NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, DECEMBER 1, 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. Election Impact on the Affordable Care Act
    b. Orange County Delegation
    c. Strategic Planning Follow-up
    d. Intergovernmental Transfer (IGT) Update
    e. State Budget Uncertainty Regarding Future of OneCare Connect
    f. OneCare Connect Television Taping
    g. Member Advisory Committee Recruitment

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 November 3, 2016 Regular Meeting of the CalOptima Board of Directors
    b. Receive and File Minutes of the September 21, 2016 Meeting of the CalOptima Board of Directors' Quality Assurance Committee, the September 15, 2016 Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the October 27, 2016 and September 22, 2016 Meetings of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee, the October 13, 2016 Meeting of the CalOptima Board of Directors' Provider Advisory Committee, and the July 14, 2016 Meeting of the CalOptima Board of Directors' Member Advisory Committee

3. Consider Approval of Proposed Changes to CalOptima's Annual Investment Policy for Calendar Year 2017

4. Consider Authorizing Request for Waiver Allowing Nurse Practitioners to Provide Primary Care at the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Center

5. Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million

6. Consider Ratification of the 2016 CalOptima Utilization Management Work Plan

7. Consider Authorizing and Directing Execution of Amendments to CalOptima's Primary and Secondary Agreements with the California Department of Health Care Services

8. Consider Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2016-17 Operating Budget

REPORTS

9. Approve CalOptima Strategic Plan for 2017-2019

10. Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan

11. Consider Recommended Appointment to the CalOptima Board of Directors' Member Advisory Committee (MAC); Consider Recommended Appointments of MAC Chair and Vice Chair

12. Consider Extending the Timeframe for the Qualifying New Network to Complete Readiness Assessment Requirements

13. Consider Extending the Timeframe for Qualifying Existing Health Networks that Elected to Change their Contracting Models to Complete Readiness Assessment Requirements

14. Consider Approval of Unbudgeted Expenses Related to Member Focused Communications for OneCare Connect

15. Consider Authorization of the Expenditure Plan for Available Intergovernmental Transfer (IGT) Funds, Including Reallocation of Dollars from IGT 1, IGT 2 and IGT 3, and Allocation of Dollars from IGT 4 and IGT 5

16. Consider Adoption of Resolution Approving CalOptima Updated 2017 Compliance Plan and Authorizing the Chief Executive Officer to Approve New, Revised, and Retired Office of Compliance Policies and Procedures

17. Consider Adoption of Resolution to Amend CalOptima's Conflict of Interest Code

18. Consider Adoption of Resolution Approving Updated Human Resources Policies and Amendment to Executive Employment Agreement

19. Consider Approval of Expenditures and Contract Related to Financial Analysis and Regulatory Requirements Assessment of Converting OneCare from a Dual Eligible Special Needs Plan (D-SNP) to a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP)

20. Consider Authorization of Expenditures to Fund Membership Dues for Medicaid Health Plans of America

21. Consider Authorization of Extension of Contract for Federal Advocacy Services

22. Consider Authorization of Expenditures in Support of CalOptima's Participation in 2017 Lunar New Year Festivals

S22A Consider Amendment of Kaiser Foundation Health Plan, Inc. (Kaiser) Medi-Cal Full-Risk Health Network Contract to Extend Agreement

ADVISORY COMMITTEE UPDATES

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

24. Member Advisory Committee Update

25. Provider Advisory Committee Update

INFORMATION ITEMS

26. October 2016 Financial Summary

27. Compliance Report

28. 2017-18 Legislative Priorities

29. Federal and State Legislative Advocates Reports

30. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

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

CS 2 CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. Government Code Section 54956.9, subdivision (d)(1) One Case: University of California, Irvine v. CalOptima. Orange County Superior Court (OCSC) Case No. 30-2014-00727747-CU-BC-CJC

ADJOURNMENT

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

MEMORANDUM

DATE:	December 1, 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

Election Impact on the Affordable Care Act

Last month's election raises important questions about the Affordable Care Act (ACA) in general and more specifically California's expansion of Medi-Cal and the respective future of each. Like many other health plans, CalOptima is monitoring and working to assess potential impacts regarding preliminary information coming from our associations as well as other principal stakeholders. These sources are cautioning against undue speculation and recommend a watchful approach until more formal plans are put forward. To date, two main themes that may affect CalOptima have arisen: 1) The future of the federal financing obligation of the Medicaid expansion (MCE) population (Medi-Cal expansion in California) and 2) Potential changes to the structure of the federal Medicaid program. With regard to Medi-Cal expansion, please note that irrespective of what the new Administration and Congress may decide on MCE funding, Mercer, the state's actuarial consultant, anticipates that MCE rates will continue their downward trajectory toward Temporary Assistance for Needy Families (TANF) – or, "Medi-Cal classic" – rates in the coming year based on the continuing trend in utilization data from the MCE population. The second theme that has emerged is the overall makeup of the Medicaid program, specifically whether the program will be converted into a block grant program or potentially a per-capita cap system. Regardless, given the complexity of these and other important issues as well as the political climate in Washington, D.C., it is anticipated that there will be numerous discussions and debates in 2017 with any substantive changes not occurring until late 2017 or 2018 at the earliest. CalOptima staff continues to engage in discussions and will continue to keep your Board abreast of any significant developments.

Orange County Delegation

The November general election also produced several changes regarding representation for Orange County. At the federal level, there will be two new representatives in Washington, D.C. for the county. Kamala Harris was elected to succeed Sen. Barbara Boxer and will begin her 6-year term in 2017. In the House of Representatives, all of the Orange County incumbents were re-elected. In addition, former Supervisor, Assembly Member and State Senator Lou Correa won the seat previously held by Loretta Sanchez. In Sacramento, there are several changes to note. It is still too close to call regarding the State Senate seat previously held by Bob Huff, as Ling Ling Chang and Josh Newman remain only several hundred votes apart with several thousand ballots still left to count. However, State Senator John Moorlach easily won his re-election bid. In the State Assembly, incumbent Assembly Members Daly, Brough, Harper and Allen were all re-

Back to Agenda

elected to another 2-year term; while Phillip Chen, Dr. Steven Choi and Sharon Quirk-Silva won new terms representing Orange County in the Assembly.

There were three (3) ballot measures of interest to CalOptima. Propositions 52, 55 and 56 were all approved by California voters. All the initiatives are expected to have a potential significant, positive impact on Medi-Cal funding. Proposition 52 will permanently extend the Hospital Quality Assurance Fee (QAF) — which was set to expire January 1, 2018. The QAF reimburses hospitals for the uncompensated cost of providing care to Medi-Cal beneficiaries and the uninsured. Since the majority of the fee revenue is designated for Medi-Cal funding, it is matched with federal dollars and then disbursed back to hospitals. Proposition 55 will extend the personal income tax on wealthy individuals (those earning more than $250,000 annually - originally in place through Proposition 30) for an additional 12 years through 2030. While these dollars are not specifically earmarked for the Medi-Cal program, they are designed to bolster the state general fund, which could create downstream positive impacts on the Medi-Cal program. Separately, Proposition 56 will increase the state excise tax on cigarettes by $2 per pack, from 87 cents to $2.87, on April 1, 2017. It will also extend its application to e-cigarettes. A large portion of the revenue raised by the expanded tobacco tax will be designated for supplementing the state's Medi-Cal budget. The non-partisan Legislative Analyst's Office estimates that Medi-Cal will receive $710 million to $1 billion in Proposition 56 funding in FY 2017–18.

Strategic Planning Follow-up

The November Board meeting included a strategic planning workshop at which we heard from DHCS Director Jennifer Kent about the trends, opportunities and challenges facing the Medi-Cal program. Bobbie Wunsch, of Pacific Health Consulting group, facilitated Board discussion about the strategic direction CalOptima should take to respond to the evolving health care environment and strengthen our position as a valued asset in our community. Four primary themes emerged from the workshop discussion by the CalOptima Board:1) the need to address behavioral health and substance abuse (opioid epidemic) issues, 2) provider access/availability and collaboration, 3) understanding the needs of our members and community, and 4) need for delivery system integration/reform. Staff has integrated the Board feedback and suggestions into the details of the updated Strategic Plan to ensure that our priorities and strategies address these areas. The updated final draft of the calendar year 2017-2019 Strategic Plan is being presented for adoption by your Board in December.

IGT Update

The IGT Ad Hoc met to review and discuss the Reallocation and Expenditure Plan for Intergovernmental Transfer (IGT) 1 through 5 Funds. Board members Alex Nguyen, Scott Schoeffel and Supervisor Do provided feedback and their recommendations were incorporated into the IGT Expenditure Plan. Action items recommended by the ad hoc include approval of the expenditure of $12.8 million in internally initiated projects that are a high priority and time-sensitive, and conducting a comprehensive Member Health Needs Assessment which may take approximately 9 months to complete, from the selection of a consultant to completion of the assessment. The results of the Member Health Needs Assessment will be the driving factor in the determination of projects to be funded with approximately $15 million in IGT Community Grant

Back to Agenda

dollars. Distribution of these dollars will achieved through a competitive grant RFP award process.

State Budget Uncertainty Regarding Future of OneCare Connect
Cal MediConnect (OneCare Connect in Orange County) includes 11 health plans in six counties. CalOptima launched OneCare Connect in July 2015. As part of the enabling statute that established Cal MediConnect, the legislature gave the Department of Finance (DOF) authority to eliminate the program if it does not result in cost-savings for the state. Last year, there was concern amongst the health plans that Cal MediConnect would be eliminated, since the governor mentioned that the program had not met enrollment goals. CalOptima, along with other health plans, worked closely with the California Association of Health Plans (CAHP) to advocate with key state officials to continue the program for another year. We communicated to state officials that the program enjoys high levels of member satisfaction, and, while enrollment numbers may not be ideal, these programs take time to see results. While Cal MediConnect was given another year to continue, this January there is yet again a possibility of elimination.

Along with other CEOs, I have worked closely with key influencers in Sacramento to reiterate the value of OneCare Connect. We have provided data that shows positive trends in health care outcomes. We also received more than 50 letters of support for the continuation of OneCare Connect from providers; member advocates, community- based organizations, and elected officials across the county. With the release of the governor's 2017-18 state budget proposal in January, we will learn if the program will continue or be eliminated. If the program is eliminated, it will likely wind down during the 2017 calendar year, and we will explore options with the federal Centers for Medicare & Medicaid Services (CMS) and the state Department of Health Care Services (DHCS) to ensure that OneCare Connect members continue to receive coordinated benefits through other programs.

OneCare Connect Television Taping
On November 7, I was interviewed on Little Saigon TV. Hosted by local doctors, Dr. Toan Tran and Dr. Dillion Tran, the hour-long program focused on OneCare Connect and aired in both English and Vietnamese languages.

Member Advisory Committee Recruitment
As you know, the Member Advisory Committee advises the CalOptima Board of Directors and staff on issues pertaining to CalOptima's members. The MAC meets bi-monthly and is currently seeking a candidate who works with Orange County's foster children population. This seat will have an effective term through June 30, 2018. With your extensive base of community stakeholders, I wanted to pass the information along to you for assistance in recruiting. Please refer candidates to our website (link) for information and to download the application. The deadline is December16th.

Back to Agenda

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

November 3, 2016

A Regular Meeting of the CalOptima Board of Directors was held on November 3, 2016, at CalOptima, 505 City Parkway West, Orange, California. Vice Chair Lee Penrose called the meeting to order at 2:04 p.m. Director Schoeffel led the Pledge of Allegiance.

ROLL CALL

Members Present: Lee Penrose, Vice Chair; Supervisor Lisa Bartlett, Ria Berger, Ron DiLuigi, Supervisor Andrew Do, Dr. Nikan Khatibi, Alexander Nguyen, M.D., Scott Schoeffel, Paul Yost, M.D.

Members Absent: Mark Refowitz, Chair (non-voting)

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

Vice Chair Penrose announced the following changes to the agenda: The Board to adjourn to closed session (Agenda Items CS 1 and CS 2) before considering Agenda Item 9, Consider Ratification and Approval of Expenditures and Contracts Related to Health Insurance Portability and Accountability Act (HIPAA) Security Breach Response; and Authorize Contract Amendment to Provide HIPAA Security Breach Response Services, and Agenda Item 17, Strategic Planning Session.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

The CEO Report was accepted as presented.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 9-0-0)***

Back to Agenda

REPORTS

Vice Chair Penrose noted the following for the record: 1) Due to potential conflicts of interest based on campaign contributions under the Levine Act, Supervisor Bartlett did not participate in the discussion and vote on Agenda Items 3 and 4, and Supervisor Do did not participate in the discussion and vote on Agenda Items 3-6; 2) Director Yost did not participate in the discussion and vote on Agenda Item 3 based on potential conflicts of interest due to his provider affiliations; and 3) Director Schoeffel did not participate on Agenda Items 3, 4, and 6 due to potential conflicts of interest and left the room during the discussion and vote.

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

Vice Chair Penrose noted that this item was continued at the October 6, 2016 Board meeting due to a lack of quorum. At that meeting, Director Khatibi reported on the work with fellow ad hoc members Director Berger and Chair Refowitz that focused on health network contracts for the Medi-Cal Expansion population. The proposed action is consistent with the ad hoc's recommendations.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors maintained current rates paid to contracted Medi-Cal Physician Hospital Consortium (PHC) Health Networks for Medi-Cal Expansion Members through June 30, 2017, and authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into amendments to extend the AMVI Care Health Network, CHOC Health Alliance, CHOC Hospital, Family Choice Health Network, OC Advantage and Fountain Valley Hospital Medi-Cal Physician Hospital Consortium Health Network Contracts through June 30, 2017 on the same terms and conditions. (Motion carried 5-0-0; Supervisors Bartlett and Do, and Director Yost recused; Director Schoeffel absent)***

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

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into amendments to extend the AltaMed Health Services, AMVI/Prospect Medical Group, Arta Western Medical Group, Family Choice Medical Group, Monarch HealthCare, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Group OneCare Shared Risk Health Network Contracts for the period January 1, 2017 through December 31, 2017, add provisions related to Personal Care Coordinators and Health Network sanctions, and update policies as***

Back to Agenda

applicable. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)

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

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to exercise an option to extend the Liberty Dental Plan of California, Inc. contract for OneCare members for calendar year 2017 under the existing terms and conditions. (Motion carried 7-0-0; Supervisor Do recused; Director Schoeffel absent)***

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

Action: ***On motion of Director Yost, seconded and carried, the Board of Directors authorized the Chief Executive Officer to make increased Medi-Cal payments for specific services to qualifying primary care providers who submitted attestations between January 1 and June 15, 2015. (Motion carried 7-0-0; Supervisor Do recused; Director Schoeffel absent)***

7. Consider Adoption of Resolution Approving Updated Human Resources Policies

Katia Taylor, Human Resources Interim Director, presented the recommended action to adopt Resolution No. 16-1103, Approving CalOptima's Updated Human Resources Policies, and approve proposed market adjustments for various positions.

Ms. Taylor proposed additional revisions to Policy GA.8032, Employee Dress Code. Section IX. Glossary, Definition of Casual Attire was revised to read: "Casual Attire does not include any type of jogging or sweat suits/sweatpants; halter tops; spaghetti strap shirts; see-through clothing; ripped jeans; shorts (at or above the knee); clothing that exposes the stomach area or other parts of the body incompatible with a professional environment; clothing displaying any written words or symbols, with the exception of CalOptima logo attire, brand names or symbols, sports teams, or university/school/club names or logos; and hats, unless prior approval from Human Resources is given."

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors adopted Resolution No. 16-1103, Approving CalOptima's Updated Human Resources Policies, as revised, and approved proposed market adjustments for various positions as presented. (Motion carried 9-0-0)***

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

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors authorized expenditures of up to $2,500 for CalOptima's***

participation in the FVCA 2017 Annual Health Summit, February 27–28, 2017 in Sacramento, California; 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 as presented. (Motion carried 9-0-0)

ADVISORY COMMITTEE UPDATES

The following Advisory Committee Updates were accepted as presented:

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

INFORMATION ITEMS

The following Information Items were accepted as presented:

13. September 2016 Financial Summary
14. Compliance Report
15. Federal and State Legislative Advocates Reports
16. CalOptima Community Outreach and Program Summary

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 2:23 p.m. pursuant to: 1) CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION: Significant exposure to litigation pursuant to Government Code section 54956.9, subdivision (d)(2): (One case); and 2) CONFERENCE WITH LEGAL COUNSEL – EXISTING LITIGATION. Government Code Section54956.9, subdivision (d)(1) Two Cases: 1) Saddleback Memorial Medical Center v. CalOptima. Orange County Superior Court (OCSC) Case No. 30-2015-00808448-CU-CO-CJC; and 2) Orange Coast Memorial Medical Center v. CalOptima, OCSC Case No. 30-2016-00847325-CU-BC-CJC

The Board reconvened to open session at 2:58 p.m. with no reportable actions taken.

The Board considered Agenda Items 9 and 17.

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

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors: 1) Ratified identified expenditures of up to $330,000 related to HIPAA security breach response, and ratified contracts with vendors to provide services related to HIPAA security breach response; and 2) Authorized the expenditure of up to $300,000 in additional consulting support and other remediation efforts; and authorized the Chief Executive Officer, with the assistance of legal counsel, to contract with vendor(s) as appropriate to provide services related to HIPAA security breach response,***

consistent with CalOptima Board-approved procurement policies. (Motion carried 9-0-0)

17. Strategic Planning Session

Chief Executive Officer Michael Schrader introduced Jennifer Kent, Director, California Department of Health Care Services, who presented an overview of the Medi-Cal program from the state's perspective, federal Medicaid regulation changes and future initiatives that may impact CalOptima.

Mr. Schrader presented a review of the 2013-2016 Strategic Plan accomplishments. Bobbie Wunsch of the Pacific Health Consulting Group provided an overview of the process involved in developing the proposed 2017-2019 Strategic Plan. Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) Chair Patty Mouton, and Provider Advisory Committee (PAC) Chair Teri Miranti reported on the participation and input that the OCC MAC, the Member Advisory Committee, and the PAC provided in the development of the proposed strategic plan.

Ms. Wunsch reviewed the framework for the proposed 2017-2019 Strategic Plan, which includes three main priority areas – innovation, value, and partnerships and engagement. Two key building blocks were also identified: workforce performance and financial strength. Ms. Wunsch facilitated Board discussion regarding the evolving health care environment and strengthening CalOptima's position as a valued asset in the community, and big ideas to consider in the proposed strategic plan. After considerable discussion, the Board identified several issues, including: opioid and substance abuse, physical and behavioral health, childhood obesity, member access to care and transportation barriers, children's oral health, homelessness, partnering with health networks and providers to look at innovations related to the health care delivery system, the impact of changing demographics and the availability of resources to meet the rising demand for health care services.

The Board also discussed the construct of the proposed strategic plan versus the prior strategic plan. Mr. Schrader stated that staff will review the plan construct, and build a crosswalk between the 2013-2016 Strategic Plan and the proposed 2017-2019 Strategic Plan, include the issues discussed, and identify where these issues will reside in the new plan. An updated draft of the 2017-2019 Strategic Plan will be presented at the December 1, 2016 Board meeting for further discussion and input.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Board members extended thanks to members of the community for their participation in the development of the proposed strategic plan, and thanked staff and Ms. Wunsch for their work on the strategic planning process.

ADJOURNMENT

Hearing no further business, the meeting was adjourned at 5:48 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: December 1, 2016

Back to Agenda

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

September 21, 2016

CALL TO ORDER

Chair Paul Yost called the meeting to order at 5:30 p.m., and Director Khatibi led the Pledge of Allegiance.

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

Members Absent: Ria Berger

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

PUBLIC COMMENTS

There were no requests for public comment.

MANAGEMENT REPORTS

Michael Schrader, Chief Executive Officer, reported that the National Committee for Quality Assurance (NCQA) released its 2016-2017 Medicaid Health Insurance Plan Ratings, and CalOptima is California's top Medi-Cal plan for the third year in a row. It was noted that CalOptima is in the top 10% nationally for Medicaid plans based on quality of care and member satisfaction.

MINUTES

1. Approve the Minutes of the May 18, 2016 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Director Khatibi, seconded and carried, the Committee approved the Minutes of the May 18, 2016 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Director Berger absent)***

Back to Agenda

REPORTS

2. Consider Recommending Board of Directors' Approval of Amendment to the Measurement Year 2016 Pay for Value Program Payment Methodology for Medi-Cal

Richard Helmer, M.D., Chief Medical Officer, presented the action to recommend Board of Directors' approval of an amendment to the Measurement Year 2016 Pay for Value (P4V) Program payment methodology for Medi-Cal. The Measurement Year CY 2016 P4V Program for Medi-Cal and OneCare Connect was approved by the Board of Directors on April 7, 2016. An overview of the current P4V program, including Medi-Cal P4V clinical measures, Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, and OneCare Connect P4V clinical measures was presented for discussion.

The proposed Medi-Cal P4V scoring was revised to reflect the same scoring and improvement points for HEDIS and CAHPS as follows: 1) Performance Points for HEDIS and CAHPS: 1 point: >= 50th percentile; 2 points: >= 75th percentile; 3 points: >= 90th percentile; and no points <50th percentile; and 2) Improvement Points for HEDIS and CAHPS: 1 point for increasing 1 percentile level; negative one (-1) point for decreasing 1 percentile level. It was noted that this alignment leverages improvement efforts and efficiencies that the Health Networks implement for other health plans.

Action: ***On motion of Chair Yost, seconded and carried, the Committee recommends Board of Directors' approval of an amendment to the Measurement Year 2016 Pay for Value Program Payment Methodology for Medi-Cal, which defines the allocations, scoring methodology and distribution for performance and improvement, subject to regulatory approval, as applicable, with noted scoring revisions. (Motion carried 3-0-0; Director Berger absent)***

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

Medical Director Miles Masatsugu, M.D., presented the action recommending Board of Directors' authorization to expend IGT 1 funds to expand the Child and Adolescent components of the Shape Your Life weight management program for CalOptima Medi-Cal members, and authorize the Chief Executive Officer (CEO) to contract with the vendor(s) selected through a Request for Proposal (RFP) process to provide group-based child and adolescent Shape Your Life program interventions.

Dr. Masatsugu presented an overview of the assessment conducted of CalOptima's obesity programs, and the redesigned weight management program, Shape Your Life. On March 6, 2014, the Board approved the allocation of $500,000 of IGT 1 funds for high-risk children's programs, which to date, have not been expended. As proposed, $150,000 of these funds would be used for group-based weight management childhood obesity interventions, $100,000 for member and provider incentives, and up to $250,000 over two years to hire one new project manager to help in the expansion of the child and adolescent components of the Shape Your Life program. It was noted that the proposed member and provider incentive payment and methodology will be finalized based on funds available,

Back to Agenda

Department of Health Care Services' approval of the member incentive plan, and participant engagement.

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

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended that the Board of Directors authorize the expenditure of $500,000 in IGT 1 funds to expand the child and adolescent components of the Shape Your Life weight management program for CalOptima Medi-Cal members, and authorize the CEO to contract with vendors(s) selected through an RFP process to provide group-based child and adolescent Shape Your Life program interventions as presented. (Motion carried 3-0-0; Director Berger absent)***

4. Consider Recommending Board of Directors' Approval to Distribute Provider Payments that Support Initiatives to Reduce 30-day All Cause (Non Maternity Related) Avoidable Hospital Readmissions for Medi-Cal

Dr. Helmer presented the action to recommend Board of Directors' approval to distribute provider incentive payments for 30-day All Cause (non maternity related) Avoidable Readmission Reduction Program for Medi-Cal to the highest performing health networks and hospitals, and recommend discontinuing the Readmission Program. A review of the program parameters and payment methodology approved by the Board of Directors in March 2014, and the proposed payment distributions to health networks and hospitals totaling $442,874 in IGT 1 funds for Medi-Cal incentive payments for the 30-day All Cause (non maternity related) Avoidable Readmission Reduction Program was presented for discussion. As proposed, upon Board approval of the distribution of these incentive payments, this initiative will be discontinued and restructured to meet CalOptima's long term goal of a sustainable reduction in readmissions.

Action: ***On motion of Director Khatibi, seconded and carried, the Committee recommended Board of Directors' approval to distribute incentive payments related to the 30-day All Cause (non maternity related) Avoidable Readmission Reduction Program for Medi-Cal to the highest performing health networks and hospitals, and recommended Board approval to discontinue the Readmission Program as presented. (Motion carried 3-0-0; Director Berger absent)***

5. Consider Recommending Board of Directors' Approval of Amendment to the 2016 Quality Improvement Program Description Regarding Culturally Competent Access and Delivery of Services

Dr. Helmer presented the action to recommend Board of Directors' approval of an amendment to the 2016 Quality Improvement (QI) Program Description regarding cultural competency training in order to comply with new federal requirements that health plans must have methods to promote access and delivery of services in a culturally competent manner. The proposed amendment to CalOptima's 2016 QI Program Description includes language ensuring that all covered services are provided in a culturally and linguistically appropriate manner.

Back to Agenda

Action: ***On motion of Chair Yost, seconded and carried, the Committee recommends Board of Directors' approval of an amendment to CalOptima's 2016 Quality Improvement Program Description regarding culturally competency training as presented. (Motion carried 3-0-0; Director Berger absent)***

6. Consider Recommending Revision to the FY 2016-17 Board of Directors' Quality Assurance Committee Meeting Schedule

Chair Yost presented the action to recommend Board of Directors' approval of revisions to the FY 2016-17 CalOptima Board of Directors Meeting Schedule to change the Board of Directors' Quality Assurance Committee (QAC) meeting schedule through June 30, 2017. As proposed, the QAC will meet at 3 p.m. on Wednesday, November 16, 2016, and Wednesday, February 15, 2017. It was also recommended to revise the date and time of the meeting scheduled on Wednesday, May 17, 2017 to Wednesday, May 10, 2017 at 3:00 p.m.

Action: ***On motion of Chair Yost, seconded and carried, the Committee recommended Board of Directors' approval of the revisions to the FY 2016-17 Board of Directors' Meeting Schedule to change the Board of Directors' Quality Assurance Committee Meeting date and time through June 30, 2017 as revised. (Motion carried 3-0-0; Director Berger absent)***

INFORMATION ITEMS

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

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, reported on PMAC activities, including an update on transportation and a discussion on increasing physician hours at the PACE Center. The next quarterly PMAC meeting is scheduled on September 26, 2016 at 11:00 a.m.

8. Intergovernmental Transfer (IGT) Update

Cheryl Meronk, Strategic Development Director, provided an overview of the IGT funding process, funding categories, and a status report of IGT transactions to date. An IGT expenditure plan will be presented to the Board of Directors for consideration at the December 1, 2016 meeting.

9. PACE Year Three Preliminary Audit Results

Dr. Masatsugu presented a review of the preliminary results of the PACE Year Three audit conducted by the Centers for Medicare & Medicaid Services (CMS) and the Department of Health Care Services (DHCS). The CMS/DMHC PACE audit was performed in late August, and the review period was November 2015 through August 2016. Preliminary audit findings indicate that 11 elements were met, and 3 elements were not met in the areas of Quality Assessment Performance Improvement, transportation services, and infection control. Remediation in these areas is ongoing. It was noted that the auditors were impressed with the PACE Center and the progress made over the first three years of the program.

Back to Agenda

10. Quarterly Reports to the Quality Assurance Committee

Quality Improvement Report
Caryn Ireland, Quality Analytics Executive Director, provided an overview of the Quality Improvement Program, and Quality Improvement Committee activities during the second quarter of 2016, including cultural and linguistic services, disease management, case management, pharmacy management, behavioral health, credentialing, and highlights of potential quality issues.

Member Trend Report
Janine Kodama, Grievance and Appeals Director, presented a brief review of member complaint trends and interventions for all CalOptima programs during the first quarter of 2016. It was noted that all quality of care concerns are referred to the Quality Improvement department for investigation, and CalOptima works with health networks and providers on interventions.

COMMITTEE MEMBER COMMENTS
Committee members congratulated staff on the NCQA rating and for all of their time and work.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 7:05 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: November 16, 2016

Back to Agenda

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

SEPTEMBER 15, 2016

CALL TO ORDER
Chair Lee Penrose called the meeting to order at 2:00 p.m. Director DiLuigi led the Pledge of Allegiance.

