	This new position will be responsible for managing the Behavioral Health employees and be the primary liaison between CalOptima and its contracted Managed Behavioral Health Organization (MBHO) across all lines of business.	N/A	August 2016

Summary of Market Adjustment Changes

For August 2016 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Changed
Claims Examiner	H	N/A	In order to address the critical need to hire and retain difficult to find claims personnel. HR performed a market analysis and concluded that to remain competitive salaries needed adjustment to maintain with market trends.	8 Claims Examiner will receive between a 4%-8% adjustment. The total impact for the current fiscal year is $16,607.05.	August 2016
Claims Examiner Sr.	I	N/A	In order to address the critical need to hire and retain difficult to find claims personnel. HR performed a market analysis and concluded that to remain competitive salaries needed adjustment to maintain with market trends.	25 Claims Examiner Sr. will receive between 0.4%-23% adjustment. The total impact for the current fiscal year is $83,705.71.	August 2016
Claims Examiner - Lead	J	N/A	In order to address the critical need to hire and retain difficult to find claims personnel. HR performed a market analysis and concluded that to remain competitive salaries needed adjustment to maintain with market trends.	1 Claims Examiner - Lead will receive an 8% adjustment. The total impact for the current fiscal year is $3,553.74.	August 2016
Data Entry Tech (Claims)	F	N/A	In order to address the critical need to hire and retain difficult to find claims personnel. HR performed a market analysis and concluded that to remain competitive salaries needed adjustment to maintain with market trends.	4 Data Entry Techs (Claims) will receive between a 6%-15% adjustment. The total impact for the current fiscal year is $11,438.86.	August 2016

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Changed
Director Claims Administration	P	N/A	In order to address the critical need to hire and retain difficult to find claims personnel. HR performed a market analysis and concluded that to remain competitive salaries needed adjustment to maintain with market trends.	1 Director will receive a 5% adjustment. The total impact for the current fiscal year is $6,520.17.	August 2016
Manager Claims	N	N/A	In order to address the critical need to hire and retain difficult to find claims personnel. HR performed a market analysis and concluded that to remain competitive salaries needed adjustment to maintain with market trends.	3 Managers will receive between a 3%-13% adjustment. The total impact for the current fiscal year is $21,549.31.	August 2016
Supervisor Claims	K	N/A	In order to address the critical need to hire and retain difficult to find claims personnel. HR performed a market analysis and concluded that to remain competitive salaries needed adjustment to maintain with market trends.	4 Supervisors will receive between a 4%-13% adjustment. The total impact for the current fiscal year is $17,165.53.	August 2016
Director Government Affairs	P	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties, responsibilities and performance expectations.	1 Director will receive a 7% adjustment. The total impact for the current fiscal year is $8,130.46.	August 2016

Summary of Executive Salary Changes

For August 2016 Board Meeting:

Pursuant to the Compensation Administration Guidelines adopted as part of CalOptima Policy GA. 8057: Compensation Program, the Board will be informed of all Chief and Executive Director compensation changes. The below changes were determined as part of the merit process and consistently administered to all employees based on the combination of performance rating and position of pay within the pay range.

Title	Salary Adjustment - Fiscal Impact (% Increase)	Effective on Pay Date
Deputy Chief Counsel	The total impact for the current fiscal year is $9,538.30. (4.40%)	July 15, 2016
Chief Medical Officer	The total impact for the current fiscal year is $14,102.85. (4.20%)	July 15, 2016
Executive Director Program Implementation	The total impact for the current fiscal year is $4,602.00. (2.30%)	July 15, 2016
Chief Information Officer	The total impact for the current fiscal year is $11,044.59. (4.40%)	July 15, 2016
Executive Director Clinical Operations	The total impact for the current fiscal year is $5,082.00. (2.20%)	July 15, 2016
Chief Financial Officer	The total impact for the current fiscal year is $12,797.40. (4.40%)	July 15, 2016
Deputy Chief Medical Officer	The total impact for the current fiscal year is $9,561.75. (3.00%)	July 15, 2016
Executive Director Public Affairs	The total impact for the current fiscal year is $9,162.00. (5.00%)	July 15, 2016
Executive Director Compliance	The total impact for the current fiscal year is $9,500.00. (5.00%)	July 15, 2016
Executive Director Quality Analytics	The total impact for the current fiscal year is $8,800.00. (4.40%)	July 15, 2016
Chief Operating Officer	The total impact for the current fiscal year is $9,488.96. (4.00%)	July 15, 2016

AGENDA ITEM 40 TO FOLLOW CLOSED SESSION

Consider Ratification of Supplemental Benefit Recommendations to the Centers for Medicare & Medicaid Services and the California Department of Health Care Services for the OneCare Connect Program

Board of Directors Meeting
August 4, 2016

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

At the June 23, 2016 OneCare Connect Member Advisory Committee (OCC MAC) meeting, OCC MAC members were provided an overview on supplemental transportation benefits for OneCare Connect members at the request of Member Christine Chow. This benefit provides 30 one-way taxi trips per calendar year for health care related services with the highest utilization going to a physician's office.

OCC MAC members received an update on OCC member enrollment. As of June 16, 2016, OCC enrollment was 18,431 members with a June opt-out rate of 60.12%. The June opt-out rate for Long-Term Care (LTC) facilities was 69.75%.

OCC MAC members were informed that an ongoing tracking survey of the state's dual Medicare and Medi-Cal beneficiaries, conducted on behalf of the SCAN Foundation and the California Department of Health Care Services (DHCS), indicated that Cal MediConnect enrollees are expressing increased confidence in the program and increased satisfaction with their health care services over time. The most commonly cited problem was a member's physician not being available through the Cal MediConnect program.

OCC MAC Member Jorge Sole, Social Services Agency (SSA), presented an overview of the Orange County SSA Adult Services Division. The Adult Services division has responsibility for Adult Protective Services (APS) and In-Home Supportive Services (IHSS). APS is a state mandated program that responds to allegations of elder and dependent adult abuse while IHSS is a state program that helps pay for services provided to low-income elderly, blind or disabled individuals so they can remain safely in their own home. OCC MAC members requested Member Sole to provide additional information on these programs at a future meeting.

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

Board of Directors Meeting
August 4, 2016

Provider Advisory Committee (PAC) Update

June 9, 2016 PAC Meeting

Ten (10) PAC members were in attendance at the June 9, 2016 meeting.

As a follow up to the April 14, 2016 PAC Meeting, Ladan Khamseh, Chief Operating Officer, provided an update on the Health Network Minimum and Maximum Enrollment. Ms. Khamseh discussed CalOptima Medi-Cal Policy EE.1106, Health Network (HN) and CalOptima Community Network (CCN) Minimum and Maximum Enrollment, which applies to Medi-Cal members only, and requires the Health Networks and CCN to maintain an enrollment of at least 5,000 members following the first 12 months after initial member enrollment. After a robust discussion on the allowance of additional time to grow their memberships, PAC members recommended that the new health networks be given an additional 18 months to achieve that goal. The additional 18 months is contingent on the new health networks continuing to be in good standing operationally.

Dr. Richard Helmer, Chief Medical Officer, provided an update regarding four (4) initiatives currently being worked on in Medical Affairs. They include the California Children Services, Whole Person Care, Health Homes, and the Long-Term Care Initiative that was recently approved by CMS and the State. Dr. Helmer also updated the PAC members on the Pay for Value program. The PAC was in concurrence with two information system initiatives: real-time tracking of members who present to the emergency department and/or admitted, and a robust CalOptima provider portal that would provide bi-directional information for utilization, care and quality management.

Edwin Poon, Ph.D., Director of Behavioral Health, gave a presentation on the upcoming CalOptima Managed Behavioral Healthcare Organization Request for Proposal (RFP). Dr. Poon suggested that a PAC member be appointed to the RFP review panel. Dr. Alan Edwards has agreed to represent the PAC as a member of this panel. PAC members also expressed concerns about the adequate assessment of the behavioral health network during the RFP process.

PAC members also received information on the Groups Needs Assessment (GNA), which is required by Department of Health Care Services to be completed at least once every five years. The GNA is scheduled to be conducted during 3rd Quarter, 2016; results will be shared with PAC when available.

PAC received the following updates from CalOptima executive staff at the June 9, 2016 PAC meeting: CFO Financial Update for April, COO Update and a Federal and State Budget update.

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

Board of Directors Meeting
August 4, 2016

Member Advisory Committee Update

At the July 14, 2016, Member Advisory Committee (MAC) meeting, MAC members welcomed Christine Tolbert, the newly appointed representative for Persons with Special Needs. MAC also recognized the returning MAC members, including Christina Sepulveda, Children's Representative; Lisa Workman, Consumer Representative; Gene Howard, Foster Children Representative; Velma Shivers, Long-Term Care (LTC) Representative; Sally Molnar, Medically Indigent Persons' Representative; and Sr. Mary Therese Sweeney, Persons with Mental Illness Representative.

MAC members received a presentation on Easter Seals of Southern California from Kathleen Kolenda, Vice President Adult Day Services. Ms. Kolenda presented an overview on Easter Seals' programs and their rebranding campaign. CalOptima's Chief Operating Officer, Ladan Khamseh, presented on the Health Network Minimum Enrollment Requirement. Following a robust discussion, MAC members reached consensus to support the recommendation to the CalOptima Board to extend the health network minimum enrollment timeframe to a maximum of 30 months, contingent upon the health network's performance and meeting operational requirements. MAC members also received these additional CalOptima presentations: Health Education and Cultural and Linguistic Group Needs Assessment; California Children's Services Redesign Update; and Intergovernmental Transfer Update.

MAC is currently recruiting for a candidate to represent Recipients of CalWORKs, as this seat was recently vacated. Application information is available on the CalOptima website. All interested stakeholders are encouraged to apply.

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

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Financial Summary

June 2016

Board of Directors Meeting

August 4, 2016

Chet Uma

Chief Financial Officer

FY 2015-16: Consolidated Enrollment

- June 2016 MTD:
  - Overall enrollment was 807,932 member months
    - Actual higher than budget by 9,936 or 1.2%
      - Medi-Cal: favorable variance of 9,522 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: favorable variance of 524 members
    - 2.9% increase from prior month
      - OneCare Connect: increase of 15,465 due to YTD true-up
      - Medi-Cal: increase of 7,246 from May 2016 due to:
        - Increase in TANF of 5,022
        - Increase in MCE of 2,175
    - 7.3% or 54,874 increase in enrollment from prior year

FY 2015-16: Consolidated Enrollment (Cont.)

- June 2016 YTD:
  - Overall enrollment reached 9,396,457 member months
    - Actual lower than budget by 77,052 or 0.8%
      - Medi-Cal: unfavorable variance of 6,925
        - TANF enrollment lower than budget
        - Offset by higher than budget enrollment in MCE and SPD categories
      - OneCare Connect: unfavorable variance of 67,236 or 36.8% due to higher than expected opt-out rate
      - OneCare: unfavorable variance of 2,991

FY 2015-16: Consolidated Revenues

- June 2016 MTD:
  - Actual higher than budget by $21.1 million or 7.3%
    - OneCare Connect: unfavorable variance of $7.5 million based upon actual cohort experience YTD true-up
    - Medi-Cal: favorable to budget by $11.6 million
      - Favorable volume variance of $2.8 million due to higher enrollment
      - Favorable in price variance of $8.7 million due to Q4 true-up accrual for Hep C and state IHSS report, along with favorable actual to budget rate variances

- June 2016 YTD:
  - Actual lower than budget by $61.4 million, or 1.9%
    - OneCare Connect: unfavorable variance of $123.0 million due to lower actual enrollment than budget
    - Medi-Cal: higher than budget by $53.8 million
      - Additional IHSS revenue was recorded based on County IHSS expense report and favorable offset for margin adjustments

FY 2015-16: Consolidated Medical Expenses

- June 2016 MTD:
  - Actual higher than budget by $28.5 million or 10.5%
    - OneCare Connect: favorable variance of $6.8 million due price variance of $7.7 million, offset by volume variance of ($.9) million
    - Medi-Cal: unfavorable variance of $27.5 million
      - MCE member 85% MLR reconciliation adjustment
      - Higher LTC expenses due to less than anticipated eligible members transferring to OneCare Connect

- June 2016 YTD:
  - Actual lower than budget by $52.1 million or 1.7%
    - OneCare Connect: favorable variance of $114.7 million due to lower actual enrollment than budget
    - Medi-Cal: unfavorable variance of $62.6 million due to high LTC expenses

- Medical Loss Ratio (MLR):
  - June 2016 MTD: Actual: 97.2% Budget: 94.4%
  - June 2016 YTD: Actual: 96.0% Budget: 95.8%

FY 2015-16: Consolidated Administrative Expenses

- June 2016 MTD:
  - Actual lower than budget by $3.1 million or 23.6%
    - Salaries and Benefits: favorable variance of $3.1 million driven by lower than budgeted FTE of 165
    - Other categories: unfavorable variance of $22,504

- June 2016 YTD:
  - Actual lower than budget by $46.5 million or 30.3%
    - Salaries and Benefits: favorable variance of $22.2 million due to under budgeted FTE of 2,439
    - Professional Fees and Purchased Services: favorable variance of $9.7 million ($3.0 million and $6.7 million, respectively)
    - Printing and Postage: favorable variance of $5.5 million

- Administrative Loss Ratio (ALR):
  - June 2016 MTD: Actual: 3.2% Budget: 4.5%
  - June 2016 YTD: Actual: 3.4% Budget: 4.8%

FY 2015-16: Change in Net Assets

- June 2016 MTD:
  - $2.2 million surplus
  - $1.0 million unfavorable to budget
    - Attributable to:
      - Higher revenue of $21.1 million
      - Savings in administrative expenses of $3.1 million
      - Higher investment income of $3.6 million
      - Offset by higher than budgeted medical expenses of $28.5 million

- June 2016 YTD:
  - $32.5 million surplus
  - $48.6 million favorable to budget
    - Attributable to:
      - Savings in medical expenses of $52.1 million
      - Savings in administrative expenses of $46.5 million
      - Higher investment income of $11.4 million
      - Offset by lower than budgeted revenue of $61.4 million

FY 2015-16: Change in Net Assets (cont.)

- June 2016 YTD variance attributable to:
  - Medi-Cal: $10.6 million surplus; $27.0 million favorable to budget
    - Higher revenue of $53.8 million
    - Savings in administrative expenses of $35.7 million
    - Offset by higher than budgeted medical expenses of $62.6 million
  - OneCare Connect: $0.7 million deficit; $2.1 million favorable to budget
    - Favorable medical expenses of $114.7 million
    - Favorable administrative expenses of $10.4 million
    - Offset by lower than budgeted revenue of $123.0 million
  - PACE: $1.5 million deficit; $1.0 million favorable to budget
    - Favorable medical expenses of $35,771
    - Favorable administrative expenses of $248,491
    - Favorable revenue of $681,299
  - OneCare: $10.5 million surplus; $7.2 million favorable to budget
    - Primarily driven by HCC adjustment

Enrollment Summary: June 2016

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
56,812	47,881	8,931	18.7%	Aged	718,938	661,330	57,608	8.7%
628	737	(109)	(14.8%)	BCCTP	7,999	8,840	(841)	(9.5%)
48,708	49,707	(999)	(2.0%)	Disabled	620,998	631,919	(10,921)	(1.7%)
3,314	2,359	955	40.5%	LTC	42,218	37,239	4,979	13.4%
228,962	201,785	27,177	13.5%	MCE	2,582,856	2,392,895	189,961	7.9%
438,289	464,704	(26,415)	(5.7%)	TANF	5,218,248	5,465,737	(247,489)	(4.5%)
776,713	767,173	9,540	1.2%	Medi-Cal	9,191,252	9,197,960	(6,708)	(0.1%)
461	479	(18)	(3.8%)	MSSP	5,531	5,748	(217)	(3.8%)
777,174	**767,652**	**9,522**	**1.2%**	**Total Medi-Cal**	**9,196,783**	**9,203,708**	**(6,925)**	**(0.1%)**
29,416	**28,892**	**524**	**1.8%**	**OneCare Connect**	**115,514**	**182,750**	**(67,236)**	**(36.8%)**
168	**154**	**14**	**9.1%**	**PACE**	**1,618**	**1,518**	**100**	**6.6%**
1,174	**1,298**	**(124)**	**(9.6%)**	**OneCare**	**82,542**	**85,533**	**(2,991)**	**(3.5%)**
807,932	**797,996**	**9,936**	**1.2%**	**CalOptima Total**	**9,396,457**	**9,473,509**	**(77,052)**	**(0.8%)**

Financial Highlights: June 2016

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
807,932	797,996	9,936	1.2%	Member Months	9,396,457	9,473,509	(77,052)	(0.8%)
308,779,646	287,655,531	21,124,116	7.3%	Revenues	3,163,753,022	3,225,157,710	(61,404,688)	(1.9%)
300,134,135	271,590,756	(28,543,379)	(10.5%)	Medical Expenses	3,037,911,046	3,090,026,559	52,115,513	1.7%
9,970,384	13,047,560	3,077,177	23.6%	Administrative Expenses	106,865,927	153,406,548	46,540,621	30.3%
(1,324,872)	**3,017,215**	**(4,342,087)**	**(143.9%)**	**Operating Margin**	**18,976,050**	**(18,275,397)**	**37,251,447**	**(203.8%)**
3,512,849	202,605	3,310,244	1633.8%	Non Operating Income (Loss)	13,548,308	2,166,874	11,381,434	525.2%
2,187,977	**3,219,820**	**(1,031,843)**	**(32.0%)**	**Change in Net Assets**	**32,524,358**	**(16,108,523)**	**48,632,881**	**(301.9%)**
97.2%	94.4%	(2.8%)		Medical Loss Ratio	96.0%	95.8%	(0.2%)	
3.2%	4.5%	1.3%		Administrative Loss Ratio	3.4%	4.8%	1.4%	
(0.4%)	1.0%	(1.5%)		Operating Margin Ratio	0.6%	(0.6%)	1.2%	
100.0%	100.0%	0.0%		Total Operating	100.0%	100.0%	0.0%	

Consolidated Performance Actual vs. Budget: June 2016 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(11.0)	(0.1)	(10.9)	Medi-Cal	10.6	(16.4)	27.0
9.0	0.5	8.5	OneCare	10.5	3.3	7.2
0.5	2.8	(2.3)	OCC	(0.7)	(2.7)	2.1
0.0	0.0	0.0	ASO	0.1	0.0	0.1
0.2	(0.2)	0.4	PACE	(1.5)	(2.5)	1.0
(1.3)	**3.0**	**(4.3)**	**Operating**	**19.0**	**(18.3)**	**37.3**
3.5	0.2	3.3	Inv./Rental Inc, MCO tax	13.5	2.2	11.4
3.5	**0.2**	**3.3**	**Non-Operating**	**13.5**	**2.2**	**11.4**
2.2	**3.2**	**(1.0)**	**TOTAL**	**32.5**	**(16.1)**	**48.6**

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Consolidated Revenue & Expense: June 2016 MTD