Members Present: Lee Penrose, Chair; Ron DiLuigi, Scott Schoeffel

Members Absent: All members present

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

MANAGEMENT REPORTS

Chief Financial Officer Report
Chief Financial Officer Chet Uma provided an update on the status of the contract award following CalOptima's Request for Proposal process for internal auditor services, CalOptima's annual financial audit, and audits recently conducted by the Department of Managed Health Care and the Centers for Medicare & Medicaid Services.

PUBLIC COMMENT
Dr. Marie Torres and Daniela Tena-Perez, AltaMed Health Services – Oral re: Agenda Item 5, Program of All-Inclusive Care for the Elderly (PACE) Operational Analysis and Business Plan.

INVESTMENT ADVISORY COMMITTEE UPDATE

1. Treasurer's Report

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

Back to Agenda

CONSENT CALENDAR

2. Approve the Minutes of the May 19, 2016 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the April 25, 2016 Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

REPORTS

3. Consider Recommending Board of Directors Receive and File the Fiscal Year 2016 CalOptima Audited Financial Statements

John Blakey of Moss-Adams, LLP, CalOptima's independent financial auditor, presented the audit of the consolidated financial statement for the fiscal year ending June 30, 2016. Mr. Blakey noted a change in the draft financial statements related to CalPERS pension to read 2% @ 60. This change will appear in the financial statements to be presented to the Board of Directors in October.

A detailed review of the areas of audit emphasis were presented to the Committee for discussion, including capitation revenue and receivables, cash and investments, medical claims liability, and required communications. Mr. Blakey reported that Moss Adams will issue an unmodified opinion on the financial statements indicating that the FY 2016 financial statements fairly state the financial condition of CalOptima in all material respects.

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

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended the Board of Directors receive and file the FY 2016 CalOptima Audited Financial Statements. (Motion carried 3-0-0)***

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Committee recommended the Board of Directors reappoint David Young to the Board of Directors' Investment Advisory Committee for a two-year term beginning October 6, 2016. (Motion carried 3-0-0)***

5. Consider Program of All-Inclusive Care for the Elderly (PACE) Operational Analysis and Business Plan

Richard Helmer, M.D., Chief Medical Officer, presented a detailed review of CalOptima's PACE program, including historical trends and comparison data, current performance, opportunities for improvement and proposed intervention plans. Dr. Helmer reported that CalOptima PACE is generally meeting benchmarks, performance is consistent with start-up experience, the growth rate is ahead of budget and national benchmarks, and breakeven is projected by late 2017.

Back to Agenda

It was noted that in February 2016, the Board of Directors authorized staff to submit a PACE Service Area Expansion (SAE) application to the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) for south Orange County, and to initiate a Request for Proposals (RFP) process to implement Alternative Care Settings (ACS) model for PACE expansion satellite locations. The proposed ACS expansion model would use and strengthen existing community resources without capital investment, use a scalable model responsive to demand, and allows for rapid countywide expansion. Proposed federal PACE legislation may allow greater participation of community physicians that may decrease the need for transportation to a PACE clinic and lower the barrier for enrollment in PACE. It was recommended that ACS planning begin when breakeven performance of CalOptima's PACE program is assured.

After considerable discussion of the matter, Committee members directed staff to provide the following information at the November Finance and Audit Committee meeting: per member per month cost comparison for like population, and predictive modeling without the PACE program; additional information on the ACS model versus Community-Based Adult Services (CBAS) model and the financial risk to CalOptima; and alternative models to expand access including models previously considered but ruled out.

6. Consider Recommending that the Board of Directors Authorize Contract with Vendor to Conduct a Medical Loss Ratio Audit of CalOptima's Contracted Health Networks Participating in the Medi-Cal and OneCare Connect Programs and to Approve Budget Allocation

Action: ***On motion of Director DiLuigi, seconded and carried, the Committee recommended the Board of Directors authorize the Chief Executive Officer to enter into a contract with Provencio Advisory Services, with the assistance of legal counsel, to conduct a Medical Loss Ratio (MLR) audit of CalOptima's contracted health networks participating in the Medi-Cal and OneCare Connect Programs effective October 10, 2016. As recommended, the contract will be for a three year term, with two additional one-year extension options, each exercisable at CalOptima's sole discretion; and approved the allocation of $233,200 from existing reserves to fund the contract through June 30, 2017. (Motion carried 3-0-0)***

7. Consider Recommending that the Board of Directors Authorize Modifications to the Process by Which CalOptima Makes Payments to the Long-Term Care (LTC) Facilities and Hospice Agencies for LTC Services

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended the Board of Directors authorize and direct staff to implement a process to ensure that rates for LTC facilities and hospice agencies are paid in accordance with both interim and final annual changes to the California Department of Health Care Services (DHCS) rates within 90 days of notification from DHCS, subject to reconciliation of interim payments to final rates and retroactive adjustments, as appropriate. (Motion carried 3-0-0)***

Back to Agenda

INFORMATION ITEMS

The following Information Items were accepted as presented:

8. Intergovernmental Transfer (IGT) Update
9. July 2016 Financial Summary
10. CalOptima Computer Systems Security Update
11. Cost Containment Improvements/Initiatives
12. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Reinsurance Report
    c. Health Network Financial Report
    d. Purchasing Report

COMMITTEE MEMBER COMMENTS

Committee members thanked staff for the thorough presentation on the PACE Program.

ADJOURNMENT

Hearing no further business, Chair Penrose adjourned the meeting at 4:04 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: November 17, 2016

Back to Agenda

MINUTES

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

October 27, 2016

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on October 27, 2016, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Patty Mouton called the meeting to order at 3:06 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Ted Chigaros, Christine Chow, John Dupies, Sandy Finestone, Susie Gordee, Sara Lee, Patty Mouton, Lena Berlove (non-voting), Jorge Sole (non-voting), Erin Ulibarri (non-voting)
Members Absent:	Gio Corzo, Josefina Diaz, Donta Harrison, Adam Crits (non-voting)
Others Present:	Ladan Khamseh, Chief Operating Officer; Dr. Richard Helmer, Chief Medical Officer; Candice Gomez, Executive Director, Program Implementation; Caryn Ireland, Executive Director, Quality Analytics; Belinda Abeyta, Director, Customer Service; Dr. Emily Fonda, Medical Director; Chet Uma, Chief Financial Officer; Tracy Hitzeman, Interim Executive Director, Clinical Operations; Arif Shaikh, Director Government Affairs; Becki Melli, Staff to OCC MAC

MINUTES

Approve the Minutes of the September 22, 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 September 22, 2016 minutes as submitted.***

PUBLIC COMMENT
There were no requests for public comment.

CEO AND MANAGEMENT Reports

Chief Medical Officer (CMO) Update
Dr. Richard Helmer, Chief Medical Officer, provided a brief update on the status of the Managed Behavioral Health Organization (MBHO). At the September 1, 2016 Board of Directors meeting, the Board authorized staff to enter into a contract with Magellan Health Inc. to provide

Back to Agenda

behavioral health services for CalOptima members, effective January 1, 2017. CalOptima has been working with Magellan on an implementation plan that includes ensuring the adequacy of the provider network so members may retain the same providers when possible and having a customer service center located in Orange County. Magellan is working to meet all expectations by the implementation date.

Dr. Helmer provided an update on OneCare members who are currently in a facility for custodial level long-term care. A proposal regarding a new payment methodology to change how their long-term care will be managed and enable these OneCare members to enroll in OneCare Connect will be presented for consideration at a future Board of Directors meeting.

INFORMATION ITEMS

Community-Based Adult Services (CBAS) Statistics and Trends

Cathy Osborn, CBAS Program Manager, presented an overview on CBAS statistics and trends. CalOptima began administering the CBAS benefit in July 2012 with an average of 2,077 members during the first quarter. Currently, the average number of CalOptima members receiving the CBAS benefit is 2,032. Ms. Osborn also noted that on average, CBAS members have more diagnoses and higher acuity levels than the general population. In addition, this population visits the emergency department more frequently and has higher inpatient utilization. CBAS members receive regular nursing oversight at the CBAS center. Ms. Osborn reported that CalOptima's Community Relations department provides outreach and awareness to the community regarding CBAS and the Long-Term Services and Supports department provides regular CBAS trainings to health networks, long-term care (LTC) facilities and other home and community-based service providers.

Hospice Benefit for OneCare Connect Members

Marsha Petersen, Manager, Long-Term Services and Supports, presented an overview on the hospice benefit for OneCare Connect members. If an OCC member elects the Medicare hospice benefit, the member may remain in the OCC program; however, the member will obtain the hospice services through the Medicare fee-for-service (FFS) benefit as a "carve out" and are reimbursed by Medicare not OCC. Election of hospice services does not change the Medi-Cal component. Ms. Petersen explained the hospice levels of care, including routine home care, continuous home care, respite and general inpatient care. In 2016, the hospice payment process changed, so that an authorization is no longer required for routine home care, continuous home care, and respite levels of care. OCC MAC requested additional presentations on hospice benefits in future meetings.

Chair Mouton reordered the agenda to hear item VI.F. OCC MAC Member Presentation on Orange County Aging Report and Strategic Plan.

Back to Agenda

OCC MAC Member Presentation on Orange County (OC) Aging Report and Strategic Plan

Members Christine Chow, Alzheimer's Orange County, and Erin Ulibarri, Orange County Office on Aging, co-presented on the 2016 Older Adult Profile and the OC Strategic Plan for Aging. Member Ulibarri provided an overview of the health and wellbeing of the older adult population in Orange County, highlighting key health, social, and economic indicators. She reported that by 2040, approximately one in four residents would be 65 or older. In addition, the physician workforce specializing in geriatrics is less than 25% of the recommended number. Member Chow explained that the purpose of the Strategic Plan for Aging is to prepare Orange County for the growing numbers of seniors and the issues they face. Using qualified data and assessments on the state of seniors, the strategy will focus on where seniors are the most vulnerable and in need, with concrete steps to address those needs over time. Member Chow reported that committees are meeting to review short-term plan recommendations and initial research for longer-term planning efforts, with plan finalization and implementation in the summer of 2017.

OneCare Connect Update

Candice Gomez, Executive Director, Business Integration, provided an update on the new OneCare Connect benefits that are retroactive to July 2016. The new benefits include two acupuncture visits per calendar month and continuity of care for Medi-Cal services, increasing the benefit from six months to 12 months. Ms. Gomez added that effective January 1, 2017, fitness benefit options will be added, including a health club membership, fitness classes, and home fitness kits. In addition, the transportation benefit will increase from 30 to 60 one-way taxi rides. Ms. Gomez stated that member notifications are scheduled.

Legislative Update

Arif Shaikh, Director, Government Affairs, provided an update on the status of California's Coordinated Care Initiative (CCI). Given that the FY 2017–18 State Budget is being formulated for January 2017, there is attention on whether CCI has delivered the anticipated financial savings. By statute, CCI can be terminated if the initiative does not realize cost savings. To demonstrate to the governor that broad interest in maintaining the CCI exists, an advocacy campaign engaged stakeholders to send letters of support. Mr. Shaikh reported that in less than a week, CalOptima stakeholders generated nearly 30 letters to the governor from key influencers, such as elected officials, provider groups, community-based organizations and associations. CalOptima appreciates the support from local stakeholders.

OCC MAC Member Updates

Chair Mouton reminded the committee members to complete the mandatory CalOptima annual Compliance Training required by the Centers for Medicare & Medicaid Services (CMS) and other regulatory agencies. The deadline for completion is November 4, 2016.

Chair Mouton announced that Member Sara Lee would present the quarterly report on the Ombudsman update at the November 17, 2016 meeting. At the December OCC MAC meeting, Chair Mouton will be presenting on the Orange County Advanced Care Planning Project.

Back to Agenda

Chair Mouton announced that the next OneCare Connect MAC meeting is November 17, 2016 at 3:00 p.m.

ADJOURNMENT

Hearing no further business, Chair Mouton adjourned the meeting at 5:01 p.m.

/s/ Cindi Reichert
Cindi Reichert
Program Assistant

Approved: 11.17.2016

Back to Agenda

MINUTES

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

September 22, 2016

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on September 22, 2016, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Patty Mouton called the meeting to order at 3:02 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Ted Chigaros, Christine Chow, Gio Corzo, Josefina Diaz, John Dupies, Susie Gordee, Sara Lee, Patty Mouton, Lena Berlove (non-voting), Adam Crits (non-voting), Erin Ulibarri (non-voting)

Members Absent: Sandy Finestone, Donta Harrison, Jorge Sole (non-voting)

Others Present: Michael Schrader, Chief Executive Officer, Ladan Khamseh, Chief Operating Officer; Candice Gomez, Executive Director, Program Implementation; Caryn Ireland, Executive Director, Quality Analytics; Phil Tsunoda, Executive Director, Public Affairs; Albert Cardenas, Associate Director, Customer Service; Dr. Donald Sharps, Medical Director, Medical Management; Tracy Hitzeman, Interim Executive Director, Clinical Operations; Becki Melli, Staff to OCC MAC

MINUTES

Approve the Minutes of the August 25, 2016 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Member Gio Corzo, seconded and carried, the OCC MAC approved the August 25, 2016 minutes as submitted.***

PUBLIC COMMENT
There were no requests for public comment.

REPORTS

Consider Recommendation for OCC MAC Chair and Vice Chair
Chair Mouton reported that following the Board's approval of the addition of a vice chair on the committee, OCC MAC opened nominations for the OCC MAC chair and vice chair positions. OCC MAC received one interested candidate for each position. Patty Mouton, Home and

Community-Based Services (HCBS) Representative Serving Seniors, applied for the chair position and Gio Corzo, Community-Based Adult Services (CBAS) Provider Representative, applied for the vice chair position. The Nominations Ad Hoc, consisting of members Lena Berlove, Sandy Finestone and Erin Ulibarri, recommended the committee consider these candidates for Board consideration.

Action: ***On motion of Member Ted Chigaros, seconded and carried, the OCC MAC recommended Patty Mouton as the OCC MAC Chair, and Gio Corzo as the OCC MAC Vice Chair for the remainder of FY 2016-2017.***

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer (CEO) Update

Michael Schrader, Chief Executive Officer, announced that the National Committee for Quality Assurance (NCQA) reported its quality ratings for Medicaid plans on September 20, 2016. CalOptima is California's top-rated Medi-Cal plan for the third year in a row, according to the NCQA's Medicaid Health Insurance Plan Ratings 2016-2017. CalOptima received a score of four out of five, the highest score awarded to any Medi-Cal plan in California. Only 15 of the 171 Medicaid plans reviewed nationwide scored higher. CalOptima's accreditation status went from 'accredited' to 'commendable'.

Chief Medical Officer (CMO) Update

Donald Sharps, M.D., Medical Director, provided a brief update on the Managed Behavioral Health Organization (MBHO) Request for Proposal (RFP) process. On September 1, 2016, the CalOptima Board of Directors authorized staff to enter into a contract with Magellan Health Inc., within 30 days to provide behavioral health services for CalOptima Medi-Cal, OneCare, and OneCare Connect members effective January 1, 2017. It was noted that Applied Behavior Analysis (ABA) services are included in the MBHO.

INFORMATION ITEMS

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

Rena Smith, Director, PACE, presented an overview of the PACE program, including eligibility requirements, services provided, and the role of PACE in the continuum of care. She explained that PACE is a community-based program that provides all necessary medical and social services to seniors, noting that it offers seniors an opportunity to stay in their homes and maintain their independence. An Interdisciplinary Team (IDT) composed of eleven health care professionals provides individualized care for each PACE participant. Ms. Smith noted that the PACE center is the first and only PACE program in Orange County, with California having 13 PACE programs in total.

Back to Agenda

OneCare Connect Member Enrollment Update

Albert Cardenas, Associate Director, Customer Service, provided an update on the current OneCare Connect enrollment. As of September 14, 2016, enrollment was 17,750. The top three health networks with the highest enrollment were Monarch, Prospect Medical Group, and CalOptima Community Network. There were 181 OneCare Connect members in a deeming status, as of September 12, 2016.

Legislative Update

Phil Tsunoda, Executive Director, Public Affairs, reported that CalOptima staff is in the process of developing the proposed 2017-2018 legislative platform. Staff will reach out to the advisory committees for input before presenting the proposed platform to the CalOptima Board for consideration.

OCC MAC Member Presentation on Legal Aid Society of Orange County

Member Josefina Diaz, Litigation Paralegal, Legal Aid Society of Orange County (LASOC), presented an overview of her agency. LASOC provides free civil legal service to low income residents of Orange County who are at or below the poverty level. The LASOC is a non-profit corporation funded by the Legal Services Corporation in Washington D.C, and by public and private sources. Ms. Diaz reported that LASOC handles the following types of cases: family; landlord/tenant; government benefits; education; consumer problems; bankruptcy; and health advocacy. LASOC also manages certain programs and services for seniors, the homeless, and health consumers. The Legal Hotline provides legal counseling and advice on a wide range of legal issues.

OCC MAC Member Updates

Chair Mouton reminded the Committee to complete the mandatory CalOptima Annual Compliance Training required by the Centers for Medicare & Medicaid Services (CMS) and other regulatory agencies. The deadline for completion is November 4, 2016.

Chair Mouton also reminded the Committee of the importance of attending OCC MAC meetings. She added that Committee members should RSVP before the meeting so staff knows if there will be a quorum. Chair Mouton noted that the November OCC MAC meeting is on November 17, 2016, due to the Thanksgiving holiday. In response to Chair Mouton's request for future OCC MAC agenda items, suggestions included information on long-term care and hospice care.

Chair Mouton announced that the next OneCare Connect MAC meeting is October 27, 2016 at 3:00 p.m.

ADJOURNMENT

Hearing no further business, Chair Mouton adjourned the meeting at 3:53 p.m.

/s/ Cindi Reichert
Cindi Reichert
Program Assistant

Approved: 10.27.2016

Back to Agenda

MINUTES

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

October 13, 2016

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, October 13, 2016 at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Miranti, PAC Chair, called the meeting to order at 8:00 a.m., and Dr. Edwards led the Pledge of Allegiance.

ESTABLISH QUORUM

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

MINUTES

Approve the Minutes of the September 8, 2016 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Ross, seconded and carried, the Committee approved the minutes of the September 8, 2016 meeting. (Motion carried 11-0-0; Members Batra, Kahn, Orras and Pimentel absent)***

PUBLIC COMMENTS

No requests for public comment were received.

Back to Agenda

On behalf of the PAC, Chair Miranti thanked out-going Chair Jena Jensen for her service as PAC Chair for the last two years.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, updated the PAC on Board actions from the October 6, 2016, Board Meeting. Mr. Schrader discussed the implementation of the Whole Child Model (WCM) for the California Children's Services (CCS) Program that was signed into law on September 25, 2016 by the Governor. Statewide, the CCS program will transfer approximately 12,000 children with serious illness or chronic medical conditions no earlier than January 1, 2018. This will transition CCS from a fee-for-service system run by counties to a benefit administered by Medi-Cal managed care plans. Stakeholder meetings are being planned and two new advisory committees will be established for this program. The advisory committees consist of a Family Advisory Committee made up of CCS parents, and a Clinical Advisory Committee led by Dr. Richard Helmer, Chief Medical Officer and other CCS providers. Both advisory committees would report to the State into a larger advisory committee at the State level.

Mr. Schrader provided an update on CalOptima's PACE Program. Due to membership growth, increased revenues and decreasing expenses on a per member per month level, the PACE Center appears much closer to the breakeven position than had been projected. It was noted that CalOptima received a rate increase from the State and CMS for calendar year 2016. Mr. Schrader also reported on the proposed expansion for the PACE program using an alternative care-setting model. This model would utilize the existing PACE Center as a hub and utilize Community Based Adult Services (CBAS) programs as additional facilities.

Mr. Schrader also informed the PAC that for the third consecutive year, the National Committee for Quality Assurance (NCQA) awarded CalOptima the designation of top Medi-Cal plan in California. Mr. Schrader thanked the PAC for their commitment to helping CalOptima reach this goal.

Mr. Schrader also noted that the 2017-2019 Strategic Plan will be discussed at the November 3, 2016 Board Meeting. The 2017-2019 Strategic Plan is scheduled to be presented to the Board for consideration at the December 2016 meeting.

Chief Financial Officer Update

Chet Uma, Chief Financial Officer, presented CalOptima's Financial Report for August 2016, as well as a review of the Health Network Enrollment Summary for the month of August.

Chief Medical Officer Update

Dr. Richard Helmer, Chief Medical Officer, provided an update on the Long Term Care (LTC) program. Dr. Helmer noted that CMS has approved CalOptima's LTC program incentive methodology. This program is part of the Cal MediConnect LTC program, and staff proposes naming it "Long Term Connect" by CalOptima. He noted that the program would be modeled

Back to Agenda

after the CalOptima Model of Care (MOC)/Care Management program, and would include a special health risk assessment for members in facilities.
Dr. Helmer also discussed the Pay For Value program and the planned transition to the new behavioral health vendor, Magellan, scheduled for January 1, 2017.

Chief Operating Officer Update
Ladan Khamseh, Chief Operating Officer, updated the PAC on OneCare and OneCare Connect plan additions. Beginning January 1, 2017, OneCare and OneCare Connect members will be able to take advantage of a gym benefit available at a wide variety of gym facilities through the county, administered by American Specialty Health. These members will also have increased taxi benefit, which is increasing from 30 rides to 60 one-way rides per year.

INFORMATION ITEMS

Federal and State Budget Update
Phil Tsunoda, Executive Director, Public Policy and Public Affairs, noted that the State Legislature and Congress have adjourned in advance of the November general election.

Consumer Assessment of Health Plans Survey (CAHPS) Medi-Cal Plan Level Survey Results/Primary Care Physician Experience Survey Results
Marsha Choo, Manager of Quality Initiatives presented results from a Medi-Cal CAHPS survey. Ms. Choo reviewed the Medi-Cal child plan level CAHPs results, the Medi-Cal adult plan level results and the OneCare results with the PAC members.

Ms. Choo also presented results from the Primary Care Physician Experience survey. She noted that physicians were surveyed to measure the performance of CalOptima's health care service delivery system from the perspective of the physicians it serves. The survey tool was developed by CalOptima and administered and analyzed by a contracted survey vendor.

After much discussion, the CAHPS Ad Hoc Committee consisting of committee members Caliendo, Miranti, Pham and Ross indicated a need for an additional ad hoc meeting to review these results and discuss steps that can be taken to raise scores above the current benchmark levels.

PAC Member Comments
Chair Miranti suggested that PAC consider whether the Chair should form an ad hoc to assist with LTC/Skilled Nursing facility issues with hard to place patients. This would allow for collaboration with all the health networks to resolve these issues.

Member Ross requested that Magellan be invited to the December 8, 2016 PAC meeting to discuss their provider network and their plan to transition members from existing providers prior to January 1, 2017.

Chair Miranti recommended that PAC members attend the Strategic Planning session at the November 3, 2016 Board meeting, and reminded members that their annual compliance training is due by November 4, 2016.

Back to Agenda

ADJOURNMENT

There being no further business before the Committee, Chair Miranti adjourned the meeting at 9:50 a.m.

/s/ *Cheryl Simmons*
Cheryl Simmons
Staff to the PAC

Approved: November 10, 2016

Back to Agenda

MINUTES

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

July 14, 2016

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on July 14, 2016, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Mallory Vega called the meeting to order at 2:37 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Mallory Vega, Chair; Suzanne Butler; Connie Gonzalez; Donna Grubaugh; Gene Howard; Sally Molnar; Velma Shivers; Sr. Mary Therese Sweeney; Christine Tolbert; Lisa Workman

Members Absent: Sandy Finestone; Victoria Hersey; Patty Mouton; Christina Sepulveda

Others Present: Ladan Khamseh, Chief Operating Officer; Candice Gomez, Executive Director, Program Implementation; Caryn Ireland, Executive Director Quality Analytics; Arif Shaikh, Director, Government Affairs; Belinda Abeyta, Director, Customer Service; Becki Melli, Customer Service

MINUTES

Approve the Minutes of the May 12, 2016 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

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

PUBLIC COMMENT
There were no requests for public comment.

Chair Vega welcomed MAC's new member Christine Tolbert, Persons with Special Needs Representative. Chair Vega also recognized the MAC members that were reappointed for another term, 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.

PRESENTATIONS
Kathleen Kolenda, Vice President Adult Day Services, Easter Seals, presented an overview on Easter Seals' programs and rebranding campaign. Ms. Kolenda explained that one of the fastest growing programs at Easter Seals is serving children with Autism. Recent legislation requires health

Back to Agenda

care providers to assist persons diagnosed with Autism Spectrum Disorder (ASD) in obtaining necessary therapies. Easter Seals is a clinical service provider for all therapy services for ASD in California. They also collaborate with the Regional Center of Orange County (RCOC) to serve individuals with intellectual disabilities, which is the Adult Day services portion of Easter Seals. In addition, Easter Seals offers a senior program that supports seniors with age related challenges. Easter Seal provides support for living options, residential service, and group home arrangements.

CHIEF EXECUTIVE OFFICER AND MANAGEMENT TEAM DISCUSSION

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, reported that with the passage of Senate Bill 75, children under 19 years of age became eligible for full-scope Medi-Cal benefits regardless of immigration status, as long as they meet all other eligibility requirements. Approximately 6,000 members transitioned into full-scope Medi-Cal with CalOptima on June 1, 2016. CalOptima anticipates an additional 2,400 members will transition in July.

Ms. Khamseh reminded the committee that July is the last month of passive enrollment for the OneCare Connect program. After July, members must voluntarily enroll in OneCare Connect.

INFORMATION ITEMS

MAC Member Updates

Chair Vega announced that 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.

Health Network Minimum Enrollment Requirement

Ms. Khamseh reported that CalOptima is reviewing its minimum enrollment requirement for health networks (HNs) to maintain at least 5,000 members, following the first 12 months after initial member enrollment. This policy, which affects Medi-Cal HNs and the CalOptima Community Network (CCN), is designed to ensure the viability of HNs, support administrative efficiencies and stabilize the delivery system. A few new networks from CalOptima's recent HN expansion may require additional time to achieve the minimum enrollment requirement. Upon discussion of allowing HNs' an extension of the minimum enrollment timeframe, the Provider Advisory Committee (PAC) supported a recommendation to the Board to extend the timeframe to a maximum of 30 months. Following a robust discussion, MAC members concurred with PAC 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.

Health Education and Cultural and Linguistic Group Needs Assessment

Pshyra Jones, Director, Health Education and Disease Management, reported on Health Education's Group Needs Assessment (GNA). Ms. Jones explained that the Department of Health Care Services (DHCS) requires Medi-Cal managed care plans to conduct GNAs to identify members' needs,

Back to Agenda

including gaps in services, health education and cultural and linguistic (C&L) programs and resources. In addition, the GNA must address the following areas: special needs of seniors and persons with disabilities; special health care needs of children and adults; needs of members with limited English proficiency; and needs of members from diverse cultural and ethnic backgrounds. The goal of the GNA is to improve the members' health outcomes by evaluating health risks, identifying health needs, prioritizing health education and C&L services and enhancing quality improvement programs. CalOptima mailed over 18,000 surveys in June 2016. Once the results are in, CalOptima will be able to evaluate the data for health related trends within the community, identify areas for collaboration with providers and community agencies, and develop short-term and long-term action plans.

California Children's Services: Whole-Child Model

Candice Gomez, Executive Director, Program Implementation, presented on the California Children's Services (CCS) redesign update, which is now being called the Whole-Child Model. CCS is a statewide program providing medical care, case management, physical therapy, occupational therapy and financial assistance for children meeting eligibility criteria. Eligibility includes the following criteria: children aged 21 years and under; must meet specific medical conditions; must meet Medi-Cal or CCS financial eligibility; and have a medical condition that is eligible for the Medical Therapy Program (MTP). CCS funding is through county, state and federal money. There are approximately 13,000 children currently enrolled in CCS and approximately 90% of them are CalOptima members. Ms. Gomez explained that the state is proposing transitioning the fee-for-service CCS program into managed care under the Whole-Child Model. Health plans will be responsible for case management, care coordination, provider referral, and service authorization. The state will transition CCS to county organized health systems in a phased in approach starting 2017, with CalOptima expected to be phased in January 2018. Health plans will also have financial risk for the Medi-Cal members. The county will remain responsible for eligibility determination, the MTP and have administrative and financial responsibility for non-Medi-Cal children. Ms. Gomez reported that DHCS would conduct a comprehensive review and assess CalOptima's readiness using the same standards as apply to the Knox Keene plans.

Intergovernmental (IGT) Update

Cheryl Meronk, Director, Strategic Development, provided an update on IGT funding. Ms. Meronk explained that IGT 4 funding was $6.96 million and the Board approved five priority-funding areas for IGT 4: adult mental health; children's mental health; reducing childhood obesity, strengthening the safety net; and improving children's health. In addition, consideration was given to planning and implementing programs required under the Health Homes and the 1115 Waiver whole person care pilot initiatives.

Ms. Meronk stated that CalOptima is partnering with five entities within the community this year: University of California, Irvine; Orange County Health Care Agency; City of Newport Beach Fire Department; City of Orange Fire Department; and Children's and Family Commission. CalOptima anticipates approximately $16 Million for IGT 5. CalOptima staff will be working collaboratively with the funders and advisory committees on specific expenditure recommendations once the final IGT 5 amount to CalOptima has been confirmed by DHCS.

Back to Agenda

In response to Member Sally Molnar's question about the use of IGT funds for ongoing budget line items at CalOptima, Ms. Meronk confirmed that the funds are more suited for one time only special projects, capital expenditures, and general enhancement of services that do not extend current budget expenses. Ms. Meronk indicated that CalOptima may carry over funding that was previously allocated. Therefore, CalOptima is in the process of spending IGT 1, 2, and 3 funds.

Federal and State Budget and Legislative Update

Arif Shaikh, Director, Government Affairs, announced that Governor Brown signed the California FY 2016-17 State Budget into law on June 27, 2016. The budget reflects General Fund savings of $1.1 billion related to the passage and approval of the Managed Care Organization (MCO) tax. The MCO tax is a health care financing program used by California to access federal matching dollars. The new MCO tax takes effect July 2016, and runs for three years through June 2019. Among other significant impacts, the MCO tax revenue will facilitate the continuation of the Coordinated Care Initiative (CCI), contingent on improvements in enrollment, the restoration of In-Home Supportive Services (IHSS) service hours and the allocation of increased funding for programs serving people with developmental disabilities. With the approval of the MCO tax, the budget authorizes CCI (CalOptima's OneCare Connect program) through January 1, 2018. However, the Administration continues to share its concerns regarding participation rates in the program. If participation rates in the program are not improved by January 1, 2017, CCI could cease operating effective January 1, 2018. CalOptima will continue working with state and federal regulators, as well as health care stakeholders, to identify strategies to increase enrollment in OneCare Connect. The budget allocates $3.7 million from the General Fund to restore acupuncture as a covered Medi-Cal benefit beginning July 1, 2016. The acupuncture benefit was eliminated in 2009 as part of the state's response to the 2008 recession. CalOptima is awaiting guidance from DHCS on how the restoration of this benefit will be implemented. CalOptima's PACE center has the second lowest state reimbursement rates. The state association, CalPACE, is working on finding ways to improve the reimbursement rates and the overall program. CalPACE has also been working with DHCS on ways to update and modernize the program.

ADJOURNMENT

Hearing no further business, Chair Vega adjourned the meeting at 4:37 p.m. The next MAC meeting is scheduled on September 8, 2016 at 2:30 p.m.

/s/ Cindi Reichert
Cindi Reichert
Program Assistant

Approved: 11/10/2016

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Approval of Proposed Changes to CalOptima's Annual Investment Policy for Calendar Year 2017

Contact

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

Recommended Action

Recommend approval of the extension of the current Annual Investment Policy (AIP) for Calendar Year (CY) 2017.

Background

At the February 27, 1996, meeting, the CalOptima Board of Directors (Board) approved the original AIP covering investments made between March 1, 1996 and February 28, 1997. In September 1996, the Board authorized the creation of the Investment Advisory Committee (IAC). The IAC reviews the AIP each year, and recommends changes in said policy to the FAC and the Board for their respective approvals.

At the December 3, 2015, meeting, the Board approved changes to the AIP for CY 2016. At that time, staff, in conjunction with Meketa Investment Group, Inc., and CalOptima's investment managers, Payden & Rygel and Logan Circle Partners, recommended revisions to the AIP to:

- Add the National Credit Union Administration as a permitted investment under "Federal Agencies and U.S. Government Sponsored Enterprises;"
- Add language to allow supranational obligations as a permitted investment pursuant to the 2015 Local Agency guidelines with a maximum term in the Operating Fund of 450 days and a lower maximum amount of fifteen percent (15%) and adds supranationals to the list of eligible floating rate securities; and
- Other minor and conforming changes.

Discussion

Payden & Rygel, Logan Circle Partners, and Wells Capital Management, CalOptima's investment managers, and Meketa Investment Group, Inc., CalOptima's investment adviser submitted proposed revisions to the AIP for CY 2017, which has not been incorporated in the policy at this time. Staff has reviewed the proposed revisions and will submit the AIP to the CalOptima Policy Review Committee to complete the internal administrative policy review process.

Upon completion of policy review process, Management will present the revised AIP for CY 2017 to IAC for review and approval. In the interim, Management recommends that the current AIP remain in effect for CY 2017 until an updated version is approved by the Board.

Back to Agenda

Fiscal Impact
There is no immediate fiscal impact.

Rationale for Recommendation
Extending the effective date of the current AIP will enable CalOptima to continue meeting our goals to maintain safety of principal, and achieve a market rate of return while maintaining necessary liquidity during periods of uncertainty. Per the review conducted by Meketa Investment Group, Inc., there were no changes in the California Government Code affecting local agencies noted for the ensuing calendar year.

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

Attachments
Proposed 2017 Annual Investment Policy (effective January 1, 2017)

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

Back to Agenda

CalOptima

(The Orange County Health Authority, a Public Agency)

~~2016~~2017

Annual Investment Policy

Adopted

By the

Board of Directors

On

December ~~3~~1, ~~2015~~2016

Back to Agenda

CalOptima
Annual Investment Policy

I. PURPOSE

This Annual Investment Policy sets forth the investment guidelines for all Operating Funds and Board-Designated Reserve Funds of CalOptima invested on and after January 10, 2006. The objective of this Annual Investment Policy is to ensure CalOptima's funds are prudently invested according to the Board of Director's objectives to preserve capital, provide necessary liquidity and to achieve a market-average rate of return through economic cycles.

Investments may only be made as authorized by this Annual Investment Policy. The CalOptima Annual Investment Policy conforms to California Government Code section 53600 et seq. (the Code) as well as customary standards of prudent investment management. Irrespective of these policy provisions, should the provisions of the Code be or become more restrictive than those contained herein, such provisions will be considered immediately incorporated into the Annual Investment Policy and adhered to.

A. Safety of Principal -- Safety of principal is the foremost objective of CalOptima. Each investment transaction shall seek to ensure that capital losses are avoided, whether from institutional default, broker-dealer default, or erosion of market value of securities.

B. Liquidity -- Liquidity is the second most important objective of CalOptima. It is important that each portfolio contain investments for which there is a secondary market and which offer the flexibility to be easily sold at any time with minimal risk of loss of either the principal or interest based upon then prevailing rates.

C. Total Return -- CalOptima's portfolios shall be designed to attain a market-average rate of return through economic cycles given an acceptable level of risk.

II. OBJECTIVES

Safety of principal is the primary objective of CalOptima. Each investment transaction shall seek to ensure that large capital losses are avoided from securities or broker-dealer default. CalOptima shall seek to ensure that capital losses are minimized from the erosion of market value. CalOptima shall seek to preserve principal by mitigating the two types of risk: credit risk and market risk.

Credit risk, the risk of loss due to failure of the issuer of a security, shall be mitigated by investing in only permitted investments and by diversifying the investment portfolio according to this Annual Investment Policy.

Market risk, the risk of market value fluctuations due to overall changes in the general level of interest rates, shall be mitigated by matching maturity dates, to the extent possible, with CalOptima's expected cash flow draws. It is explicitly recognized herein, however that, in a diversified portfolio, occasional losses are inevitable and must be considered within the context of the overall investment return.

III. PRUDENCE

CalOptima's Board of Directors or persons authorized to make investment decisions on behalf of CalOptima, are trustees and fiduciaries subject to the prudent person standard as defined in the Code and shall be applied in the context of managing an overall portfolio.

Investment managers acting in accordance with written procedures and the Annual Investment Policy and exercising due diligence shall be relieved of personal responsibility for an individual security's credit risk or market price fluctuations, provided deviations from expectations are reported as soon as possible and appropriate action is taken to control risk.

THE PRUDENT PERSON STANDARD: When investing, reinvesting, purchasing, acquiring, exchanging, selling, or managing public funds, a trustee shall act with care, skill, prudence, and diligence under the circumstances then prevailing, including but not limited to, the general economic conditions and the anticipated needs of the agency, that a prudent person acting in a like capacity and familiarity with those matters would use in the conduct of funds of a like character and with like aims, to safeguard the principal and maintain the liquidity needs of the agency (California Government Code section 53600.3)

IV. ETHICS AND CONFLICTS OF INTEREST

CalOptima's officers, employees and Board members and Investment Advisory members involved in the investment process shall refrain from personal and professional business activities that could conflict with the proper execution of the investment program, or which could impair their ability to make impartial investment decisions. CalOptima's officers and employees involved in the investment process are not permitted to have any material financial interests in financial institutions, including state or federal credit unions, that conduct business with CalOptima, and they are not permitted to have any personal financial or investment holdings that could be materially related to the performance of CalOptima's investments.

V. DELEGATION OF AUTHORITY

Authority to manage CalOptima's investment program is derived from an order of the Board of Directors. Management responsibility for the investment program is hereby delegated to CalOptima's Treasurer as appointed by the Board of Directors, for a one-year period following the approval of the Annual Investment Policy. The Board of Directors may renew the delegation of authority annually. No person may engage in investment transactions except as provided under the terms of this Annual Investment Policy and the procedures established by the Treasurer.

The Treasurer shall be responsible for all actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Board approved investment managers.

A. Financial Benchmarks

CalOptima's investment portfolios shall be designed to attain a market-average rate of return through economic cycles given an acceptable level of risk. The performance benchmark for each investment portfolio will be based upon published market indices for short-term investments of comparable risk and duration. These performance benchmarks will be reviewed periodically by CalOptima's Treasurer and the Investment Managers and will be approved by the Board of Directors.

B. Safekeeping

The investments purchased by an Investment Manager shall be held by the custodian bank acting as the agent of CalOptima under the terms of a custody agreement in compliance with California Government Code section 53608.

C. Periodic Review of the Annual Investment Policy

The Treasurer is responsible for providing the Board of Directors with an Annual Investment Policy for review and adoption by the Board and to ensure that all investments made are in compliance with this Annual Investment Policy. This Annual Investment Policy shall be reviewed annually by the Board of Directors at a public meeting pursuant to California Government Code section 53646, subdivision (a).

The Treasurer is responsible for directing CalOptima's investment program and for compliance with this policy pursuant to the delegation of authority to invest funds or to sell or exchange securities. The Treasurer shall make a quarterly report to the Board of Directors in accordance with California Government Code section 53646, subdivision (b).

D. Treasurer's Procedures

The following procedures will be performed by the Treasurer:

1. The Operating Funds and Board-Designated Reserve Funds targeted average maturities will be established and reviewed periodically.

2. All Investment Managers will be provided a copy of the Annual Investment Policy, which will be appended to an Investment Manager's investment contract. Any investments made by an Investment Manager outside the Annual Investment Policy may subject the Investment Manager to termination for cause.

3. Investment diversification and portfolio performance will be reviewed monthly by the Treasurer to ensure that risk levels and returns are reasonable and that investments are diversified in accordance with this policy.

4. The Treasurer will evaluate and select all Investment Managers for review and approval by the Chief Executive Officer and the Board of Directors.

E. Duties and Responsibilities of the Investment Advisory Committee:

The Treasurer and staff are responsible for the oversight of CalOptima's investment portfolio. The Board of Directors is responsible for CalOptima's Annual Investment Policy. The Investment Advisory Committee shall not make or direct CalOptima staff to make any particular investment, purchase any particular investment product, or do business with any particular investment companies or brokers. It shall not be the purpose of the Investment Advisory Committee to advise on particular investment decisions of CalOptima.

The duties and responsibilities of the Investment Advisory Committee shall consist of the following:

1. Annually review CalOptima's Annual Investment Policy before its consideration by the Board of Directors and recommend revisions, as necessary, to the Finance and Audit Committee of the Board of Directors.

2. Quarterly review CalOptima's investment portfolio for conformance with CalOptima's Annual Investment Policy diversification and maturity guidelines, and make recommendations to the Finance and Audit Committee of the Board of Directors as appropriate.

3. Provide comments to CalOptima's staff regarding potential investments and potential investment strategies.

4. Perform such additional duties and responsibilities pertaining to CalOptima's investment program as may be required from time to time by specific action and direction of the Board of Directors.

VI. DEFINITIONS

A. Operating Funds are intended to serve as a money market account for CalOptima to meet daily operating requirements. Deposits to this fund are comprised of State warrants that represent CalOptima's monthly capitation revenues from its State contracts. Disbursements from this fund to CalOptima's operating cash accounts are intended to meet operating expenses, payments to providers and other payments required in day-to-day operations.

B. Board-Designated Reserve Funds are established to fund unexpected agency needs and not intended for use in the normal course of business. The amount of Board-Designated Reserve Funds should be offset by any working capital or net current asset deficits. The desired level for these funds is a minimum of 1.4 and maximum of 2.0 months' of capitation revenues as specified by CalOptima Policy GA.3001: Board-Designated Reserve Funds. The Board-Designated Reserve Funds shall be managed and invested as follows:

1. Tier One

   a. Used for the benefit and protection of CalOptima's long-term financial viability;

   b. Used to cover "Special Purposes" as defined in CalOptima Policy GA.3001: Board-Designated Reserve Funds; or

c. May be used for operational cash flow needs in lieu of a bank line of credit in the event of disruption of monthly capitation revenue receipts from the State, subject to the Board-Designated Reserve Funds having a "floor" equal to Tier Two requirements.

2. Tier Two

a. Used to meet CalOptima's regulatory compliance requirements; or

b. Currently defined as CalOptima's tangible net equity requirements as defined by subdivision (e) of section 1300.76 of Title 28 of the California Code of Regulations.

VII. PERMITTED INVESTMENTS

CalOptima shall invest only in instruments as permitted by the Code, subject to the limitations of this Annual Investment Policy. Permitted investments under the Operating Funds, unless otherwise specified, are subject to a maximum stated term of four hundred fifty (450) days (Code is five years). Permitted investments under the Board-Designated Reserve Funds, unless otherwise specified, are subject to a maximum stated term of five (5) years (Code is five years). The Board of Directors must grant express written authority to make an investment or to establish an investment program of a longer term.

Maturity shall mean the stated final maturity of the security. Term or tenure shall mean the remaining time to maturity when purchased.

Permitted investments shall include:

A. U.S. Treasuries

These investments are direct obligations of the United States of America and securities which are fully and unconditionally guaranteed as to the timely payment of principal and interest by the full faith and credit of the United States of America.

U.S. Government securities include:

1. Treasury Bills: U.S. government Securities issued and traded at a discount;

2. Treasury Notes and Bonds: Interest bearing debt obligations of the U.S. government which guarantees interest and principal payments;

3. Treasury Separate Trading of Registered Interest and Principal Securities (STRIPS): U.S. Treasury securities that have been separated into their component parts of principal and interest payments and recorded as such in the Federal Reserve book-entry record-keeping system;

4. Treasury Inflation Protected (TIPs) securities: Special Treasury notes or bonds that offer protection from inflation. Coupon payments and underlying principal are automatically increased to compensate for inflation as measured by the consumer price index (CPI); and

5. Treasury Floating Rate Notes (FRNs): U.S. Treasury bonds issued with a variable coupon.

U.S. Treasury coupon and principal STRIPS, as well as TIPs are not considered to be derivatives for the purpose of this Annual Investment Policy and are, therefore, permitted investments pursuant to the Annual Investment Policy.

Maximum Term: Operating Funds – 450 days (Code 5 years)
Board Designated Reserve Funds –

Tier One – five years (Code 5 years)
Tier Two – five years (Code 5 years)

B. Federal Agencies and U.S. Government Sponsored Enterprises

These investments represent obligations, participations, or other instruments of, or issued by, a federal agency or a U.S. government sponsored enterprise, including those issued by, or fully guaranteed as to principal and interest by, the issuers. These are U.S. Government related organizations, the largest of which are government financial intermediaries assisting specific credit markets (e.g., housing, agriculture). Often simply referred to as "Agencies", the following are specifically allowed:

1. Federal Home Loan Banks (FHLB);

2. Federal Home Loan Mortgage Corporation (FHLMC);

3. Federal National Mortgage Association (FNMA);

4. Federal Farm Credit Banks (FFCB);

5. Government National Mortgage Association (GNMA);

6. Small Business Administration (SBA);

7. Export-Import Bank of the United States;

8. U.S. Maritime Administration;

9. Washington Metro Area Transit;

10. U.S. Department of Housing & Urban Development;

11. Tennessee Valley Authority;

12. Federal Agricultural Mortgage Company (FAMC);

13. Temporary Liquidity Guarantee (TLG) Program securities;

14. Temporary Corporate Credit Union Liquidity Guarantee Program (TCCULGP) securities;

15. Federal Deposit Insurance Corporation (FDIC)-backed Structured Sale Guaranteed Notes (SSGNs); and

16. National Credit Union Administration (NCUA) securities.

Any Federal Agency and U.S. Government Sponsored Enterprise security not specifically mentioned above is not a permitted investment.

Maximum Term: Operating Funds – 450 days (Code 5 years)
Board Designated Reserve Funds –

Tier One – five years (Code 5 years)
Tier Two – five years (Code 5 years)

C. State and California Local Agency Obligations

Registered state warrants, treasury notes or bonds of any U.S. state and bonds, notes, warrants or other evidences of indebtedness of any local agency of the State of California, including bonds payable solely out of revenues from a revenue producing property owned, controlled, or operated by the state or local agency or by a department, board, agency or authority of the State or local agency. Such obligations must be issued by an entity whose general obligation debt is rated P-1 by Moody's or A-1 by Standard & Poor's or equivalent or better for short-term obligations, or A by Moody's or A by Standard & Poor's or better for long-term debt. Public agency bonds issued for private purposes (e.g., industrial development bonds) are specifically excluded as allowable investments.

Maximum Term: Operating Funds –450 days (Code 5 years)
Board Designated Reserve Funds –

Tier One – five years (Code 5 years)
Tier Two – five years (Code 5 years)

D. Bankers Acceptances

Time drafts which a bank "accepts" as its financial responsibility as part of a trade finance process. These short-term notes are sold at a discount, and are obligations of the drawer (i.e., the bank's trade finance client) as well as the bank. Once accepted, the bank is irrevocably obligated to pay the bankers acceptance (BA) upon maturity, if the drawer does not. Eligible bankers acceptances:

1. Are eligible for purchase by the Federal Reserve System, and are drawn on and accepted by a bank rated F1 or better by Fitch Ratings or are rated A-l for short-term deposits by Standard & Poor's or P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency; and

2. May not exceed the five percent (5%) limit of any one commercial bank and may not exceed the five percent (5%) limit for any security of any bank.

Maximum Term: Operating Funds – 180 days (Code)

Board Designated Reserve Funds –

Tier One – 180 days (Code)
Tier Two – 180 days (Code)

E. Commercial Paper

Commercial paper (CP) is unsecured promissory notes issued by companies and government entities at a discount. CP is negotiable (i.e., marketable or transferable), although it is typically held to maturity. The maximum maturity is two hundred seventy (270) days, with most CP issued for terms of less than thirty (30) days. CP must meet the following criteria:

1. Rated P-1 by Moody's or A-1 or better by Standard & Poor's;

2. Have an A or higher rating for the issuer's debt, other than CP, if any, as provided for by Moody's or Standard & Poor's;

3. Issued by corporations organized and operating within the United States and having total assets in excess of five hundred million dollars ($500,000,000); and

4. May not represent more than ten percent (10%) of the outstanding CP of the issuing corporation.

Maximum Term: Operating Funds – 270 days (Code)
Board Designated Reserve Funds

Tier One – 270 days (Code)
Tier Two – 270 days (Code)

F. Negotiable Certificates of Deposit

A negotiable (i.e., marketable or transferable**)** receipt for a time deposit at a bank or other financial institution for a fixed time and interest rate. Negotiable Certificates of Deposit must be issued by a nationally or state-chartered bank or state or federal association or by a state licensed branch of a foreign bank, which have been rated F1 or better by Fitch Ratings, or are rated A-l for short-term deposits by Standard & Poor's and P-1 for short-term deposits by Moody's, or are comparably rated by a nationally recognized rating agency.

Maximum Term: Operating Funds – one year (Code)
Board Designated Reserve Funds –

Tier One – one year (Code 5 years)
Tier Two – one year (Code 5 years)

G. Repurchase Agreements

A purchase of securities under a simultaneous agreement to sell these securities back at a fixed price on some future date.

U.S. Treasury and U.S. Agency Repurchase Agreements collateralized by the U.S. Government may be purchased through any registered primary broker-dealer subject to the Securities Investors Protection Act or any commercial bank insured by the Federal Deposit Insurance Corporation so long as at the time of the investment, such primary dealer (or its parent) has an uninsured, unsecured and unguaranteed obligation rated P-1 short-term or A-2 long-term or better by Moody's, and A-1 short-term or A long-term or better by Standard & Poor's, provided:

1. A broker-dealer master repurchase agreement signed by the investment manager (acting as "Agent") and approved by CalOptima;

2. The securities are held free and clear of any lien by CalOptima's custodian or an independent third party acting as agent ("Agent") for the custodian, and such third party is (i) a Federal Reserve Bank, or (ii) a bank which is a member of the Federal Deposit Insurance Corporation and which has combined capital, surplus and undivided profits of not less than fifty million dollars ($50,000,000) and the custodian shall have received written confirmation from such third party that it holds such securities, free and clear of any lien, as agent for CalOptima's custodian;

3. A perfected first security interest under the Uniform Commercial Code, or book entry procedures prescribed at 31 C.F.R. § 306.1 et seq. or 31 C.F.R. § 350.0 et seq. in such securities is created for the benefit of CalOptima's custodian and CalOptima; and

4. The Agent provides CalOptima's custodian and CalOptima with valuation of the collateral securities no less frequently than weekly and will liquidate the collateral securities if any deficiency in the required one hundred and two percent (102%) collateral percentage is not restored within one (1) business day of such valuation.

Maximum Term: Operating Funds – 30 days (Code 1 year)
Board Designated Reserve Funds –

Tier One – 30 days (Code 1 year)
Tier Two – 30 days (Code 1 year)

Reverse repurchase agreements are not allowed.

H. Corporate Securities

Notes issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state, and operating within the U.S.

1. For the purpose of this Annual Investment Policy, corporate securities that are rated "A" or better by Moody's, Standard & Poor's, or Fitch Ratings Service.

2. Are issued by corporations organized and operating within the U.S. or by depository institutions licensed by the U.S. or any state and operating within the U.S. and have total assets in excess of five hundred million dollars ($500,000,000), and

3. May not represent more than ten percent (10%) of the issue in the case of a specific public offering. This limitation does not apply to debt that is "continuously offered" in a mode similar to commercial paper, i.e., medium term notes ("MTNs"). Under no circumstance can the MTNs or any other corporate security of any one corporate issuer represent more than five percent (5%) of the portfolio.

Maximum Term: Operating Funds – 450 days (Code 5 years)
Board Designated Reserve Funds –

Tier One – five years (Code 5 years)
Tier Two – five years (Code 5 years)

I. Money Market Funds

Shares of beneficial interest issued by diversified management companies (i.e., money market funds):

1. Which are rated AAA (or equivalent highest ranking) by two of the three largest nationally recognized rating services; and

2. Such investment may not represent more than ten percent (10%) of the money market fund's assets.

J. Joint Powers Authority Pool

Shares of beneficial interest issued by a joint powers authority organized pursuant to California Government Code section 6509.7. A joint powers authority formed pursuant to California Government Code section 6509.7 may issue shares of beneficial interest to participating public agencies. Each share represents an equal proportional interest in the underlying pool of securities owned by the joint powers authority. The underlying pool of securities are those securities and obligations that are eligible for direct investment by local public agencies. The joint powers authority issuing the shares shall have retained an investment advisor that meets all of the following criteria:

1. Registered or exempt from registration with the Securities and Exchange Commission;

2. No less than five (5) years of experience investing in the securities and obligations authorized in the Code; and

3. Assets under management in excess of five hundred million dollars ($500,000,000).

A joint powers authority pool shall be rated AAA (or equivalent highest ranking) by two of the three largest nationally recognized rating services.

Such investment may not represent more than ten percent (10%) of the joint powers authority pool’s assets.

Term: N/A

K. Mortgage or Asset-backed Securities

Pass-through securities are instruments by which the cash flow from the mortgages, receivables or other assets underlying the security is passed-through as principal and interest payments to the investor.

Though these securities may contain a third party guarantee, they are a package of assets being sold by a trust, not a debt obligation of the sponsor. Other types of "backed" debt instruments have assets (e.g., leases or consumer receivables) pledged to support the debt service.

Any mortgage pass-through security, collateralized mortgage obligations, mortgage-backed or other pay-through bond, equipment lease-backed certificate, consumer receivable pass-through certificate, or consumer receivable-backed bond which:

1. Are rated AA- by a nationally recognized rating service; and

2. Are issued by an issuer having an A (Code) or better rating by a nationally recognized rating service for its long-term debt.

Maximum Term: Operating Funds – 450 days (Code 5 years)
Board Designated Reserve Funds –

Tier One – five years stated final maturity (Code 5 years)
Tier Two – five years stated final maturity (Code 5 years)

L. Variable and Floating Rate Securities

Variable and floating rate securities are appropriate investments when used to enhance yield and reduce risk. They should have the same stability, liquidity and quality as traditional money market securities. A variable rate security provides for the automatic establishment of a new interest rate on pre-determined reset dates. For the purposes of this Annual Investment Policy, a variable rate security and floating rate security shall be deemed to have a maturity equal to the period remaining to that pre-determined interest rate reset date, so long as no investment shall be made in a security that at the time of the investment has a term remaining to a stated final maturity in excess of five (5) years.

Variable and floating rate securities, which are restricted to investments in permitted Federal Agencies and U.S. Government Sponsored Enterprises securities, Corporate Securities, Mortgage or Asset-backed Securities, Negotiable Certificates of Deposit, and Municipal Bonds (State and Local Agency Obligations)must utilize a single, market-determined short-term index rate, such as U. S. Treasury bills, Federal Funds, commercial paper, London Interbank Offered Rate (LIBOR), or Securities Industry and Financial Markets Association (SIFMA) that is pre-determined at the time of issuance of the security. In addition, permitted variable and floating rate securities that have an embedded unconditional put option must have a stated final maturity of the security no greater than five (5) years from the date of purchase. Investments in floating rate securities whose reset is calculated using more than one of the above indices are not permitted, i.e., dual index notes. Ratings for variable and floating rate securities shall be

limited to the same minimum ratings as applied to the appropriate asset security class outlined elsewhere in this policy.

Maximum Term: Operating Funds – 450 days (Code 5 years)
Board Designated Reserve Funds –
Tier One – five years (Code 5 years)
Tier Two – five years (Code 5 years)

M. Supranational Obligations

Supranational institutions are international institutions formed by two (2) or more governments that transcend boundaries to pursue mutually beneficial economic or social goals. The three (3) supranational institutions that issue or unconditionally guarantee obligations that are eligible investments are:

1. International Bank for Reconstruction and Development (IBRD);

2. International Finance Corporation (IFC); and

3. Inter-American Development Bank (IADB).

Supranational obligations shall be rated AA by two of the three largest nationally recognized rating services. Such investment may not represent more than fifteen percent (15%) of invested funds.