	Total Medi-Cal	OneCare	OneCare Connect	PACE	Behavioral Health ASO	Consolidated
Member Months	$ 777,174	1,174	29,416	168	-	807,932
REVENUES						
Capitation revenue	$ 241,175,373	$ 19,697,853	$ 46,801,924	$ 1,104,496	$ -	$ 308,779,646
Other Income	-	-	-	-	-	-
Total Operating Revenues	241,175,373	19,697,853	46,801,924	1,104,496	-	308,779,646
MEDICAL EXPENSES						
Provider capitation	79,882,556	7,295,209	8,466,942	-	-	95,644,707
Facility inpatient	28,979,900	3,438,155	16,222,953	-	-	48,641,009
Ancillary		35,080	654,400	-	-	689,481
Skilled Nursing		77,756	8,386,053	-	-	8,463,809
Facility outpatient	9,246,089	-	-	17,295	-	9,263,384
Professional Claims	15,017,384	-	-	287,750	-	15,305,134
Prescription drugs	33,024,920	54,946	4,159,609	88,911	-	37,328,385
Long-term care facility payments	44,848,360	-	-	(6,957)	-	44,841,403
Contingencies	33,456,516	-	-	-	-	33,456,516
Medical management	2,418,426	(921,989)	3,897,120	-	-	5,393,557
Reinsurance & other	301,261	325,966	125,268	358,762	(4,506)	1,106,751
Total Medical Expenses	247,175,411	10,305,123	41,912,345	745,760	(4,506)	300,134,135
Medical Loss Ratio	**102.5%**	**52.3%**	**9.4%**	**67.5%**	**0.0%**	**97.2%**
GROSS MARGIN	(6,000,038)	9,392,730	4,889,579	358,735	4,506	8,645,512
ADMINISTRATIVE EXPENSES						
Salaries, wages & employee benefits	3,301,101	47,668	731,049	103,614	-	4,183,431
Professional fees	1,167,527	32,150	-	17,299	-	1,216,976
Purchased Services	684,183	(995)	257,512	0	-	940,701
Printing and Postage	637,410	(9,171)	53,616	554	-	682,409
Depreciation and Amortization	312,460		-	2,014	-	314,474
Other Expenses	2,346,896	32,469	6,795	16,022	-	2,402,182
Indirect cost allocation, Occupancy Expense	(3,442,611)	326,758	3,348,535	(2,471)	-	230,211
Total Administrative Expenses	5,006,966	428,879	4,397,507	137,032	0	9,970,384
Admin Loss Ratio	**2.1%**	**2.2%**	**0.0%**	**12.4%**	**0.0%**	**3.2%**
INCOME (LOSS) FROM OPERATIONS	(11,007,004)	8,963,851	492,072	221,703	4,506	(1,324,872)
INVESTMENT INCOME	-	-	-	-	-	3,759,091
NET RENTAL INCOME	-	-	-	-	-	(246,534)
OTHER INCOME	292	-	-	-	-	292
CHANGE IN NET ASSETS	**$ (11,006,713)**	**$ 8,963,851**	**$ 492,072**	**$ 221,703**	**$ 4,506**	**$ 2,187,977**

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Consolidated Revenue & Expense: June 2016 YTD

	Total Medi-Cal	OneCare	OneCare Connect	PACE	Behavioral Health ASO	Consolidated
Member Months	$ 9,196,783	82,542	115,514	1,618	-	9,396,457
REVENUES						
Capitation revenue	$ 2,829,513,864	$ 104,201,695	$ 220,185,401	$ 9,852,063	$ -	$ 3,163,753,022
Other Income	-	-	-	-	-	-
Total Operating Revenues	2,829,513,864	104,201,695	220,185,401	9,852,063	-	3,163,753,022
MEDICAL EXPENSES						
Provider capitation	935,362,635	37,814,530	52,626,053	-	-	1,025,803,219
Facility inpatient	551,235,947	32,695,791	63,498,285	-	-	647,430,023
Ancillary		2,570,774	6,117,962	-	-	8,688,736
Skilled Nursing		2,421,560	36,512,397	-	-	38,933,958
Facility outpatient	94,866,563	-	-	1,919,801	-	96,786,365
Professional Claims	150,750,494	-	-	2,330,299	-	153,080,793
Prescription drugs	390,552,822	6,969,100	34,398,340	927,315	-	432,847,577
Quality Incentives		899,979				899,979
Long-term care facility payments	548,781,360	-	-	66,409	-	548,847,769
Contingencies	25,311,893	-	-	-	-	25,311,893
Medical management	31,619,582	2,401,457	11,141,681	-	-	45,162,720
Reinsurance & other	7,557,730	951,552	828,015	4,851,259	(70,542)	14,118,015
Total Medical Expenses	2,736,039,027	86,724,744	205,122,734	10,095,084	(70,542)	3,037,911,046
Medical Loss Ratio	**96.7%**	**83.2%**	**7.1%**	**102.5%**	**0.0%**	**96.0%**
GROSS MARGIN	93,474,837	17,476,951	15,062,668	(243,022)	70,542	125,841,976
ADMINISTRATIVE EXPENSES						
Salaries, wages & employee benefits	53,310,505	3,455,079	6,855,201	1,017,034	-	64,637,819
Professional fees	4,020,569	294,018	2,150	51,319	-	4,368,057
Purchased Services	8,621,000	546,310	1,375,355	9,381	(17)	10,552,029
Printing and Postage	4,035,083	136,607	1,245,375	34,711	(405)	5,451,370
Depreciation and Amortization	3,114,413		-	27,849	-	3,142,263
Other Expenses	14,573,007	434,327	33,557	88,940	13	15,129,845
Indirect cost allocation, Occupancy Expense	(4,795,540)	2,150,808	6,206,375	22,902	-	3,584,545
Total Administrative Expenses	82,879,038	7,017,150	15,718,012	1,252,136	(409)	106,865,927
Admin Loss Ratio	**2.9%**	**6.7%**	**0.0%**	**12.7%**	**0.0%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS	10,595,799	10,459,802	(655,345)	(1,495,157)	70,951	18,976,050
INVESTMENT INCOME	-	-	-	-	-	13,879,371
NET RENTAL INCOME	-	-	-	-	-	(332,491)
NET GRANT INCOME	(154)	-	-	-	-	(154)
OTHER INCOME	1,582	-	-	-	-	1,582
CHANGE IN NET ASSETS	**$ 10,597,227**	**$ 10,459,802**	**$ (655,345)**	**$ (1,495,157)**	**$ 70,951**	**$ 32,524,358**

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Balance Sheet: As of June 2016

ASSETS		
Current Assets		
	Operating Cash	$244,488,626
	Catastrophic Reserves	11,462,767
	Investments	1,019,264,632
	Capitation receivable	465,142,156
	Receivables - Other	21,608,851
	Prepaid Expenses	6,784,247
	Total Current Assets	**1,768,751,279**
Capital Assets	Furniture and equipment	28,851,790
	Leasehold improvements	11,240,138
	505 City Parkway West	46,707,144
		86,799,071
	Less: accumulated depreciation	(31,803,507)
	Capital assets, net	**54,995,564**
Other Assets	Restricted deposit & Other	277,378
	Board-designated assets	
	Cash and cash equivalents	10,144,103
	Short term investments	-
	Long term investments	465,713,885
	Total Board-designated Assets	475,857,987
	Total Other Assets	**476,135,365**
	Deferred outflows of Resources - Pension Contributions	3,787,544
	Deferred outflows of Resources - Difference in Experience	1,215,473
TOTAL ASSETS & OUTFLOWS		**2,304,885,226**

LIABILITIES & FUND BALANCES		
Current Liabilities		
	Accounts payable	$5,815,278
	Medical claims liability	598,694,858
	Accrued payroll liabilities	11,431,792
	Deferred revenue	589,328,793
	Deferred revenue - CMS	1,373,849
	Deferred lease obligations	273,428
	Capitation and withholds	401,826,302
	Accrued insurance costs	0
	Total Current Liabilities	**1,608,744,299**
Other (than pensions) post employment benefits liability		27,327,000
Net Pension Liabilities		6,942,207
Long Term Liabilities		150,000
TOTAL LIABILITIES		**1,643,163,507**
Deferred inflows of Resources - Exceess Earnings		502,900
Deferred inflows of Resources - Changes in Assumptions		1,651,640
	Tangible net equity (TNE)	89,283,747
	Funds in excess of TNE	570,283,432
Net Assets		**659,567,179**
TOTAL LIABILITIES, INFLOWS & FUND BALANCES		**2,304,885,226**

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Board Designated Reserve and TNE Analysis As of June 2016

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	135,378,209				
	Tier 1 - Logan Circle	125,346,300				
	Tier 1 - Wells Capital	125,392,844				
Board-designated Reserve		386,117,353	283,760,118	443,636,060	102,357,235	(57,518,707)
TNE Requirement	Tier 2 - Logan Circle	89,740,634	89,283,747	89,283,747	456,887	456,887
	Consolidated:	**475,857,987**	**373,043,865**	**532,919,807**	**102,814,122**	**(57,061,820)**
	Current reserve level	*1.79*	*1.40*	*2.00*		

CalOptima
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UNAUDITED FINANCIAL STATEMENTS

June 2016

Table of Contents

CalOptima - Consolidated
Financial Highlights
For the Twelve Months Ended June 30, 2016

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
807,932	797,996	9,936	1.2%	Member Months	9,396,457	9,473,509	(77,052)	(0.8%)
308,779,646	287,655,531	21,124,116	7.3%	Revenues	3,163,753,022	3,225,157,710	(61,404,688)	(1.9%)
300,134,135	271,590,756	(28,543,379)	(10.5%)	Medical Expenses	3,037,911,046	3,090,026,559	52,115,513	1.7%
9,970,384	13,047,560	3,077,177	23.6%	Administrative Expenses	106,865,927	153,406,548	46,540,621	30.3%
(1,324,872)	**3,017,215**	**(4,342,087)**	**(143.9%)**	**Operating Margin**	**18,976,050**	**(18,275,397)**	**37,251,447**	**(203.8%)**
3,512,849	202,605	3,310,244	1633.8%	Non Operating Income (Loss)	13,548,308	2,166,874	11,381,434	525.2%
2,187,977	**3,219,820**	**(1,031,843)**	**(32.0%)**	**Change in Net Assets**	**32,524,358**	**(16,108,523)**	**48,632,881**	**(301.9%)**
97.2%	94.4%	(2.8%)		Medical Loss Ratio	96.0%	95.8%	(0.2%)	
3.2%	4.5%	1.3%		Administrative Loss Ratio	3.4%	4.8%	1.4%	
(0.4%)	1.0%	(1.5%)		Operating Margin Ratio	0.6%	(0.6%)	1.2%	
100.0%	100.0%	0.0%		Total Operating	100.0%	100.0%	0.0%	

CalOptima
Financial Dashboard
For the Twelve Months Ended June 30, 2016

MONTH

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	776,713	767,173	9,540	1.2%
OneCare	1,174	1,298	(124)	(9.6%)
OneCare Connect	29,416	28,892	524	1.8%
PACE	168	154	14	9.1%
MSSP	461	479	(18)	(3.8%)
Total	807,932	797,996	9,936	1.2%

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal (w/ MSSP)	$ (11,007)	$ (80)	$ (10,926)	(13619.1%)
OneCare	8,964	500	8,464	1693.5%
OneCare Connect	492	2,755	(2,263)	(82.1%)
PACE	222	(158)	379	240.5%
ASO	5	-	5	100.0%
505 Bldg.	(247)	(6)	(241)	(4197.5%)
Investment Income & Other	3,759	208	3,551	1704.4%
Total	$ 2,188	$ 3,220	$ (1,032)	(32.0%)

MLR

	Actual	Budget	% Point Var
Medi-Cal (w/ MSSP)	102.5%	95.7%	(6.8)
OneCare	52.3%	77.1%	24.8
OneCare Connect	89.6%	89.8%	0.2

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal (w/ MSSP)	$ 5,007	$ 9,973	$ 4,966	49.8%
OneCare	429	159	(270)	(170.3%)
OneCare Connect	4,398	2,793	(1,604)	(57.4%)
PACE	137	122	(15)	(12.1%)
Total	$ 9,970	$ 13,048	$ 3,077	23.6%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	770	884	114
OneCare	7	-	(7)
OneCare Connect	240	292	52
PACE	39	45	6
MSSP	17	18	0
Total	1,073	1,239	165

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,009	868	141
OneCare	168	-	-
OneCare Connect	123	99	24
PACE	4	3	1
MSSP	26	27	(0)
Total	1,330	997	165

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	9,191,252	9,197,960	(6,708)	(0.1%)
OneCare	82,542	85,533	(2,991)	(3.5%)
OneCare Connect	115,514	182,750	(67,236)	(36.8%)
PACE	1,618	1,518	100	6.6%
MSSP	5,531	5,748	(217)	(3.8%)
Total	9,396,457	9,473,509	(77,052)	(0.8%)

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal (w/ MSSP)	$ 10,597	$ (16,354)	$ 26,951	164.8%
OneCare	10,460	3,261	7,198	220.7%
OneCare Connect	(655)	(2,722)	2,067	75.9%
PACE	(1,495)	(2,461)	966	39.2%
ASO	71	-	71	100.0%
505 Bldg.	(332)	(333)	1	0.2%
Investment Income &	13,881	2,500	11,381	455.2%
Total	$ 32,526	$ (16,109)	$ 48,634	301.9%

MLR

	Actual	Budget	% Point Var
Medi-Cal (w/ MSSP)	96.7%	96.3%	(0.4)
OneCare	83.2%	89.2%	5.9
OneCare Connect	93.2%	93.2%	0.0

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal (w/ MSSP)	$ 82,879	$ 118,554	$ 35,675	30.1%
OneCare	7,017	7,252	235	3.2%
OneCare Connect	15,718	26,100	10,382	39.8%
PACE	1,252	1,501	248	16.6%
Total	$ 106,866	$ 153,407	$ 46,540	30.3%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	8,884	10,500	1,616
OneCare	824	947	123
OneCare Connect	1,928	2,533	605
PACE	429	518	89
MSSP	207	213	6
Total	12,272	14,711	2,439

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,035	876	159
OneCare	100	90	10
OneCare Connect	60	72	(12)
PACE	4	3	1
MSSP	27	27	(0)
Total	1,225	1,068	157

CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended June 30, 2016

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	807,932		797,996		9,936	
Revenues						
Medi-Cal	$ 241,175,373	$ 310.32	$ 229,583,475	$ 299.07	$ 11,591,898	$ 11.25
OneCare	19,697,853	16,778.41	2,879,038	2,218.06	16,818,815	14,560.35
OneCare Connect	46,801,924	1,591.04	54,263,717	1,878.16	(7,461,793)	(287.12)
PACE	1,104,496	6,574.38	929,301	6,034.42	175,195	539.96
Total Operating Revenue	308,779,646	382.19	287,655,531	360.47	21,124,116	21.71
Medical Expenses						
Medi-Cal	247,175,411	318.04	219,690,530	286.19	(27,484,881)	(31.86)
OneCare	10,305,123	8,777.79	2,220,586	1,710.78	(8,084,537)	(7,067.01)
OneCare Connect	41,912,345	1,424.81	48,714,783	1,686.10	6,802,438	261.28
PACE	745,760	4,439.05	964,856	6,265.30	219,095	1,826.25
ASO for Specialty Mental Health Srvcs	(4,506)	-	-	-	4,506	-
Total Medical Expenses	300,134,135	371.48	271,590,756	340.34	(28,543,379)	(31.14)
Gross Margin	8,645,512	10.70	16,064,775	20.13	(7,419,263)	(9.43)
Administrative Expenses						
Salaries and benefits	4,183,431	5.18	7,283,112	9.13	3,099,681	3.95
Professional fees	1,216,976	1.51	346,696	0.43	(870,280)	(1.07)
Purchased services	940,701	1.16	1,949,492	2.44	1,008,792	1.28
Printing and Postage	682,409	0.84	889,184	1.11	206,775	0.27
Depreciation and amortization	314,474	0.39	460,712	0.58	146,238	0.19
Other	2,402,182	2.97	1,717,742	2.15	(684,440)	(0.82)
Indirect Cost Allocation, Occupancy Expense	230,211	0.28	400,623	0.50	170,412	0.22
Total Administrative Expenses	9,970,384	12.34	13,047,560	16.35	3,077,177	4.01
Income (Loss) From Operations	(1,324,872)	(1.64)	3,017,215	3.78	(4,342,087)	(5.42)
Investment income						
Interest income	1,051,280	1.30	208,342	0.26	842,938	1.04
Realized gain/(loss) on investments	(22,090)	(0.03)	-	-	(22,090)	(0.03)
Unrealized gain/(loss) on investments	2,729,901	3.38	-	-	2,729,901	3.38
Total Investment Income	3,759,091	4.65	208,342	0.26	3,550,750	4.39
Net Rental Income	(246,534)	(0.31)	(5,737)	(0.01)	(240,797)	(0.30)
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	-	-	-	-	-	-
QAF/IGT	-	-	-	-	-	-
Other Income	292	0.00	-	-	292	0.00
Change In Net Assets	**2,187,977**	**2.71**	**3,219,820**	**4.03**	**(1,031,843)**	**(1.33)**
Medical Loss Ratio	**97.2%**		**94.4%**		**(2.8%)**	
Administrative Loss Ratio	**3.2%**		**4.5%**		**1.3%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

CalOptima - Consolidated - Year to Date
Statement of Revenue and Expenses
For the Twelve Months Ended June 30, 2016

	Year to Date					
	Actual		Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	9,396,457		9,473,509		(77,052)	
Revenues						
Medi-Cal	$ 2,829,513,864	$ 307.66	$ 2,775,665,280	$ 301.58	$ 53,848,583	$ 6.08
OneCare	104,201,695	1,262.41	97,086,739	1,135.08	7,114,956	127.33
OneCare Connect	220,185,401	1,906.14	343,234,927	1,878.17	(123,049,526)	27.97
PACE	9,852,063	6,089.04	9,170,764	6,041.35	681,299	47.69
Total Operating Revenue	3,163,753,022	336.70	3,225,157,710	340.44	(61,404,688)	(3.74)
Medical Expenses						
Medi-Cal	2,736,039,027	297.50	2,673,465,362	290.48	(62,573,664)	(7.02)
OneCare	86,724,744	1,050.67	86,573,367	1,012.16	(151,377)	(38.51)
OneCare Connect	205,122,734	1,775.74	319,856,974	1,750.24	114,734,241	(25.50)
PACE	10,095,084	6,239.24	10,130,855	6,673.82	35,771	434.58
ASO for Specialty Mental Health Srvcs	(70,542)	-	-	-	70,542	-
Total Medical Expenses	3,037,911,046	323.30	3,090,026,559	326.18	52,115,513	2.87
Gross Margin	125,841,976	13.39	135,131,151	14.26	(9,289,175)	(0.87)
Administrative Expenses						
Salaries and benefits	64,637,819	6.88	86,831,477	9.17	22,193,658	2.29
Professional fees	4,368,057	0.46	7,326,477	0.77	2,958,420	0.31
Purchased services	10,552,029	1.12	17,251,353	1.82	6,699,324	0.70
Printing and Postage	5,451,370	0.58	10,912,596	1.15	5,461,226	0.57
Depreciation and amortization	3,142,263	0.33	5,528,546	0.58	2,386,284	0.25
Other	15,129,845	1.61	20,736,536	2.19	5,606,692	0.58
Indirect cost allocation, Occupancy Expense	3,584,545	0.38	4,819,563	0.51	1,235,018	0.13
Total Administrative Expenses	106,865,927	11.37	153,406,548	16.19	46,540,621	4.82
Income (Loss) From Operations	18,976,050	2.02	(18,275,397)	(1.93)	37,251,447	3.95
Investment income						
Interest income	9,220,074	0.98	2,500,000	0.26	6,720,073	0.72
Realized gain/(loss) on investments	422,387	0.04	-	-	422,387	0.04
Unrealized gain/(loss) on investments	4,236,911	0.45	-	-	4,236,911	0.45
Total Investment Income	13,879,371	1.48	2,500,000	0.26	11,379,371	1.21
Net Rental Income	(332,491)	(0.04)	(333,126)	(0.04)	636	(0.00)
Total Net Operating Tax	(0)	(0)	-	-	(0)	(0)
Total Net Grant Income	(154)	(0)	-	-	(154)	(0)
QAF/IGT	-	-	-	-	-	-
Other Income	1,582	0	-	-	1,582	0
Change In Net Assets	**32,524,358**	**3.46**	**(16,108,523)**	**(1.70)**	**48,632,881**	**5.16**
Medical Loss Ratio	**96.0%**		**95.8%**		**(0.2%)**	
Administrative Loss Ratio	**3.4%**		**4.8%**		**1.4%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended June 30, 2016

	Total Medi-Cal	OneCare	OneCare Connect	PACE	Behavioral Health ASO	Consolidated
Member Months	$ 777,174	1,174	29,416	168	-	807,932
REVENUES						
Capitation revenue	$ 241,175,373	$ 19,697,853	$ 46,801,924	$ 1,104,496	$ -	$ 308,779,646
Other Income	-	-	-	-	-	-
Total Operating Revenues	241,175,373	19,697,853	46,801,924	1,104,496	-	308,779,646
MEDICAL EXPENSES						
Provider capitation	79,882,556	7,295,209	8,466,942	-	-	95,644,707
Facility inpatient	28,979,900	3,438,155	16,222,953	-	-	48,641,009
Ancillary		35,080	654,400	-	-	689,481
Skilled Nursing		77,756	8,386,053	-	-	8,463,809
Facility outpatient	9,246,089	-	-	17,295	-	9,263,384
Professional Claims	15,017,384	-	-	287,750	-	15,305,134
Prescription drugs	33,024,920	54,946	4,159,609	88,911	-	37,328,385
Long-term care facility payments	44,848,360	-	-	(6,957)	-	44,841,403
Contingencies	33,456,516	-	-	-	-	33,456,516
Medical management	2,418,426	(921,989)	3,897,120	-	-	5,393,557
Reinsurance & other	301,261	325,966	125,268	358,762	(4,506)	1,106,751
Total Medical Expenses	247,175,411	10,305,123	41,912,345	745,760	(4,506)	300,134,135
Medical Loss Ratio	**102.5%**	**52.3%**	**9.4%**	**67.5%**	**0.0%**	**97.2%**
GROSS MARGIN	(6,000,038)	9,392,730	4,889,579	358,735	4,506	8,645,512
ADMINISTRATIVE EXPENSES						
Salaries, wages & employee benefits	3,301,101	47,668	731,049	103,614	-	4,183,431
Professional fees	1,167,527	32,150	-	17,299	-	1,216,976
Purchased Services	684,183	(995)	257,512	0	-	940,701
Printing and Postage	637,410	(9,171)	53,616	554	-	682,409
Depreciation and Amortization	312,460		-	2,014	-	314,474
Other Expenses	2,346,896	32,469	6,795	16,022	-	2,402,182
Indirect cost allocation, Occupancy Expense	(3,442,611)	326,758	3,348,535	(2,471)	-	230,211
Total Administrative Expenses	5,006,966	428,879	4,397,507	137,032	0	9,970,384
Admin Loss Ratio	**2.1%**	**2.2%**	**0.0%**	**12.4%**	**0.0%**	**3.2%**
INCOME (LOSS) FROM OPERATIONS	(11,007,004)	8,963,851	492,072	221,703	4,506	(1,324,872)
INVESTMENT INCOME	-	-	-	-	-	3,759,091
NET RENTAL INCOME	-	-	-	-	-	(246,534)
OTHER INCOME	292	-	-	-	-	292
CHANGE IN NET ASSETS	**$ (11,006,713)**	**$ 8,963,851**	**$ 492,072**	**$ 221,703**	**$ 4,506**	**$ 2,187,977**
BUDGETED CHANGE IN ASSETS	(80,229)	499,787	2,755,439	(157,782)	-	3,219,820
VARIANCE TO BUDGET - FAV (UNFAV)	(10,926,483)	8,464,063	(2,263,366)	379,486	4,506	(1,031,843)

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Twelve Months Ended June 30, 2016

	Total Medi-Cal	OneCare	OneCare Connect	PACE	Behavioral Health ASO	Consolidated
Member Months	$ 9,196,783	82,542	115,514	1,618	-	9,396,457
REVENUES						
Capitation revenue	$ 2,829,513,864	$ 104,201,695	$ 220,185,401	$ 9,852,063	$ -	$ 3,163,753,022
Other Income	-	-	-	-	-	-
Total Operating Revenues	2,829,513,864	104,201,695	220,185,401	9,852,063	-	3,163,753,022
MEDICAL EXPENSES						
Provider capitation	935,362,635	37,814,530	52,626,053	-	-	1,025,803,219
Facility inpatient	551,235,947	32,695,791	63,498,285	-	-	647,430,023
Ancillary		2,570,774	6,117,962	-	-	8,688,736
Skilled Nursing		2,421,560	36,512,397	-	-	38,933,958
Facility outpatient	94,866,563	-	-	1,919,801	-	96,786,365
Professional Claims	150,750,494	-	-	2,330,299	-	153,080,793
Prescription drugs	390,552,822	6,969,100	34,398,340	927,315	-	432,847,577
Quality Incentives		899,979				899,979
Long-term care facility payments	548,781,360	-	-	66,409	-	548,847,769
Contingencies	25,311,893	-	-	-	-	25,311,893
Medical management	31,619,582	2,401,457	11,141,681	-	-	45,162,720
Reinsurance & other	7,557,730	951,552	828,015	4,851,259	(70,542)	14,118,015
Total Medical Expenses	2,736,039,027	86,724,744	205,122,734	10,095,084	(70,542)	3,037,911,046
Medical Loss Ratio	**96.7%**	**83.2%**	**7.1%**	**102.5%**	**0.0%**	**96.0%**
GROSS MARGIN	93,474,837	17,476,951	15,062,668	(243,022)	70,542	125,841,976
ADMINISTRATIVE EXPENSES						
Salaries, wages & employee benefits	53,310,505	3,455,079	6,855,201	1,017,034	-	64,637,819
Professional fees	4,020,569	294,018	2,150	51,319	-	4,368,057
Purchased Services	8,621,000	546,310	1,375,355	9,381	(17)	10,552,029
Printing and Postage	4,035,083	136,607	1,245,375	34,711	(405)	5,451,370
Depreciation and Amortization	3,114,413		-	27,849	-	3,142,263
Other Expenses	14,573,007	434,327	33,557	88,940	13	15,129,845
Indirect cost allocation, Occupancy Expense	(4,795,540)	2,150,808	6,206,375	22,902	-	3,584,545
Total Administrative Expenses	82,879,038	7,017,150	15,718,012	1,252,136	(409)	106,865,927
Admin Loss Ratio	**2.9%**	**6.7%**	**0.0%**	**12.7%**	**0.0%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS	10,595,799	10,459,802	(655,345)	(1,495,157)	70,951	18,976,050
INVESTMENT INCOME	-	-	-	-	-	13,879,371
NET RENTAL INCOME	-	-	-	-	-	(332,491)
NET GRANT INCOME	(154)	-	-	-	-	(154)
OTHER INCOME	1,582	-	-	-	-	1,582
CHANGE IN NET ASSETS	**$ 10,597,227**	**$ 10,459,802**	**$ (655,345)**	**$ (1,495,157)**	**$ 70,951**	**$ 32,524,358**
BUDGETED CHANGE IN ASSETS	(16,354,098)	3,261,469	(2,722,051)	(2,460,718)	-	(16,108,523)
VARIANCE TO BUDGET - FAV (UNFAV)	26,951,325	7,198,332	2,066,706	965,561	70,951	48,632,881

June 30, 2016 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $2.2 million, $1.0 million unfavorable to budget
- Operating deficit is $1.3 million with a surplus in non-operating of $3.5 million

YTD RESULTS:

- Change in Net Assets is $32.5 million, $48.6 million favorable to budget
- Operating surplus is $19.0 million, and non-operating surplus is $13.5 million

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(11.0)	(0.1)	(10.9)	Medi-Cal	10.6	(16.4)	27.0
9.0	0.5	8.5	OneCare	10.5	3.3	7.2
0.5	2.8	(2.3)	OCC	(0.7)	(2.7)	2.1
0.0	0.0	0.0	ASO	0.1	0.0	0.1
0.2	(0.2)	0.4	PACE	(1.5)	(2.5)	1.0
(1.3)	**3.0**	**(4.3)**	**Operating**	**19.0**	**(18.3)**	**37.3**
3.5	0.2	3.3	Inv./Rental Inc, MCO tax	13.5	2.2	11.4
3.5	**0.2**	**3.3**	**Non-Operating**	**13.5**	**2.2**	**11.4**
2.2	**3.2**	**(1.0)**	**TOTAL**	**32.5**	**(16.1)**	**48.6**

CalOptima

Enrollment Summary

For the Twelve Months Ended June 30, 2016

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
56,812	47,881	8,931	18.7%	Aged	718,938	661,330	57,608	8.7%
628	737	(109)	(14.8%)	BCCTP	7,999	8,840	(841)	(9.5%)
48,708	49,707	(999)	(2.0%)	Disabled	620,998	631,919	(10,921)	(1.7%)
3,314	2,359	955	40.5%	LTC	42,218	37,239	4,979	13.4%
228,962	201,785	27,177	13.5%	MCE	2,582,856	2,392,895	189,961	7.9%
438,289	464,704	(26,415)	(5.7%)	TANF	5,218,248	5,465,737	(247,489)	(4.5%)
776,713	767,173	9,540	1.2%	Medi-Cal	9,191,252	9,197,960	(6,708)	(0.1%)
461	479	(18)	(3.8%)	MSSP	5,531	5,748	(217)	(3.8%)
777,174	**767,652**	**9,522**	**1.2%**	**Total Medi-Cal**	**9,196,783**	**9,203,708**	**(6,925)**	**(0.1%)**
29,416	**28,892**	**524**	**1.8%**	**OneCare Connect**	**115,514**	**182,750**	**(67,236)**	**(36.8%)**
168	**154**	**14**	**9.1%**	**PACE**	**1,618**	**1,518**	**100**	**6.6%**
1,174	**1,298**	**(124)**	**(9.6%)**	**OneCare**	**82,542**	**85,533**	**(2,991)**	**(3.5%)**
807,932	**797,996**	**9,936**	**1.2%**	**CalOptima Total**	**9,396,457**	**9,473,509**	**(77,052)**	**(0.8%)**
				Enrollment (By Network)				
46,601	44,778	1,823	4.1%	HMO	527,943	524,737	3,206	0.6%
230,153	238,695	(8,542)	(3.6%)	PHC	2,714,540	2,817,763	(103,223)	(3.7%)
343,359	358,863	(15,504)	(4.3%)	Shared Risk Group	4,109,970	4,239,594	(129,624)	(3.1%)
156,600	124,837	31,763	25.4%	Fee for Service	1,838,799	1,615,866	222,933	13.8%
776,713	767,173	9,540	1.2%	Medi-Cal	9,191,252	9,197,960	(6,708)	(0.1%)
461	479	(18)	(3.8%)	MSSP	5,531	5,748	(217)	(3.8%)
777,174	**767,652**	**9,522**	**1.2%**	**Total Medi-Cal**	**9,196,783**	**9,203,708**	**(6,925)**	**(0.1%)**
29,416	**28,892**	**524**	**1.8%**	**OneCare Connect**	**115,514**	**182,750**	**(67,236)**	**(36.8%)**
168	**154**	**14**	**9.1%**	**PACE**	**1,618**	**1,518**	**100**	**6.6%**
1,174	**1,298**	**(124)**	**(9.6%)**	**OneCare**	**82,542**	**85,533**	**(2,991)**	**(3.5%)**
807,932	**797,996**	**9,936**	**1.2%**	**CalOptima Total**	**9,396,457**	**9,473,509**	**(77,052)**	**(0.8%)**

CalOptima
Enrollment Trend by Network Type
Fiscal Year 2016

Network Type	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	MMs
HMO													
Aged	275	274	276	268	271	266	278	279	292	321	329	344	3,473
BCCTP	-	-	-	-	2	4	3	8	3	-	1	1	22
Disabled	1,705	1,709	1,719	1,715	1,731	1,719	1,730	1,762	1,772	1,774	1,791	1,801	20,928
MCX	9,194	9,431	9,678	9,990	10,203	10,411	10,388	10,966	11,395	11,966	12,298	12,596	128,516
TANF	30,496	30,681	30,806	31,011	30,829	31,059	30,898	31,405	31,713	32,336	31,911	31,859	375,004
	41,670	42,095	42,479	42,984	43,036	43,459	43,297	44,420	45,175	46,397	46,330	46,601	527,943
PHC													
Aged	1,209	1,265	1,286	1,264	1,316	1,355	1,342	1,368	1,395	1,426	1,433	1,499	16,158
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	8,147	8,148	8,139	8,080	8,141	8,031	7,995	7,989	7,982	7,953	7,948	7,921	96,474
MCX	31,591	32,558	33,426	34,638	35,529	36,352	35,625	35,756	36,915	36,841	37,341	37,729	424,301
TANF	179,126	179,848	180,626	181,957	182,035	182,975	180,992	180,811	182,902	182,564	180,767	183,004	2,177,607
	220,073	221,819	223,477	225,939	227,021	228,713	225,954	225,924	229,194	228,784	227,489	230,153	2,714,540
Shared Risk Group													
Aged	7,127	7,221	7,326	7,156	7,377	7,406	7,401	7,456	7,523	7,542	7,617	7,747	88,899
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	15,565	15,485	15,439	15,178	15,245	15,067	14,906	14,838	14,833	14,761	14,666	14,560	180,543
MCX	125,793	127,941	130,404	133,133	135,550	138,081	133,138	133,838	137,814	136,404	138,189	139,165	1,609,450
TANF	186,142	186,379	186,841	188,949	188,873	189,378	185,442	184,420	186,187	184,751	181,833	181,888	2,231,083
	334,627	337,026	340,010	344,416	347,045	349,932	340,887	340,552	346,357	343,458	342,305	343,360	4,109,975
Fee for Service (Dual)													
Aged	52,530	52,110	51,992	51,739	51,522	51,041	43,625	43,676	43,398	43,439	43,177	43,270	571,519
BCCTP	35	35	34	33	36	47	35	32	34	33	25	27	406
Disabled	25,713	25,495	25,271	25,063	24,900	24,467	20,344	20,231	20,109	19,929	19,904	19,865	271,291
LTC	3,391	3,395	3,337	3,347	3,311	3,228	3,089	2,993	2,928	2,939	2,912	2,935	37,805
MCX	2,904	2,965	2,934	3,034	3,007	3,152	3,023	3,084	3,031	2,976	2,929	2,884	35,923
TANF	1,358	1,383	1,381	1,361	1,346	1,387	1,169	1,195	1,181	1,168	1,164	1,131	15,224
	85,931	85,383	84,949	84,577	84,122	83,322	71,285	71,211	70,681	70,484	70,111	70,112	932,168
Fee for Service (Non-Dual)													
Aged	2,401	2,671	1,925	3,122	3,136	3,318	3,581	3,234	3,697	3,769	4,083	3,952	38,889
BCCTP	629	620	594	693	683	652	648	614	626	615	597	600	7,571
Disabled	3,962	4,076	3,598	4,454	4,222	4,283	4,473	4,438	4,516	4,630	4,549	4,561	51,762
LTC	406	389	255	388	380	371	367	354	358	386	380	379	4,413
MCX	25,032	26,395	24,324	29,312	30,062	31,335	35,646	35,939	37,304	36,699	36,030	36,588	384,666
TANF	28,959	29,852	31,084	32,224	33,662	34,025	38,963	38,289	37,601	36,670	37,593	40,408	419,330
	61,389	64,003	61,780	70,193	72,145	73,984	83,678	82,868	84,102	82,769	83,232	86,488	906,631
MEDI-CAL TOTAL													
Aged	63,542	63,541	62,805	63,549	63,622	63,386	56,227	56,013	56,305	56,497	56,639	56,812	718,938
BCCTP	664	655	628	726	721	703	686	654	663	648	623	628	7,999
Disabled	55,092	54,913	54,166	54,490	54,239	53,567	49,448	49,258	49,212	49,047	48,858	48,708	620,998
LTC	3,797	3,784	3,592	3,735	3,691	3,599	3,456	3,347	3,286	3,325	3,292	3,314	42,218
MCX	194,514	199,290	200,766	210,107	214,351	219,331	217,820	219,583	226,459	224,886	226,787	228,962	2,582,856
TANF	426,081	428,143	430,738	435,502	436,745	438,824	437,464	436,120	439,584	437,489	433,268	438,290	5,218,248
	743,690	750,326	752,695	768,109	773,369	779,410	765,101	764,975	775,509	771,892	769,467	776,713	9,191,252
PACE	101	114	119	123	124	129	135	140	142	158	165	168	1,618
OneCare	13,021	12,803	12,628	12,455	12,166	11,891	1,375	1,288	1,285	1,276	1,180	1,174	82,542
OneCare Connect	2	954	1,666	2,496	3,189	4,437	12,090	15,550	15,936	15,827	13,951	29,416	115,514
MSSP	455	458	466	466	465	464	461	458	459	456	462	461	5,531
TOTAL	757,269	764,655	767,574	783,649	789,313	796,331	779,162	782,411	793,331	789,609	785,225	807,932	9,396,457

ENROLLMENT:

Overall MTD enrollment was 807,932

- Favorable to budget by 9,936
- Increased 22,708 or 2.9% from prior month
- Increased 54,874 or 7.3% from prior year (June 2015)

Medi-Cal enrollment was 777,174

- Favorable to budget by 9,522 primarily driven by:
    - TANF unfavorable by 26,412
    - Offset with Medi-Cal Expansion favorable by 27,177 and Aged by 8,931
- Increased 7,246 from prior month

OneCare enrollment was 1,174

- Unfavorable to budget by 124
- Decreased 6 from prior month

OneCare Connect enrollment was 29,416

- Favorable to budget by 524
- Increased 15,465 from prior month (YTD true-up)

PACE enrollment at 168

- Favorable to budget by 14
- Increased 3 from prior month

Overall YTD enrollment was 9,396,457

- Unfavorable to budget by 77,052

CalOptima - MediCal Total
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
777,174	767,652	9,522	1.24%	Member Months	9,196,783	9,203,708	(6,925)	-0.08%
				Revenues				
241,175,373	229,583,475	11,591,898	5.05%	Capitation revenue	2,829,513,864	2,775,665,280	53,848,583	1.94%
0	0	0	0.00%	Grant & other income	0	0	0	0.00%
241,175,373	229,583,475	11,591,898	5.05%	Total Operating Revenues	2,829,513,864	2,775,665,280	53,848,583	1.94%
				Medical Expenses				
79,882,556	82,756,439	2,873,883	3.47%	Provider capitation	935,362,635	998,461,044	63,098,409	6.32%
28,979,900	43,761,586	14,781,686	33.78%	Facility inpatient	551,235,947	515,580,117	(35,655,830)	-6.92%
9,246,089	9,989,239	743,151	7.44%	Facility outpatient	94,866,563	123,622,145	28,755,582	23.26%
15,017,384	20,646,550	5,629,166	27.26%	Professional Claims	150,750,494	224,887,198	74,136,704	32.97%
33,024,920	31,748,273	(1,276,647)	-4.02%	Prescription drugs	390,552,822	376,705,025	(13,847,797)	-3.68%
44,848,360	31,206,237	(13,642,124)	-43.72%	Long-term care facility payments	548,781,360	439,396,612	(109,384,748)	-24.89%
33,456,516	(4,729,014)	(38,185,530)	-807.47%	Contingencies	25,311,893	(56,748,169)	(82,060,062)	-144.60%
2,418,426	3,764,015	1,345,590	35.75%	Medical Management	31,619,582	45,005,336	13,385,754	29.74%
301,261	547,205	245,944	44.95%	Reinsurance & other	7,557,730	6,556,054	(1,001,677)	-15.28%
247,175,411	219,690,530	(27,484,881)	-12.51%	Total Medical Expenses	2,736,039,027	2,673,465,362	(62,573,664)	-2.34%
(6,000,038)	9,892,945	(15,892,983)	-160.65%	Gross Margin	93,474,837	102,199,918	(8,725,081)	-8.54%
				Administrative Expenses				
3,301,101	5,946,681	2,645,580	44.49%	Salaries, wages & employee benefits	53,310,505	70,809,230	17,498,725	24.71%
1,167,527	184,495	(983,032)	-532.82%	Professional fees	4,020,569	6,337,977	2,317,408	36.56%
684,183	1,471,838	787,654	53.52%	Purchased services	8,621,000	13,001,893	4,380,892	33.69%
637,410	650,579	13,169	2.02%	Printing and postage	4,035,083	7,936,053	3,900,971	49.16%
0	0	0	0.00%	Occupancy expenses	0	0	0	0.00%
312,460	458,456	145,996	31.85%	Depreciation & amortization	3,114,413	5,501,474	2,387,061	43.39%
2,346,896	1,668,737	(678,159)	-40.64%	Other operating expenses	14,573,007	19,845,426	5,272,418	26.57%
(3,442,611)	(407,612)	3,034,999	744.58%	Indirect cost allocation	(4,795,540)	(4,878,037)	(82,498)	-1.69%
5,006,966	9,973,174	4,966,208	49.80%	Total Administrative Expenses	82,879,038	118,554,016	35,674,978	30.09%
				Operating Tax				
9,197,960	11,432,500	2,234,540	19.55%	Tax Revenue	111,355,973	138,066,217	26,710,244	19.35%
0	11,432,500	11,432,500	100.00%	Premium tax expense	0	138,066,217	138,066,217	100.00%
9,197,960	0	(9,197,960)	0.00%	Sales tax expense	111,355,973	0	(111,355,973)	0.00%
0	0	0	0.00%	Total Net Operating Tax	(0)	0	(0)	0.00%
				Grant Income				
0	617,857	(617,857)	-100.00%	Grant Revenue	0	4,325,000	(4,325,000)	-100.00%
0	525,179	525,179	100.00%	Grant expense - Service Partner	0	3,676,250	3,676,250	100.00%
0	92,679	92,679	100.00%	Grant expense - Adminsitrative	154	648,750	648,596	99.98%
0	0	0	0.00%	Total Net Grant Income	(154)	0	(154)	0.00%
0	0	0	0.00%	QAF and IGT - Net	0	0	0	0.00%
292	0	292	0.00%	Other income	1,582	0	1,582	0.00%
(11,006,713)	(80,229)	(10,926,483)	-13619.09%	Change in Net Assets	10,597,227	(16,354,098)	26,951,325	164.80%
102.5%	95.7%	-6.8%	-7.1%	Medical Loss Ratio	96.7%	96.3%	-0.4%	-0.4%
2.1%	4.3%	2.3%	52.2%	Admin Loss Ratio	2.9%	4.3%	1.3%	31.4%