Maximum Term: Operating Funds – 450 days (Code 5 years)
Board Designated Reserve Funds –
Tier One – five years (Code 5 years)
Tier Two – five years (Code 5 years)

N. Pooled Investments

Pooled investments include deposits or investments pooled with those of other local agencies consistent with the requirements of Government Code section 53635 *et seq*. Such pools may contain a variety of investments but are limited to those permissible under the Code.

VIII. **POLICIES**

A. Securities Lending

Investment securities shall not be lent to an Investment Manager or broker-dealer.

B. Leverage

The investment portfolio, or investment portfolios managed by an Investment Manager, cannot be used as collateral to obtain additional investable funds.

C. Other Investments

Any investment not specifically referred to herein will be considered a prohibited investment.

D. Underlying Nature of Investments

CalOptima reserves the right to prohibit its Investment Managers from making investments in organizations which have a line of business that is visibly in conflict with the interests of public health, as defined by the CalOptima Board of Directors. Furthermore, CalOptima reserves the right to prohibit investments in organizations with which it has a business relationship through contracting, purchasing or other arrangements.

A list of prohibited investments does not currently exist. However, CalOptima's Board of Directors will provide its Investment Managers, and investment advisors with a list, should such a list be adopted by CalOptima in the future, of corporations that do not comply with this Annual Investment Policy and shall immediately notify its Investment Managers and investment advisors of any changes.

E. Investment Managers

Investment Managers must certify that they will purchase securities from broker-dealers (other than themselves) or financial institutions in compliance with California Government Code section 53601.5 and this Annual Investment Policy.

F. Derivatives

Except as expressly permitted by this policy, investments in derivative securities are not allowed.

G. Rating Category

Rating category shall mean with respect to any long-term category, all ratings designated by a particular letter or combination of letters, without regard to any numerical modifier, plus or minus sign or other modifier.

H. Rating Downgrades

CalOptima may from time to time be invested in a security whose rating is downgraded below the quality criteria permitted by this Annual Investment Policy.

If the rating of any security held as an investment falls below the investment guidelines, the Investment Manager shall notify the Treasurer or designee within two (2) business days of the downgrade. A decision to retain a downgraded security shall be approved by the Treasurer or designee within five (5) business days of the downgrade.

I. Maximum Stated Term

Maximum stated term for permitted investments shall be determined based on the settlement date (not the trade date) upon purchase of the security and the stated final maturity of the security.

J. Diversification Guidelines

Diversification guidelines ensure the portfolio is not unduly concentrated in the securities of one type, industry, or entity, thereby assuring adequate portfolio liquidity should one sector or company experience difficulties.

CalOptima's Investment Managers must review the respective portfolios they manage to ensure compliance with CalOptima's diversification guidelines on a continuous basis.

INSTRUMENTS	MAXIMUM % OF PORTFOLIO AT TIME OF PURCHASE
A. U.S. Treasuries (including U.S. Treasury Coupon and principal STRIPS as well as TIPs)	100% (Code)
B. Federal Agencies and U.S. Government Sponsored Enterprises	100% (Code)
C. State and California Local Agency Obligations	25% (Code 100%)
D. Bankers Acceptances	30% (Code 40%)
E. Commercial Paper	25% (Code)
F. Negotiable Certificates of Deposit	30% (Code)
G. Repurchase Agreements	100% (Code)
H. Corporate Securities	30% (Code)
I. Money Market Funds	20% (Code)
J. Joint Powers Authority Pool	100% (Code)
K. Mortgage and Asset-backed Securities	20% (Code)
L. Variable and Floating Rate Securities	30% (Code
M. Supranational Obligations	15% (Code 30%)

1. Issuer or Counterparty Diversification Guidelines – The percentages specified below shall be adhered to on the basis of the entire portfolio:

   a. Any one Federal Agency or Government Sponsored Enterprise — None

   b. Any one repurchase agreement counterparty name
      If maturity/term is $\leq$ 7 days — 50%
      If maturity/term is > 7 days — 25%

2. Issuer/Counterparty Diversification Guidelines for All Other Securities described in Section VII, subsections A-L: Permitted Investments of this Annual Investment Policy.

Any one corporation, bank, local agency, or other corporate name for one or more series of securities, and specifically with respect to special purpose vehicles issuers for mortgage and asset-backed securities, the maximum applies to all such securities backed by the same type of assets of the same issuer. 5%

3. Each Investment Manager shall adhere to the diversification limits discussed in this section. If one Investment Manager exceeds the aforementioned diversification limits, the Investment Manager shall inform the CalOptima Treasurer and Investment Advisor (if any) by close of business on the day of the occurrence. Within the parameters authorized by the Code, the Investment Advisory Committee recognizes the practicalities of portfolio management, securities maturing, and changing status, and market volatility, and, as such, will consider breaches in:

   a. The context of the amount in relation to the total portfolio concentration;

   b. Market and security specific conditions contributing to a breach in policy; and

   c. The Investment Managers' actions to enforce the spirit of the policy and decisions made in the best interest of the portfolio.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Consider Authorizing Request for Waiver Allowing Nurse Practitioners to Provide Primary Care at the CalOptima Program of All-Inclusive Care for the Elderly (PACE) Center

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer to file a waiver request for CalOptima's Program of All-Inclusive Care for the Elderly (PACE) for Section 903 of the Benefits Improvement and Protection Act (BIPA) of 2000, to the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) in order to allow Nurse Practitioners (NP) to provide primary care, in addition to and in collaboration with the PACE primary care physicians; and
2. Authorize contracts with NPs to provide such services, subject to the requested waiver first being granted.

Background/Discussion

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. The CalOptima PACE Center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location.

Section 903 of BIPA allows for specific modifications or waivers of certain regulatory provision to meet the needs of PACE organizations. As such, CalOptima PACE is requesting for a waiver of the regulatory sections listed below from Title 42: Public Health,§460 – PACE, in order to allow a NP to provide primary care, including assessments and reassessments, care plans, prescribing medications, and to serve on the interdisciplinary team as a primary care provider (in addition to and in collaboration with the PACE primary care physician):

§ 460.102 Interdisciplinary team.

(c) *Primary care physician.* (1) Primary medical care must be furnished to a participant by a PACE primary care physician.

§ 460.104 Participant assessment.

(a) *Initial comprehensive assessment* —

(1) *Basic requirement.* The interdisciplinary team must conduct an initial comprehensive assessment on each participant. The assessment must be completed promptly following enrollment.

(2) As part of the initial comprehensive assessment, each of the following members of the interdisciplinary team must evaluate the participant in person, at appropriate intervals, and develop a discipline-specific assessment of the participant's health and

Back to Agenda

social status:

(i) Primary care physician.

(c) *Periodic reassessment* –

(1) *Semiannual reassessment.* On at least a semiannual basis, or more often if a participant's condition dictates, the following members of the interdisciplinary team must conduct an in-person reassessment:

(i) Primary care physician.

This waiver request is to allow an NP to conduct services that, as set forth in the PACE regulation, are currently assigned to the primary care physician. In California, properly qualified and licensed NP with dispensing rights may act as primary care providers in many of the same circumstances as primary care physicians. This waiver request simply asks that these rights, as permitted by California law and regulations, be extended to the provision of primary care at CalOptima PACE to enable the NP to work at the highest level of his/her licensure.

Filing of a 903 BIPA Waiver application will not add to PACE expenditures. In fact, it may reduce the amount PACE expends on Primary Care. With the NPs added ability to conduct initial and annual assessments, PACE will be able to utilize the NP where a physician would typically be needed.

Fiscal Impact

There is no additional fiscal impact. NPs will be utilized where a primary care physician would typically be needed. Funding for these NP services are budgeted under physician services in the CalOptima Fiscal Year 2016-17 Operating Budget.

Rationale for Recommendation

The ability of some PACE organizations to recruit qualified physicians serving a frail geriatric population is becoming increasingly difficult. CalOptima PACE has experienced significant difficulty in recruiting and retaining primary care physicians to meet its growth needs. This difficulty also reflects the challenging primary care access situation across certain sections of Orange County. Parts of the CalOptima service area are federally designated Medically Underserved Areas (MUAs) and/or federally designated Healthcare Professional Shortage Areas (HPSAs).[1]

As such, management requests authorization to seek a waiver which would allow Nurse Practitioners to provide primary care, including assessments and reassessments, care plans, prescribing medications, and to serve on the interdisciplinary team as a primary care provider, in addition to and in collaboration with the PACE primary care physicians.

Concurrence

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

[1] U.S. Department of Health and Human Services Administration, Health Resources and Services Administration, "Find Shortage Areas: MUA/P by State and County" and "Find Shortage Areas: HPSA by State and County;" April 2015; http://hpsafind.hrsa.gov/

Back to Agenda

Attachments
None

/s/ Michael Schrader *11/22/2016*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million

Contact

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

Recommended Actions

1. Approve the Quality Improvement activities listed on Attachment 1;
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to contract with new vendors and amend existing vendor contracts, as appropriate, for quality improvement-related services, including NCQA consulting and provider coaching services, incentive distribution and tracking services, PSA development services, survey implementation services, and material and print services selected consistent with CalOptima's Board-approved procurement process;
3. Direct staff to develop Member and Provider incentive programs in the amounts listed on Attachment 1., subject to applicable regulatory approval and guidelines, and final approval by the CalOptima Board prior to implementation; and
4. Authorize unbudgeted expenditures not to exceed $1.1 million to implement these initiatives.

Background

In CalOptima's 2013-2016 Strategic Plan, one of the strategic priorities was related to Quality Programs and Services. As a part of this strategic priority, CalOptima has worked diligently to provide members with access to quality health care services and ensure optimal health outcomes for all our members.

One of the areas of focus within Quality Programs and Services is CalOptima's performance in the National Committee for Quality Assurance (NCQA) accreditation and ratings. The evaluation criterion for the NCQA health plan ratings consists of three dimensions: Prevention, Treatment and Member Satisfaction. According to the most recent NCQA Health Plan Ratings, (NCQA's Medicaid Health Insurance Plan Ratings 2015-2016) CalOptima scored 4 out of 5 on Prevention, 3.5 out of 5 on Treatment, and 2.5 out of 5 in Customer Service. Health Plans are rated on a 5 point scale. CalOptima achieved an overall rating of 4 out of 5. CalOptima has the distinction of being the top rated Medicaid Health plan in California for the past three years. CalOptima is proud to be the only California Medicaid health plan accredited at the "commendable" level by NCQA. Additionally, CalOptima has achieved a 3.5 out of 5.0 "STAR" rating for Medicare by the Centers for Medicare & Medicaid Services (CMS).

Although CalOptima has achieved much success in our quality programs, we have also identified two measures that were below the minimum performance level (MPL) established by the California

Back to Agenda

Department of Health Care Services (DHCS), and we have prospectively identified other quality measures on the decline that are required for NCQA accreditation and health plan ratings. In order to maintain or exceed our quality performance levels, it is imperative to consider additional interventions which are necessary to achieve these goals, as referenced in our 2016 QI Program Description (Clinical Data Warehouse section, pg 41). These include utilizing multiple levers (direct-to-member, direct-to-provider, incentives, communication strategies, etc.) and programs planned as ongoing strategies throughout the calendar year.

In preparing the CalOptima FY 2016-17 Operating Budget, staff applied the regular budgeting methodology which used the past year's actual run-rate assumptions to allocate funds to various categories, units and lines of business. Upon further review, it became clear that additional funding was necessary to meet existing program commitments for Medi-Cal quality monitoring, reporting and improvement as well as new and expanded quality programs.

Discussion

Maintaining CalOptima's "commendable" accreditation status and rating by NCQA as a top Medicaid plan in California requires ongoing investment in innovative quality initiatives focused on underperforming measures as well as measures aligned with NCQA accreditation, health plan ratings, as well as DHCS and CMS requirements. Funding is also requested to maintain current vendor contracts utilized for quality reporting and to support annually required trainings for quality staff.

Expenditures requested are classified as:

• Budget augmentation for current quality initiatives:	$ 457,740
• New requests for quality initiatives:	$ 605,839
Total Request	$1,063,579

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities provides additional detail on the quality related programs, initiatives and proposed incentives. Member and provider incentive programs will be established by CalOptima. Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives. All member and provider incentive programs will be fully developed and returned for Board approval prior to implementation, as well as regulatory approval, as applicable.

Fiscal Impact

The recommended action to appropriate and authorize expenditures of up to $1.1 million for Medi-Cal quality improvement and accreditation activities is an unbudgeted item. Management is requesting Board approval to authorize an additional amount of up to $1.1 million in medical expenses to fund the cost of the quality improvement activities.

Back to Agenda

Rationale for Recommendation

CalOptima staff believes that by partnering with our Health Network and provider community, targeted, impactful interventions will result in improvements in our quality scores, to maintain our NCQA Commendable status.

Concurrence

Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer
Board of Directors' Quality Assurance Committee
Board of Directors' Finance and Audit Committee

Attachments

- Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities
- PowerPoint Presentation: Quality Analytics Budget

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

11/22/2016 — **Date**

Back to Agenda

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

A. Budget Augmentation for Current Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Surveys & NCQA Fees	• Addition of CG CAHPs - Adult & Child • Fee increases for regular CAHPS • Implement SPD CAHPS • Additional record retrieval for Medical Record Review • Increase in NCQA required fees • Timely Access Survey	$252,937
NCQA Consultant	• RFP results did not produce viable option; completed bid exception for known entity due to timeframe	$17,375
Quality Initiatives in Flight	• Flu/pneumococcal shot reminders • Preventive care visits • Pharyngitis kits • Readmissions project (CMS QIP) • Member & provider communications (more non-adherent members; more measures to move) •	$138,793
	• Member and provider incentives	$12,380
Required Training	• Annual Inovalon & HEDIS Best Practices training • CME expenses for physician training • Provider education activities • New hire equipment	$28,480
Miscellaneous		$7,775
Total		**$457,740**

Back to Agenda

Attachment 1: Summary of Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

B. New Request for Quality Initiatives

Item	Detail	Amount (Not to Exceed)
Member Programs	• Prenatal/postpartum incentive (Increase volume of outreach; $10,887 • Breast cancer screening -Downward trend Reminder mailing & incentive; $99,900 • Cervical cancer screening -Below MPL Reminder mailing & incentive; $149,900	$260,687
Provider Programs	• Physician office extended hours pilot project - MPL measures ($10,000) • Prenatal/postpartum provider office incentive ($5,000) • PCP office staff incentives for well women visits/screenings ($75,000) • Physician office extended hours initiative mailing ($2,500)	$92,500
Member Experience Initiatives	• Member focus groups, supplemental survey, provider CME ($72,525) • Practice coaches for member experience ($18,840)	$91,365
Provider Toolkits	• AWARE toolkit on antibiotic use ($5,000) • Provider Outreach/Education on AAB Measure (Below MPL; $1,500)	$6,500
Outreach Projects	• PSA for well women visits (Feb & May) - Culturally-specific radio stations ($99,900) • Child & Adolescent Outreach and Events for Childhood Immunizations (13% decrease; $44,887) • Educational posters/print ads for physician offices for Women's Wellness Campaign ($10,000)	$154,787
Total		**$605,839**

Back to Agenda

Quality Analytics Budget

Board of Directors' Quality Assurance Committee Meeting
November 16, 2016

Board of Directors' Finance and Audit Committee Meeting
November 17, 2016

Richard Bock, MD, Deputy CMO
Caryn Ireland, Executive Director, Quality

Back to Agenda

FY 2016-2017 Budget

- Budget augmentation for current quality initiatives: $457,740
  - Surveys & NCQA Fees
  - NCQA Consultant
  - Quality Initiatives in Flight
  - Required Training
  - Miscellaneous

- New requests for quality initiatives: $605,839
  - Member Programs
  - Provider Programs
  - Member Experience Initiatives
  - Provider Toolkits
  - Outreach Projects

Back to Agenda

Budget Augmentation for Current Quality Initiatives: $457,740

- Surveys & NCQA Fees: $252,937
  - Addition of CG CAHPS – Adult & Child
  - Fee increases for regular CAHPS
  - Implement SPD CAHPS
  - Additional record retrieval for Medical Record Review
  - Increase in NCQA required fees
  - Timely Access Survey
- NCQA Consultant: $17,375
  - RFP results did not produce viable option; completed bid exception for known entity due to timeframe
- Quality Initiatives in Flight: $151,173
  - Flu/pneumococcal shot reminders
  - Preventive care visits
  - Pharyngitis kits
  - Readmissions project (CMS QIP)
  - Member communications (more non-adherent members; more measures to move)
  - Member and provider incentives

Back to Agenda

Budget Augmentation for Current Quality Initiatives (cont.)

- Required Training $28,480
  - Annual Inovalon & HEDIS Best Practices training
  - CME expenses for physician training
  - Provider education activities
  - New hire equipment

- Miscellaneous $7,775

Back to Agenda

Funding for Additional Program: $605,839

- **Member Programs** — $260,687
  - Prenatal/postpartum incentive (Increase volume of outreach)
  - Breast Cancer Screening (Downward trend)
  - Cervical Cancer Screening (Below MPL)
- **Provider Programs** — $92,500
  - Physician office extended hours pilot project – MPL measures
  - Prenatal/postpartum provider office incentive
  - PCP office staff incentives for well women visits/screenings
  - Physician office extended hours initiative mailing
- **Member Experience Initiatives** — $91,365
  - Member focus groups, supplemental survey, provider CME
  - Practice coaches for member experience
- **Provider Toolkits** — $6,500
  - AWARE toolkit on antibiotic use
  - Provider outreach/education on AAB Measure (Below MPL)
- **Outreach Projects:** — $154,787
  - PSA for well women visits (Feb & May) – Culturally-specific radio stations
  - Child & adolescent outreach and events for childhood immunizations (13% decrease)
  - Educational posters/print ads for physician offices for Women's Wellness Campaign

Back to Agenda

Description of Additional Programs	Amount
Member Programs	$260,687
Prenatal/postpartum incentive (Increase volume of outreach)	$10,887
Breast cancer screening (Downward trend)	$99,900
Cervical cancer screening (Below MPL) - Reminder mailing and member incentives	$149,900
Provider Programs	$92,500
Physician office extended hours pilot project – MPL measures	$10,000
Prenatal/postpartum provider office incentive	$5,000
PCP office staff incentives for well women visits/screenings	$75,000
Physician office extended hours initiative mailing	$2,500
Member Experience	$91,365
Member focus groups ($50K), supplemental survey ($20,475), provider CME ($7K)	$72,525
Practice coaches for member experience	$18,840
Provider Tool Kits	$6,500
AWARE Toolkit on antibiotic use	$5,000
Provider outreach/education on AAB Measure (Below MPL)	$1,500
Outreach Projects	$154,787
PSA for well women visits (Feb & May) – Culturally-specific radio stations	$99,900
Child & adolescent outreach and events for childhood immunizations (13% decrease)	$44,887
Educational posters/print ads for physician offices for Women's Wellness Campaign	$10,000
Total	**$605,839**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
6. Consider Ratification of the 2016 CalOptima Utilization Management Work Plan

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

Recommended Action
Consider ratification of the attached 2016 Utilization Management Work Plan.

Background/Discussion
On March 23, 2016, revisions to the 2016 Utilization Management Program were presented to the CalOptima Board of Directors' Quality Assurance Committee for the Committee's recommendation to the CalOptima Board of Directors. On April 7, 2016, these proposed revisions to the 2016 Utilization Management Program were presented to, and approved by, the CalOptima Board of Directors. It was intended that the 2016 Utilization Management Work Plan would accompany the Utilization Management Program for approval, but the Work Plan was not included in the documents reviewed by the Quality Assurance Committee and approved by the Board of Directors.

Staff is now requesting that the Quality Assurance Committee review and recommend ratification of the attached Work Plan to the Board of Directors.

Fiscal Impact
Approval of the 2016 Utilization Management Work Plan will have no fiscal impact.

Rationale for Recommendation
Approval of revisions for the 2016 Utilization Management Work Plan is recommended to ensure implementation of the approved 2016 Utilization Management Program.

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

Attachments
1. 2016 Utilization Management Work Plan
2. Board of Directors' Action dated April 7, 2016, Approve the 2016 CalOptima Utilization Management Program and 2016 Work Plan

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

11/22/2016 — **Date**

Back to Agenda

CalOptima
2016 Utilization Management Workplan and Evaluation
OneCare Connect, OneCare and Medi-Cal
January, 2016

INITIAL WORKPLAN AND APPROVAL:

Submitted and approved by UMC Date: 1/28/2016

Submitted and approved by Board Date:

Submitted and approved by Board of Director's Date:
Quality Assurance Committee (QAC)

Utilization Management Committee Chairperson:

Francesco Federico MD, Medical Director Date:

Board of Directors' Quality Assurance Committee Chairperson:

~~Viet Van Dang~~Paul Yost, MD Date:

FINAL EVALUATION APPROVAL:

Submitted and approved by Board Date:

Submitted and approved by UMC Date:

Submitted and approved by Board of Director's Date:
Quality Assurance Committee (QAC)

Utilization Management Committee Chairperson:

Francesco Federico MD, Medical Director Date:

Board of Directors' Quality Assurance Committee Chairperson:

~~Viet Van Dang,~~Paul Yost, MD Date:

Back to Agenda

Preface

1/28/16

Health Services Team,

In accordance with CalOptima's contract with the California Department of Health Care Services and as reflected in each individual Health Network contract, this message is intended to affirm the requirement that any employee engaged in making decisions regarding the authorization and/or provision of covered services to members shall:

- Make decision based only on appropriateness of care and services and existence of coverage
- Not specifically reward practitioners or other individuals for issuing denials of coverage
- Not encourage decisions that result in underutilization

Nor shall such an employee have any fiscal or administrative duties or responsibilities that may unduly influence medical judgments. Neither CalOptima nor its contracted networks use incentives to create barriers to care and services.

This message will be shared with all staff engaged in making decisions related to authorization of medical care or services.

Thank You,

Francesco Federico, MD
Medical Director Utilization Management

I. Projects and Initiatives

A. Utilization Management (UM) Medical Management Re-Design — Owner: Debra Armas

The Approach

1. **Goals**
   a. Operation effectiveness improvement of Authorization (Prior, Concurrent, Retro)
   b. Compliance Maintenance (Contractual, Regulatory, Legal, Agency)

2. **Tactics**
   a. General
      - Accountability
      - Team Promotion
      - Collaboration (Inter / Intra Department) Eliminate “Siloing”
      - Technology Integration (Altruista Guiding Care)
      - Promotion of evidence based medicine in decision making
      - Promotion of a culture of Utilization Management: Knowledge, Identification, Prioritization, Collaboration, Consultation
      - Separation of medical decisions from fiscal / administrative management (see letter to Health Services team)

   b. Specific
      - Authorization
        - Prior
          - Process Efficiency
          - Provider portal submission increase
          - Collaboration with levels of review by intake, nurses, medical directors
        - Concurrent
          - Improved Reporting (Education, Onsite Nurses)
          - Use of evidenced based decision making processes(MCG)
          - Collaboration with levels of review by intake, nurses, and medical directors
        - Retro
          - Information Collection, Analysis, Decision

3. **Metrics Defined**
   - Authorization Prior Metrics (Production, Timeliness, Accuracy)
   - Authorization Concurrent (Production, Transfers to proper level of care)
   - Authorization Retro (Use of Authorization process)

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

B. Behavioral Health (BH) Integration — Owner: Donald Sharps, MD

The Approach

1. **Goals**
   a. Guidelines: monitor professional / regulatory practice guidelines and make available for PCPs, review practice guidelines from delegated MBHOs that are made available for BH providers, utilize evidenced based guidelines
   b. For Medi-Cal program – monitor utilization of outpatient BH benefits, including psychiatrist office visits, psychotherapy, psychological testing, Applied Behavior Analysis (ABA) for Autism Spectrum Disorders (ASD), and Comprehensive Diagnostic Evaluations
   c. For OneCare program – monitor utilization of outpatient and inpatient BH benefits, including psychiatrist office visits, psychotherapy, psychological testing, inpatient bed days, and follow-up after hospitalization
   d. Monitor MBHOs and County SPMI participation in integrated services including ICT / ICP participation and LTC / medical Hospital BH consultations
   e. Monitor appropriateness of pharmacy utilization for psychotherapeutic medications, access and availability, specific HEDIS CCI measures, patient and provider satisfaction, PCPs MH and substance use disorder interventions
   f. For OneCare program – monitor utilization of outpatient and inpatient BH benefits, including psychiatrist office visits, psychotherapy, psychological testing, inpatient bed days, and follow-up after hospitalization

2. **Tactics**
   a. Review delegated MBHOs' UM reports
   b. Corroborate delegated MBHOs' Um reports with CalOptima data and identify clarifying metrics
   c. Develop and use reports from CalOptima data for non-delegated UM activities
   d. Coordinate with BHQI as well as other departments within CalOptima
   e. Develop UM criteria for BH

3. **Metrics Defined**
   a. Delegated MBHOs' UM reports
   b. Trended MBHOs' encounter data PMPY and compare to over and under utilization
   c. Trended MBHOs' encounter data by type of service, provider type and aid code
   d. For Medi-Cal program – Trended encounter data for ABA per utilizing member per week and compare to over and under utilization
   e. For OneCare program – Trended encounter data for follow up after hospitalization
   f. Trended MBHOs and County SPMI participation in integrated services in ICT / ICP participation
   g. Trended MBHOs and County SPMI participation in LTC / medical hospital BH consultations
   h. HEDIS data for antidepressant medications and ADHD medications
   i. Other non pharmacy specific HEDIS and CCI measures
   j. Access and availability reports, monitoring
   k. Grievances and appeals reports
   l. Patient and provider surveys
   m. SBIRT and PHQ-9 encounter data

Back to Agenda

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

C. UM Data Management

Owner: Francesco Federico, MD

The Approach

1. **Goals**
   - Medical Management UM Data Management will develop standardized dynamic / static UM reports utilizing Enterprise Analytics resources and education / training in use of the DataMart.
   - UM patterns - understanding patterns / trends using analytics resource tools
   - Strategies (tactics) to affect UM outcomes
   - Monitoring of UM metrics

2. **Tactics**
   - Continued refinement of analytic toosl (Data Mart)
   - Continued collaboration development of select, standard, periodic reporting
   - Assistance in development of critical metrics and benchmarks
   - Collaboration (interdisciplinary) in Dashboard Development
   - Develop Enterprise Analytics (Data Mart) training program for medical management personnel

3. **Metrics Defined**
   - Dashboard Development
   - Standard periodic reporting
   - Data Mart continued development / use
   - Technology Integration (Altruista)
   - Enterprise Analytics (Data Mart) training program - Development / Implementation
   - Development of standardized regular report

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

D. UM Delegated Provider Group (PMG) Oversight (Monitoring) Owner: Solange Marvin / Debra Armas

The Approach

1. **Goals**
   a. Improve CalOptima process for PMG oversight and monitoring of UM functions

2. **Tactics**
   a. Data generation, collection, monitoring, analysis, actions from internal (CalOptima) and external (PMG) sources

3. **Metrics Defined**
   a. Authorization process metrics (timelines, clinical decision making, letter score) in urgent / routine / denial / extended / EIOD situations in both Medi-Cal and OneCare Connect/One Care
   b. Encounter data submission tracking
   c. ER visit data
   d. Facility UM data (Admits/1000, ALOS, Bed days/1000, Readmissions)
   e. Authorization, submission - tracking
   f. Authorization approved - use

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

E. Utilization Outlier Trends

Owner: ??, MD

- **Authorizations (Prior), Tracking (Provider), and Use (Member)**
- **Under Utilization Areas / Trend**

The Approach

1. **Goals**
   - To track provider authorization submitted – **submission authorizations tracking**
   - To track use by member of authorizations approved – **approved authorizations use**
2. **Tactics**
   - Data from providers - authorization, submission logs
   - Data (Internal) – approved use by member
3. **Metrics Defined**
   - Define standard expectation
   - Define interval (monthly, quarterly, yearly)

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

E. Utilization Outlier Trends

Owner: Francesco Federico, MD

- **UM Pattern Outlier Trending**
  - High Cost Members (eg. top 20 list)
  - High Cost Pharmacy (eg. Hepatitis C, ACTHAR, Tyrosine Kinase inhibiter use, etc.)
  - High cost specialties (eg. oncology, cardiology, orthopedics, ophthalmology, etc.)
  - High cost treatments: devices (eg. LVADs), equipment (eg. wheelchairs, etc.)

The Approach

1. **Goals**
   - Highlight outliers
   - Focus on outliers
   - Monitoring outliers
   - Action plan on outliers

2. **Tactics**
   - Specific collection of information from diverse disciplines
   - Specific action plan
   - Collection, generation, distributor (regular) of outlier trend report

3. **Metrics Defined**
   - High cost members report
   - High cost pharmacy report
   - High cost specialty report
   - High cost treatment (devices, equipment) report
   - Under utilization trending report

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

II. Operational Performance

A. Authorization (Prior) for Expedited / Urgent / Routine / Retro Requests

Owner: Debra Armas

- **Non-pharmacy prior authorization turnaround time**

The Approach

1. **Goals**
   a. Regulatory compliance

2. **Tactics**
   a. Improve process

3. **Metrics Defined**
   a. Turnaround time report (trend)
   b. Delineate regulatory / CalOptima standards
      - Expedited
      - Routine 4-5 days
      - Urgent 36-48 hrs
      - Retro
   c. Benchmark 100% which complies with regulatory standards

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

II. Operational Performance

A. Authorization (Prior) for Expedited / Urgent / Routine / Retro Requests

Owner: Kris Gericke

- **Pharmacy turnaround time**

The Approach

1. **Goals**
    a. Regulatory / CalOptima compliance

2. **Tactics**
    a. Improve process

3. **Metrics Defined**
    a. Pharmacy turnaround time report (trend)
    a. Delineate regulatory / CalOptima standard
    a. Benchmark is definition

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

II. Operational Performance

A. Authorization (Prior) for Expedited / Urgent / Routine / Retro

Owner: Suzanne Harvey

- **LTSS (CBAS, LTC) applies to CBAS only (LTC TAT in development)**

The Approach

1. **Goals**
   a. Regulatory / CalOptima compliance

2. **Tactics**
   a. Improve process

3. **Metrics Defined**
   a. Long Term Care (LTC) turnaround time report (trend) – if available
   b. Community Based Adults Services (CBAS) turnaround time report
   c. Delineate regulatory / CalOptima standards
   d. Goal is 100% compliance

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

II. Operational Performance

B. Online Referral Rate Submission Increase in non network providers (COD and CCN) Owner: Debra Armas

The Approach

1. **Goals**
   a. To increase the number of online submissions

2. **Tactics**
   a. Assess provider online capabilities
   b. Education of providers and office staff

3. **Metrics Defined**
   a. Online referrals definition – online referrals / authorization request
   b. Historic results Q1 + Q2 = 34 – 45% Q3 = 38%
   c. Benchmark 2015 was 60%, 2016 TBD

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

II. Operational Performance

C. Inter-Rater Reliability (Physicians, Nurses, Pharmacy) pertains to agency quality review in UM, CBAS, MSSP, LTC by annual review of selected auths

Owner: Debra Armas

The Approach

1. **Goals**
   a. Achieve quality goal set by agencies

2. **Tactics**
   a. Education of staff in MCG use
   b. Annual internal exam

3. **Metrics Defined**
   a. Benchmark 90%
   b. Historic results

	UM	CBAS	MSSP	LTC
Q1				
Q2				
Q3				
Q4				

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

II. Operational Performance

D. Denial Letter Process

Owner: Debra Armas / Myra Bandawal

The Approach

1. **Goals**
    a.

2. **Tactics**
    a.

3. **Metrics Defined**
    a. Goal is 100% Compliance
    b. Historic results

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

III. Utilization Performance

A. Facility Utilization

Owner: Nguyen Luu-Trong, MD

- **Facility (Acute, Post Acute)**

The Approach

1. **Goals**
   - To achieve appropriate level of utilization in facilities
   - To promote healthcare value ((Q + S)/C)
   - To improve quality (member satisfaction, provider satisfaction, member experience)

2. **Tactics**
   - Data Generation (monthly, quarterly, yearly) by CalOptima, by Comparative (CA state, Network, CCN)
   - Utilization of concurrent review process (CCR)
     a. Evidence based authorization decision making using MCG guidelines
     b. Collaboration with case management at facilities, and with CalOptima for complex care patients
     c. Hospitalist program promotion including collaboration with / use of contracted hospitalists, monitoring the acceptance of hospitalist use in our hospital network
     d. ER diversion program coordination with hospitalists, CalOptima care management, CCR nurses, hospital ER staff
     e. Enhance data collection from hospitals by fax, by e-mail, by access to hospital electronic records (select facilities) both onsite by CalOptima nurses (select facilities) and offsite by CalOptima nurses
     f. Promotion of appropriate physician peer to peer communication
     g. Promotion of concurrent review medical management collaboration, communication, education
   - Utilization of care management (CC) resources
   - Focused UM attention (ie – 1 day admits, readmissions, LTC pilot support)

3. **Metrics Defined**
   - Standard facility UM metrics such as admits/1000, bed days/1000, ALOS, ER visits, re-admissions
   - CalOptima contracted hospitalist use / acceptance

CalOptima
A Public Agency
Better. Together.

UM Data Medical Management Quarterly

Medi-Cal

COD A		MBRS	Admits/ 1000	ALOS	Bdky Reported	Bdky Updated	Goal Bdky	V_1	V_2
Q1	SPD								
	TANF > 18								
	TANF < 18								
Q2	SPD								
	TANF > 18								
	TANF < 18								
Q3	SPD								
	TANF > 18								
	TANF < 18								
Q4	SPD								
	TANF > 18								
	TANF < 18								
YTD	SPD								
	TANF > 18								
	TANF < 18								

CCN Gen		MBRS	Admits/ 1000	ALOS	Bdky Reported	Bdky Updated	Goal Bdky	V_1	V_2
Q1	SPD								
	TANF > 18								
	TANF < 18								
Q2	SPD								
	TANF > 18								
	TANF < 18								
Q3	SPD								
	TANF > 18								
	TANF < 18								
Q4	SPD								
	TANF > 18								
	TANF < 18								
YTD	SPD								
	TANF > 18								
	TANF < 18								

CCN Complex		MBRS	Admits/ 1000	ALOS	Bdky Reported	Bdky Updated	Goal Bdky	V_1	V_2
Q1	SPD								
	TANF > 18								
	TANF < 18								
Q2	SPD								
	TANF > 18								
	TANF < 18								
Q3	SPD								
	TANF > 18								
	TANF < 18								
Q4	SPD								
	TANF > 18								
	TANF < 18								
YTD	SPD								
	TANF > 18								
	TANF < 18								

Shared Risk		MBRS	Admits/ 1000	ALOS	Bdky Reported	Bdky Updated	Goal Bdky	V_1	V_2
Q1	SPD								
	TANF > 18								
	TANF < 18								
Q2	SPD								
	TANF > 18								
	TANF < 18								
Q3	SPD								
	TANF > 18								
	TANF < 18								
Q4	SPD								
	TANF > 18								
	TANF < 18								
YTD	SPD								
	TANF > 18								
	TANF < 18								

Notes: V_1 = Variance to goal for the current quarter:
V_2 = Variance to actual for the quarter (prior year)

Back to Agenda

UM Data Medical Management Quarterly

Medicare

Shared Risk OneCare		MBRS	Admits/ 1000	ALOS	Bdky Reported	Bdky Updated	Goal Bdky	V_1	V_2
Q1									
Q2									
Q3									
Q4									
YTD									

		MBRS	Admits/ 1000	ALOS	Bdky Reported	Bdky Updated	Goal Bdky	V_1	V_2
Q1									
Q2									
Q3									
Q4									
YTD									

CCN OneCare Connect		MBRS	Admits/ 1000	ALOS	Bdky Reported	Bdky Updated	Goal Bdky	V_1	V_2
Q1									
Q2									
Q3									
Q4									
YTD									

Shared OneCare Connect		MBRS	Admits/ 1000	ALOS	Bdky Reported	Bdky Updated	Goal Bdky	V_1	V_2
Q1									
Q2									
Q3									
Q4									
YTD									

Notes: V_1 = Variance to goal for the current quarter:
V_2 = Variance to actual for the quarter (prior year)

Back to Agenda

A. Facility Utilization

Owner: Emily Fonda, MD

▪ LTSS Facility UM

The Approach

1. **Goals**
   - To develop a Long Term Care (LTC) strategy that will
     - Improve utilization of ER visits, readmissions
     - Increase member satisfaction
     - Increase HEDIS scores

2. **Tactics**
   - Utilize LTSS department resources

3. **Metrics Defined**
   - Facility UM metrics (admits/1000, bed days/1000, ALOS, ED visits)
   - Other metrics (hospitalization, nursing home admissions, hospital re-admissions)

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

UM Data Medical Management: LTSS Program (Pilot) Quarterly

LTSS													LTC	
		MBRS		A/1000	ALOS	Goal Bd/1000	Actual Bd/1000	Re-admits		ED Visits			V_1	V_2
Q1	IHSS													
	LTC													
	CBAS													
	MSSP													
Q2	IHSS													
	LTC													
	CBAS													
	MSSP													
Q3	IHSS													
	LTC													
	CBAS													
	MSSP													
Q4	IHSS													
	LTC													
	CBAS													
	MSSP													
YTD	IHSS													
	LTC													
	CBAS													
	MSSP													

Notes: Focus currently on LTC population
NHA = Nursing home A/1000 within one year
Re-ad = Re-admits/1000 to hospital within 30 days
V_1 = Variance to goal for current quarter:
V_2 = Variance to actual for prior year quarter

III. Utilization Performance

B. Pharmacy Utilization

Owner: Kris Gericke

The Approach

1. **Goals**
   a. Improve pharmacy department utilization, monitoring, identification of cost / quality outliers and reporting
   b. Improve pharmacy department drug authorization process
   c. Promotion of evidence based medicine approach to pharmacy decision making
   d. Effective transition of new PBM
   e. Maintain compliance (contractual, regulatory, legal, quality)
   f. Review by P & T committee

2. **Tactics**
   a. Non-Specialty Drugs (Definition)
      1) Better reporting
      2) Refinement of authorization review process by using:
         - CalOptima formulary
         - Generic policy
         - Step drug therapy
         - Limited dispensing
         - Tracking of drug effectiveness

   b. Specialty Drugs (Definition)
      1) Better drug reporting using claims authorization process, electronic records
      2) Refinement with authorization review process by using:
         - CalOptima formulary
         - Generic program
         - Hepatitis C drug state practices / protocol guide
         - Step drug therapy
         - Reviews of select drug outliers (cost; quality) by pharmacy staff, by medical directors
         - Defining medical decision authorities: CalOptima policy, state law, contracts, compliance, MCG
         - Limited dispensing
         - Tracking of drug effectiveness

3. **Metrics Defined**
   - Costs (overall, per prescription)
   - Prescriptions (dispensed)

Back to Agenda

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

See Pharmacy Attachment

III. Utilization Performance

C. Emergency Department (ED) Utilization — Owner: Himmet Dajee, MD

The Approach

1. **Goals**
   a. To achieve appropriate ER utilization by members by providers

2. **Tactics**
   - ER diversion program
   - 24 hr on call health line (nurse)
   - Education of members and providers regarding appropriate ER use
   - Model of care designed to proactively deal with complex care patients
   - High utilizer tracking, referral to CM
   - Provider access assurance by monitoring office times, communication, on call
   - Urgent care promotion: location, services, differences in wait times, differences in services
   - UM data tracking by network (delegated vs. CCN), by provider
   - Long term care pilot promotion / support
   - Focus on excess use by providers (corrected for acuity, insurance class, co-morbidities)
   - Education of provider / members on the CalOptima pharmacy limited emergency prescription (outpatient) 2 days(maximum) by pharmacy
   - Homelessness issue address (task force)
   - Mental health issues identification, coordination, complex care management (ICT)
   - Member communication: newsletter (re screenings, medication management, nurse advice line), wellness events (free flu shots, health screening), new member orientation (re ER/UC, NEMT, Taxi, etc)
   - Provider communication: hours of operation (UC), access availability standards, screening standards, etc.

3. **Metrics Defined**
   - ER visits/1000
   - Urgent care visits/1000

III. Utilization Performance

D. Community Network (CN) Development — Owner: Francesco Federico, MD

The Approach

1. **Goals**
   a. Promote better quality healthcare value through appropriate utilization, improved services
   b. Delineate types of complex care populations served
   c. Promote an effective network comparable to existing CalOptima Network
   d. Promote better patient experience through expanded member and provider choice through the CN network

2. **Tactics**
   - UM Data Management (generation, analysis, metrics, action)
   - Multidisciplinary team based management approach
   - Utilization performance enhancement utilizing comparisons to historical, other network, regional, material trends

3. **Metrics Defined**
   - Facility utilization metrics
   - ED utilization metrics
   - Pharmacy UM performance (TBD)
   - Outpatient utilization performance (TBD)

Monitoring	Narrative	Next Steps
Q1		
Q2		
Q3		
Q4		
Year End		
Outcomes	**Results / Metrics**	**Next Steps**
Q1		
Q2		
Q3		
Q4		
Year End		

Evaluation	Self Scoring (Scale 0 (Low) 10 (High)	Notes:
Q1	Score 0 | | | | 5 | | | | 10	
Q2	Score 0 | | | | 5 | | | | 10	
Q3	Score 0 | | | | 5 | | | | 10	
Q4	Score 0 | | | | 5 | | | | 10	
Year End	Score 0 | | | | 5 | | | | 10	

Back to Agenda

~~Attachments~~

- ~~Facility UM~~
- ~~Pharmacy UM~~

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 7, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Approve the 2016 CalOptima Utilization Management Program and 2016 Work Plan

Contact

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

Recommended Action

Approve the recommended revisions to the 2016 Utilization Management Program and 2016 Work Plan.

Background

Utilization Management activities are conducted to ensure that member's needs are always at the forefront of any determination regarding care and services. The program is established and conducted as part of CalOptima's purpose and mission to ensure the delivery of medically necessary, achievable, quality member care through the consistent delivery of health care services. It provides for the consistent delivery of quality health care services in a coordinated, comprehensive manner, without discrimination based on health status, and in a culturally competent manner. It also ensures that medical decision making is not influenced by financial considerations, does not reward practitioners or other individuals for issuing denials of coverage, nor does the program encourage decisions that result in underutilization. Additionally, the Utilization Management Program is conducted to ensure compliance with CalOptima's obligations to meet contractual, regulatory and accreditation requirements.

CalOptima's Utilization Management Program ("the UM Program") must be reviewed and evaluated annually by the Board of Directors. The UM Program defines the structure within which utilization management activities are conducted, and establishes measurable processes for systematically coordinating, managing and monitoring members to achieve positive member outcomes.

CalOptima has updated the 2016 program with revisions and a change to format to ensure that it is aligned to reflect required regulatory and accreditation changes, along with strategic organizational changes, to ensure that all regulatory and accreditation requirements are met.

Discussion

The 2016 Utilization Management Program is based on the Board-approved 2015 Utilization Management Program and describes: (i) the scope of the program as well as structure and services provided; (ii) the populations served- including both Medi-Cal and Medicare members; (iii) key business processes and the integration across CalOptima; and (iv) important aspects of care and service for all lines of business. It is consistent with regulatory requirements, NCQA standards and CalOptima's own Success Factors.

The revisions are summarized as follows:

- Added information regarding Medi-Cal Managed Long Term Services and Supports
- Reflect the name change of Long Term Care to Long Term Support Services and added

Back to Agenda

- Multipurpose Senior Services Program (MSSP) and In Home Support Services (IHSS)
- Revised and added Behavioral Health Services
- Revised Services Not Provided by CalOptima
- Added Regional Center of Orange County
- Added responsibilities for Chief Medical Officer
- Added Director of Utilization Management description
- Added Executive Director of Quality and Analytics description
- Added Director of Long Term Services and Supports description
- Added Long Term Services and Supports Resources
- Removed Team Leads
- Revised Committee Structure organizational chart
- Revised and added detail regarding Behavioral Health Quality Improvement Committee
- Added Long Term Services and Supports QISC structure and responsibilities
- Added information on Pharmacy Department denial and appeals rights and process
- Added Long Term Services and Supports review criteria reference guidelines
- Added Pharmaceutical turnaround time guidelines
- Updated criteria and guidelines used for UM decision making

The recommended changes are necessary to meet the requirements specified by the Centers for Medicare & Medicaid Services, California Department of Health Care Services, and NCQA accreditation standards.

Fiscal Impact
There is no fiscal impact.

Concurrence
CalOptima Utilization Management Subcommittee
Gary Crockett, Chief Counsel
Board of Directors' Quality Assurance Committee

Attachments
PowerPoint Presentation – 2016 Utilization Management Program Description
2016 Utilization Management Program – Executive Summary
2016 Utilization Management Program – Program Changes
Draft 2016 CalOptima Utilization Management Program

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

04/01/2016 — **Date**

Back to Agenda

2016 Utilization Management Program Description

Board of Directors Meeting
April 7, 2016

Debra Armas
Director of Utilization Management

Back to Agenda

CalOptima's 2016 UM Program

The 2016 Utilization Management Program is based on the Board-approved 2015 Utilization Management Program and describes:

(i) the scope of the program as well as structure and services provided;

(ii) the populations served- including both MediCal and Medicare members;

(iii) key business processes and the integration across CalOptima; and

(iv) important aspects of care and service for all lines of business. It is consistent with regulatory requirements, NCQA standards and CalOptima's own Success Factors.

Back to Agenda

Approval Process

- Must be reviewed and evaluated annually by the Board of Directors.
- Document has been vetting by the following committees:

  - Internal Utilization Management Group
  - External Utilization Management Committee
    - Composition includes currently practicing Community Physicians-Member of the OCMA
  - Quality Assurance Committee
    - Extensive discussion on the 2015 Program Evaluation and the 2016 Program Work Plan and Evaluation as a basis for the development of the revised document

Back to Agenda

Background

- Utilization Management activities ensure member's needs are always at the forefront of any determination regarding care and services.
- Provides for consistent delivery of quality health care services in a coordinated, comprehensive manner, without discrimination based on health status, and in a culturally competent manner.

Back to Agenda

Background

- Medical decision making not influenced by financial consideration
  - ➢ does not reward for issuing denials of coverage
  - ➢ does not encourage decisions that result in underutilization.
- Defines the structure within which utilization management activities are conducted, and establishes measurable processes for systematically coordinating, managing and monitoring members to achieve positive member outcomes.
- Reflects required regulatory and accreditation changes, strategic organizational changes, and ensures that all regulatory and accreditation requirements are met.

Back to Agenda

Program Updates:

- Criteria and Guidelines used for UM decision making

Back to Agenda

Program Additions:

- Description for Executive Director of Quality and Analytics
- Responsibilities for Chief Medical Officer
- Description for Director of Utilization Management
- Description for Director of Long Term Services and Supports
- Long Term Services and Supports structure and description and review criteria reference guidelines
- Regional Center of Orange County description
- Pharmacy turnaround time guidelines
- Pharmacy denial and appeals rights and process

Back to Agenda

Program Changes/Revisions:

- Behavioral Health services description
- Services not provided by CalOptima
- UM Committee organizational chart

Back to Agenda

Program Items Removed

- Team leads from UM department structure

Back to Agenda

2016 UTILIZATION MANAGEMENT (UM) PROGRAM
EXECUTIVE SUMMARY

ADMINISTRATIVE UPDATES

Updated the Scope to include Home and Community Based Services, (CBAS). Updated Goals to include Long Term Services and Supports, In-Home Supportive Services, (IHSS), Multipurpose Senior Services Program, (MSSP), and CBAS.

Committee Structure Organizational Chart updated to reflect all programs with Utilization Management Oversight.

RESPONSIBILITY, AUTHORITY AND ACCOUNTABILITY

The following positions were added as resources to the UM Department as they play a key role in the assurance that both the department and all delegated entities meet CalOptima's standards and requirements

Defined the Deputy Chief Medical Officer in conjunction with the Chief Medical Officer.

Director of Utilization Management assists in the development and implementation of the Utilization Management Program, policies, and procedures. Ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The Director of Utilization Management also provides supervisory oversight and administration of the Utilization Management Program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization and Quality Improvement Committees, participates in the Utilization Management Committee and the Benefit Management Subcommittee.

Executive Director of Quality and Analytics provides oversight of key medical affairs functions including: Quality Management, Quality Analytics, Health Education and Disease Management. The ED of Quality and Analytics serves as a member of the executive team and, with the CMO, ensures that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals, and objectives for CalOptima. Position will anticipate, continuously improve, communicate and leverage resources. The ED of Quality and Analytics will balance achieving set accountabilities with constraints of limited resources.

Director of Long Term Services and Supports is responsible for LTSS programs which include Community Based Adult Services, (CBAS), In-Home Supportive Services, (IHSS), Long Term Care Services, (LTC, and Multipurpose Senior Services Program, (MSSP). The position supports a "Member-Centric" approach to help to keep members in the least restrictive living

Back to Agenda

environment. Collaborates with stakeholders including community partners and ensures LTSS services provided are procedures and processes related to the LTSS program operations. Also, added LTSS supporting roles to provide a multidisciplinary program structure.

NEW PROGRAMS

Medi-Cal Managed Long Term Services and Supports

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

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

Expanded Behavioral Health to include OneCare and OneCare Connect behavioral health services.

Expanded Services Not Provide by CalOptima, defining the Regional Center of Orange County, (RCOC).

CALOPTIMA APPROVED GUIDELINES

Updated list to reflect all guidelines that are utilized and indicate that delegated entities must use the same or similar nationally recognized criteria. These include:

- Medi-Cal Manual of Criteria, published by the State of California;
- National Comprehensive Cancer Network (NCCN) Guidelines;
- Centers of Excellence guidelines;
- Specialty Guidelines such as the American Academy of Pediatric Guidelines (AAP);
- Evidence based nationally recognized criteria such as MCG;
- CalOptima Level of Care Criteria for outpatient behavioral health services;
- CalOptima Medical Policy and Medi-Cal Benefits Guidelines;
- National and Local Determination Guidelines.

Updated UM Decision and Notification Timelines to add pharmacy timeliness guidelines for clinical decision making. Also, added guidelines for denial review and notification for pharmacy determinations.

Back to Agenda

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
ADMINISTRATIVE UPDATES			
<u>Services Not Provided by CalOptima</u> Under its Medi-Cal Program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible populations. Certain health care services are not provided by CalOptima, as determined by law and/or regulatory contract. Other services may be provided by different agencies including those indicated below: • Specialty mental health services are administered by the Orange County Health Care Agency (HCA) County Mental Health Plan. • Dental services are provided through California's Denti-Cal program. • California Children's Services (CCS) is a statewide program managed by the Department of Health Care Services (DHCS) and authorizes and pays for specific medical services and equipment provided by CCS-approved specialists for children with certain physical limitations and chronic health conditions or diseases. • Regional Center of Orange County as a local agency contracted by the State by the State of California to coordinate lifelong services and supports for people with developmental disabilities, Regional Center of Orange County, (RCOC), provides services and supports that are as diverse as the people served. Each person serviced by RCOC has an individual Family Service Plan, (IFSP), - that addresses his or her individual needs. The following are types of services and supports available through RCOC, or that RCOC can assist clients and families access through other sources: o Prenatal Diagnostic Evaluation o Early Intervention Services, (Birth to		Services Not Provided by CalOptima	11

Back to Agenda

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
36 months) o Therapy Services o Respite Care Services o Child Care Services o Adult Day Program Services, (Employment and Community-Based Activities) o Transportation Services o Residential Services o Psychological, Counseling and Behavioral Services o Medical and Dental Services o Equipment and Supplies o Social and Recreational Services In addition, CalOptima provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap around services that enhance their medical benefits. These linkages are established through special programs, such as the CalOptima Community Liaisons, and specific program Memoranda of Understanding (MOU) with other community agencies and programs, such as the Orange County Heath Care Agency's California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The UM Department coordinates activities with the Case Management and/or Disease Management Departments to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources. **Added:** **Deputy Chief Medical Officer** fulfills all of the roles and responsibilities of the office of the CMS in conjunction with and/or in the absence of the CMO, (as outlined above). **Director of Utilization Management** assists in the development	Human Resources	CalOptima Officers and Directors CalOptima Officers and	13 14

Back to Agenda

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
and implementation of the Utilization Management Program, policies, and procedures. Ensures the appropriate use of evidenced-based clinical review criteria/guidelines for medical necessity determinations. The Director of Utilization Management also provides supervisory oversight and administration of the Utilization Management Program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization and Quality Improvement Committees, participates in the Utilization Management Committee and the Benefit Management Subcommittee.		Directors	
Executive Director of Quality and Analytics provides oversight of key medical affairs functions including: Quality Management, Quality Analytics and Disease Management which includes health education programs. The ED of Quality and Analytics serves as a member of the executive team and, with the CMO, ensures that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals, and objectives for CalOptima. Position will anticipate, continuously improve, communicate and leverage resources. The ED of Quality and Analytics will balance achieving set accountabilities with constraints of limited resources.	Human Resources	CalOptima Officers and Directors	15
Committee Structure Org Chart Addition of the newly formed OneCare Connect Member Advisory Committee (OCC MAC)	Utilization Management Program	Committee Structure	24
NEW PROGRAMS **Medi-Cal Managed Long Term Services and Supports** Beginning July 1, 2015, Long Term Services and Supports, (LTSS) became a CalOptima benefit for all Medi-Cal enrollees. CalOptima ensures LTSS services are available to members who have health care needs and meet the program eligibility criteria and guidelines. The LTSS program has two primary components	Long Term Care	Medi-Cal Managed Long Term Services and Supports	4 and 5

Back to Agenda

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
with four programs. • Community Based Adult Services (CBAS) - CalOptima provides CBAS as a health plan benefit. CalOptima utilizes the Department of Health Services, (DHCS), approved CBAS Eligibility Determination Tool, (CEDT), criteria to assess a member's health condition and make a medical determination for the program. The Community Bases Adult Services is an outpatient, facility-based program that offers health and social services to seniors and persons with disabilities. • Nursing Facility Services for Long Term Care Services - CalOptima utilizes the DHCS Medi-Cal Criteria Chapter, Criteria for Long Term Care Services and Title 22, CCR, Sections: 51003, 51303, 51511(b), 51334, 51335, and 51343. CalOptima is responsible for the clinical review, medical determination and performs authorization functions for Long Term Care services for the following levels of care: o Nursing Facility Level B, (Long Term Care) o Nursing Facility Level A o Subacute Adult and Pediatric o Intermediate Care Facility / Developmentally Disabled, (ICF/DD) o Intermediate Care Facility / Developmentally Disabled Habilitative, (ICF/DD-H) o Intermediate Care Facility / Developmentally Disabled Nursing, (ICF/DD-N) • Multipurpose Senior Services Program, (MPSS) - CalOptima is responsible for identification referral and coordination of integrated services within the MSSP Site. The CalOptima MSSP Site adheres to the California Department of Aging contract and eligibility determination criteria. • In-Home Supportive Services, (IHSS), - CalOptima and the health networks are responsible for identification, referral and provide care coordination. CalOptima collaborates with Orange County Social Services Agency, (SSA), In-Home Supportive Services, Orange County Public Authority and health networks to ensure members receive appropriate level of care services.			