MEDI-CAL INCOME STATEMENT – JUNE MONTH:

REVENUES of $241.2 million are favorable to budget by $11.6 million, driven by:

- Price related variance of: $8.7 million includes Q4 true-up accrual for Hep C and state IHSS report, along with favorable actual to budget rate variances

- Volume related variance of: $2.8 million due to the higher enrollment

MEDICAL EXPENSES: Overall $247.2 million, unfavorable to budget by $27.5 million due to:

- **Capitation** is favorable to budget $2.9 million due to:
  - 0 Price related variance of: $3.9 million
  - 0 Volume related unfavorable variance of: $1.0 million

- **Total Claim Payments** are favorable to budget $6.2 million due to:
  - 0 Price related favorable variance of: $7.9 million related to actuarial experience and true-up to County IHSS expense report
  - 0 Volume related unfavorable variance of: $1.7 million

- **Contingencies** are unfavorable to budget $38.2 million driven by:
  - o Expense due to risk corridor recovery to bring FY16 MLR to 95% and prior years to 85% per DHCS contract

ADMINISTRATION EXPENSES are $5.0 million, favorable to budget $5.0 million, driven by:

- Salary & Benefits: $2.6 million favorable to budget

- Non-Salary: $2.3 million favorable to budget across most categories

CHANGE IN NET ASSETS is ($11.0) million for the month, unfavorable to budget by $10.9 million

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
29,416	28,892	524	1.8%	Member Months	115,514	182,750	(67,236)	(36.8%)
				Revenues				
46,801,924	54,263,717	(7,461,793)	(13.8%)	Capitation revenue	220,185,401	343,234,927	(123,049,526)	(35.8%)
46,801,924	54,263,717	(7,461,793)	(13.8%)	Total Operating Revenue	220,185,401	343,234,927	(123,049,526)	(35.8%)
				Medical Expenses				
8,466,942	15,793,088	7,326,146	46.4%	Provider capitation	52,626,053	99,896,202	47,270,149	47.3%
16,222,953	7,870,893	(8,352,060)	(106.1%)	Inpatient	63,498,285	49,877,260	(13,621,024)	(27.3%)
654,400	3,061,399	2,406,999	78.6%	Ancillary	6,117,962	19,346,077	13,228,115	68.4%
8,386,053	15,630,102	7,244,049	46.3%	Skilled nursing facilities	36,512,397	98,926,112	62,413,715	63.1%
4,159,609	3,519,575	(640,034)	(18.2%)	Prescription drugs	34,398,340	31,175,143	(3,223,197)	(10.3%)
0	480,763	480,763	100.0%	Quality incentives	0	3,040,979	3,040,979	100.0%
3,897,120	1,420,981	(2,476,139)	(174.3%)	Medical management	11,141,681	11,662,171	520,490	4.5%
125,268	937,982	812,714	86.6%	Other medical expenses	828,015	5,933,029	5,105,014	86.0%
41,912,345	48,714,783	6,802,438	14.0%	Total Medical Expenses	205,122,734	319,856,974	114,734,241	35.9%
4,889,579	5,548,934	(659,355)	(11.9%)	Gross Margin	15,062,668	23,377,953	(8,315,285)	(35.6%)
				Administrative Expenses				
731,049	1,248,867	517,818	41.5%	Salaries, wages & employee benefits	6,855,201	10,997,329	4,142,128	37.7%
0	114,367	114,367	100.0%	Professional fees	2,150	405,500	403,350	99.5%
257,512	423,593	166,081	39.2%	Purchased services	1,375,355	3,321,639	1,946,284	58.6%
53,616	198,601	144,985	73.0%	Printing and postage	1,245,375	2,437,356	1,191,981	48.9%
6,795	1,866	(4,929)	(264.2%)	Other operating expenses	33,557	280,954	247,397	88.1%
3,348,535	806,201	(2,542,334)	(315.3%)	Indirect cost allocation, Occupancy Expense	6,206,375	8,657,226	2,450,851	28.3%
4,397,507	2,793,495	(1,604,012)	(57.4%)	Total Administrative Expenses	15,718,012	26,100,003	10,381,991	39.8%
				Operating Tax				
698,704	0	698,704	0.0%	Tax Revenue	2,289,461	0	2,289,461	0.0%
698,704	0	(698,704)	0.0%	Sales tax expense	2,289,461	0	(2,289,461)	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
492,072	2,755,439	(2,263,366)	(82.1%)	Change in Net Assets	(655,345)	(2,722,051)	2,066,706	75.9%
89.6%	89.8%	0.2%	0.2%	Medical Loss Ratio	93.2%	93.2%	0.0%	0.0%
9.4%	5.1%	(4.2%)	(82.5%)	Admin Loss Ratio	7.1%	7.6%	0.5%	6.1%

ONECARE CONNECT INCOME STATEMENT – JUNE MONTH:

REVENUES of $46.8 million are unfavorable to budget by $7.5 million based upon cohort experience

MEDICAL EXPENSES are favorable to budget $6.8 million due to:

- Delayed transition of skilled nursing facility members

ADMINISTRATIVE EXPENSES are unfavorable to budget by $1.6 million due to:

- The indirect allocation true-up for the last quarter of fiscal 2016

CHANGE IN NET ASSETS is $0.5 million, unfavorable to budget by $2.3 million

CalOptima - OneCare
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,174	1,298	(124)	(9.6%)	Member Months	82,542	85,533	(2,991)	(3.5%)
				Revenues				
19,697,853	2,879,038	16,818,815	584.2%	Capitation revenue	104,201,695	97,086,739	7,114,956	7.3%
19,697,853	2,879,038	16,818,815	584.2%	Total Operating Revenue	104,201,695	97,086,739	7,114,956	7.3%
				Medical Expenses				
7,295,209	1,027,371	(6,267,838)	(610.1%)	Provider capitation	37,814,530	32,885,589	(4,928,941)	(15.0%)
3,438,155	847,534	(2,590,621)	(305.7%)	Inpatient	32,695,791	34,230,158	1,534,367	4.5%
35,080	54,494	19,414	35.6%	Ancillary	2,570,774	3,521,972	951,198	27.0%
77,756	47,287	(30,469)	(64.4%)	Skilled nursing facilities	2,421,560	3,172,622	751,062	23.7%
54,946	134,061	79,115	59.0%	Prescription drugs	6,969,100	4,762,268	(2,206,832)	(46.3%)
0	17,304	17,304	100.0%	Quality incentives	899,979	1,140,147	240,168	21.1%
(921,989)	(110,972)	811,017	730.8%	Medical management	2,401,457	3,788,843	1,387,386	36.6%
325,966	203,507	(122,459)	(60.2%)	Other medical expenses	951,552	3,071,768	2,120,216	69.0%
10,305,123	2,220,586	(8,084,537)	(364.1%)	Total Medical Expenses	86,724,744	86,573,367	(151,377)	(0.2%)
9,392,730	658,452	8,734,278	1326.5%	Gross Margin	17,476,951	10,513,372	6,963,579	66.2%
				Administrative Expenses				
47,668	(110)	(47,778)	(43497.7%)	Salaries, wages & employee benefits	3,455,079	3,975,621	520,541	13.1%
32,150	36,833	4,683	12.7%	Professional fees	294,018	451,000	156,981	34.8%
(995)	44,532	45,527	102.2%	Purchased services	546,310	813,444	267,135	32.8%
(9,171)	35,836	45,008	125.6%	Printing and postage	136,607	489,187	352,580	72.1%
32,469	41,573	9,104	21.9%	Other operating expenses	434,327	505,466	71,138	14.1%
326,758	0	(326,758)	0.0%	Indirect cost allocation, Occupancy Expense	2,150,808	1,017,186	(1,133,622)	(111.4%)
428,879	158,664	(270,215)	(170.3%)	Total Administrative Expenses	7,017,150	7,251,903	234,753	3.2%
8,963,851	499,787	8,464,063	1693.5%	Change in Net Assets	10,459,802	3,261,469	7,198,332	220.7%
52.3%	77.1%	24.8%	32.2%	Medical Loss Ratio	83.2%	89.2%	5.9%	6.7%
2.2%	5.5%	3.3%	60.5%	Admin Loss Ratio	6.7%	7.5%	0.7%	9.8%

CalOptima - PACE
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
168	154	14	9.1%	Member Months	1,618	1,518	100	6.6%
				Revenues				
744,824	615,420	129,404	21.0%	Medi-Cal capitation revenue	6,734,190	6,072,084	662,106	10.9%
571,037	313,881	257,156	81.9%	MediCare capitation revenue	3,319,584	3,098,680	220,904	7.1%
(211,365)	0	(211,365)	0.0%	MediCare Part D Revenue	(201,711)	0	(201,711)	0.0%
1,104,496	929,301	175,195	18.9%	Total Operating Revenues	9,852,063	9,170,764	681,299	7.4%
				Medical Expenses				
264,977	254,453	(10,523)	(4.1%)	Clinical salaries & benefits	2,694,159	2,911,829	217,670	7.5%
0	0	0	0.0%	Pace Center Support salaries & benefits	0	0	0	0.0%
0	0	0	0.0%	Provider capitation	0	0	0	0.0%
17,295	128,744	111,449	86.6%	Claims payments to hospitals	1,919,801	1,269,048	(650,753)	(51.3%)
287,750	196,607	(91,142)	(46.4%)	Professional Claims	2,330,299	2,380,842	50,542	2.1%
88,911	83,160	(5,751)	(6.9%)	Prescription drugs	927,315	819,720	(107,595)	(13.1%)
(6,957)	13,643	20,600	151.0%	Long-term care facility payments	66,409	59,399	(7,010)	(11.8%)
56,320	100,100	43,780	43.7%	Patient Transportation	609,687	986,700	377,013	38.2%
48,342	54,141	5,800	10.7%	Depreciation & amortization	668,386	649,696	(18,691)	(2.9%)
37,655	38,370	715	1.9%	Occupancy expenses	451,859	453,630	1,771	0.4%
22,825	64,663	41,838	64.7%	Utilities & Facilities Expense	178,029	233,770	55,741	23.8%
95	2,329	2,234	95.9%	Purchased Services	1,619	28,330	26,711	94.3%
(96,959)	10,442	107,401	1028.6%	Indirect Allocation	97,796	102,928	5,132	5.0%
0	0	0	0.0%	Reinsurance	0	0	0	0.0%
25,507	18,203	(7,304)	(40.1%)	Other Expenses	149,725	234,963	85,238	36.3%
745,760	964,856	219,095	22.7%	Total Medical Expenses	10,095,084	10,130,855	35,771	0.4%
358,735	(35,555)	394,290	1109.0%	Gross Margin	(243,022)	(960,092)	717,070	74.7%
				Administrative Expenses				
103,614	87,674	(15,940)	(18.2%)	Salaries, wages & employee benefits	1,017,034	1,049,297	32,264	3.1%
17,299	11,000	(6,299)	(57.3%)	Professional fees	51,319	132,000	80,681	61.1%
0	9,530	9,530	100.0%	Purchased services	9,381	114,378	104,996	91.8%
554	4,167	3,613	86.7%	Printing and postage	34,711	50,000	15,289	30.6%
2,014	2,256	242	10.7%	Depreciation & amortization	27,849	27,072	(777)	(2.9%)
16,022	5,566	(10,455)	(187.8%)	Other operating expenses	88,940	104,691	15,751	15.0%
(2,471)	2,034	4,505	221.5%	Indirect cost allocation, Occupancy Expense	22,902	23,189	287	1.2%
137,032	122,227	(14,805)	(12.1%)	Total Administrative Expenses	1,252,136	1,500,626	248,491	16.6%
221,703	(157,782)	379,486	240.5%	Change in Net Assets	(1,495,157)	(2,460,718)	965,561	39.2%
67.5%	103.8%	36.3%	35.0%	Medical Loss Ratio	102.5%	110.5%	8.0%	7.2%
12.4%	13.2%	0.7%	5.7%	Admin Loss Ratio	12.7%	16.4%	3.7%	22.3%

CalOptima - Behavioral Health ASO
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2016

Month								
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	0	0	0.0%	Other Income	0	0	0	0.0%
0	0	0	0.0%	Total Operating Revenues	0	0	0	0.0%
				Medical Expenses				
(4,506)	0	4,506	0.0%	Other Medical	(70,542)	0	70,542	0.0%
0	0	0	0.0%	Medical management	0	0	0	0.0%
(4,506)	0	4,506	0.0%	Total Medical Expenses	(70,542)	0	70,542	0.0%
4,506	0	4,506	0.0%	Gross Margin	70,542	0	70,542	0.0%
				Administrative Expenses				
0	0	0	0.0%	Salaries, wages & employee benefits	0	0	0	0.0%
0	0	0	0.0%	Professional fees	0	0	0	0.0%
0	0	0	0.0%	Purchased services	(17)	0	17	0.0%
0	0	0	0.0%	Printing and postage	(405)	0	405	0.0%
0	0	0	0.0%	Depreciation & amortization	0	0	0	0.0%
0	0	0	0.0%	Other operating expenses	13	0	(13)	0.0%
0	0	0	0.0%	Indirect cost allocation, Occupancy Expense	0	0	0	0.0%
0	0	0	0.0%	Total Administrative Expenses	(409)	0	409	0.0%
4,506	0	4,506	0.0%	Change in Net Assets	70,951	0	70,951	0.0%
0.0%	0.0%	0.0%	0.0%	Medical Loss Ratio	0.0%	0.0%	0.0%	0.0%
0.0%	0.0%	0.0%	0.0%	Admin Loss Ratio	0.0%	0.0%	0.0%	0.0%

CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
24,056	20,473	3,583	17.5%	Rental income	375,749	245,679	130,070	52.9%
24,056	20,473	3,583	17.5%	Total Operating Revenue	375,749	245,679	130,070	52.9%
				Administrative Expenses				
1,235	2,085	850	40.8%	Professional fees	14,741	25,020	10,279	41.1%
29,250	22,912	(6,337)	(27.7%)	Purchase services	304,598	274,949	(29,649)	(10.8%)
144,989	136,086	(8,903)	(6.5%)	Depreciation & amortization	1,730,385	1,633,036	(97,349)	(6.0%)
18,904	15,110	(3,793)	(25.1%)	Insurance expense	178,941	181,324	2,383	1.3%
92,106	161,923	69,817	43.1%	Repair and maintenance	1,162,254	1,943,077	780,824	40.2%
58,701	0	(58,701)	0.0%	Other Operating Expense	623,099	0	(623,099)	0.0%
(74,595)	(311,907)	(237,313)	(76.1%)	Indirect allocation, Occupancy Expense	(3,305,779)	(3,478,600)	(172,822)	(5.0%)
270,590	26,210	(244,380)	(932.4%)	Total Administrative Expenses	708,239	578,805	(129,434)	(22.4%)
(246,534)	(5,737)	(240,797)	(4197.5%)	Change in Net Assets	(332,491)	(333,126)	636	0.2%

OTHER STATEMENTS – JUNE MONTH:

ONECARE INCOME STATEMENT

REVENUES of $19.7 million are favorable to budget by $16.8 million the annual revenue adjustments for HCC and part D

CHANGE IN NET ASSETS is $9.0 million, $8.5 million favorable to budget due to:

- **Medical Expenses** are $8.1 million unfavorable to budget driven by capitation and risk pool expenses for the annual revenue adjustments for HCC and part D
- **Administration Expenses** are $428.9 thousand, $270.2 thousand unfavorable to budget

PACE INCOME STATEMENT

- **Change in Net Assets** for the month is $221.7 thousand, which is operating favorable to budget by $379.5 thousand

505 CITY PARKWAY BUILDING INCOME STATEMENT

- **Change in Net Assets** for the month is ($246.5) thousand which is unfavorable to budget $240.8 thousand

CalOptima
BALANCE SHEET
June 30, 2016

ASSETS			**LIABILITIES & FUND BALANCES**		
Current Assets			Current Liabilities		
	Operating Cash	$244,488,626		Accounts payable	$5,815,278
	Catastrophic Reserves	11,462,767		Medical claims liability	598,694,858
	Investments	1,019,264,632		Accrued payroll liabilities	11,431,792
	Capitation receivable	465,142,156		Deferred revenue	589,328,793
	Receivables - Other	21,608,851		Deferred revenue - CMS	1,373,849
	Prepaid Expenses	6,784,247		Deferred lease obligations	273,428
				Capitation and withholds	401,826,302
				Accrued insurance costs	0
	Total Current Assets	**1,768,751,279**		**Total Current Liabilities**	**1,608,744,299**
Capital Assets	Furniture and equipment	28,851,790			
	Leasehold improvements	11,240,138			
	505 City Parkway West	46,707,144	Other (than pensions) post		
		86,799,071		employment benefits liability	27,327,000
	Less: accumulated depreciation	(31,803,507)	Net Pension Liabilities		6,942,207
	Capital assets, net	**54,995,564**	Long Term Liabilities		150,000
				TOTAL LIABILITIES	**1,643,163,507**
Other Assets	Restricted deposit & Other	277,378			
			Deferred inflows of Resources - Exceess Earnings		502,900
	Board-designated assets		Deferred inflows of Resources - Changes in Assumptions		1,651,640
	Cash and cash equivalents	10,144,103			
	Short term investments	-			
	Long term investments	465,713,885		Tangible net equity (TNE)	89,283,747
	Total Board-designated Assets	475,857,987		Funds in excess of TNE	570,283,432
	Total Other Assets	**476,135,365**	**Net Assets**		**659,567,179**
	Deferred outflows of Resources - Pension Contributions	3,787,544			
	Deferred outflows of Resources - Difference in Experience	1,215,473			
TOTAL ASSETS & OUTFLOWS		**2,304,885,226**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**		**2,304,885,226**