Back to Agenda

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
Director of Long Term Services and Supports is responsible for LTSS programs which include Community Based Adult Services, (CBAS), In-Home Supportive Services, (IHSS), Long Term Care Services, (LTC, and Multipurpose Senior Services Program, (MSSP). The position supports a "Member-Centric" approach to help to keep members in the least restrictive living environment. Collaborates with stakeholders including community partners and ensures LTSS services provided are procedures and processes related to the LTSS program operations. **Long Term Services and Supports Resources** The following staff positions provide support for LTSS operations: LTSS Director, (CBAS/IHSS/LTC/MSSP) The Director of Long Term Services and Support, (LTSS), will develop, manage and implement the Long Term Care Services and Support including long Term Care facilities, In-Home Supportive Services, Community Bases Adult Services and the Multipurpose Senior Services Program and staff associated with those programs. S/he will be responsible for ensuring high quality and responsive service for CalOptima members residing in Long Term Care facilities, (all levels of care), and to those members enrolled in other LTSS programs. Develops, evaluates programs and policy initiatives affecting seniors and (SNF/Subacute/ICF/ICF-DD/N/H) and other LTSS services. Experience & Education • 5 – 7 years varied related experience, including 5 years of supervisory experience with experience in supervising groups of staff in a similar environment. • Bachelor's degree in Nursing or in a related field required. • Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable. • Some experience in government or public environment preferred • Experience in the development and implementation of	Human Resources	Director of Long Term Services and Supports	16

Back to Agenda

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
new programs LTSS Manager, RN, (CBAS/IHSS/LTC) The Manager is expected to develop and manage the Long Term Services and Supports Department's work activities and personnel. S/he will ensure that services standards are met and operations are consistent with the health plan's policies and regulatory and accrediting agency requirements to ensure high quality and responsive service for CalOptima's members who are receiving long term care services and supports. The Manager much have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, health networks, and other internal and external customers in a professional and competent manager. This position will work in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving long term care services Experience and Education • A current and unrestricted RN license in the State of California • A Bachelor's degree or relevant experience in a healthcare field preferred • 5 - 7 years varied clinical experience required • 3 - 5 years supervisory/management experience in a managed care setting and /or nursing facility • Experience in government or public environment preferred • Experience in death with geriatrics and persons with disabilities LTSS Supervisor, RN,(CBAS, IHSS, LTC) The Supervisor is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of long term care services and supports to members in the community and institutionalized setting. The Supervisor is responsible for the management of the day-to-day operational activities for LTSS programs: Long Term Care, (LTC), Community Based Adult Services, (CBAS), and In-Home Support Services, (IHSS), and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a			

Back to Agenda

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor will be resolving members and providers issues and barriers ensuring excellent customer service. Additional responsibilities include: Managing staff coverage in all areas of LTSS to complete assignments, orienting, and training of new employees to ensure contractual and regulatory requirements are met. Experience and Education • A current unrestricted RN license in the State of California • A bachelor's degree or relevant experience in a healthcare field preferred • 3 years varied experience at a health plan, medical group, or skilled nursing facilities required • Experience in interacting/managing with geriatrics and persons with disabilities • Supervisory/management experience in utilization management activities • Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time. Medical Case Managers The LTSS Medical Case Manager, (MCM), is part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, provides coordination of care, and provides ongoing case management services for CalOptima members in Long term Care, (LTC), facilities and members receiving Community Bases Adult Services, (CBAS). Reviews and determines medical eligibility based on approved criteria/guidelines, NCQA standards, Medicare and Medi-Cal guidelines, and facilitates communication and coordination amongst all participants of the health care team and the member to ensure services are provided to promote quality, cost-effective outcomes. The LTSS MCM provides case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. The LTSS MCM is the subject			

Back to Agenda

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
matter expert and acts as a liaison to Orange County bases community agencies, CBAS center, skilled nursing facilities, and to members and providers. Experience and Education • A current and unrestricted RN license in the State of California • A current unrestricted LVN license in the State of California • Minimum of 3years managed care or nursing facility experience • Excellent interpersonal skills • Computer literacy required Valid driver's license and vehicle, or approved means of transportation , an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time CBAS Program Manager (MSW/MS) The CBAS Program Manager is responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. The Program Manager is responsible for the annual CBAS Provider Workshop, CBAS process improvement, reporting requirements, reviews monthly files audit, develops inter-rater reliability questions, performs psychosocial and functional assessments, a liaison and a key contact person for California Department of Health Care Services (DHCS), California Department Office of Aging (CDA), CBAS Coalition and CBAS centers. The CBAS Program Manager is responsible developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies. Experience & Education • Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required. Masters preferred. • Minimum of three (3) years 3-5 years CBAS and program development experience • Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired. • Previous work experience in managing programs and			

Back to Agenda

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
building relationships with community partners is preferred. • Excellent interpersonal skills • Computer literacy required • Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 5% of the time or more while traveling to CBAS centers and community events. **LTSS Committee QISC** The purpose of the LTSS QISC: • Engage stakeholders input on ways to best integrate the LTSS programs with managed care delivery system and improved quality of care • Improving and providing coordinated care for CalOptima Members who resides in long term care facilities and those who receive Home- and Community Based Services (HCBS). **The LTSS QISC Responsibilities**: • Identify barriers to keeping Members safe in their own homes or in the community, develop solutions, make appropriate recommendations to improve discharge planning process and preventing inappropriate admissions • Evaluate the performance, success, and challenges of LTSS program providers of the following services: CBAS, IHSS, MSSP and other Home and Community Based Services (HCBS) • Monitor the important aspects of quality of care, qualify of services, patient safety by collecting and organizing data for all selected indicators • Provide input on enhancing the capacity and coordination among LTSS providers, community-based organizations, housing providers, and managed care plans to care for individuals discharged from institutions.	Long Term Care	Long Term Services and Supports Quality Improvement Subcommittee (LTSS QISC)	28, 29 and 30

Back to Agenda

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
• Identify and recommend topics for LTSS providers workshops, educations and trainings The LTSS QISC Structure: • The designated Chairman of the LTSS QISC is the Medical Director, Senior Programs, who is responsible for chairing the Committee. • The composition of the LTSS QISC includes but is not limited to the following: o Nursing Facility Administrators o Community Based Adult Services (CBAS) Administrators o Orange County Social Services Agency, Deputy Director or Designee o Multipurpose Senior Services Program, Site Director or Designee o Chief Medical Officer/Deputy Medical Officer o Medical Director QI and Analytics o Medical Director UM o Executive Director Clinical Operations o Executive Director Quality Analytics o LTSS Manager(s) o LTSS Director • The LTSS QISC meets quarterly at a minimum or more frequently as needed. • The LTSS Activity Summary includes, but is not limited to, will be reported to QIC. o Member review of Hospital Admission for each LTSS program; o Member review of Emergency Department visit for each LTSS program; o Members review for Hospital Readmissions for each LTSS program; o Health Risk Assessment results for LTC OCC members; o LTC Provider Annual Workshop; o CBAS Provider Workshop; o CBAS Centers Profile o LTC Profile o Care Coordination and Interdisciplinary Care Team Participation by LTSS staff;			

Back to Agenda

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
○ Total number of participants by LTSS program • In addition, LTSS utilization activities include, but are not limited to, will be reported to UMC. ○ Community Based Adult Services (CBAS) statistics such as to number of participants, assessment type, turnaround time, denials rates; ○ Long Term Care (LTC) Statistics include, but is not limited to, bed type, turnaround time, denials rate; ○ Multipurpose Senior Services Program (MSSP) statistics such as total number of participants, total number of termination, number of ER visits, ALOS, SNF admissions. ○ LTSS Inter-Rater Reliability study result; ○ Rate Adjustments for LTC facilities			
CHANGES TO CURRENT PROGRAMS **<u>Behavioral Health Services</u>** **<u>OneCare and OneCare Connect Behavioral Health Services</u>** CalOptima has contracted with Windstone Behavioral Health for the behavioral health services portion of care for the OneCare line of business. CalOptima is responsible for credentialing the provider network and for Grievances and Appeals (GARS). CalOptima delegates Utilization Management to Windstone. Evidence based MCG guidelines are utilized in the UM decision making process. CalOptima members access Behavioral Health Services by calling Windstone at 1-800-577-4701. If office based services are appropriate, the member is registered and referrals to the appropriate provider are given to the member. If ambulatory Specialty Mental Health needs are identified, services may be rendered at the County Mental Health Plan. CalOptima offers screening, brief intervention, and referral to	Behavioral Health	OneCare and OneCare Connect Behavioral Health Services	6

Back to Agenda

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
treatment (SBIRT) services to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary. **Behavioral Health Quality Improvement Committee (BHQIC)** • Ensure adequate provider availability and accessibility to effectively serve the membership • Oversee the functions of delegated activities • Monitor that care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards • Ensure that Member benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over utilization • Utilize Member and Network Provider satisfaction study results when implementing quality activities • Maintain compliance with evolving National Committee for Quality Assurance (NCQA) accreditation standards • Communicate results of clinical and service measures to Network Providers • Document and report all monitoring activities to appropriate committees The designated Chairman of the BHQIC is the Medical Director of the Behavioral Health Integration who is responsible for chairing the Committee, as well as reporting findings and recommendations to the QIC. The composition of the BHQI Committee is defined in the BHQI Charter. The BHQI meets quarterly at a minimum or more frequently as needed. **Pharmacy** CalOptima's written notification of pharmacy denials to members and their treating practitioners contains: • A description of appeal rights, including the member's	Behavioral Health Pharmacy	Behavioral Health Quality Improvement Committee (BHQIC) Pharmacy Determinations	27 36

Back to Agenda

2016 UTILIZATION MANAGEMENT PROGRAM

Change	Source	Section -2016 Program Draft	Page –2016Program Draft
right to submit written comments, documents or other information relevant to the appeal • Shall also contain an explanation of the appeal process, including the appeal time frames and the member's right to representation • A description of the expedited appeal process for urgent preservices or urgent concurrent denials • Notification that expedited external review can occur concurrently with the internal appeal process for urgent care • A qualified pharmacist may approved an appeal, however all appeals upheld must be reviewed by a licensed physician reviewer. CalOptima gives practitioners the opportunity to discuss pharmacy UM denial decisions			
CALOPTIMA APPROVED GUIDELINES • Updated to reflect current guidelines that are utilized and indicate that delegated entities must use the same or similar nationally recognized criteria for Utilization Management Activities • Added Pharmaceutical Authorization Guidelines • Added Long Term Services and Supports Guidelines **<u>UM Decision Notification Timelines</u>** • Updated to include Pharmaceutical decision making timeframes for all lines of business	Preventative and Clinical Practice Guidelines Utilization Management Timeliness Standards	Authorization Review Roles UM Decision and Notification Timelines	41 and 42 47 and 48
NEW BENEFITS			
SYSTEMS			

Back to Agenda

2016
UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Back to Agenda

2016~~5~~
UTILIZATON MANAGEMENT PROGRAM
SIGNATURE PAGE

Utilization Management Committee Chairperson:

_____ _____
~~Richard Helmer, M.D~~ Francesco Federico M.D. **DATE:**
~~Date~~
~~Chief Medical Officer~~ UM MedicalDirector

Board of Directors' Quality Assurance Committee Chairperson:

_____ _____
Viet Van Dang, MD **Date**

Board of Directors Chairperson:

_____ _____
Mark Refowitz **Date**

Back to Agenda

TABLE OF CONTENTS

Back to Agenda

20165 UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

Purpose

The mission of CalOptima is to provide members with access to quality health care services delivered in a cost effective and compassionate manner.

The purpose of the Utilization Management (UM) Program Description is to define the structures and processes within the Utilization Management Department, including assignment of responsibility to appropriate individuals, in order to deliver quality, coordinated healthcare services to CalOptima members. All services are designed to serve the culturally diverse needs of the CalOptima population and are delivered at the appropriate level of care, in an effective, timely manner by delegated and non-delegated providers.

Scope

The scope of the Utilization Management Program (UM Program) is comprehensive and applies to all eligible members across all product types, age categories and range of diagnoses. The UM Program incorporates all care settings including preventive, emergency, primary, specialty, behavioral health, home and community based services, as well as acute, short term, long term facility and ancillary care services.

Goals

The goals of the UM Program are to optimize members' health status, sense of well-being, productivity, and access to quality, cost efficient health care, while at the same time actively managing the appropriate utilization of health plan services in order to ensure that appropriate processes are used to review and approve the provision of medically necessary covered services. The clinical goals include but are not limited to:

- Assist in the coordination of medically necessary medical and behavioral healthcare services as indicated by evidence based clinical criteria.
- Assure that care provided conforms to acceptable clinical quality standards.
- Enhance the quality of care for members by promoting coordination and continuity of care and service, especially during member transitions between different levels of care.
- Provide a mechanism to address access, availability, and timeliness of care.
- Clearly define staff responsibility for clinical activities specifically regarding decisions of medical necessity.
- Establish the process used to review and approve the provision of medical and behavioral healthcare services, including timely notification to members and/or providers of an appeal process for adverse determinations.
- Identify high-risk, high cost members for referral to the - Case Management and Care Coordination Programs- including Complex Case Management, Long Term Services and Supports, and/or the Disease Management/Health Education Programs - when indicated and provided by CalOptima.
- Promote a high level of satisfaction across members, practitioners, stakeholders, and client organizations.
- Comply with all applicable regulatory and accrediting agency rules, regulations and standards, and applicable state and federal laws that govern the utilization management process.

- Protect the confidentiality of member protected health information and other personal/provider information.
- Provide a mechanism and process for identifying potential quality of care issues and reporting them to the Quality Improvement Department for further action when necessary.
- Identify and resolve problems and issues that result in over or under utilization and the inefficient or inappropriate delivery of health care services.
- Identify opportunities to optimize the health of members through quality initiatives for disease/health education management programs, focused population interventions, and preventive care services, and coordinating the implementation of these initiatives with the activities delegated to contract Health Maintenance Organizations (HMOs), Physician-Hospital Consortias (PHCs), Shared Risk Medical Groups (SRGs) and Provider Medical Groups (PMGs).
- Optimize the member's health benefits by linking and coordinating services with the appropriate county/state sponsored programs such as Community Based Adult Services, (CBAS), In-Home Supportive Services (IHSS), and Multipurpose Senior Services Program, (MSSP).
- Educate practitioners, providers, HMOs, PHCS, SRGs and PMGs on CalOptima's Utilization Management policies , procedures and program requirements to ensure compliance with the goals and objectives of the UM Program.
- Monitor utilization practice patterns of practitioners to identify variations and implement best practice guidelines.

Providers

Contracted Health Networks/ Network Providers/Hospitals

In 2014, CalOptima contracted with a variety of Health Networks to provide care to Orange County's beneficiaries. Since 2008 CalOptima has also included Health Maintenance Organizations (HMOs), Physician/Hospital Consortias (PHCs), and Shared Risk Medical Groups (SRGs). CalOptima's HMOs, PHCs, and SRGs include over 3,500 Primary Care Providers (PCPs) and 30 hospitals and clinics. New networks that demonstrate the ability to comply with CalOptima's delegated requirements will be added as needed.

Payment Arrangements

Each PHC is composed of a Primary Medical Group and one hospital. The SRGs are composed of a physician group which assumes risk for professional services, while the hospital risk resides at the CalOptima level. The Physician group is capitated, and responsible for all primary and specialty physician services. The Hospitals are reimbursed by CalOptima on a fee-for-service basis. Members must access in-network physicians and CalOptima-contracted hospitals. Select physician groups are delegated for the following clinical and administrative function. See next section.

Under Shared Risk in Medi-Cal, CalOptima maintains greater financial risk than under the current PHC model, but the provider medical group (PMG) participates in risk sharing through a risk pool agreement and/or incentive pool with CalOptima. OneCare (dual eligible program) is comprised of a variety of provider groups in a delegated model with a variety of payor arrangements for administrative services (medical and behavioral health).

Delegation

CalOptima Physician groups are delegated for the following clinical and administrative functions:

- Utilization and Case Management
- Claims ~~professional~~
- Contracting
- Credentialing of practitioners
- Member Services
- Cultural and Linguistic Services

CalOptima delegates various UM activities to entities that demonstrate the ability to meet CalOptima's standards, as outlined in the UM plan and policies and procedures. CalOptima conducts ongoing oversight on a regular basis and performs an annual review of each delegate's UM program. Delegation is dependent upon the following factors:

- A pre-delegation review to determine the ability to accept assignment of the delegated function(s).
- Executed Delegation Agreement with the organization to which the UM activities have been delegated clarify the responsibilities of the delegated group and CalOptima. This agreement specifies the standards of performance to which the contracted group has agreed.
- Conformation to CalOptima's UM standards; including timeframes outlined in CalOptima's policy and procedure. (GG.1508: Authorization and Processing of Referrals; Attachment A, Timeliness of UM Decisions and Notifications).
- Delegate's written UM Program Description/Plan are reviewed annually and approval by CalOptima's Quality Improvement Committee (QIC).
- Submission of required monthly reports which include but are not limited to; UM data, denial information and quality assurance/improvement issues and activities.

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

- Annual approval of the delegate's UM program (or portions of the program that are delegated); as well as any significant program changes that occur during the contract year.
- Routine reporting of key performance metrics that are required and/or developed by CalOptima's Audit and Oversight Department, UMC and/or QIC.
- Annual or more frequent evaluation to determine whether the delegated activities are being carried out according to Plan standards and state program requirements.

In the event that the delegated provider does not perform contractually specified delegated duties, CalOptima may take action up to and including selected reviews, corrective actions, sanctions, capitation adjustments, probation, suspension or de-delegation.

~~In the instance where the delegate is NCQA Accredited, CalOptima may assume that the delegate is carrying out responsibilities in accordance with NCQA standards and revise the annual audit or evaluation, per state or CMS contract requirements.~~ At the time of pre-delegation, CalOptima evaluates the compatibility of the delegate's UM Program with CalOptima's UM Program. Once delegation is approved, CalOptima requires that the delegate provide the appropriate reports as determined by CalOptima to monitor the delegate's continued compliance with the needs of CalOptima. CalOptima annually reviews ongoing accreditation

status and compliance.~~CalOptima annually reviews ongoing accreditation status and compliance.~~ Oversight for all delegated activities is performed by CalOptima's Audit and Oversight Department.

Member Focused Program

CalOptima is committed to "Member Centric" care that recognizes the beliefs, traditions, customs and individual differences of the diverse population served. Beginning with the identification of needs, through a Group Needs Assessment, programs are developed to address the specific education, treatment, and cultural norms of the population while impacting the overall wellness of a specific community. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation. Please refer to CalOptima's Cultural and Linguistic Services Policies DD 2002 (Medi-Cal) and MA 4002 (OneCare) for a detailed description of the program.

CalOptima Products

Medi-Cal Program

~~1. General Scope of Services~~

Healthcare services provided include, but are not limited to, the following:

- Preventive Services
- Inpatient and Ambulatory Behavioral Health Services
- Dental Services
- Long Term Supportive Services
- Primary Care
- Specialty Care
- Complex Case Management
- Emergency Services
- Urgent Care
- Inpatient and Ambulatory Medical Services
- Ancillary Services

Medi-Cal Managed Long Term Services and Supports

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

Nursing Facility:

- Nursing Facility Services for Long Term Care Services - CalOptima utilizes the DHCS Medi-Cal Criteria Chapter, Criteria for Long Term Care Services and Title 22, CCR, Sections: 51003, 51303, 51511(b), 51334, 51335, and 51343. CalOptima is responsible for

the clinical review, medical determination and performs authorization functions for Long Term Care services for the following levels of care:

- Nursing Facility Level B, (Long Term Care)
- Nursing Facility Level A
- Subacute Adult and Pediatric
- Intermediate Care Facility / Developmentally Disabled, (ICF/DD)
- Intermediate Care Facility / Developmentally Disables Habilitative, (ICF/DD-H)
- Intermedicate Care Facility / Developmentally Disabled Nursing, (ICF/DD-N)

Home and Community Based Services:

- Community Based Adult Services (CBAS) - CalOptima provides CBAS as a health plan benefit. CalOptima utilizes the Department of Health Services, (DHCS), approved CBAS Elegibility Determination Tool, (CEDT), criteria to assess a member's health condition and make a medical determination for the program. The Communit Bases Adult Services is an outpatient, facility-based program that offers health and social services to seniors and persons with disabilities.

- Multipurpose Senior Services Program, (MSSP) - CalOptima is responsible for identificationm referral and coordination of integrated services within the MSSP Site. The CalOptima MSSP Site adheres to the California Department of Aging contract and elegibility determination criteria.

- In-Home Supportive Services, (IHSS), - CalOptim and the health networks are responsible for identification, referral and provide care coordination. CalOptima collaborates with Orange County Social ServicesAgency, (SSA), In-Home Supportive Services, Orange County Public Authority and health networks to ensure members receive appropriate level of care services.

Behavioral Health Services

Medi-Cal Ambulatory Behavioral Health Services

~~Beginning January 1, 2104, CalOptima contracted with College Health IPA (CHIPA) for essential behavioral health services mandated by the Affordable Care Act~~. CalOptima delegates College Health Independent Practice Association~~-~~CHIPA for utilization Management of the Provider Network. CHIPA sub-contracts and delegates to Beacon Health Strategies, LLC (Beacon) other functions that include credentialing the provider network, the Access Line, and several quality improvement functions.

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

CalOptima members access Behavioral Health Services by calling the CalOptima Behavioral Health Line at: 1-855-877-3885~~00-723-8461 Access Line.~~ A CHIPA / Beacon clinician~~contracted, employed clinician on the Access Line~~ assesses the level of care needed. If office based services are appropriate, the member is registered in the CHIPA / Beacon system and referrals to an appropriate provider are given to the member. If more complex needs are identified, the member is referred to the County for Specialty Mental Health Plan for Specialty Mental Health s~~S~~, these~~ervices. These services are "carved out" by the California Department of Health Care Services to the Orange County Department of Mental Health Services and~~ are not the responsibility of CalOptima.

~~Effective September 15, 2014,~~ CalOptima covers behavioral health treatment (BHT) for members 20 and younger with a diagnosis of Autism Spectrum Disorder (ASD). BHT services are managed by CHIPA / Beacon. Members can access BHT services by calling the 24/7 CalOptima Behavioral Health Line at 1-855-877-3885~~Access Line~~.

CalOptima offers screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

CalOptima ensures members with coexisting medical and behavioral health care needs have adequate coordination and continuity of their care. ~~The UM staff identifies members with combined medical and psychiatric diagnoses through various means, including, but not limited to, internal resources, such as case management and the delegated entities' case management staff. These members are managed throughout the continuum of care, and~~ communication with both the medical and behavioral health specialists occurs as needed to enhance continuity by ensuring members receive timely and appropriate access and to facilitate communication ~~care, and to facilitate communication~~ between the medical and behavioral health practitioners involved ~~in the care~~.

Services Not Provided by CalOptima

Under its Medi-Cal Program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible populations. Certain health care services are not provided by CalOptima, as determined by law and contract. Other services may be provided by different agencies including those indicated below:

- Specialty mental health services are administered by the Orange County Health Care Agency (HCA) County Mental Health Plan.
- Dental services are provided through California's Denti-Cal program.
- California Children's Services (CCS) is a statewide program managed by the Department of Health Care Services (DHCS) and authorizes and pays for specific medical services and equipment provided by CCS-approved specialists for children with certain physical limitations and chronic health conditions or diseases.

- Regional Center of Orange County as a local agency contracted by the State by the State of California to coordinate lifelong services and supports for people with developmental

disabilities, Regional Center of Orange County, (RCOC), provides services and supports that are as diverse the the people served. Each person serviced by RCOC has an individual Family Service Plan, (IFSP), - that addresses his or her individual needs. The following are types of services and supports available through RCOC, or that RCOC can assist clients and families access through other sources:

- Prenatal Diagnostic Evaluation
- Early Intervention Services, (Birth to 36 months)
- Thereapy Services
- Respite Care Services
- Child Care Services
- Adult Day Program Services, (Employment and Community-Based Activities)
- Transportation Services
- Residential Services
- Psychological, Counseling and Behavioral Services
- Medical and Dental Services
- Equipment and Supplies
- Social and Recreational Services

In addition, CalOptima provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive wrap around services that enhance their medical benefits. These linkages are established through special programs, such as the CalOptima Community Liaisons, and specific program Memoranda of Understanding (MOU) with other community agencies and programs, such as the Orange County Heath Care Agency's California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The UM Department coordinates activities with the Case Management and/or Disease Management Departments to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

OneCare- and OneCare Connect Behavioral Health Services

CalOptima has contracted with Windstone Behavioral Health for the behavioral health services portion of care for the OneCare and OneCare Connect line of business. CalOptima is responsible for credentialing the provider network and for grievances and appeals. CalOptima delegates Utilization Management to Windstone. Evidence based MCG guidelines are utilized in the UM decision making process.

CalOptima members access Behavioral Health Services by calling Windstone at 1-800-577-4701. If office based services are appropriate, the member is registered and referrals to the appropriate provider are given to the member. If ambulatory Specialty Mental Health needs are identified, services may be rendered at the County Mental Health Plan.

CalOptima offers screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

~~Cal MediConnect (Onecare Connect) Behavioral Health Services~~

~~CalOptima has contracted with Windstone Behavioral Health for the behavioral health services portion of care for the OneCare Connect line of business. CalOptima is responsible for credentialing the provider network and for Grievances and Appeals (GARS). CalOptima delegates Utilization Management to Windstone. Evidence based MCG guidelines are utilized in the UM decision making process.~~

~~CalOptima members access Behavioral Health Services by calling Windstone at 1-800-577-4701. If office based services are appropriate, the member is registered and referrals to the appropriate provider are given to the member. If ambulatory Specialty Mental Health needs are identified, services may be rendered at the County Mental Health Plan.~~

~~CalOptima offers screening, brief intervention, and referral to treatment (SBIRT) services to members 18 and older who misuse alcohol. Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.~~

~~Continuity and coordination of behavioral health care may involve CalOptima or a delegated HMO, PHC, SRG or PMG Case Managers communicating and coordinating care directly between PCPs and behavioral health specialists. These Case Managers are responsible for assuring that individual members with coexisting medical and behavioral disorders receive appropriate treatment in the appropriate ambulatory and/or inpatient setting.~~

~~Services Not Provided by CalOptima~~

~~Under its Medi-Cal Program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible populations. Certain health care services are not provided by CalOptima, as determined by law and/or regulatory contract. Other services may be provided by different agencies including those indicated below:~~

- ~~Specialty mental health services are administered by the Orange County Health Care Agency (HCA).~~
- ~~Dental services are provided through California's Denti-Cal program.~~
- ~~California Children's Services (CCS) is a statewide program managed by the Department of Health Care Services (DHCS) and authorizes and pays for specific medical services and equipment provided by CCS-approved specialists for children with certain physical limitations and chronic health conditions or diseases.~~

~~In addition, CalOptima provides linkages with community programs to ensure that members with special health care needs, or high risk or complex medical and developmental conditions, receive~~

wrap around services that enhance their medical benefits. These linkages are established through special programs, such as the CalOptima Community Liaisons, and specific program Memoranda of Understanding (MOU) with other community agencies and programs, such as the Orange County Heath Care Agency's California Children's Services, Orange County Department of Mental Health, and the Regional Center of Orange County. The UM staff and delegated entity practitioners are responsible for identification of such cases, and coordination of referral to appropriate State agencies and specialist care when the benefit coverage of the member dictates. The UM Department coordinates activities with the Case Management and/or Disease Management Departments to assist members with the transition to other care, if necessary, when benefits end. This may include informing the member about ways to obtain continued care through other sources, such as community resources.

2. **CalOptima Direct (COD)**

CalOptima Direct is a fee-for-service program administered by CalOptima to serve Medi-Cal members in special situations, including foster children, dual eligible (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's Medicare Advantage (MA) SNP, members in skilled nursing facilities, and share of cost members. COD also currently includes the following categories of vulnerable and complex/catastrophic care members: transplants, hemophilia, HIV, end stage renal disease (ESRD), and the Seniors and Persons with Disabilities Program.

To date, CalOptima has contracted with over 700 specialists and various ancillary providers and hospitals. Some of these specialists are hospitalist physicians who collaborate with CalOptima's Utilization Management staff to manage inpatient services.

CalOptima Direct (COD) is comprised of two distinct components: [d1]

a. CalOptima Direct Administrative (COD-A) is a fee-for-service program administered by CalOptima. Some members are enrolled in COD-A on a permanent basis, and may not be eligible to join a health network because they meet certain COD-A eligibility criteria. Permanent members of COD-A include share of cost members, dually eligible beneficiaries (members eligible with both Medicare and Medi-Cal), retro-assigned, and out of Orange County residents. COD-A also provides benefits to new members transitioning to a health network that are enrolled in CalOptima Direct on a temporary basis.

[d2]

b. CalOptima Care Network (CCN) is designed to ensure that all members in this network have a primary care physician (PCP) who is accountable for coordinating all aspects of the member's care, including making referrals to contracted specialists. CCN members have the opportunity to select a contracted PCP of their choice, or are assigned to a PCP if they do not select one. CCN PCPs are reimbursed on a fee-for service basis. Members enrolled in CCN include foster care children, members with qualifying conditions, such as End Stage Renal Disease, Seniors and Persons with Disabilities, University of California Irvine (UCI) Federally Qualified Health Center (FQHC) members, transplant patients, breast and cervical cancer patients, and long-term care patients.

3. **CalOptima Community Network**

Beginning in March 2015, the CalOptima Community Network (CN) is scheduled to be operationalized was open to new members beginning in March of 2015. . CN This is a managed

Back to Agenda

care program administered by CalOptima to serve Medi-Cal members and dual eligibles (those with both Medicare and Medi-Cal), who elect to participate in the Cal MediConnect program detailed below. This network is open to participation of any willing and qualified provider. CalOptima already contracts with a variety of providers: Physician Hospital Consortia, one HMOs, and many Shared Risk Groups.~~Medi-Cal networks~~. With the new launch of Community Network, individual providers will now have the option of contracting directly with CalOptima.

Dual Eligible Program

~~1.~~ OneCare

~~a. Scope of Services~~

OneCare provides a comprehensive scope of services for the dual eligible members. These services include, but are not limited to the following:

- ~~o~~ Preventive Services
- ~~o~~ Behavioral Health
- ~~o~~ Dental Services
- ~~o~~ Long Term Services and Supports~~Supportive Services~~
- ~~o~~ Primary Care
- ~~o~~ Specialty Care
- ~~o~~ Complex Case Management
- ~~o~~ Emergency Services
- ~~o~~ Inpatient Services
- ~~o~~ Urgent Care Services
- Ancillary Services
- ~~o~~ Pharmacy

OneCare provides health care services to seniors and persons with disabilities (SPDs) and only enrolls beneficiaries who Medicaid qualifies as a zero cost sharing Medicaid subset.

OneCare members qualify for Medicare by age (turning 65) or by disability (24 months of SSDI, ESRD, or ALS.) Nearly one third of OneCare members are under 65. OneCare members qualify for Medicaid by standards established by the State of California and administered at the county social services agency level. The standards for qualifying for State Medicaid include a review of income, assets, and in some cases, medical condition.

The threshold languages spoken by the majority of OneCare members are English, Spanish, Farsi and Vietnamese. OneCare members represent over twenty ethnic groups including White, Asian/Pacific Islander, Alaskan native, American Indian, Black, and Hispanic.

The management of OneCare's Medicare covered benefits is delegated to the PMGs. CalOptima manages the Medi-Cal wrap around and taxi transportation determinations. Cal Optima performs concurrent review for members who are admitted to out of area hospitals.

~~CalOptima has contracted with Windstone Behavioral Health for the behavioral health services portion of care as part of the OneCare line of business. CalOptima is responsible for credentialing the provider network and for Grievances and Appeals (GARS). CalOptima delegates Utilization~~

~~Management of the Provider Network to Windstone. Evidence based MCG guidelines are utilized in the UM decision making process.~~

~~MCG supports the application of criteria based on individual needs and assessment of the health care delivery system. Additionally all UM decision makers are involved in the inter-rater reliability process on a new hire and annual basis.~~

~~CalOptima members access Behavioral Health Services by calling Windstone at 1-800-577-4701. If office based services are appropriate, the member is registered and referrals to the appropriate provider are given to the member. If more complex needs are identified, the member is referred to the County for Specialty Mental Health Services. These services are "carved out" by the California Department of Health Care Services to the Orange County Department of Mental Health Services and are not the responsibility of CalOptima~~.

~~Providers in primary care settings screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary. Windstone provides the outpatient counseling services for those members referred for service under OneCare membership. For more intensive non-Medicare reimbursable services the responsibility would fall under Drug Medi-Cal and these members would be routed to services at County Alcohol and Drug Services or community services providers in the region.~~

~~Continuity and coordination of behavioral health care may involve CalOptima or a delegated PMG Case Manager communicating and coordinating care directly between PCPs and behavioral health specialists.~~

CalOptima works with community programs to ensure that individual needs are met for members with special health care needs and/or chronic or high risk complex medical conditions, including, but not limited to, Meals on Wheels, Dayle MacIntosh Developmental Center, Orange County Social Service Agency, Orange County Goodwill and Orange County Community Centers with direct links to the Long Term Support Services and Supports (LTSS) and the Orange County Aging and Disability Resource Center (ADRC).

To ensure that coordinated community and clinical services are accessible and available to these Seniors and Persons with Disabilities (SPD) members, CalOptima has developed a robust Model of Care that defines case management activities that includes nurses, social workers, behavioral health specialists, and personal care coordinators (PCCs). These case management services are designed to ensure coordination and continuity of care for every member and are described in the Case Management Program Description.

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

- Dental Services ~~(benefit expired 1/1/15)~~
- Vision
- Non-Medical Transportation (benefit decreased for 2015)

~~2.~~ **Cal MediConnect (OneCare Connect)**

~~Beginning July 1st, 2015 CalOptima will launch its Cal MediConnect program (~~Cal Optima's OneCare Connect Program~~OneCare Connect).~~, a~~ The(~~ Cal MediConnect~~) program~~ is a three (3) year demonstration project in an effort by California and the federal government to begin the process, through a single organized health care delivery system, of integrating the delivery of medical, behavioral health, long term care services and support and community based services for dual eligible beneficiaries. The program's goal is to help members stay in their homes for as long as possible and shift services out of institutional settings and into the home and community. A key feature of CalOptima is identifying high-risk enrollees who need comprehensive care coordination, and assembling an appropriate care team to develop and track an individualized care plan.

~~Regional Center of Orange County (ADD description here)~~

CalOptima Board of Directors

Authority, Responsibility and Accountability

The CalOptima Board of Directors has ultimate authority, accountability and responsibility for the quality of care and service provided to CalOptima members. The responsibility to oversee the Utilization Management program is delegated by the Board of Directors to the Board's Quality Assurance Committee (QAC). The Board holds the Chief Executive Officer (CEO) and the Chief Medical Officer (CMO) accountable and responsible for the quality of care and service provided to members. The responsibility for the direction and management of the UM Program has been delegated to the Chief Medical Officer (CMO). Before coming to the Board of Directors for approval, the UM Program is reviewed and approved by the Utilization Management Sub-Committee (UMC), the Quality Improvement Committee (QIC) and the Quality Assurance Committee (QAC) on an annual basis.

CalOptima Officers and Directors

Chief Medical Officer

The Chief Medical Officer (CMO) has operational responsibility for and provides support to CalOptima's UM Program. CalOptima's CMO, Deputy CMO, and Executive Vice President of Clinical Operations, and/or any designee as assigned by CalOptima's CEO are the senior executives responsible for implementing the UM program including appropriate use of health care resources, medical and behavioral quality improvement, medical and behavioral utilization review and authorization, case management, disease management and health education program implementations, with successful operation of the QIC, QAC and UMC.

The CMO's responsibilities include, but are not limited to coordination and oversight of the following activities:

- Assists in the development/revision of UM policies and procedures as necessary to meet state and federal statutes, regulations and accrediting agency requirements;
- Monitors compliance with the UM Program;
- Appoints the Chairperson of the UMC;
- Chairs the Utilization Management Workgroup (UMG);

- Provides clinical support to the UM staff in the performance of their UM responsibilities;
- Assures that the medical necessity criteria used in the UM process are appropriate and reviewed by physicians and other practitioners according to policy but not less than annually;
- Assures that the medical necessity criteria are applied in a consistent manner;
- Ensures that there are no financial incentives for practitioners or other individuals conducting utilization review for issuing denials of coverage, services, or care;
- Assures that reviews of cases that do not meet medical necessity criteria are conducted by appropriate physicians or other appropriate healthcare professionals in a manner that meets all pertinent statutes and regulations and takes into consideration the individual needs of the involved members;
- Assures that appropriate healthcare professionals review, approve, and sign denial letters for cases that do not meet medical necessity criteria after appropriate review has occurred in accordance with UM Policy and Procedure GG.1508: Authorization and Processing of Referrals;
- Assures the medical necessity appeal process is carried out in a manner that meets all applicable contractual requirements, as well as all federal and state statutes and regulations, is consistent with all applicable accreditation standards, and is done in a consistent and efficient manner;
- Provides a point of contact for practitioners calling with questions about the UM process;
- Communicates/consults with practitioners in the field as necessary to discuss UM issues;
- Coordinates and oversees the delegation of UM activity as appropriate and monitors that
- delegated arrangement to ensure that all applicable contractual requirements and accreditation standards are met;
- Assures there is appropriate integration of physical and behavioral health services for all Plan members;
- Participates in and provides oversight to the UMC and all other physician committees or Subcommittees;
- Recommends and assists in monitoring corrective actions, as appropriate, for practitioners with identified deficiencies related to UM;
- Serves as a liaison between UM and other Plan departments;
- Educates practitioners regarding UM issues, activities, reports, requirements, etc.;
- Reports UM activities to the QIC as needed.

Deputy Chief Medical Officer fulfills all of the roles and responsibilities of the office of the CMS in conjunction with and/or in the absence of the CMO, (as outlined above).

Executive Director of Clinical Operations (ED) is responsible for oversight of all operational aspects of key Medical Affairs functions including: Utilization Management, Case Management, Behavioral Health, Managed Long Term Services and Support (MLTSS) programs, along with all new program implementations related to initiatives in these areas. The ED of Clinical Operations serves as a member of the executive team and, with the CMO, ensures that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next level capabilities and operational efficiencies consistent with CalOptima's strategic plan, goals, and objectives. The Executive Director is expected to anticipate, continuously improve, communicate and leverage resources, as well as balance achieving set accountabilities with constraints of limited resources.

Medical Director of Utilization Management assists in the development and implementation of the Utilization Management Program, policies, and procedures. Ensures that an appropriate licensed professional conducts reviews on cases that do not meet medical necessity and utilizes evidence based review criteria/guidelines for any potential adverse determinations of care and/or service. In collaboration with the CMO, the Medical Director of Utilization Management also provides supervisory oversight and administration of the Utilization Management Program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization and Quality Improvement Committees, serves as the Chair of the Utilization Management Committee and the Benefit Management Subcommittee, and may participate in the CalOptima Medical Directors Forum. Other related duties may also be performed at the discretion of the Chief Medical Officer.

~~Part Time~~ Utilization Management~~M~~ Medical Director Ensures quality medical service delivery to members managed directly by CalOptima and is responsible for medical direction and clinical decision making in utilization management. In this role, the Medical Director oversees the utilization management activities of staff that work in concurrent, prospective and retrospective medical management activities, and works with the clinical staff that supports the utilization management process. The Medical Director works closely with the nursing leadership of these departments, and also works in collaboration with the Chief Medical Officer and all clinical staff within CalOptima.

Medical Director, Behavioral Health provides leadership and program development expertise in the creation, expansion and/or improvement of services and systems ensuring the integration of physical and behavioral health care services for CalOptima members. Provides clinical and operational oversight for behavioral health benefits and services provided to members. Works closely with all departments to ensure appropriate access and coordination of behavioral healthcare services, improves member and provider satisfaction with services and ensures quality behavioral health outcomes. The Behavioral Health Medical Director is involved in the implementation, monitoring and directing of the behavioral health aspects of the UM Program.

Medical Director, Senior Programs, is a key member of the medical management team and is responsible for the MediConnect (OneCare), Managed Long Term Support and Services (MLTSS) programs, and Case Management and Transitions of Care programs. Provides physician leadership in the Medical Affairs division, including acting as liaison to other CalOptima operational and support departments. The Medical Director is also expected to work in collaboration with the other Medical Directors and the clinical staff within Disease Management, Grievance and Appeals, and Provider Relations. The Medical Director works closely with the nursing and non-clinical leadership of these departments.

Medical Director Disease Management/Health Education/Program for All Inclusive Care for the Elderly (PACE) Programs is responsible for providing physician leadership in the clinical and operational oversight of the development and implementation of disease management and health education programs while also providing clinical quality oversight of the PACE Program.

Director of Utilization Management assists in the development and implementation of the Utilization Management Program, policies, and procedures. Ensures the appropriate use of

evidenced-based clinical review criteria/guidelines for medical necessity determinations. The Director of Utilization Management also provides supervisory oversight and administration of the Utilization Management Program, oversees all clinical decisions rendered for concurrent, prospective and retrospective reviews that support UM medical management decisions, serves on the Utilization and Quality Improvement Committees, participates in the Utilization Management Committee and the Benefit Management Subcommittee.

Director of Clinical Pharmacy Management leads the development and implementation of the Pharmacy Management Program, develops and implements Pharmacy Management Department policies and procedures; ensures that a licensed pharmacist conducts reviews on cases that do not meet review criteria/guidelines for any potential adverse determinations, provides supervision of the coordination of Pharmacy related clinical affairs, and serves on the Pharmacy and Therapeutics Subcommittee and Quality Improvement Committees. A Pharmacist oversees the implementation, monitoring and directing of pharmacy services.

Executive Director of Behavioral Health Integration provides leadership and program development expertise in the creation, expansion and improvement of services and systems that leads to the integration of physical and behavioral health care services for CalOptima members. S/he leads and assists the organization in developing and successfully implementing short and long term strategic goals and objectives toward integrated care. This position plays a key leadership role in coordinating with all levels of CalOptima staff, including the Board of Directors and executive staff, members, providers, health network management, legal counsel, State and Federal officials, and representatives of other agencies. S/he is responsible for monitoring, analyzing, and reporting to senior staff on changes in the healthcare delivery environment and program opportunities affecting or available to assist CalOptima in integrating physical and behavioral health care services.

Executive Director of Quality and Analytics~~Compliance~~ provides oversight of key medical affairs functions including: Quality Management, Quality Analytics and Disease Management which includes health education programs. The ED of Quality and Analytics serves as a member of the executive team and, with the CMO, ensures that Medical Affairs is aligned with CalOptima's strategic and operational priorities. This position is a key leader within the health plan and has the accountability to lead the areas assigned to next-level capabilities and operational efficiencies consistent with the strategic plan, goals, and objectives for CalOptima. Position will anticipate, continuously improve, communicate and leverage resources. The ED of Quality and Analytics will balance achieving set accountabilities with constraints of limited resources.

Director of Quality is responsible for ensuring that CalOptima and its HMOs PHCs, SRGs and PMGs meet the requirements set forth by Department of Health Care Services (DHCS), Center for Medicare/Medicaid Services (CMS), and Department of Managed Health Care (DMHC). The Compliance staff works in collaboration with the CalOptima Quality Improvement Department to refer any potential sustained noncompliance issues or trends encountered during audits of health networks, provider medical groups, and other functional areas, such as Utilization Management and Credentialing, and Grievance & Appeals Resolution Services, as appropriate. The staff evaluates the results of performance audits to determine the appropriate course of action to achieve desired results. Functions relating to fraud and abuse investigations, referrals, and prevention are handled by the Office of Compliance.

Director, Audit and Oversight oversees and conducts independent performance audits of CalOptima operations, Pharmacy Benefits Manager (PBM) operations and Physician Medical Group (PMG) delegated functions with an emphasis on efficiency and effectiveness and in accordance with State/Federal requirements, CalOptima policies, and industry best practices. This Director role is to ensure that CalOptima and its subcontracted health networks perform consistently with both CMS and State requirements for all programs. Specifically, this position leads the department in developing audit protocols for all internal and delegated functions to ensure adequate performance relative to both quality and timeliness. Responsible to ensure the implementation of strategic and tactical direction to improve the efficiency and effectiveness of internal processes and controls as well as delegated functions. This position interacts with the Board of Directors, CalOptima executives, departmental management, health network management and Legal Counsel.

Director of Case Management is responsible for Case Management, Transitions of Care and the clinical operations for~~of~~ the Medi-Cal, OneCare, and MediConnect programs. S/he supports improving quality and access through seamless care coordination for targeted member populations. Develops and implements policies, procedures and processes related to program operations.

Director of Disease Management/Health Education is responsible for the development and implementation of Disease Management/Health Education programs and determines priorities for health education and member self-care management. The position also oversees the group needs assessments to identify health education, and cultural and linguistic opportunities that improve the well-being of specific member populations. The position is also responsible for provider clinical office education for the promotion of quality initiatives.

Director of Long Term Services and Supports is responsible for LTSS programs which include Community Based Adult Servicces, (CBAS), In-Home Supportives Services, (IHSS), Long Term Care Services, (LTC, and Multipurpose Senior Services Program, (MSSP). The position supports a "Member-Centric" approach to help to keep members in the least restrictive living environment. Collaborates with stakeholders including community partners and ensures LTSS services provided are procedures and processes related to the LTSS program operations.

Utilization Management Resources

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

RN Managers (Referral/Prior Authorization/Retrospective Review and Concurrent Review) manage the day-to-day operational activities of the department to ensure staff compliance with company policies and procedures, and regulatory and accreditation agency requirements. The Managers develop, implement and maintain processes and strategies to ensure the delivery of quality healthcare services to members while establishing and maintaining collaborative working relationships with internal and external resources in order to ensure appropriate support for utilization activities.

Experience & Education

- A current and unrestricted RN license in the State of California.
- A Bachelor's degree or relevant experience in a healthcare field.
- 5 years varied clinical experience required.
- 5-7 years managed care experience preferred.
- 2-3 years supervisory/management experience in utilization management activities.

RN Supervisor (Concurrent Review) monitors and oversees the daily departmental work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload, and is a resource to the Concurrent Review staff regarding CalOptima policies and procedures as well as regulatory and accreditation requirements governing inpatient concurrent review and authorization processing while providing ongoing monitoring and development of staff.

Experience & Education

- A Bachelor's Degree or relevant experience in a healthcare field.
- Current and unrestricted Registered Nurse (RN) license
- 5 - 7 years of managed care experience
- Supervisor experience in Managed Care/Utilization Management preferred.

RN Supervisor (Referral/Prior/Retrospective Authorization) monitors and oversees the daily departmental work activities to ensure that service standards are met, makes recommendations regarding assignments based on assessment of workload, and is a resource to the Prior Authorization staff regarding CalOptima policies and procedures as well as regulatory requirements governing prior and retrospective authorization processing while providing ongoing monitoring and development of staff.

Experience & Education

- A Bachelor's Degree or relevant experience in a healthcare field.
- Current and unrestricted Registered Nurse (RN) license
- 3 - 5 years of managed care experience.
- Supervisor and/or Lead experience in Managed Care/Utilization Management preferred.

~~Team Leads are responsible for achieving overall clinical performance goals through day to day direction of the designated clinical care team, coordinating operational processes, and monitoring performance to achieve consistent process standards and metrics through quality assessments, training, and improvement tactics, and in compliance with regulatory and accreditation standards.~~

~~Education and/or Experience~~

- ~~Current and unrestricted California Registered Nurse (RN) or Licensed Vocational Nursing (LVN) license.~~
- ~~Minimum two years recent acute clinical experience; two years' experience in utilization management in a health plan, medical group or IPA setting is preferred.~~
- ~~Current Certified Case Manager (CCM) preferred.~~

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

Experience & Education

- Current and unrestricted California Board Licensed Vocational Nurse (LVN) or Registered Nurse (RN) license
- Minimum of three (3) years current clinical experience.
- Excellent telephone skills required.
- Computer literacy required.
- Excellent interpersonal skills.

Medical Assistants are responsible for effective, efficient and courteous interaction with practitioners, members, family and other customers, under the direction of the licensed Case Manager. The Medical Assistant performs medical, administrative, routine medical administrative tasks specific to the assigned unit and office support functions. The Medical Assistant also authorizes requested services according to departmental guidelines. All potential denial, and/or modifications of Provider service requests are discussed with the appropriate Medical Director, who makes the final determination.

Experience & Education

- High school graduate or equivalent; a minimum of 2 years of college preferred.
- 2 years of related experience that would provide the knowledge and abilities listed.

Program Specialist~~Administrative Assistant~~ provides high level administrative ~~secretarial~~ support to the Director of Utilization Management, the RN Managers, Supervisors and the UM Medical Directors.

Experience & Education

- High school diploma or equivalent; a minimum of 2 years of college preferred.
- Courses in basic administrative education that provide the knowledge and abilities listed or equivalent clerical/administrative experience.
- 2-3 years previous administrative experience preferred.

Pharmacy Department Resources

Pharmacy Director develops, implements, and administers all aspects of the CalOptima pharmacy management program as part of the managed care system, with closed formulary rebate programs, Drug Utilization Evaluation (DUE) and Drug Utilization Review (DUR) programs,

contracts with and manages the pharmacy network and oversees the day-to-day functions of the contracted pharmacy benefit management vendor (PBM). The Pharmacy Director is also responsible for administration of pharmacy services delivery, including, but not limited to, the contract with the third party auditor, and has frequent interaction with external contacts, including local and state agencies, contracted service vendors, pharmacies, and pharmacy organizations.

Experience & Education

- A current, valid, unrestricted California State Pharmacy License and Pharm.D. required.
- American Society of Health System Pharmacists (ASHP) accredited residency in Pharmacy Practice or equivalent experience required.
- Experience in clinical pharmacy, formulary development and implementation that would have developed the knowledge and abilities listed.

Pharmacy Manager assists the Pharmacy Director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of healthcare provided to Members enrolled in the CalOptima Delegated Health Plans and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), the Pharmacy Manager promotes clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guidelines and on an ongoing basis, researches, develops, and updates drug utilization management strategies and intervention techniques. The Pharmacy Manager develops and implements methods to measure the results of these programs, assists the Pharmacy Director in preparing drug monographs and reports for the Pharmacy & Therapeutics Committee, interacts frequently and independently with other department directors, managers, and staff, as needed to perform the duties of the position, and has frequent interaction with external contacts, including the pharmacy benefit managers' clinical department staff.

Experience & Education

- At least 3 years experience in clinical pharmacy practice, including performing drug use evaluations and preparing drug monographs and other types of drug information for Pharmacy & Therapeutics Committees.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- A current, valid, unrestricted California State Pharmacy License and Pharm.D. required.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

Clinical Pharmacists assist the Pharmacy Director and pharmacy staff with the ongoing development and implementation of targeted drug utilization and disease state management strategies to control costs and improve the quality and outcomes of healthcare provided to Members enrolled in the CalOptima Health Networks and CalOptima Direct. Through various modalities (e.g., provider/plan profiling, member drug profile reviews, development and updating of drug utilization criteria, and case-by-case intervention), they promote clinically appropriate prescribing practices that conform to CalOptima, as well as national practice guideline. On an

ongoing basis, research, develop, and update drug utilization management strategies and intervention techniques and develop and implement methods to measure the results of these programs. They assist the Pharmacy Director in preparing drug monographs and reports for the Pharmacy & Therapeutics Committee, interacts frequently and independently with other department directors, managers, and staff as needed to perform the duties of the position, and have frequent interaction with external contacts, including the pharmacy benefit managers' clinical department.

Experience & Education

- Three (3) years experience in clinical pharmacy practice including performing drug use evaluations and preparing drug monographs and other types of drug information for Pharmacy & Therapeutics Committees.
- Current knowledge and expertise in clinical pharmacology and disease states required.
- Basic working knowledge of the Medi-Cal or Medicaid programs preferred.
- A current, valid, unrestricted California State Pharmacy License and Pharm.D. required.
- ASHP accredited residency in Pharmacy Practice or equivalent background/experience required.

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

Experience & Education

- PharmD degree from an accredited college of pharmacy.
- Eligibility for licensure in California.

PBM (Pharmacy Benefits Manager) staff evaluates pharmacy prior authorization requests in accordance with established drug Clinical Review Criteria that are consistent with current medical practice and Title 22, California Code of Regulations definition of medical necessity and that have been approved by CalOptima's Pharmacy and Therapeutics Committee. CalOptima pharmacists, with a current license to practice without restriction, review all pharmacy prior authorization requests that do not meet drug Clinical Review Criteria. CalOptima pharmacists with a current license to practice without restriction perform all denials.

Long Term Services and Supports Resources

The following staff positions provide support for LTSS operations:

LTSS Director, (CBAS/IHSS/LTC/MSSP) The Director of Long Term Services and Supports, (LTSS), will develop, manage and implement the Long Term Care Services and Support including long Term Care facilities, In-Home Supportive Services, Community Bases Adult Services and the Multipurpose Senior Services Program and staff associated with those programs. S/he will be

responsible for ensuring high quality and responsive service for CalOptima members residing in Long Term Care facilities, (all levels of care), and to those members enrolled in other LTSS programs. Develops, evaluates programs and policy initiatives affecting seniors and (SNF/SubAcute/ICF/ICF-DD/N/H) and other LTSS services.

Experience & Education

- 5 – 7 years varied related experience, including 5 years of supervisory experience with experience in supervising groups of staff in a similar environment.
- Bachelor's degree in Nursing or in a related field required.
- Master's degree in Health Administration, Public Health, Gerontology, or Licensed Clinical Social Worker is desirable.
- Some experience in government or public environment preferred
- Experience in the development and implementation of new programs

LTSS Manager, RN, (CBAS/IHSS/LTC) The Manager is expected to develop and manage the Long Term Services and Supports Department's work activities and personnel. S/he will ensure that services standards are met and operations are consistent with the health plan's policies and regulatory and accrediting agency requirements to ensure high quality and responsive service for CalOptima's members who are receiving long term care services and supports. The Manager much have strong team leadership, problem solving, organizational, and time management skills with the ability to work effectively with management, staff, providers, vendors, health networks, and other internal and external customers in a professional and competent manager. This position will work in conjunction with various department managers and staff to coordinate, develop, and evaluate programs and policy initiatives affecting members receiving long term care services

Experience and Education

- A current and unrestricted RN license in the State of California
- A Bachleor's degree or relevant experience i a healthcare field preferred
- 5 - 7 years varied clinical experience required
- 3 - 5 years supervisory/management experience in a managed care setting and /or nursing facility
- Experience in government or public environment prefered
- Experience in dealth with geriatrics and persons with disabilities

LTSS Supervisor, RN,(CBAS, IHSS, LTC) The Supervisor is responsible for planning, organizing, developing and implementing the principles, programs, policies and procedures employed in the delivery of long term care services and supports to members in the community and institutionalized setting. The Supervisor is responsible for the management of the day-to-day operational activities for LTSS programs: Long Term Care, (LTC), Community Based Adult Services, (CBAS), and In-Home Support Services, (IHSS), and personnel, while interacting with internal/external management staff, providers, vendors, health networks, and other internal and external customers in a professional, positive and competent manner. The position's primary responsibilities are the supervision and monitoring of the ongoing and daily activities of the department's staff. In addition, the supervisor will be resolving members and providers issues and barriers ensuring excellent customer service. Additional responsibilities include: Managing staff

coverage in all areas of LTSS to complete assignments, orienting, and training of new employees to ensure contractural and regulatory requirements are met.

Experience and Education

- A current unrestricted RN license in the State of California
- A bachelor's degree or relevant experience in a healthcare field preferred
- 3 years varied experience at a health plan, medical group, or skilled nursing facilities required
- Experience in interacting/managing with geriatrics and persons with disabilities
- Supervisory/management experience in utilization management activities
- Valid dirver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 30% of the time.

Medical Case Managers The LTSS Medical Case Manager, (MCM), is part of an advanced specialty collaborative practice, responsible for case management, care coordination and function, provides coordination of care, and provides ongoing case management services for CalOptima members in Long term Care, (LTC), facilities and members receiving Community Bases Adult Services, (CBAS). Reviews and determines medical eligibility based on approved criteria/guidelines, NCQA standards, Medicare and Medi-Cal guidelines, and facilitates communication and coordination amongst all participants of the health care team and the member to ensure services are provided to promote quality, cost-effective outcomes. The LTSS MCM provides case management in a collaborative process that includes assessment, planning, implementation, coordination, monitoring and evaluation of the member's needs. The LTSS MCM is the subject matter expert and acts as a liaison to Orange County bases community agencies, CBAS center, skilled nursing facilities, and to members and providers.