CalOptima
Board Designated Reserve and TNE Analysis
as of June 30, 2016

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	135,378,209				
	Tier 1 - Logan Circle	125,346,300				
	Tier 1 - Wells Capital	125,392,844				
Board-designated Reserve		386,117,353	283,760,118	443,636,060	102,357,235	(57,518,707)
TNE Requirement	Tier 2 - Logan Circle	89,740,634	89,283,747	89,283,747	456,887	456,887
	Consolidated:	**475,857,987**	**373,043,865**	**532,919,807**	**102,814,122**	**(57,061,820)**
	Current reserve level	1.79	1.40	2.00		

CalOptima
Statement of Cash Flows
June 30, 2016

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	2,187,977	32,524,358
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	459,464	4,872,648
Changes in assets and liabilities:		
Prepaid expenses and other	(1,416,793)	(6,784,247)
Catastrophic reserves		
Capitation receivable	(241,640,188)	92,614,603
Medical claims liability	62,139,692	(71,638,442)
Deferred revenue	(21,245,409)	379,691,595
Payable to providers	(26,962,265)	111,193,390
Accounts payable	3,608,230	(16,314,919)
Other accrued liabilities	3,517,265	6,324,557
Net cash provided by/(used in) operating activities	(219,352,027)	532,483,542
GASB 68 CalPERS Adjustments	(4,641,485)	(3,478,118)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	119,604,759	(273,472,024)
Purchase of property and equipment	(785,602)	(6,518,824)
Change in Board designated reserves	(2,653,952)	(15,581,239)
Net cash provided by/(used in) investing activities	116,165,205	(295,572,086)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(107,828,307)	233,433,338
CASH AND CASH EQUIVALENTS, beginning of period	$363,779,699	22,518,055
CASH AND CASH EQUIVALENTS, end of period	**$ 255,951,393**	**$ 255,951,393**

BALANCE SHEET:

ASSETS Increased $19.8 million from May

- **Cash and Cash Equivalents** decreased by $107.8 million from May based upon month-end cut-off and cash funding requirements
- **Net Capitation Receivables** increased $240.4 million based upon receipt timing and receivables
- **Investments** decreased $119.6 million due to month-end cut-off and cash funding requirements

LIABILITIES increased $21.1 million from May

- **Deferred Revenue** decreased by $21.2 million from May due to:
    - Accrual of CMS HCC revenues received in July (mainly OneCare)
- **Medical Claim Liability** increased by $62.1 million from May based upon payment timing and actuarial estimates
- **Incentives and Risk Pool** decreased $14.7 million based upon timing of pool estimates, recalculations and payouts

NET ASSETS are $659.6 million

CalOptima Foundation
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2016
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
9,397	0	9,397	100.0%	Income - Grant	304,593	331,766	(27,173)	(8.2%)
35,042	0	35,042	100.0%	In Kind Revenue - HITEC Grant	348,697	0	348,697	100.0%
0	0	0	0.0%	In Kind Revenue - Foundation Corporate	33	0	33	100.0%
44,439	0	44,439	0.0%	Total Operating Revenue	653,323	331,766	321,557	96.9%
				Operating Expenditures				
22,701	7,373	(15,327)	(207.9%)	Personnel	243,440	88,481	(154,959)	(175.1%)
12,220	3,556	(8,664)	(243.6%)	Taxes and Benefits	119,647	42,705	(76,942)	(180.2%)
1,855	0	(1,855)	(100.0%)	Travel	5,324	0	(5,324)	(100.0%)
228	0	(228)	(100.0%)	Supplies	2,091	0	(2,091)	(100.0%)
5,204	0	(5,204)	(100.0%)	Contractual	202,403	310,766	108,363	34.9%
2,232	231,282	229,051	99.0%	Other	92,176	2,796,383	2,704,207	96.7%
44,439	242,212	197,773	81.7%	Total Operating Expenditures	665,082	3,238,335	2,573,253	79.5%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
0	(242,212)	(242,212)	100.0%	Program Income	(11,758)	(2,906,569)	(2,894,810)	99.6%

CalOptima Foundation
Balance Sheet
June 30, 2016

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,894,845	Accounts payable-Current	35,298
Grants receivable	35,359	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	61
Total Current Assets	**2,930,204**	Grants-Foundation	0
		Total Current Liabilities	**35,359**
		Total Liabilities	**35,359**
		Net Assets	**2,894,845**
TOTAL ASSETS	**2,930,204**	**TOTAL LIABILITIES & NET ASSETS**	**2,930,204**

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 $44.4 thousand for June and $653.3 thousand YTD FY16
    - HITEC Grant YTD revenue totaled $304.6 thousand, which left $27.2 thousand remaining in HITEC Grant funding as of June 2016
    - CalOptima in-kind YTD contribution totaled $348.7 thousand
- Revenue budget variances attributed to:
    - Grant funding originally allocated July-September 2015 for original extension, later ONC extended it through October 2016
    - CalOptima in-kind revenue was not included in FY16 budget

Expenses

- $665.1 thousand for grant related activities incurred in FY16 YTD
- Expense categories include staff services, travel and miscellaneous supplies
    - $2.6 million favorable to budget
    - FY16 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
- $35.0 thousand current month grant receivable for ONC draw down of HITEC grant

Liabilities

- $35.0 thousand current month provider payable for HITEC grant services

Budget Allocation Changes
Reporting changes for June 2016

Transfer Mon	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	MediCal	Human Resources Professional Fees	Human Resources Professional Fees	$19,428	Re-purpose funds for CareerBuilder Professional Searches & Software	2016
July	Capital	Facilities - Car Charging Station	PACE - Blinds	$13,000	Re-purpose FY15 unspent Board approved budget to purchase blinds for PACE	2016
July	Capital	Facilities - Board Breakout Room 104 & 105	PACE - Water Softener	$40,000	Re-purpose FY15 unspent Board approved budget to purchase water softener for PACE	2016
July	Capital	Facilities - Car Charging Station	Facilities - Beacon Space Re-Wiring	$26,000	Re-purpose FY15 unspent Board approved budget to re-wire the 7th floor space previously occupied by Beacon	2016
August	MediCal	Executive - Other Pay	Compliance - Professional	$99,000	Funds needed for Susan Miller Consulting for DHCS/DHMC	2016
August	OneCare	Compliance - Professional	Executive - Other Pay	$99,000	Re-allocate funds from department for DHCS/DMHC consulting services	2016
August	OneCare Connect	Community Relations - Public Activities; Printing	Community Relations - Professional Fees	$10,000	Consulting services to address opt-out rate for OneCare Connect specifically in the Vietnamese community	2016
September	MediCal	IGT - Security Audit Remediation	IGT - Case Management	$99,000	Re-allocate funds from IGT Security Audit Remediation to fund services done by Altruista	2016
September	MediCal	Human Resources - Professional Fees - Sal & Comp Research; Executive Coaching	Human Resources - Professional Fees	$29,000	Re-purpose additional funds needed to cover SageView, CalOptima's 457b Plan Reviewer	2016
September	MediCal	Government/Legislative Affairs - Membership	Government/Legislative Affairs - Professional Fees	$42,612	Re-allocate funds from Membership for consultation services that strengthen relationship between CalOptima & local Vietnamese providers	2016
September	MediCal	IS Application Development -Professional Fees	IS Application Development - Maintenance HW/SW	$18,400	Re-allocate funds for add-on service by Ceridian for ACA reporting requirement, which is annual filing of ACA forms required by the Taxing Authority	2016
October	MediCal	IS Application Mgmt - Professional Fees	Quality Analytics - Purchased Services - Member Satisfaction Surveys	$75,000	Transfer of funds budgeted in IS Application Mgmt to Quality Analytics for Member Experience Survey	2016
October	MediCal	Quality Analytics - Incentives	Quality Analytics - Purchased Services - Access & Avail Study	$80,000	Funds needed for the Timely Access Survey for 2016	2016
October	OneCare	Health Network Provider Relations - In Home Assessments	Health Network Provider Relations - RADV Plan Audit	$25,000	Additional funds needed for the RADV Plan Audit	2016
October	MediCal	Human Resources - Purchased Services	Human Resources - Professional Fees - Sal & Comp Research	$18,500	Funds needed for Pearl Meyer Salary Structure review and Senior Management benchmarking	2016
November	MediCal	Cultural & Linguistic - Member Communications	Grievances & Appeals Resolution Office - Purchased Services & Office Supplies	$40,000	Funds needed to cover office supplies & services from ImageNet	2016
November	MediCal	eBusiness - Purchased Services	eBusiness - Purchased Services	$11,648	Re-purpose funds from FY16 AMA Royalty to pay for SAAS License Fee	2016
November	OneCare	Quality Analytics - Member Communications - QIP Activities	Quality Analytics - Purchased Services - Member Satisfaction Surveys	$20,000	Funds needed to cover OC Group Level CAHPS (member experience) survey	2016
November	MediCal	Process Excellence - Professional Fees	Executive - Other Pay	$50,000	Funds needed to cover RADV Plan Audit Chart Administrative Fee	2016
November	OneCare	Executive Office - Other Pay	Health Network Provider Relations - RADV Plan Audit	$50,000	Funds needed to cover RADV Plan Audit Chart Administrative Fee	2016
December	PACE	PACE - DME	PACE - Recreation Therapy Supplies	$10,000	Funds needed for member recreation therapy supplies	2016
December	MediCal	Compliance - Professional Fees	Audit & Oversight - Professional Fees	$12,500	Re-allocate funds from Compliance to Audit & Oversight for review of audit tools and protocols for A&O audit processes	2016
December	MediCal	IS-Infrastructure - Minor Equipment & Supplies	IS-Infrastructure - Software Maintenance	$29,000	Funds needed for maintenance expense relating to the HPCA e-mail archiving system	2016
January	MediCal	Facilities - Repairs & Maintenance - Building	Facilities - Comp Supply/Minor Equipment	$75,000	Funds needed for signage, furniture, adds move and change and other additional FF&E	2016
January	Capital	Facilities - 10th Floor Renovation - Common Corridor	Facilities - 505 Building Tiles	$11,500	Funds needed for purchased of floor tiles as part of upcoming remodel of common area restroom throughout the building	2016
January	MediCal	Executive Office - Professional Fees	Executive Office - Purchased Services	$15,000	Re-purpose $15,000 specified for Prof Fees - Legal to be used for an armed security officer at all board of directors meeting	2016
January	Capital	Facilities - Board Dias/Table	PACE - Water Softener	$36,000	Re-purposed unspent board approved budget of $36,000 specified for Board Dias/Table to be used for PACE Water Softener	2016
January	Capital	Facilities - Board Dias/Table	Facilities - Sound Recording System	$46,000	Re-purposed unspent board approved budget of $46,000 specified for Board Dias/Table to be used for Sound Recording System	2016
February	MediCal	Community Relations - Public Activities	Community Relations - Professional Fees	$17,000	Re-allocate funds from Public Activities to Professional Fees to cover community liaison consultants to assist with community relation functions.	2016
February	Capital	IS-Applications Management - Altruista Provider Portal Network	IS-Applications Management - Claims Editor	$31,700	Re-allocate capital funds to cover full cost of the claim editor program	2016
February	OneCare	Audit & Oversight - Professional Fees	Compliance - Professional Fees	$75,000	Re-allocate professional fees funds from Audit & Oversight to Compliance to cover Deloitte audit expenses	2016
March	OneCare Connect	Communications - Public Activities, Printing	Communications - Advertising	$75,182	Re-allocate funds from Public Activities and Printing to Advertising	2016
April	MediCal	Health Ed & Disease Mgmt - Purchased Services - Childhood Obesity	Health Ed & Disease Mgmt - Professional Fees	$40,000	Re-allocate funds from Purchased Services - Childhood Obesity to Professional Fees to pay for Group Needs Assessment which is a requirement for DHCS	2016
April	MediCal	IS-Infrastructure - Purchased Services - Disaster Recovery Services	IS-Infrastructure - Subscriptions	$76,000	Re-allocate funds from Purchased Services (Disaster Recovery Technology Services) to Subscriptions to pay for Gartner Renewal (5/1/16 - 4/30/17) and other subscription related expenses	2016
April	MediCal	Medical Management - Professional Fees - Recruiting Utilization Management & Quality Analytics Directors	Medical Management - Professional Fees - Organ Transplant Vendor (Axia)	$60,000	Re-purpose funds from Professional Fees - Recruiting Utilization Management & Quality Analytics Directors to pay for Organ Transplant Vendor (Axia)	2016
April	OneCare	Cultural & Linguistic Services - Member Communications	Cultural & Linguistic Services - Purchased Services - Interpreting	$20,000	Re-allocate funds from Member Communication to Purchased Services - Interpreting to pay for interpreting services	2016
April	MediCal	Human Resources - Purchased Services	Human Resources - Professional Fees, Training & Seminars, Office Supplies	$10,000	Re-allocate funds from Purchased Services to Professional Fees, Training & Seminars, and Office Supplies to pay for Future Sense training assessment, Skillsoft (LMS) training courses, and office supplies	2016
April	MediCal	IS-Infrastructure - Telephone	IS-Infrastructure - Software Maintenance	$21,000	Re-allocate funds from Telephone to Software Maintenance to cover cost of Microsoft Agreement/Licenses	2016
May	MediCal	Human Resources - Purchased Services	Human Resources - Advertising	$15,000	Re-allocate funds from Purchased Services to Advertising to pay for LinkedIn Career Pages - Silver Plus and other advertising expenses	2016
May	MediCal	Community Relations - Public Activities	Community Relations - Public Activities	$22,668	Re-purpose funds within Public Activities to pay for incentives/promotional items	2016
May	MediCal	IS-Infrastructure - Professional Fees - Enterprise Risk & Information Security Program	IS-Infrastructure - Professional Fees - Microsoft Premier Support Consulting Services	$81,504	Re-purpose funds within Professional Fess (Enterprise Risk & Security Program) to cover cost of Microsoft Premier Support Consulting Services	2016
May	COREC	REC - Other	REC - Purchased Services - General	$22,000	Re-allocate funds to cover costs for mailing care packages to the provider offices for the celebration and acknowledgement of 1,000 Primary Care Providers that achieve Meaningful Use Stage under ONC grant	2016

Board of Directors' Meeting
August 4, 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 a regulator.

A. Updates on Regulatory Audits

1. OneCare

- OneCare Validation Audit: From March 29 -30, 2016, the Centers for Medicare & Medicaid Services (CMS) conducted a validation audit of CalOptima's OneCare program to validate that the deficiencies identified in the March 2015 final audit report have been remediated. By way of background, the March 2015 final audit report identified four (4) corrective actions required (CARs) and two (2) immediate corrective actions required (ICARs). On May 31, 2016, CMS provided an audit close-out notification letter to CalOptima. CMS noted that the validation audit provided CMS with a reasonable assurance that CalOptima is in compliance with program requirements tested during the audit.

- Medicare Part C Contract-Level Risk Adjustment Data Validation (RADV) Audit: On September 14, 2015, CMS notified CalOptima of its selection for the CY2012 Medicare Part C Contract-Level Risk Adjustment Data Validation (RADV) audit for OneCare. CMS will be conducting a medical records review to validate the accuracy of the CY 2012 Medicare Part C risk adjustment data and payments. CalOptima submitted all requested medical records to the CMS contractor by May 10, 2016. CalOptima is currently waiting for feedback from CMS.

- Medicare Part C National Risk Adjustment Data Validation (RADV) Audit: On January 27, 2016, CMS notified CalOptima that it was selected for the CY 2014 Medicare Part C National Risk Adjustment Data Validation (RADV) audit for OneCare. CalOptima must submit all requested medical records to the CMS contractor by June 20, 2016. CalOptima has submitted the requested medical records to CMS on April 21, 2016. CalOptima is currently waiting for feedback from CMS.

- Medicare Parts C & D Data Validation Audit: As required by CMS on an annual basis, CalOptima has contracted with Advent Advisory Group, LLC (Advent) to conduct a review of reporting processes, including policies and procedures, source codes, and data files for Part C and D reports submitted during contract year (CY) 2015 for both OneCare and OneCare Connect programs. On April 13, 2016, Advent conducted a virtual audit on

reporting processes for all Parts C and D reporting requirements. On June 28, 2016, CalOptima received final reports for each measure. Both OneCare and OneCare Connect received an overall passing score of 95% and 100%, respectively. Advent is expected to schedule a closing conference with CalOptima in the next few weeks.

- 2016 CMS Website Monitoring Results: On June 3, 2016, CMS notified CalOptima that it reviewed CalOptima's website to evaluate compliance with elements of 42 C.F.R. §§ 422.111(h)(2), 423.128(d)(2) and the Medicare Marketing Guidelines between January and April of 2016. CalOptima received a score of 100% for OneCare.

2. OneCare Connect

- CY 2016 Quality Withhold Performance Measure Validation: On November 12, 2015, CMS' contractor, Health Services Advisory Group (HSAG), notified CalOptima that it would be conducting a Quality Withhold Performance Measure Validation (PMV) for OneCare Connect for CY 2016. The validation audit was performed via webex on April 5, 2016. On June 30, 2016, HSAG released its final report to CalOptima. HSAG determined the measure data were compliant with CMS' specifications and the data, as reported, were valid and accurate. No findings were issued.

- One Care Connect Mock Audit: CalOptima anticipates that CMS will select its OneCare Connect program for a full-scope program audit some time in CY 2016. As such, 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 the week of June 6, 2016, and will continue through August 2016.

- 2016 CMS Website Monitoring Results: On June 3, 2016, CMS notified CalOptima that it reviewed CalOptima's website to evaluate compliance with elements of 42 C.F.R. §§ 422.111(h)(2), 423.128(d)(2) and the Medicare Marketing Guidelines between January and April of 2016. CalOptima received a score of 100% for OneCare Connect.

3. PACE

- 2016 Annual PACE Audit: On June 30, 2016, CMS issued an engagement letter to CalOptima PACE for the annual audit scheduled to occur from August 29 - September 1, 2016. Pre-audit file submissions are due to CMS by July 29, 2016.

4. Medi-Cal

- DHCS conducted an onsite audit of CalOptima's Medi-Cal program from February 8 – 19, 2016. The review period was from February 1, 2015 - November 30, 2015. 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 a final report, which identified three (3) findings in the following areas --- initial health assessment, confidentiality rights, and fraud, waste, and

abuse (FWA). DHCS requires CalOptima to respond to the findings in the form of a corrective action plan by August 15, 2016.

5. Other

- 2016 DMHC Routine Examination: On June 22, 2016, the Department of Managed Health Care (DMHC) notified CalOptima that it will conduct a routine examination of CalOptima's financial and administrative affairs beginning on August 15, 2016. The audit will primarily focus on CalOptima's Healthy Families Program in place during the review period, and on CalOptima's organization-wide finances.

B. Regulatory Compliance Notices

1. On 7/13/16, CMS issued notices of non-compliance to CalOptima for recent call center monitoring activities for both OneCare and OneCare Connect. CMS' contractor, IMPAQ International, Inc., conducted an extensive call center monitoring study from February 18, 2016 - June 3, 2016. For both OneCare and OneCare Connect, CMS found the area of interpreter availability to be non-compliant during the call center monitoring. Although CMS is not requiring further action from CalOptima at this time, the expectation is for CalOptima to take steps to improve interpreter availability.

2. On 7/5/16, CMS issued a notice of non-compliance to CalOptima PACE for failure to successfully complete automated true out-of-pocket (TrOOP) balance transfer (ATBT) transactions within the established timeframes for CY 2015. While a response to CMS is not required from CalOptima at this time, a process must be put in place for CalOptima PACE to successfully transfer TrOOP balances after the initial fifteen (15) day period from the effective date of the new enrollment.

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
February 2016	10%	NA	N/A	40%	89	94%	96%	0%
March 2016	27%	NA	N/A	3%	75%	88%	93%	25%
April 2016	67%	100%	85%	0%	94%	88%	88%	18%

- The lower scores for timeliness for urgent PA requests were due to the following reasons:
  - Failure to meet decision timeframe (72 hours)

- The lower scores for timeliness for routine PA requests were due to the following reasons:
  - Failure to meet decision timeframe (5 business days)
  - Failure to meet provider initial (24 hours) and written (2 business days) notification timeframes

- The lower scores for timeliness for extended PA requests were due to the following reasons:
  - Failure to meet decision timeframe (14 calendar days)
  - Failure to meet member written notification timeframe (2 business days)

- The lower scores for clinical decision making (CDM) for denials were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision
  - Failure to obtain adequate clinical information for 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

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2016	100%	97%	100%	100%
March 2016	100%	100%	100%	100%
April 2016	93%	97%	100%	100%

- The compliance rate for denied claims accuracy and timeliness has been consistent at 100% from February to April 2016.

- The lower review score for paid claims timeliness was due to a failure to meet claims processing timeframe (45 business days/60 calendar days).

- Lower scores for paid claims accuracy were due to the following reasons:
  - Claims underpaid/overpaid
  - Information on hard copy claim does not match claim in the system

2. Internal Audits: OneCare

- OneCare Pharmacy: Decision timeliness for coverage determinations are reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
February 2016	100%
March 2016	100%
April 2016	100%

  - Monitoring scores for coverage determination timeliness remain consistent at 100% from February to April 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
February 2016	0	0	NA
March 2016	4	0	100%
April 2016	1	0	100%

  - The compliance rate for protected classes of drugs has been at 100% for March and April 2016.

  - There were no protected drug cases reported for the month of February 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
February 2016	15	0	100%
March 2016	23	0	100%
April 2016	20	2	90%

- The compliance rate for unprotected classes of drugs has been consistently at or above 90% from February to April 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
February 2016	No DMR Requests
March 2016	100%
April 2016	No DMR Requests

- There were no DMR requests for the months of February and April 2016.

- For March 2016, 100% of DMR cases were compliant.

- OneCare Utilization Management (UM):

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
February 2016	Nothing to Report	Nothing to Report	Nothing to Report	67%	67%	Nothing to Report	Nothing to Report	Nothing to Report
March 2016	Nothing to Report	Nothing to Report	Nothing to Report	100%	67%	Nothing to Report	Nothing to Report	Nothing to Report
April 2016	Nothing to Report	Nothing to Report	Nothing to Report	100%	78%	Nothing to Report	Nothing to Report	Nothing to Report

- The lower letter scores for SOD were due to the following reasons:
  - Failure to use approved CMS letter templates
  - Failure to use lay language

- The lower timeliness scores for SOD were due to the following reason:
  - Failure to meet decision timeframe (14 calendar days)

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2016	100%	100%	100%	93%
March 2016	100%	87%	100%	100%
April 2016	90%	100%	100%	83%

- The monitoring scores for denied claims timeliness have remained consistent at 100% from February to April 2016.

- The lower score for paid claims timeliness was due to a failure to meet claims processing timeframes (30 calendar days for clean claims/60 calendar days for unclean claims).

- The lower scores for claims accuracy were due to the following reasons:
  - Claims denied in error
  - Pricing error resulting in underpayment or overpayment of claims
  - Claims developed in error

3. Internal Audits: OneCare Connect

- OneCare Connect Pharmacy: Decision timeliness for coverage determinations are reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
February 2016	99.7%
March 2016	100%
April 2016	100%

- Timeliness for coverage determinations remained consistent at or near 100% from February to April 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
February 2016	9	0	100%
March 2016	15	0	100%
April 2016	10	0	100%

- The monitoring scores for clinical decision making for protected drug cases remain consistent at 100% from February to April 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
February 2016	111	6	94.6%
March 2016	105	8	92.4%
April 2016	110	7	93.6%

- The monitoring results for clinical decision making for unprotected classes of drugs range from about 92% to 95% from February to April 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
February 2016	13	0	100%
March 2016	12	1	91.7%
April 2016	13	0	100%

- DMRs have been 100% compliant in February and April 2016.

- The lower score for March was due to check payment information that was not made available for the review period.

- OneCare Connect Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgents	CDM for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
February 2016	100%	NA	83%	50%	75%	NTR	NTR	NTR	NTR	NTR	NTR
March 2016	85%	NA	52%	23%	3%	NTR	NTR	NTR	NTR	NTR	NTR
April 2016	0%	100%	94%	25%	50%	67%	100%	89%	NTR	NTR	NTR

- The lower scores for timeliness for urgent PA requests were due to the following reasons:
  - Failure to meet timeframe for decision (72 hours)
  - Failure to meet timeframes for provider initial (24 hours) and written (2 business days) notifications

- The lower scores for timeliness for routine PA requests were due to the following reasons:
  - Failure to meet timeframe for decision (5 business days)
  - Failure to meet timeframe for provider initial (24 hours) notification

- The lower letter scores for routine PA requests were due to the following reasons:
  - Failure to issue letter in member's preferred language
  - Failure to use lay language

- <u>OneCare Connect Claims:</u> Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2016	100%	100%	100%	100%
March 2016	97%	87%	100%	100%
April 2016	88%	88%	100%	100%

- The monitoring scores for paid claims timeliness decreased for March and April due to failure to meet claims processing timeframes (30 days for clean claims/60 days for unclean claims).

- The monitoring scores for paid claims accuracy decreased to 87% and 88%, respectively, in March and April due to the following reasons:
  - Payment made for non-payable charges
  - Claim developed in error
  - Incorrect authorization used

- The monitoring scores for denied claims timeliness and accuracy have remained at 100% from February to April 2016.

4. <u>External Audits: Medi-Cal</u>

- <u>Medi-Cal Utilization Management (UM):</u> 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 Modifieds	Letter Score for Modifieds	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
February 2016	88%	95%	87%	97%	89%	96%	89%	78%	98%	97%	100%	100%	100%
March 2016	93%	97%	93%	92%	92%	99%	97%	88%	100%	100%	50%	100%	83%
April 2016	95%	100%	100%	98%	89%	97%	95%	85%	95%	98%	39%	100%	85%

- 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 provider initial notification (24 hours)
  - Failure to provide proof of successful initial notification to requesting provider

- The lower scores for clinical decision making (CDM) were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision
  - No indication that the medical reviewer was involved in the denial determination
  - No indication of adequate clinical information obtained to make the decision to deny

- The lower letter scores were due to the following reasons:
  - Delay in notification to member and provider did not specify anticipated decision date
  - Provider notification did not include name and contact information for the medical director responsible for the decision to delay
  - 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

- <u>Medi-Cal Claims:</u> Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
February 2016	100%	100%
March 2016	97%	100%
April 2016	98%	95%

- The compliance rate for misclassified paid and denied claims has remained stable at or above 95% from February to April 2016.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2016	96%	99%	98%	98%
March 2016	99%	97%	100%	90%
April 2016	89%	88%	100%	100%

  - The compliance rate for paid claims timeliness and accuracy has decreased in April 2016 from previous months due to untimely processing (45 business days/60 calendar days).

  - The compliance rate for denied claims timeliness and accuracy has increased to 100% in April 2016.

- Medi-Cal Claims: Misclassified Hospital Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
February 2016	100%	100%
March 2016	96%	100%
April 2016	100%	77%

  - The compliance rate for misclassified denied claims decreased from 100% in March 2016 to 77% in April 2016 due to invalid billing/procedure codes.

- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2016	100%	100%	100%	100%
March 2016	100%	100%	100%	100%
April 2016	100%	100%	100%	100%

  - The compliance rate for paid claims timeliness and accuracy as well as denied claims timeliness and accuracy has remained at 100% from February to April 2016.

5. External 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
February 2016	100%	Nothing to Report	95%	100%	92%	100%	100%	100%
March 2016	83%	Nothing to Report	79%	89%	83%	67%	67%	67%
April 2016	100%	Nothing to Report	91%	100%	96%	100%	100%	100%

  - The lower letter scores were due to failure to provide the description of services in lay language.

- OneCare Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
February 2016	100%	100%
March 2016	100%	100%
April 2016	98%	97%

  - The compliance rate for misclassified paid and denied claims decreased from March to April 2016 due to the inclusion of denied line items in the paid universe and the use of invalid billing/procedure codes on the denial universe.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2016	99%	99%	99%	85%
March 2016	97%	97%	99%	84%
April 2016	98%	98%	100%	83%

- The compliance rate for paid claims timeliness and accuracy ranges from 97% to 99% from February to April 2016.

- The compliance rate for denied claims timeliness has remained stable at or above 99% from February to April 2016.

- The lower compliance rates for denied claims accuracy were due to the following reasons:
  - Failure to provide Explanation of Benefits (EOB) or Remittance Advice (RA) to provider
  - Failure to provide notification of appeal rights to provider
  - Failure to notify provider to not bill the member for the balance of the claim
  - Failure to clearly specify additional information required for pended claim

6. External Audits: OneCare Connect

- OneCare Connect Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials	Timeliness for Modifieds	Clinical Decision Making for Modifieds	Letter Score for Modifieds	Timeliness for Deferrals	Clinical Decision Making for Deferrals	Letter Score for Deferrals
February 2016	88%	Nothing to Report	58%	98%	71%	80%	96%	88%	100%	100%	67%	NA	NA	NA
March 2016	70%	33%	59%	78%	67%	61%	67%	65%	0%	33%	33%	44%	50%	50%
April 2016	86%	89%	86%	94%	77%	66%	100%	98%	43%	83%	89%	100%	100%	100%

- 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 provider initial notification (24 hours)

- The lower scores for clinical decision making were due to the following reasons:
  - Failure to provide adequate clinical information
  - Failure to cite the criteria utilized to make the decision

- The lower letter scores were due to the following reasons:
  - Failure to provide letter in member's primary language
  - Failure to provide description of services in lay 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 peer-to-peer discussion of the decision with medical reviewer

- OneCare Connect Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
February 2016	100%	100%
March 2016	99%	99%
April 2016	100%	100%

  - The compliance rate for misclassified paid and denied claims has remained stable at or above 99% from February to April 2016.

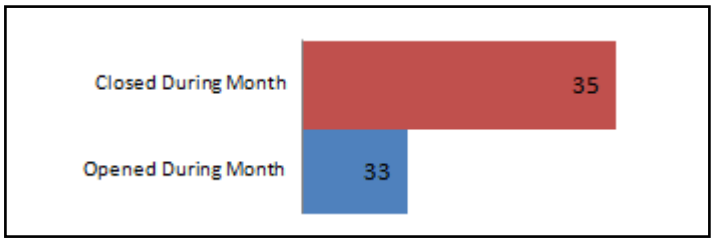
- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2016	97%	98%	100%	97%
March 2016	98%	97%	100%	77%
April 2016	99%	93%	100%	85%

  - The lower compliance rates for denied claims accuracy were due to the following reasons:
    - Failure to provide Explanation of Benefits (EOB) or Remittance Advice (RA) to provider
    - Failure to provide notification of appeal rights to provider
    - Failure to notify provider to not bill the member for the balance of the claim

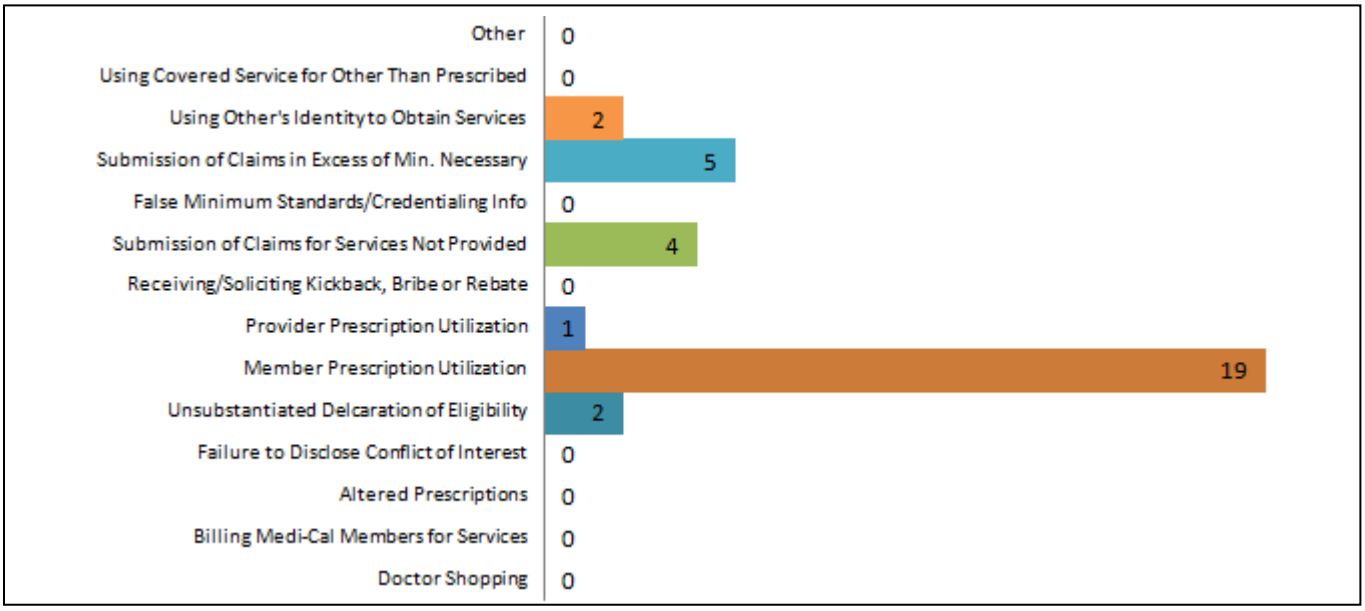
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations (June 2016)

Case Status
Case status at the end of June 2016



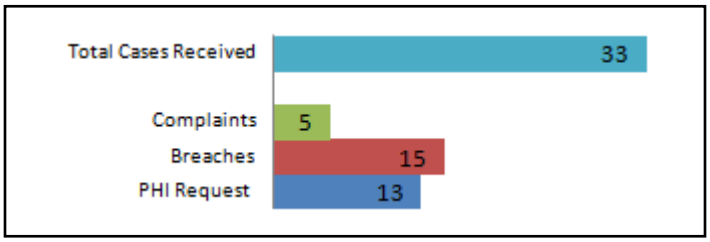
Note: Cases that are referred to DHCS or the MEDIC are not "closed" until CalOptima receives notification of case closure from the applicable government agency.

Types of FWA Cases:
(Received in June 2016)

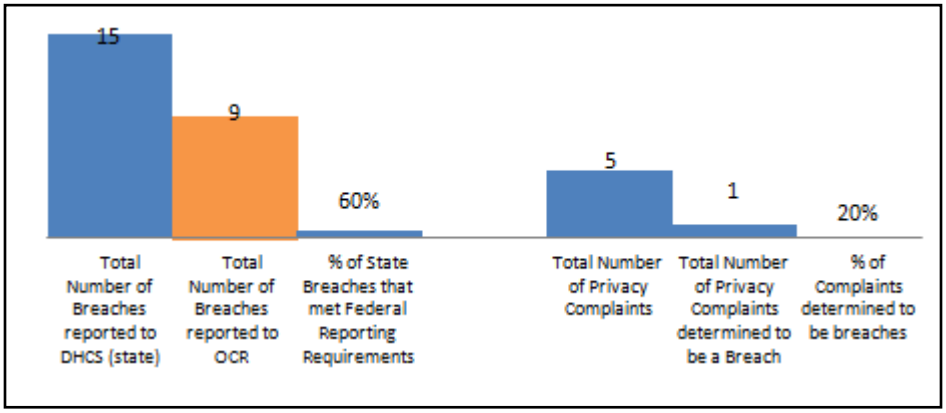


E. Privacy Cases (June 2016)

Case Status
Case status at the end of June 2016
(Case status may change throughout the month)



Privacy Statistics
(June 2016)



A Public Agency

CalOptima

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Federal & State Legislative Advocate Reports

Board of Directors Meeting

August 4, 2016

James McConnell / Edelstein Gilbert Robson & Smith

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CalOptima
Washington Report
June 30, 2016

The Fiscal Year 2017 appropriations process continued in the Senate this month with markup of the FY 2017 Labor-Health and Human Services-Education bill (S. 3040) which was approved by the Appropriations Committee on June 9.

Among the provisions funding the Department of Health and Human Services (HHS) are several of interest to CalOptima:

The Affordable Care Act (ACA). The bill does not include new language restricting HHS' authority to administer or enforce the ACA. The bill provides the Center for Medicare and Medicaid Services (CMS) with funding and program authorities that are consistent with those in Fiscal Year 2016, thereby protecting its ability to administer Medicare, Medicaid and the ACA. Whether this is reflective of a larger political change on the part of congressional majority Republicans will like rest on the outcome of this year's elections, particularly for President.

Community Health Centers (CHCs). The bill includes $1.5 billion for CHCs, protecting funding for one of the largest safety net systems of primary and preventive care in the country. Combined with the mandatory funding provided in the Medicare Access and CHIP Reauthorization Act of 2015, the program level for CHCs is $5.1 billion, $150 million more than President's request and equal to the fiscal year 2016 level. The bill directs no less than $100 million be used to expand mental health services and services to prevent and treat opioid abuse in hundreds of underserved areas around the nation.

Substance Abuse and Mental Health Services Administration (SAMHSA). The bill provides $3.7 billion for SAMHSA, which is $8 million more than the President's request. Included in the total is an additional $30 million—an increase of six percent – for the Mental Health Block Grant. The bill includes $60 million for grants for states to expand access to drug treatment services for those with a dependence on prescription opioids or heroin. This is $35 million more than fiscal year 2016. The bill also includes $26 million, $14 million more than fiscal year 2016, to prevent opioid overdoses. These funds will be used to help states purchase emergency devices that rapidly reverse the adverse effects of opioid overdoses, train first responders on how to use the emergency devices and increase public awareness of the dangers of opioid use.

Enhancing Care for individuals with Alzheimer's disease. The bill includes a new provision that requires CMS to cover patient-centered comprehensive Alzheimer's disease care planning services.

Centers for Disease Control and Prevention (CDC). The bill provides $7.1 billion to CDC, which is $76 million more than the President's request. Within the total, the bill provides $98 million, $28 million more than the request, for preventing prescription drug overdoses. These funds would allow for broad dissemination of CDC's opioid prescribing guidelines, as well as improving State Prescription Drug Monitoring programs. The bill rejects proposed reductions to immunization grants and cancer screenings, while at the same time providing the President's request of $174 million, $5 million more than last year, for polio eradication and $163 million, $3 million more than last year, for combating antibiotic resistant bacteria.

While the ACA was not the subject of "repeal and replacement" in the Senate appropriations bill, it was the focus of a new policy paper issued by House Speaker Paul Ryan (R-WI). Before leaving on the Fourth of July recess, the Speaker unveiled the outline of a plan to replace the Affordable Care Act (ACA). The proposed plan is not draft legislation, but rather a statement of principles that would form the basis for eventual legislation in the next Congress.

The proposal is part of a broader effort by Speaker Ryan to offer a Republican agenda ahead of the November elections and is the latest bid to "repeal and replace" the 2010 ACA. Unlike 50-plus previous votes which sought only to repeal the ACA, this proposal offers an alternative to the ACA, laying out what its replacement might look like under a Republican presidential administration.

Speaker Ryan is offering a series of policy proposals this year as Congressional Republicans seek to maintain control of both the House and the Senate and win the White House. Other proposals already released cover tax reform, poverty, and national security.

The 37-page health care plan would repeal all of the ACA's mandates and penalties while embracing some of the law's foundations. The proposal states that Americans should have a chance to buy health insurance regardless of their health status, and the government should have a role in setting some regulations and helping people pay for it. It would also allow states that have already expanded the number of people eligible for Medicaid under the ACA to maintain that additional coverage, although it would prevent any new states from doing so

The plan proposes to provide states a choice of either a per capita allotment, or a block grant, for their Medicaid programs beginning in Fiscal Year 2019. Depending on their unique set of circumstances, states could choose the block grant option, or otherwise default into a per capita allotment approach.

Opponents say the changes to Medicaid would effectively eliminate the ACA's Medicaid expansion, imposing costly burdens on low-income Americans. The changes

would also allow states to cut provider payments because of a smaller federal payment. The policy is built around the assumption that federal Medicaid spending can be reduced to improve efficiencies in the program.

Under the House Republican plan, the Federal Government would no longer pay a fixed share of states' Medicaid costs. Instead, it would pay its share of those costs only up to a fixed amount per beneficiary if the state elected the per capita cap, or up to a single overall amount if the state chose a block grant. The state would be responsible for all costs above the per beneficiary cap or block grant allotment.

The allotments would be determined based on each state's total Medicaid spending for each group—aged, blind and disabled, children, and adults—for full-year enrollees in FY 2016, adjusted for inflation. The plan was designed to reduce federal spending but did not provide any budget targets.

Unlike the per capita cap, the proposal does not provide specific details, at this point, on how a state's block grant amount would be set or adjusted annually. The House Republicans on Speaker Ryan's task force said they expect states would be able to use their added flexibility under the plan to cut costs without putting beneficiaries at risk of losing coverage.

When unveiling the proposal, the Speaker emphasized that the House plan would not be enacted this year.

Washington Report
July 19, 2016

On July 6 the House passed a long-delayed mental health bill (H.R. 2646) as one response to the recent spate of mass shootings. This measure, and similar ones, have been stalled for years. This legislation, sponsored by Representative Tim Murphy (R-PA) passed 422-2 after the author dropped or scaled back many of the most controversial, sweeping measures in order to secure passage.

The bill is more modest than the original plan. It aims to improve the oversight and effectiveness of federal mental health programs, and authorizes a range of grants for treatment. Republicans say mental health reform is a way to prevent mass shootings by mentally ill people. Democrats say more funding is still needed.

H.R. 2646 would create a new assistant secretary at the Department of Health and Human Services (HHS) to oversee mental health and substance abuse programs. The bill also authorizes grants for programs aimed at preventing suicide and early intervention for children with mental illnesses. Funding for the grants will depend on the annual appropriations process.

Several controversial changes were rolled back. In particular, a provision to allow Medicaid to pay for more care at mental health facilities, projected to cost tens of billions

of dollars, drew objections from Republicans. It was scaled back to codify a new regulation covering stays only if they are less than 15 days long.

Changes in the Health Insurance Portability and Accountability Act (HIPAA), meant to allow information about a mentally ill person to be shared with caregivers, were taken out after objections from Democrats and some Republicans. The bill instead directed HHS to issue regulations to clarify privacy rules.

The Senate has a companion, bipartisan bill from Senators Chris Murphy (D-CT) and Bill Cassidy (R-LA). The changes to the House bill have made it similar to the Senate bill, which was narrower and less controversial than earlier House legislation.

However, the Senate bill has faced an obstacle in that Senator John Cornyn (R-TX) wants to combine the measure with his mental health bill, which includes provisions that Democrats denounce as making it easier for mentally ill people to get guns. There has been no resolution yet on that issue, and the measure faces a tight time window on the Senate floor.

In a second piece of health care legislation, on July 8, the House passed, by a vote of 407-5, the conference report for the "Comprehensive Addiction and Recovery Act of 2016" (S. 524). The bill authorizes the Departments of Justice and HHS to issue grants to states, localities and Indian tribes for opioid abuse programs, and expands treatment services for veterans.

The legislation authorizes the Attorney General and Secretary of HHS to award grants to address the national epidemics of addiction to heroin and prescription opioids, and makes various other changes to federal law to combat opioid addiction and abuse. The conference report also allows a change in who counts as an eligible treatment provider for medication-assisted treatment for opioid addiction. It also authorizes Congress at a future time the option to appropriate funding on opioid use disorders

Congress is now in recess for the presidential nominating conventions and its annual August recess. It will return to Washington on September 6.

EDELSTEIN GILBERT ROBSON & SMITH LLC

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CalOptima Legislative Report
July 18, 2016
By Don Gilbert and Trent Smith

On behalf of our firm, Edelstein Gilbert Robson & Smith, LLC., welcome to those of you who are new CalOptima board members. Our firm has lobbied the State Legislature, the Governor, and the Department of Health Care Services (DHCS) on behalf of CalOptima for over sixteen years. Over this time period, we have had many successes for CalOptima. Our firm is well known in and around the Capitol as CalOptima's lobbyists. We are often alerted by Legislative staff or other lobbyists on matters that may be of interest to CalOptima.

CalOptima has long maintained a very good reputation in the Capitol community. CalOptima's work towards providing better health outcomes is well known and viewed as a model of service for the state and other health plans.

In addition to these monthly legislative reports, we are in regular contact with CalOptima's executive staff providing reports from Sacramento and receiving feedback to share with CalOptima's Legislative delegation and other policy makers in the Capitol. It has been a pleasure representing CalOptima in Sacramento and we look forward to meeting all of you in person and working with you to achieve CalOptima's legislative goals in Sacramento.

The Legislature returns from its summer recess on August 1. They have until midnight on August 31 to finish the balance of their work before adjourning for the year. Below is an overview of some of the bills and issues that we have been working on this year.

The biggest challenge we faced early in the year was SB 1308 by Senator Nguyen. This measure was originally introduced as a spot bill, meaning it proposed a minor technical change in law but didn't make any major changes that were of concern. However, on March 28, SB 1308 was amended to prohibit County Organized Health Systems (COHS) from spending money on promotional giveaways, staff retreats, excessive executive compensation, and promoting changes to federal or state regulatory or legislative matters. SB 1308 also prohibited a COHS from paying for a media campaign or advertising while using the image or voice of an elected official or candidate for public office.

The COHS were very concerned with SB 1308 and several of the systems quickly adopted an oppose position. SB 1308 was scheduled for a hearing in the Senate Health Committee approximately one week from the day the bill was amended. Therefore, our firm had to go to work immediately lobbying against the bill. After meeting with the author's office, we were informed that the bill would be further

amended to remove the prohibition against lobbying state and federal regulations and legislation.

However, many of the COHS were still very concerned with the remaining provisions of the bill. We started by meeting with Senator Hernandez, Chairman of the Senate Health Committee. He is familiar with COHS and their many accomplishments based on our previous lobbying efforts. We outlined our concerns and arguments against SB 1308. It was a very positive meeting. We continued our lobbying efforts by meeting with the rest of the committee members or their staffs. We also briefed the committee consultants.

As the hearing date moved closer, we felt confident in our position. We had received good feedback in our meetings, but the outcome is never certain until the votes are cast. The author, Senator Nguyen, is Vice Chair of the Senate Health Committee and is well respected among her colleagues. Thus, despite our optimism, we were prepared for a lengthy and hard fought lobbying effort if the bill passed out of the Senate Health Committee. However, Senator Nguyen ultimately decided to drop SB 1308 rather than take it up for a committee vote.

Most of the bills introduce this year did not present as big of a direct threat to CalOptima as SB 1308. Many proposed mandating health plans to provide new services. For example, AB 2207 (Wood) would have required Medi-Cal managed care plans to provide dental health screenings for eligible beneficiaries and refer them to the appropriate Medi-Cal dental provider. The author, Assemblyman Wood, is the Chair of the Assembly Health Committee and a dentist. This measure was eventually amended, likely because, as introduced, the bill would have created new costs to the Medi-Cal program. Governor Brown has traditionally opposed proposals that create new costs for the State, especially in the Medi-Cal program. As amended, AB 2207 now requires a more expedited enrollment process for dentists who wish to provide services in the Dental-Cal program.

Another bill authored by Assemblyman Wood, AB 2084, would have made comprehensive medication management (CMM) services a covered Medi-Cal benefit. The core element of a CMM is a written medication treatment plan designed to resolve and prevent medication therapy problems. The goals of a CMM is to improve quality outcomes for beneficiaries and to lower overall health care costs by optimizing appropriate medication while avoiding counteractive medications. This measure was held in the Assembly Appropriations Committee. The Appropriations Committees in both the Assembly and the Senate are tasked with analyzing the potential costs to the state that bills may impose. If the committees deem that a proposed change in law is too expensive for the state to assume, they may “hold” the bill in committee. When held in committee, the bill is defeated and may not move further in the Legislative process. Even when a bill passes one of the Appropriations Committees, it still must undergo a similar review in the second house. For example, an Assembly bill that passes out of the Assembly Appropriations Committee and eventually to the Senate, must still pass

out of the Senate Appropriations Committee. It is common for a bill to pass out of its "house of origin", but fail passage in the second house.

Another bill of interest to CalOptima was AB 2670 by Assemblyman Roger Hernandez, which required DHCS to annually administer the Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan surveys for all Medi-Cal managed care plans. The survey results would have been used to evaluate and compare health care outcomes and patient satisfaction among Medi-Cal enrollees. However, AB 2670 was held in the Assembly Appropriations Committee.

Senator Ed Hernandez, Chairman of the Senate Health Committee, authored several health related bills, including SB 960. This measure proposed adding reproductive health care to the services allowed to be conducted via telehealth. Again, the potential costs of this proposal led to the bill being held in the Senate Appropriations Committee.

Not all bills die because of potential costs to the state. Several bills proposing changes to the Medi-Cal program or other health related bills are still moving though the Legislative process, although most will undergo another Appropriations Committee review in August.

One bill still moving in the Legislature is AB 2394 by Assemblywoman Garcia. This bill proposes adding nonmedical transportation to the schedule of benefits covered under Medi-Cal. Utilization controls and permissible time and distance standards would be applicable. AB 2394 passed out of the Assembly. AB 2394 passed out of the Senate policy committee and is scheduled in August for a hearing in the Senate Appropriations Committee.

AB 2077 by Assemblywoman Burke establishes procedures to ensure that eligible recipients of insurance affordability programs move between the Medi-Cal program and other insurance affordability programs without any breaks in coverage. The bill would require an individual's case to be run through the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). Furthermore, the bill would generally prohibit Medi-Cal benefits from being terminated until at least 30 days after the county sends the notice of action terminating Medi-Cal eligibility. AB 2077 will increase the responsibilities of counties in the administration of the Medi-Cal program. AB 2077 is scheduled for an August hearing in the Senate Appropriations Committee.

Also awaiting a hearing in the Senate Appropriations Committee is AB 1831 authored by Assemblyman Low, which requires all health plans to allow for early refill of covered topical ophthalmic products at 70% of the predicted days of use. The author argues that the special early refill policy proposed in AB 1831 is necessary because eye drop medications are difficult to administer and some portion of the medication is wasted in failed attempts to place drops in the patient's eye.

Another bill introduced by Senator Hernandez, SB 999, would require health plans to authorize pharmacies to dispense a 12-month supply of FDA approved self-

administered hormonal contraceptives. The authorship of this measure has been assumed by Senator Pavley and the bill will be heard in the Assembly Appropriations Committee when the Legislature returns in August.

The biggest issue of the year for CalOptima, at least from a financial standpoint, was passage of a new Managed Care Organization (MCO) tax on health plans. The previous MCO tax, which had been deemed invalid by the Federal Government, is a complex mechanism whereby the state taxes health plans and uses the revenue to draw down additional federal funding for Medi-Cal. The tax payments are then returned to the plans in the form of higher rates. Last year the Federal Government ruled that an MCO tax must have winners and losers. In other words, some health plans would have to pay the MCO tax without eventually getting their money back.

Early MCO tax proposals would have imposed hundreds of millions of dollars in new taxes on many commercial health plans. However, the final plan offset these new costs to some health plans by lowering or eliminating other taxes on health plans. For example, the Governor's final proposal eliminated the bank and corporation tax, as well as the Gross Premiums Tax for commercial health plans.

In addition, the final plan created a new tax bracket under the MCO and further adjusted the tax rate within certain tax brackets. The final plan resulted in several large commercial health plans paying less in taxes than previously proposed, but some public health plans will pay more. The good news is that CalOptima's tax liability was relatively unchanged.

The adoption of a new MOC tax will generate over a billion dollars in federal revenue. Without this new revenue, the Governor had threatened to cut state Medi-Cal expenditure at a commensurate rate. Thus, the new MCO tax will ensure Medi-Cal plans, like CalOptima, remain funded at levels similar to past years.

In addition to the MCO tax bill, and various bills outlined above, we lobbied a budget proposal important to CalOptima. In 2015, the Administration proposed moving the California Children Services (CCS) program into managed care. Late in last year's Legislative Session the Administration put forth a plan to place the CCS population into managed care only in COHS counties. The plan was named the CCS Whole Child Model. This proposal was rejected by the Legislature because there was not enough time to fully develop the proposal and meet the concerns of various stakeholders. Instead, a bill was passed to continue excluding the CCS population from managed care for one more year.

Early this year the Governor's office placed the Whole Child proposal into budget trailer bill language. This lanuage was debated in both the Senate and Assembly Budget Sub-Committees on Health and Human Services. There was a lot of debate and public testimony. Eventually, the committees voted to reject the budget trailer bill language, recommending that the issue be debated in a policy bill.

Senator Hernandez has placed a CCS reform proposal in SB 586. Like the Administration's Whole Child Model, SB 586 is limited to COHS. However, SB 586 was drafted with input from patient advocates, providers, and labor unions and was different than the Governor's proposal in many ways.

We helped organized discussions with the key staff working on SB 586 and CalOptima to provide feedback on how the CCS program could be run by CalOptima. These discussions were very beneficial and SB 586 has been amended to reflect some of the feedback provided by CalOptima and the other COHS.

There is still a lot of work in August that must be completed on SB 586 if the measure is to become law. CCS families and providers were initially skeptical over placing the vulnerable CCS population in to managed care, even in COHS counties that have a long history of success caring for other vulnerable populations like seniors and persons with disabilities. Some of the skepticism has diminished as talks between the COHS and advocates continue. There are still a few issues concerning some very specific continuity of care matters that are still to be negotiated. We believe a resolution on these issues is forthcoming.

In addition, labor unions who represent the county workers who provide enrollment services and case management have voiced concerns over the future employment opportunities for their member under the Whole Child proposal. This issue is more complicated and may be the biggest obstacle in reaching a final agreement.

It is important to understand that ultimately the Governor and DHCS have the leverage in the CCS negotiations. The current CCS carve out from managed care expires at the end of the year. If SB 586 does not become law, DHCS can move CCS under managed care without any of the statutory guidelines included in SB 586 and supported by patient advocates, providers, and labor unions. Therefore, there is incentive for these groups to draft SB 586 in a form that is acceptable to the Governor. August will be a very busy month as the final touches are added to SB 586 and the balance of bills are dispensed with by the Legislature.

LEGISLATIVE TRACKING MATRIX

Bill No. Author	Bill Summary	Bill Status	CalOptima Position
SB 586 Hernandez	Authorizes DHCS to establish a Whole Child Model program that would transition the California Children's Services (CCS) program from the fee-for-service (FFS) delivery model to Medi-Cal managed care in specified health plans, including CalOptima. If enacted, CalOptima will be required to provide CCS services for 11,810 CCS-eligible children in Orange County.	**06/28/2016** – Passed Assembly Committee on Health, referred to Assembly Committee on Appropriations	Watch
SB 1010 Hernandez	Requires health plans or insurers to submit prescription drug rate information to the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI). This bill also requires drug manufacturers to justify their prices in these situations. This bill requires plans to report information for all covered prescription drugs no later than the date it currently reports rate information.	**06/28/2016** – Passed Assembly Committee on Health, referred to Assembly Committee on Appropriations	Watch
SB 1034 Mitchell	Prohibits health plans from denying medically necessary Behavioral Health Treatment (BHT) services for members with Autism Spectrum Disorder (ASD) based on setting, location, time of treatment, or lack of parent/caregiver participation. Based on review of current legislative language, CalOptima already complies with the provisions of this bill. This bill would also eliminate the sunset date on the health insurance mandate for plans to cover BHT services.	**06/29/2016 –** Passed Assembly Committee on Health, referred to Assembly Committee on Appropriations	Monitor
SB 1273 Moorlach	Clarifies that Mental Health Services Act (MHSA) dollars may be used by county mental health programs to provide outpatient crisis stabilization services (CSS) for eligible individuals. This bill does not directly impact CalOptima, but clarifies that individuals (including CalOptima members) in need of CSS can receive outpatient care funded by MHSA.	**06/29/2016** – Passed Assembly Committee on Health, ordered to second reading	Support
SB 1308 Nguyen	Prohibits County Organized Health Systems (COHS), including CalOptima, from utilizing funds for staff retreats, promotional giveaways, or excessive executive compensation. This bill also prohibits COHS from purchasing media campaigns that feature elected public officials.	**04/06/2016** –Removed from Senate Committee on Health hearing agenda at the request of the author	Oppose
SB 1361 Nielsen	Restores Medi-Cal coverage to provide one pair of eyeglasses every two years to a beneficiary over 21 years old whose vision is equal to or poorer than 20/40. This bill would result in changes to vision benefits for CalOptima members.	**05/16/2016** – Passed Senate Committee on Appropriations, placed on suspense file	Watch

Bill No. Author	Bill Summary	Bill Status	CalOptima Position
SB 1377 Nguyen	Appropriates $3.3 million from the General Fund to DHCS for allocation to contract with 11 non-profit Caregiver Resource Centers statewide, including one in Orange County. This bill could benefit caregivers that support cognitively impaired CalOptima members.	**04/25/2016** – Passed Senate Committee on Appropriations, placed on suspense file	Monitor
SB 1436 Bates	Requires that final action on a local public agency's executive salary, salary schedule, or compensation paid in the form of fringe benefits be made a separate discussion item and not placed on the agency's consent calendar. This bill makes a procedural change to require an oral summary report of the merit increases for the specified executives before final action is taken.	**06/29/2016** – Passed Assembly Committee on Appropriations, placed on consent calendar	Watch
AB 1051 Maienschein	Appropriates $200 million from the General Fund to the Department of Health Care Services (DHCS) for the Denti-Cal program, and requires DHCS to allocate these funds to increase funding for preventative care and case management services. Members who receive Denti-Cal benefits outside of CalOptima may be affected by the proposed increase in Denti-Cal's services.	**06/29/2016 –** Passed Senate Committee on Health, referred to Senate Committee on Appropriations	Monitor
AB 1696 Holden	Expands tobacco cessation benefits for Medi-Cal managed care plans, including increasing the number of quit attempts, expanding the list of approved medication types, and eliminating the care authorization requirement.	**06/22/2016** – Passed Senate Committee on Health, referred to Senate Committee on Appropriations	Monitor
AB 1795 Atkins	Increases funding and expands benefits of the Breast and Cervical Cancer Treatment Program (BCCTP) by extending treatment services from 18 to 24 months to the total duration of service needed for the individual, so long as the individual continues to meet eligibility requirements. This bill may affect up to approximately 650 CalOptima members who currently receive BCCTP benefits.	**06/15/2016** – Passed Senate Committee on Health, referred to Senate Committee on Appropriations	Watch
AB 2077 Burke Bonilla	Establishes procedures to ensure that individuals who move between Medi-Cal and Covered California do not experience any breaks in coverage. CalOptima is required to notify members of their change in eligibility within 10 days. This bill extends benefits for members transitioning from Medi-Cal to Covered California by 10 additional days.	**06/22/2016** – Passed Senate Committee on Health, referred to Senate Committee on Appropriations	Monitor
AB 2084 Wood	Requires comprehensive medication management (CMM) services to be a covered benefit under Medi-Cal, and requires plans that administer CMM services include	**04/05/2016** – Passed Assembly Committee on Health, referred to	Watch

Bill No. Author	Bill Summary	Bill Status	CalOptima Position
	the development and implementation of a written medication treatment plan. This bill also expands eligibility requirements for CMM services.	Assembly Committee on Appropriations	
AB 2207 Wood	Adds performance measures for the Denti-Cal FFS program and seeks to improve access to care for Denti-Cal beneficiaries by increasing the number of providers. This bill may affect CalOptima members receiving Denti-Cal services.	**06/22/2016** – Passed Senate Committee on Health, referred to Senate Committee on Appropriations	Watch
AB 2394 Garcia	Requires Medi-Cal health plans to provide non-emergency medical transportation (NEMT) services for Medi-Cal beneficiaries. This bill expands NEMT t benefits for any form of public or private transportation, as well as mileage reimbursement. This bill would result in changes to transportation benefits for CalOptima members.	**06/22/2016** — Passed Senate Committee on Health, referred to Senate Committee on Appropriations	Watch
AB 2507 Gordon	Adds video and telephone communications to the definition of telehealth. Provides that the required consent from beneficiaries for telehealth services may be digital, oral, or written. As currently drafted, this bill will not change CalOptima's services or policies since these benefits are already provided. However, it may relax restrictions for beneficiaries to approve the use of telemedicine.	**05/04/2016** – Passed Assembly Committee on Health, referred to Assembly Committee on Appropriations	Monitor
AB 2670 Hernández	Requires DHCS to annually administer the Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan survey, which is developed for all Medi-Cal managed care plans. This bill increases the frequency of the survey, and requires it to be administered in all threshold languages. The survey would also be required to show detailed information on how factors such as location, ethnicity, and gender play into quality of health care.	**04/19/2016** – Passed the Assembly Committee on Health, referred to Assembly Committee on Appropriations	Monitor
AB 2752 Nazarian	Requires health plans to notify members if a prescription drug is no longer covered by the plan, or if the plan changes its policy to no longer offer a specific drug. This bill also requires plans to annually update their provider directory with prescription drug information and to inform members through annual renewal materials if a prescription drug is no longer covered by their provider.	**04/19/2016** – Passed Assembly Committee on Health, referred to Assembly Committee on Appropriations	Watch
AB 2821 Chiu	Requires the Department of Housing and Community Development (HCD) to coordinate with DHCS to establish a housing program for Medi-Cal beneficiaries and award grants to government agencies participating in a Whole Person Care	**06/28/2016** – Passed Senate Committee on Transportation and Housing, referred to Senate	Monitor

Bill No. Author	Bill Summary	Bill Status	CalOptima Position
	(WPC) pilot program. This bill allows HCA to be eligible to receive these grant funds which may affect up to approximately 7,300 homeless CalOptima members.	Committee on Appropriations	

UPCOMING LEGISLATIVE DEADLINES

July Deadlines

July 1: Last day for policy committees to meet and report bills. Summer Recess begins upon adjournment if a Budget Bill has been passed.

August Deadlines

Aug. 1: Legislature reconvenes from Summer Recess.

Aug. 12: Last day for fiscal committees to meet and report bills.

Aug. 15-31: Floor Session only. No committee may meet for any purpose except the Rules Committee.

Aug. 19: Last day to amend on the Floor.

Aug. 31: Last day for each house to pass bills. Final Recess begins upon adjournment.

2017

Jan. 1: Statutes take effect.

* Holiday schedule subject to final approval by Rules Committee.

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities in Orange County. Our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. As one of

Orange County's largest health insurers, we provide coverage through four major programs: Medi-Cal, OneCare (HMO SNP) (a Medicare Advantage Special Needs Plan), OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) and PACE (Program of All-Inclusive Care for the Elderly).

If you have any questions regarding the above information, please contact:

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Sources: Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

Board of Directors Meeting
August 4, 2016

CalOptima Community Outreach Summary — June–July 2016

Background

CalOptima is committed to serving our community and sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through participation in public 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 be enrolled in any of CalOptima's programs.
- Branding — The event/activity promotes awareness of CalOptima in the general 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 accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and if budget available.

In addition to participating in community events, CalOptima is active on a number of committees/coalitions focused on community health with an emphasis on improving health care access, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Events Update

This last FY 2015-2016, The Community Relations department received 234 requests for CalOptima to participate in public activities.. Approximately 80 percent (187 out of 234) of the requests met at least one of the criteria required for CalOptima's participation. CalOptima participated in 118 out of the 187 approved public activities requests.

Public activities attended range from health, literacy, housing and community resource fairs, to back-to-school events, conferences and community celebrations throughout Orange County. During these events, CalOptima interacted with current and potential members of all ages and ethnic backgrounds. Approximately 74 percent of these events provided outreach to children and families, 22 percent outreached to seniors, and 2 percent outreached to veterans. The remainder of the events were educational seminars and conferences for staff development.

CalOptima also provided financial support to nearly 30 percent of the community events in which staff participated in FY 2015–16. Financial support for these events included registration fees and sponsorships. Financially supporting these community events provided CalOptima opportunities to outreach to members and potential members, promote awareness of CalOptima in the community, promote CalOptima's programs and services, and promote long-term collaborative partnerships with requesting entities.

For additional information or questions, please contact Tiffany Kaaiakamanu, Manager of Community Relations at 657-235-6872 or via email at tkaaiakamanu@caloptima.org.

Summary of Public Activities

Date	Events/Meetings	Audience Reached
6/1	• Annual Community Health and Resource Fair hosted by Friendly Center	Member/Potential Member
	• Community Resource 101 hosted by Families Forward	Health and Human Service Provider
	• Orange County Aging Services Collaborative	Health and Human Service Provider
6/2	• Resource Fair hosted by Wraparound Orange County and Family Support Network	Member/Potential Member
	• Homeless Provider Meeting	Health and Human Service Provider
6/3	• Covered Orange County General Meeting	Health and Human Service Provider
	• Help Me Grow Advisory Meeting	Health and Human Service Provider
6/4	• Health Fair hosted by Rotary Club, St. Jude Medical Center, Ketchum and YWCA	Member/Potential Member
	• World Refugee Day 2016 hosted by Refugee Forum of Orange County ($1,500 sponsorship included Facebook recognition, an outreach table, logo on stage banner and program, and certificate presented by elected officials and the executive board)	Member/Potential Member
6/6	• Orange County Health Care Agency Mental Health Services Act Steering Committee	Health and Human Service Provider
6/7	• Collaborative to Assist Motel Families	Health and Human Service Provider
	• Health Improvement Partnership Assessments	Health and Human Service Provider
6/8	• Open House hosted by Horace Mann's Elementary School	Member/Potential Member
	• Senior Care Professionals Education and Networking Breakfast	Health and Human Service Provider
6/9	• Orange County Developmental Screening Network	Health and Human Service Provider
	• Orange County Women's Health Project Advisory Board	Health and Human Service Provider
6/10	• Cypress Senior Center Community Resource Fair 2016 ($50 registration fee included an outreach table and two chairs)	Member/Potential Member
6/11	• Festival de la Salud — Abrazandola Communidad 2016	Member/Potential Member
6/14	• Resource Fair hosted by Lincoln Elementary and Latino Health Access	Member/Potential Member
	• Buena Clinton Collaborative	Health and Human Service Provider
	• Coordinated Entry's Healthcare and Housing Integration Workgroup Meeting	Health and Human Service Provider

Back to Agenda

6/15	• Covered Orange County Steering Committee	Health and Human Service Provider
	• Minnie Street Family Resource Center Professional Roundtable	Health and Human Service Provider
	• Senior Citizens Advisory Council — Health/Nutrition Sub-Committee Meeting	Health and Human Service Provider
	• Orange County Promotores	Health and Human Service Provider
	• Vietnamese American Service Providers Networking Luncheon	Health and Human Service Provider
6/16	• Bringing Parkinson's Into Focus hosted by BrightStar Care	Member/Potential Member
	• Eleventh Annual Senior Expo 2016 hosted by City of Fountain Valley Recreation and Community Services ($1,000 sponsorship included reserved premiere booth location, logo displayed on street and inside banners, logo on event website, Channel 3 TV slide, listed press releases, flier and all printed materials, two tables and four chairs)	Member/Potential Member
	• Surf City Senior Providers Network	Health and Human Service Provider
	• Meet and Greet with PARS Equality	Health and Human Service Provider
	• Orange County Children's Partnership Committee	Health and Human Service Provider
6/18	• 2016 World Elder Abuse Awareness Day hosted by North Orange County Senior Collaborative and Ageless Alliance, Inc. ($500 sponsorship included two tables, four chairs, logo on all printed materials and website)	Member/Potential Member
6/21	• Placentia Community Collaborative	Health and Human Service Provider
	• Coordinated Entry's Healthcare and Housing Integration Workgroup	Health and Human Service Provider
6/22	• CA Association of Area Agencies on Aging Advisory Board	Health and Human Service Provider
6/23	• Meeting of the Minds Conference: Breaking Down the Silos hosted by Mental Health Association of Orange County ($1,000 sponsorship included logo in event program and all media event, an outreach table, and admission for six staff)	Member/Potential Member and Health and Human Service Provider
	• Certified Application Assistance/Certified Enrollment Counselor Steering Committee Meeting	Health and Human Service Provider
6/24	• Orange County Integrative Health Initiative Launch Event	Health and Human Service Provider
6/25	• First Annual Community Resource Fair hosted by Rancho Santiago Community College District	Member/Potential Member
6/27	• Community Health Research Exchange	Health and Human Service Provider
6/28	• Santa Ana Building Healthy Community	Health and Human Service Provider
	• Meet and Greet with Newsong	Health and Human Service Provider

	• Orange County Senior Roundtable	Health and Human Service Provider
6/30	• Alzheimer's Latino Conference Meeting	Health and Human Service Provider
7/7	• Refugee Forum of Orange County	Health and Human Service Provider
	• Orange County Women's Health Project Advisory Meeting	Health and Human Service Provider
7/09	• Health and Resource Fair hosted by Orange County Bar Foundation	Member/Potential Member
7/11	• Fullerton Collaborative	Health and Human Service Provider
	• State Council on Developmental Disabilities Orange County — Regional Advisory Committee	Health and Human Service Provider
7/12	• Buena Clinton Neighborhood Coalition	Health and Human Service Provider
	• Susan G. Komen Orange County — Unidos Contra el Cancer del Seno Coalition	Health and Human Service Provider
7/13	• Buena Park Collaborative	Health and Human Service Provider
	• Anaheim Homeless Collaborative	Health and Human Service Provider
7/14	• Orange County Health Improvement Partnership	Health and Human Service Provider
	• Orange County Developmental Screening Network	Health and Human Service Provider
7/16	• Summer Health and Wellness Festival hosted by Fullerton Community Center ($100 registration fee included two tables and four chairs, agency's name listed on event host's website, and all social media outlets)	Member/Potential Member
	• Carnival for Kids hosted by Illumination Foundation ($500 sponsorship included a table and two chairs, recognition in printed materials and event signage, two VIP hospitality tent wristbands with hosted refreshments, and event sponsor certificate)	Member/Potential Member and Health and Human Service Provider
7/19	• Coordinated Entry's Healthcare and Housing Integration Working Group	Health and Human Service Provider
7/20	• Covered Orange County Steering Committee	Health and Human Service Provider
	• 26th Annual Safety Day hosted by City of Westminster	Member/Potential Member
7/21	• Orange County Children's Partnership Committee	Health and Human Service Provider
7/25	• Stanton Collaborative	Health and Human Service Provider
7/26	• Orange County Senior Roundtable	Health and Human Service Provider
	• Santa Ana Building Healthy Communities Prevention Workgroup	Health and Human Service Provider
	• Orange County Transportation Authority Special Needs Advisory Committee	Health and Human Service Provider
7/27	• California Association of Area on Aging (C4A) Advisory Board	Health and Human Service Provider

7/30	• Back to School Outreach Fair hosted by Anaheim Union High School District in partnership with the Collaborative to Assist Motel Families	Member/Potential Member
	• Family Festival hosted by Church of God Orange District	Member/Potential Member
	• 13th Annual Orange County Veterans Fair hosted by the Office of Congresswoman Loretta Sanchez	Member/Potential Member

CalOptima organized or convened the following 11 community stakeholder events, meetings and presentations:

Date	Event/Meeting	Audience Reached
6/04	• OneCare Connect Town Hall Meeting and Resource Fair (OneCare Connect presentation in English and Vietnamese) in collaboration with Harbage Consulting, Regal Medical Group, Inc., and Orange County Supervisor Andrew Do	Member/Potential Member
6/07	• CalOptima Speakers Bureau Presentation for Collaborative to Assist Motel Families — Topic: Medi-Cal Overview	Health and Human Service Provider
6/08	• Community Alliance Forum — Bridging the Changes in our Community	Health and Human Service Provider
6/14	• Speakers Bureau Presentation for Buena Clinton Youth and Family Center — Topic: Medi-Cal Overview	Health and Human Service Provider
6/21	• Speakers Bureau Presentation for Placentia Community Collaborative — Topic: Medi-Cal Overview	Health and Human Service Provider
6/24	• Monthly Health Education Seminar at the County Community Service Center hosted by CalOptima with the Assistance of Supervisor Andrew Do — Topic: How to Protect Yourself from Scams and Frauds Impacting Older Adults	Member/Potential Member
	• Speakers Bureau Presentation for 2-1-1 Orange County — Topic: Medi-Cal Overview	Health and Human Service Provider
7/16	• CalOptima Speakers Bureau Presentation for Chinese Parents Association for the Disabled — Topic: 1115 Waiver Overview	Member/Potential Member
7/20	• OneCare Connect Informational Forum for	Health and Human Service Provider

	Stakeholders, Caregivers, and Advocates in collaboration with Harbage Consulting, Orange County Aging Services Collaborative, Alzheimer's Orange County, Legal Aid Society of Orange County, and Council on Aging Orange County	
	• OneCare Connect Community Forum hosted by CalOptima in collaboration with Cypress Senior Center — Topic: OneCare Connect	Member/Potential Member
7/29	• Monthly Health Education Seminar at the County Community Service Center hosted by CalOptima with the Assistance of Supervisor Andrew Do — Topic: Understanding PACE: Program of All-Inclusive Care for the Elderly	Member/Potential Member

CalOptima endorsed the following 12 events during this reporting period (letters of support, program/public activity event with support, or use of name/logo):

1. World Refugee Day 2016 hosted by Refugee Forum of Orange County (Listed in Public Activities)

2. Cypress Senior Center Community Resource Fair 2016 (Listed in Public Activities)

3. Eleventh Annual Senior Expo 2016 hosted by City of Fountain Valley Recreation and Community Services (Listed in Public Activities)

4. 2016 World Elder Abuse Awareness Day hosted by North Orange County Senior Collaborative and Ageless Alliance, Inc. (Listed in Public Activities)

5. Meeting of the Minds Conference: Breaking Down the Silos hosted by Mental Health Association of Orange County (Listed in Public Activities)

6. Use of CalOptima's Master logo for a co-branded event flier to promote the "CalOptima PACE Presentation," on July 26, 2016 at the Fullerton Community Center.

7. Use of CalOptima's OneCare Connect logo for a collaborated event flier to promote the OneCare Connect Town Hall/Senior Resource Fair on July 20, 2016 at Alzheimer's Orange County.

8. Letter of Support for Livingstone Community Development Corporation's application to the U.S. Department of Health and Human Services, Health Resources and Services Administration, New Access Point; New and Competing Supplement/Revision Number: HRSA-17-009.

9. Letter of Support for Korean Community Services' application to the U.S. Department of Health and Human Services, Health Resources and Services Administration, New Access Points; New and Competing Supplement/Revision Number; HRSA-17-009.

10. Letter of Support for North Orange County Regional Health Foundation's application to the U.S. Department of Health and Human Services, Health Resources and Services Administration, New Access Points; New and Competing Supplement/Revision Number; HRSA-17-009.

11. Letter of Support for Share Our Selves' application to the U.S. Department of Health and Human Services, Health Resources and Services Administration, New Access Points; New and Competing Supplement/Revision Number; HRSA-17-009.

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
July 2016			
Saturday, 7/30 8am-12pm	+Anahiem UHSD and Collaboration to Assist Motel Families	**Health/Resource Fair Open to the Public**	900 S. Dale Ave. Anaheim
Saturday, 7/30 9am-1pm	+Office of Congresswoman Loretta Sanchez 13th Annual OC Veterans Fair	**Health/Resource Fair Open to the Public**	2271 W. Crescent Ave. Anaheim
Saturday, 7/30 10:30am-3pm	+Church of God Orange District Family Festival	**Health/Resource Fair Open to the Public**	410 W. Hazard Ave. Santa Ana
August 2016			
Monday, 8/1 1-4pm	++OCHCA Mental Health Services Act Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	505 E. Central Ave. Santa Ana
Tuesday, 8/2 9:30-11am	++Collaborative to Assist Motel Families	**Steering Committee Meeting: Open to Collaborative Members**	250 E. Center St. Anaheim
Wednesday, 8/3 9-10:30am	++OC Aging Services Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	2515 McCabe Way Irvine

* *CalOptima Hosted*

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Wednesday, 8/3 10am-12pm	++Anaheim Human Services Network	**Steering Committee Meeting: Open to Collaborative Members**	250 E. Center St. Anaheim
Monday, 8/8 10am-12pm	+Supportive Care Services Foundation Open House	**Health/Resource Fair Open to the Public**	13800 Arizona St. Westminster
Monday, 8/8 2:30-3:30pm	++Fullerton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	353 W. Commonwealth Ave. Fullerton
Tuesday, 8/9 11:30am-12:30pm	++Buena Clinton Neighborhood Coalition	**Steering Committee Meeting: Open to Collaborative Members**	12661 Sunswept Ave. Garden Grove
Wednesday, 8/10 10-11:30am	++Buena Park Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	7150 La Palma Ave. Buena Park
Wednesday, 8/10 12-1:30pm	++Anaheim Homeless Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	500 W. Broadway Anaheim
Thursday, 8/11 11:30am-12:30pm	++FOCUS Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	11402 Magnolia Ave. Garden Grove
Thursday, 8/11 3-5pm	++OC Women's Health Project Advisory Board	**Steering Committee Meeting: Open to Collaborative Members**	1505 E. 17th St. Santa Ana
Thursday, 8/11 6:00-8:30pm	+Huntington Beach Council on Aging GEN Silent	**Health/Resource Fair Open to the Public**	18041 Goldenwest St. Huntington Beach
Tuesday, 8/16 10-11:30am	++Placentia Community Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	849 Bradford Ave. Placentia

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Tuesday, 8/16 2-3:30pm	++Coordinated Entry's Healthcare & Housing Integration Workgroup	**Steering Committee Meeting: Open to Collaborative Members**	1505 E. 17th St. Santa Ana
Wednesday, 8/17 9-10:30am	++La Habra Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	1211 Fahringer Way La Habra
Wednesday, 8/17 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	1300 McFadden Ave. Santa Ana
Wednesday, 8/17 1-4pm	++Orange County Promotores	**Steering Committee Meeting: Open to Collaborative Members**	Location varies
Thursday, 8/18 8:30-10am	++Orange County Children's Partnership Committee	**Steering Committee Meeting: Open to Collaborative Members**	10 Civic Center Plaza Santa Ana
Thursday, 8/18 1-2:30pm	++Huntington Beach Surf City Senior Providers Network	**Steering Committee Meeting: Open to Collaborative Members**	1706 Orange Ave. Huntington Beach
Saturday, 8/20 9am-1pm	+City of Buena Park Super Senior Saturday Resource Fair	**Health/Resource Fair Open to the Public**	8150 Knott Ave. Buena Park
Monday, 8/22 9-11am	++Community Health Research and Exchange	**Steering Committee Meeting: Open to Collaborative Members**	1128 W. Santa Ana Blvd. Santa Ana
Monday, 8/22 12:30-1:30pm	++Stanton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	7800 Katella Ave. Stanton
Tuesday, 8/23 7:30-9am	++OC Senior Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	170 S. Olive Orange

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Tuesday, 8/23 3:30-4:30pm	++Santa Ana Building Healthy Communities	**Steering Committee Meeting: Open to Collaborative Members**	1902 W. Chestnut Ave. Santa Ana