Experience and Education

- A current and unrestricted RN license in the State of California
- A current unrestricted LVN license in the State of California
- Minimum of 3years managed care or nursing facility experience
- Excellent interpersonal skills
- Computer literacy required
- Valid driver's license and vedhicle, or approved means of transportation , an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 95% of the time

CBAS Program Manager (MSW/MS) The CBAS Program Manager is responsible for managing the day-to-day operations of the CBAS Program and educates CBAS centers on various topics. The Program Manager is responsible for the annual CBAS Provider Workshop, CBAS process improvement, reporting requirements, reviews monthly files audit, develops inter-rater reliability questions, performs psychosocial and functional assessments, a liaison and a key contact person for California Department of Health Care Services (DHCS), California Department Office of Aging

(CDA), CBAS Coalition and CBAS centers. The CBAS Program Manager is responsible developing strategies and solutions to effectively implement CBAS project deliverables that require collaboration across multiple agencies.

Experience & Education

- Bachelor's degree in Sociology, Psychology, Social Work or Gerontology is required. Masters preferred.
- Minimum of three (3) years 3-5 years CBAS and program development experience
- Working experience with seniors and persons with disabilities, community-based organizations, and mental illness desired.
- Previous work experience in managing programs and building relationships with community partners is preferred.
- Excellent interpersonal skills
- Computer literacy required
- Valid driver's license and vehicle, or other approved means of transportation, an acceptable driving record, and current auto insurance will be required for work away from the primary office approximately 5% of the time or more while traveling to CBAS centers and community events.

Qualifications and Training

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

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

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

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed UM employee. Licensed nursing and physician staff is monitored for appropriate application of Review Criteria/Guidelines, processing referrals/service authorizations, and inter-rater reliability. Training opportunities are addressed immediately as they are identified through regular administration of

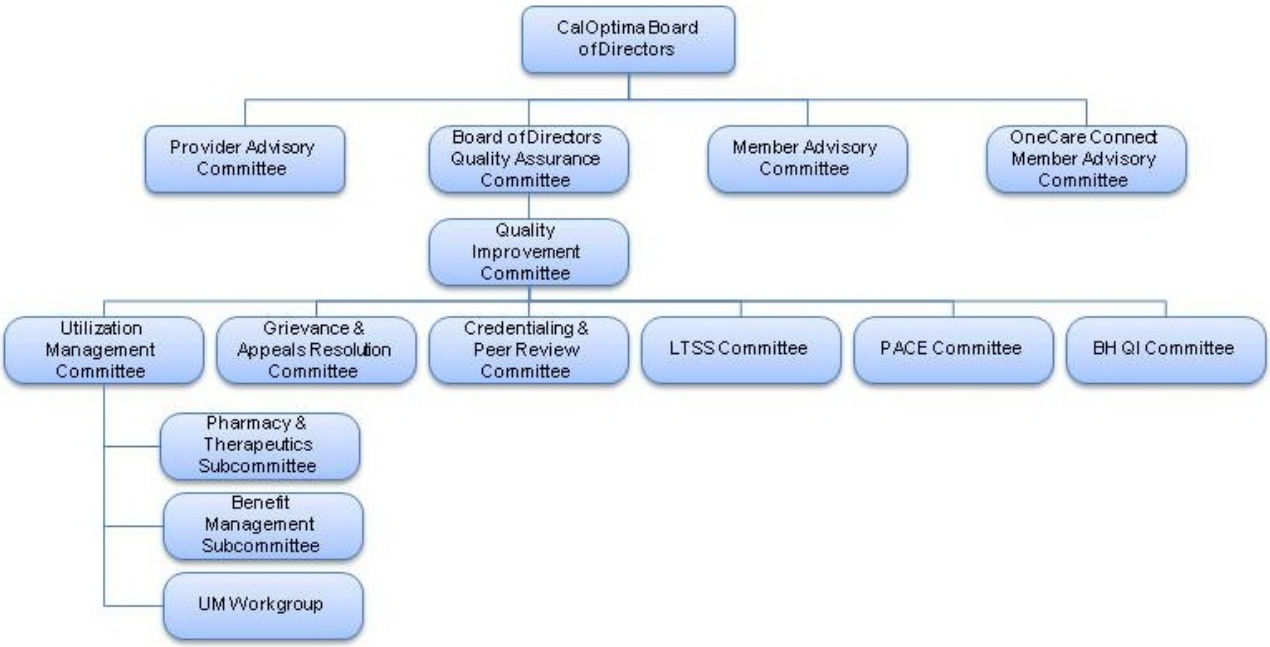
proficiency evaluations. Any employee who fails the evaluation is provided additional training and provided with a work improvement process. Formal training, including seminars and workshops, are provided to all UM staff on an annual basis.

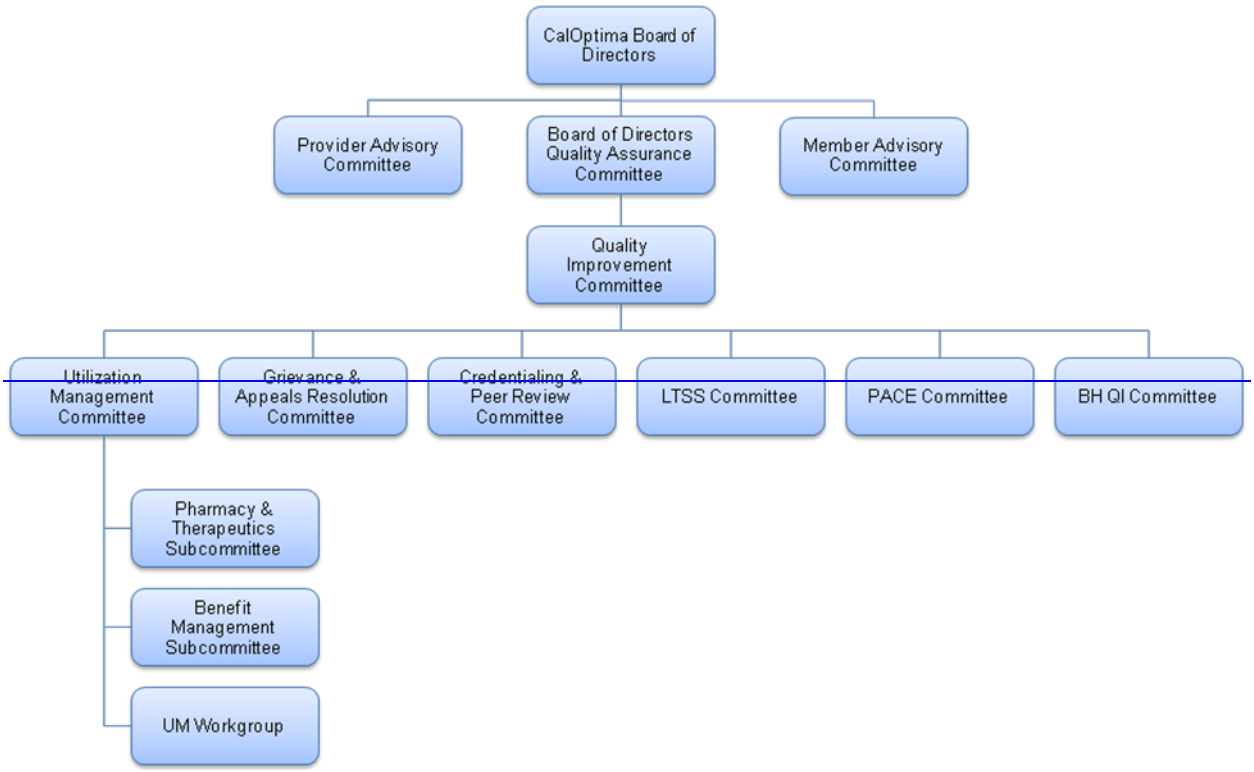
Appropriately licensed, qualified health professionals supervise the utilization management process and all medical necessity decisions. A physician or other appropriately licensed health care professional (as indicated by case type) reviews all medical necessity denials of healthcare services offered under CalOptima's medical and behavioral health benefits. Personnel employed by or under contract to perform utilization review are appropriately qualified, trained and hold current unrestricted professional licensure. This licensure is specific to the state of California. UM employee compensation includes hourly and salaried positions. All medical management staff is required to sign an Affirmative Statement regarding compensation annually. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is prohibited.

CalOptima and its delegated Utilization Review agents do not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

- The percentage of the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or
- Any other method that encourages the rendering of an adverse determination.

Committee Structure





Utilization Management Committee

The Utilization Management Committee (UMC) is responsible for the review and approval of medical necessity criteria and protocols and utilization management policies, procedures and programs. The UMC monitors and analyzes relevant data to detect and correct patterns of under or over utilization, coordination of care, appropriate use of services and resources, and member and practitioner satisfaction with the UM process.

The UMC meets quarterly and coordinates an annual review and revision of the Utilization Management Program Description, Work Plan and Annual UM Program Evaluation. Before coming to the Board of Directors for approval the documents are reviewed and approved by the Quality Improvement Committee (QIC) and Quality Assurance Committee (QAC). The Director of Utilization Management maintains detailed records of all UMC meeting minutes and recommendations for UM improvement activities made by the UMC. The UMC routinely submits meeting minutes as well as written reports regarding analysis of the above tracking and monitoring processes and status of corrective action plans to the QIC. Daily oversight and operating authority of utilization management activities is delegated to the UMC which reports up through CalOptima's QIC and ultimately to CalOptima's QAC and the Board of Directors.

Utilization Management Committee Scope

- Oversees the UM activities of CalOptima in regard to compliance with contractual requirements, Federal and State statutes and regulations, and National Committee for Quality Assurance (NCQA) requirements;
- Develops and annually reviews/approves the UM Program Description, Work Plan, criteria, policies and procedures;
- Reviews practitioner specific UM reports to identify trends and/or utilization patterns and makes recommendations to the QIC for further review;
- Reviews reports specific to facility and/or geographic areas for trends and/or patterns of under or over utilization;
- Examines appropriateness of care reports to identify trends and/or patterns of under or over utilization and refers identified practitioners to the QIC for performance improvement and/or corrective action;
- Examines results of annual member and practitioner satisfaction surveys to determine overall satisfaction with the UM program and identify areas for performance improvement;
- Provides a feedback mechanism to the QIC for communicating findings, recommendations, and a plan for implementing corrective actions related to UM issues;
- Identifies opportunities where UM data can be utilized in the development of quality improvement activities and submitted to the QIC for recommendations;
- Provides feedback to the QIC regarding effectiveness of CalOptima's P4P programs;
- Report's findings of UM studies and activities to the QIC;
- Liaisons with the QIC for ongoing review of quality indicators.

Utilization Management Committee Members
The UMC actively involves a number of actively participating network practitioners in utilization review activities as available and to the extent that there is not a conflict of interest. CalOptima's UMC is chaired by the UM Medical Director and is comprised of the:

- CMO;
- Deputy CMO;
- Executive Director Clinical Operations;
- CalOptima Medical Directors of Behavioral Health, Senior Programs, Quality and Analytics, and network Medical Directors and practitioners;
- The UMC is supported by the Medical Directors of Referral/Prior Authorization and Concurrent Review and the Director and Managers of Utilization, and any additional staff may also attend the Utilization Management Committee as appropriate.

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

The BMSC is responsible for the following:

- Recommending how to implement new or modified benefits;
- Clarifying the financial responsibility of benefit coverage;
- Recommending benefit decisions to the UMC;
- Updating and maintaining the Benefit Matrix, and
- Communicating benefit changes to staff, providers, and health networks for implementation.

The Subcommittee membership consists of the following:

- Medical Director, Utilization Management
- Executive Director Clinical Operations
- Director of Utilization Management
- Director Case Management
- Director Disease Management/Health Education
- Director Regulatory Affairs
- Director Clinical Pharmacy Management
- Director Quality and Analytics
- Director Managed Long Term Support and Services (MLTSS)
- Director Claims Management
- Director Grievance and Appeals Resolution
- Director Coding Initiatives

The BMSC meets ten times per year, and recommendations from the BMSC are reported to the UMC on a Quarterly basis.

Behavioral Health Quality Improvement Committee (BHQIC)

The Behavioral Health Quality Improvement Committee was established in 2011 with the intended purpose of:

- Ensuring members receive timely and satisfactory behavioral health care services;
- Enhancing the continuity and coordination between physical health and behavioral health care providers, and
- Guiding CalOptima towards the vision of bi-directional behavioral health care integration.
- Monitoring key areas of service utilization by ~~s to~~ members and providers, and identifying areas of improvement.

The BHQIC responsibilities are to: ~~is responsible for~~:

- ~~Monitoring key areas of service to members and providers through review of reports and presentations;~~
- ~~Identifying quality concerns, trends or systemic issues and opportunities for improvement, and~~
- ~~Communicating to the QIC its findings and recommendations.~~
- Ensure adequate provider availability and accessibility to effectively serve the membership
- Oversee the functions of delegated activities

- Monitor that care rendered is based on established clinical criteria, clinical practice guidelines, and complies with regulatory and accrediting agency standards
- Ensure that Member benefits and services are not underutilized and that assessment and appropriate interventions are taken to identify inappropriate over utilization
- Utilize Member and Network Provider satisfaction study results when implementing quality activities
- Maintain compliance with evolving National Committee for Quality Assurance (NCQA) accreditation standards
- Communicate results of clinical and service measures to Network Providers
- Document and report all monitoring activities to appropriate committees

The designated Chairman of the BHQIC is the Medical Director of the Behavioral Health Integration who is responsible for chairing the Committee, as well as reporting findings and recommendations to the QIC. The composition of the BHQI Committee is defined in the BHQIC Charter.

The BHQIC meets quarterly at a minimum or more frequently as needed.

~~The designated Chairman of the BHQIC is the Medical Director of Behavioral Health who is responsible for chairing the Committee, as well as reporting findings and recommendations to the QIC.~~

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

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

The BHQIC meets quarterly at a minimum or more frequently as needed.

Long Term Services and Supports Quality Improvement Subcommittee (LTSS QISC)

In 2014, the Long Term Services and Supports Improvement SubCommittee replaced the Long Term Care Quality Improvement Subcommittee. The LTSS QISC was created to provide a forum for LTSS programs to share best practices, identify challenges and barriers, and together find solutions that are member person-centered, maximize available resources and reducing duplicate

services while providing quality of care and ability for members to safely reside in the least restrictive living environment.

The purpose of the LTSS QISC:

- Engage stakeholders input on ways to best integrate the LTSS programs with managed care delivery system and improved quality of care
- Improving and providing coordinated care for CalOptima Members who resides in long term care facilities and those who receive Home- and Community Based Services (HCBS).

The LTSS QISC Responsibilities:

- Identify barriers to keeping Members safe in their own homes or in the community, develop solutions, make appropriate recommendations to improve discharge planning process and preventing inappropriate admissions
- Evaluate the performance, success, and challenges of LTSS program providers of the following services: CBAS, IHSS, MSSP and other Home and Community Based Services (HCBS)
- Monitor the important aspects of quality of care, qualify of services, patient safety by collecting and organizing data for all selected indicators
- Provide input on enhancing the capacity and coordination among LTSS providers, community-based organizations, housing providers, and managed care plans to care for individuals discharged from institutions.
- Identify and recommend topics for LTSS providers workshops, educations and trainings

The LTSS QISC Structure:

- The designated Chairman of the LTSS QISC is the Medical Director, Senior Programs, who is responsible for chairing the Committee.
- The LTSS Activity Summary is reported to QIC, and includes, but is not limited to the following:
    - Nursing Facility Administrators
    - Community Based Adult Services (CBAS) Administrators
    - Orange County Social Services Agency, Deputy Director or Designee
    - Multipurpose Senior Services Program, Site Director or Designee
    - Chief Medical Officer/Deputy Medical Officer
    - Medical Director QI and Analytics
    - Medical Director UM
    - Executive Director Clinical Operations
    - Executive Director Quality Analytics
    - LTSS Manager(s)
    - LTSS Director
- The LTSS QISC meets quarterly at a minimum or more frequently as needed.
- The LTSS Activity Summary includes, but is not limited to, will be reported to QIC.
    - Member review of Hospital Admission for each LTSS program;
    - Member review of Emergency Department visit for each LTSS program;
    - Members review for Hospital Readmissions for each LTSS program;
    - Health Risk Assessment results for LTC OCC members;

- LTC Provider Annual Workshop;
- CBAS Provider Workshop;
- CBAS Centerss Profile
- LTC Profile
- Care Coordination and Interdisciplinary Care Team Participation by LTSS staff;
- Total number of participants by LTSS program

- In addition, LTSS utilization activities' summary is reported to UMC, and includes, but is not limited to, the following;
  - Community Based Adult Services (CBAS) statistics such as to number of participants, assessment type, turn around time, denials rates;
  - Long Term Care (LTC) Statistics include, but is not limited to, bed type, turn around time, denials rate;
  - Multipurpose Senior Services Program (MSSP) statistics such as total number of participants, total number of termination, number of ER visits, ALOS, SNF admissions.
  - LTSS Inter-Rater Reliability study result;
  - Rate Adjustments for LTC facilities

Integration with the Quality Improvement Program

The UM Program and Workplan are evaluated and submitted for review and approval annually by both the CalOptima Utilization Management Committee and the Quality Improvement Committee (QIC), with final review and approval by the Board of Director's Quality Assurance Committee (QAC).

- Utilization data is collected, and aggregate UM data, member grievances, denials, and appeals are reviewed at the CalOptima Utilization Management Committee and recommendations are presented to the CalOptima QIC, and are presented to the participating HMOs, PHCs, SRGs and PMGs on a quarterly basis.
- The UM staff may identify actual or potential quality issues during utilization review activities. These issues are referred to the QI staff for follow-up.
- The CalOptima Quality Improvement Committee reports to the Board Quality Assurance Committee.
- The Utilization Management Committee is a sub-committee of the Quality Improvement Committee (QIC) and routinely reports activities to the QIC.

Conflict of Interest

CalOptima maintains a Conflict of Interest policy to ensure that conflicts of interest are avoided by staff and members of Committees. This policy precludes using proprietary or confidential CalOptima information for personal gain or the gain of others, as well as direct or indirect financial interests in, or relationships with, current or potential providers, suppliers, or members, except when it is determined that the financial interest does not create a conflict.

As stated in CalOptima's Human Resource Manual, a Conflict of Interest policy is provided to all employees when hired, and all Committee members, regardless of employment status (i.e., CalOptima or entity), sign a Conflict of Interest statement on an annual basis.

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

Confidentiality

CalOptima adheres to the following:

- Staff and consultants are required to sign a Confidentiality Statement and Business Associate Agreement;
- All members of the Utilization Management Committee are required to sign a Confidentiality statement at least annually;
- All employees and practitioners are allowed to access and disclose confidential information only as necessary to fulfill assigned duties and responsibilities;
- Medical information sent by mail or fax to the attention of the recipient is clearly marked "personal and confidential";
- All medical information is secured in a locked location with access limited to essential personnel only;
- Medical information stored in the software system is protected under multiple levels of security by system configuration, which includes user access passwords;
- Confidential information is destroyed by a method that induces complete destruction when no longer needed;
- CalOptima abides by all federal and state laws governing the issue of confidentiality.

The UM department complies with CalOptima's HIPPA policies and procedures and state and federal laws in the handling and protection of member and provider confidential information.

Integration with Other Processes

The UM Program, Case Management Program, Behavioral Health Program, Managed Long Term Support and Services Programs, Pharmacy and Therapeutics (P&T) Program, Quality Improvement (QI), Credentialing, and the Compliance and Audit and Oversight Programs are closely linked in function and process. The UM process utilizes quality indicators as a part of the review process and provides the results to CalOptima's QI department. As case managers perform the functions of utilization management, quality indicators, prescribed by CalOptima as part of the patient safety plan, are identified. The required information is documented on the appropriate form and forwarded to the QI department for review and resolution. As a result, the utilization of services is inter-related with the quality and outcome of the services.

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

filed in the practitioner's folder and is reviewed at the time of the practitioner's re-credentialing.

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

In addition, CalOptima coordinates utilization/care management activities with local community practitioners for activities that include, but are not limited to:

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

Utilization Management Process

The utilization management process encompasses the following program components: 24-hour seven day week nurse triage, second opinions, referral/prior authorization, concurrent review, ambulatory review, retrospective review, discharge planning and care coordination. All approved services must be medically necessary. The clinical decision process begins when a request for authorization of service is received at CalOptima level. Request types may include authorization of specialty services, second opinions, outpatient services, ancillary services, or scheduled inpatient services. The process is complete when the requesting practitioner and member (when applicable) have been notified of the determination.

Benefits

CalOptima administers health care benefits for members, as defined by contracts with the Department of Health Care Services (Medi-Cal), a variety of programs, regulations, policy letters and al the Center for Medicare and Medicaid Services benefit guidelines are maintained by CalOptima to support UM decisions. Benefit coverage for a requested service is verified by the UM staff during the authorization process. CalOptima has standardized authorization processes in place, and requires that all delegated entities to have similar program processes. Routine auditing of delegated entities is performed by the CalOptima Audit and Oversight Department via its delegation oversight team for compliance.

Utilization Management Program Structure

The UM Program is designed to work collaboratively with delegated entities, including but not limited to, physicians, hospitals, healthcare delivery organizations, and ancillary service providers in the community in an effort to assure that the member receives appropriate, cost efficient, quality-based healthcare.

The UM Program is reviewed and evaluated for effectiveness and compliance with the standards of the Department of Health Care Services (DHCS), Department of Managed Healthcare (DMHC), Centers for Medicare and Medicaid Services (CMS), California Department of Aging (CDA) and National Committee on Quality Assurance (NCQA) at least annually. Recommendations for

revisions and improvements are made, as appropriate, and subsequently annually. The Utilization Management Work Plan is based on the findings of the annual program Workplan evaluation. The structure of the UM Program is designed to promote organizational accountability and responsibility in the identification, evaluation, and appropriate utilization of health care services delivered by the CalOptima health care delivery network. Additionally, the structure is designed to enhance communication and collaboration on UM issues that affect delegated entities and multiple disciplines within the organization.

The Organization Chart and the program Committee's reporting structure accurately reflect CalOptima's Board of Directors as the governing body, identifies senior management responsibilities, as well as committee reporting structure and lines of authority. Position job descriptions and policies and procedures define associated responsibilities and accountability. The composition and functions of the Utilization Management Workgroup (UMG), and the UMC and QIC, which serve as the oversight committees for CalOptima UM functions, are contained and delineated in the Committees Charters.

The CalOptima UM Program is evaluated on an ongoing basis for efficacy and appropriateness of content by the Chief Medical Officer, Medical Directors of UM, the Executive Director of Clinical Operations, and the UMC and QIC. CalOptima-contracted delegates are delegated UM responsibilities, including the Utilization Management Program and work plans, which are presented annually to the QIC as part of CalOptima's Delegation Oversight Program. The QIC then reviews and approves or does not approve the delegate's UM Program and work plans.

Methods of Review and Authorization

Prior Authorization

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

Prior authorization is required for select services such as non-emergent inpatient admissions, elective out-of-network services, and certain outpatient services, ancillary services and specialty injectables as described on the Prior Authorization List. This list is accessible on the CalOptima website at www.caloptima.org.

Clinical Information

Prior Authorization is required for selected services appearing on a prior authorization list in the provider section on the CalOptima website at www.caloptima.org. Clinical information submitted by the provider justifies the rationale for the requested service through the authorization process which assesses medical necessity and appropriateness utilizing evidence-based guidelines upon which a determination is made.

A new medical management system, Altruista/GuidingCare ~~is scheduled to be~~ was implemented in the first quarter of 2015. This member- centric system utilizes evidence- based clinical guidelines and allows each member's care needs to be directed from a single integrated care plan that is

shared with internal and external care team members to enable collaboration, minimize barriers, and support continuity and coordination of care. The system captures data on medical, behavioral, social and personal care needs of members supporting the identification of cultural diversity and complex care needs.

In April 2012, CalOptima Link launched. The systems allows for on-line authorizations to be submitted by the health networks and processed electronically. The referrals are auto-adjudicated through referral intelligence rules (RIR). 45% of the on-line referrals met the RIR guidelines for auto approval in the 4th quarter of 2015~~4~~. Practitioners also send referrals and requests to the Utilization Management Department by mail, fax and/or telephone based on the urgency of the request.

Referrals
A referral is considered a request to CalOptima for authorization of services as listed on the Prior Authorization List. Primary Care Providers (PCP) are not required to issue paper referrals, but are required to direct the member's care and must obtain a prior authorization for referrals to certain specialty physicians and all non-emergent out-of- network practitioners as noted on the Prior Authorization List.

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

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

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

Network providers are prohibited from making referrals for designated health services to health care entities with which the practitioner or a member of the practitioner's family has a financial relationship.

Pharmaceutical Management

The Pharmacy Management Program is overseen by the CMO, and CalOptima Director of Pharmacy. All policies and procedures utilized by CalOptima related to pharmaceutical management include the criteria used to adopt the procedure as well as a process that uses clinical evidence from appropriate external organizations. The program is reviewed at least annually by the Pharmacy and Therapeutics Committee (P&T) and updated as new pharmaceutical information becomes available.

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

The CalOptima Pharmacy and Therapeutics Committee is responsible for development of the CalOptima Formulary, which is based on sound clinical evidence, and is reviewed at least annually by actively practicing practitioners and pharmacists. Updates to the CalOptima Approved Drug List are communicated to both members and providers.

If the following situations exist, CalOptima evaluates the appropriateness of prior authorization of non-formulary drugs:

- No formulary alternative is appropriate and the drug is medically necessary.
- The member has failed treatment or experienced adverse effects on the formulary drug.
- The member's treatment has been stable on a non-formulary drug, and change to a formulary drug is medically inappropriate.

To request prior authorization for outpatient medications not on the CalOptima Formulary, the physician or physician's agent must provide documentation to support the request for coverage. Documentation is provided via the CalOptima Pharmacy Prior Authorization (PA) form, which is faxed to CalOptima's Pharmacy Benefits Manager (PBM) for review. All potential authorization denials are reviewed by a Pharmacist at CalOptima, as per DHCS and DMHC regulations.
The Pharmacy Management Department profiles drug utilization by members to identify instances of polypharmacy that may pose a health risk to the member. Medication profiles for members receiving multiple medication fills per month are reviewed by a Clinical Pharmacist. Prescribing practices are profiled by practitioner and specialty groups to identify educational needs and potential over-utilization. Additional prior authorization requirements may be implemented for physicians whose practices are under intensified review.

Pharmacy Determinations

Medi-Cal

CalOptima Pharmacy Management Department delegates initial prior authorization review to the Pharmacy Benefits Manager (PBM) based on clinical prior authorization criteria developed by the CalOptima Pharmacy Management staff and approved by the CalOptima Pharmacy and Therapeutics (P&T) Committee. The PBM may approve or defer for additional information, but

final denial and appeal determinations may only be made by a CalOptima Pharmacist or CalOptima Medical Director. Final decisions for requests that are outside of the available criteria must be made by a CalOptima Pharmacist or CalOptima Medical Director.

CalOptima's written notification of pharmacy denials to members and their treating practitioners contains:

- A description of appeal rights, including the member's right to submit written comments, documents or other information relevant to the appeal
- An explanation of the appeal process, including the appeal time frames and the member's right to representation
- A description of the expedited appeal process for urgent preservices or urgent concurrent denials
- Notification that expedited external review can occur concurrently with the internal appeal process for urgent care

CalOptima gives practitioners the opportunity to discuss pharmacy UM denial decisions

OneCare

CalOptima does not delegate Pharmacy UM responsibilities. Pharmacy determinations follow the appropriate UM timeliness guidelines for medical necessity review.

The following edit checks are completed on-line, real-time, as a prescription is being dispensed:

- Duplicate Drug Therapy
- Too-Early Refill
- Low-Dose/High-Dose Alert
- Incorrect Daily Dosage
- Excessive or Questionable Days' Supply
- Drug to Drug Interaction
- Drug/Age Interaction
- Drug/Gender Interaction
- Drug/Pregnancy Interaction

Formulary

The CalOptima drug Formulary was created to offer a core list of preferred medications to all practitioners. Occasionally it is necessary to address requests from local providers to review specific drugs for addition to the Formulary. The Formulary is developed and maintained by the CalOptima Pharmacy and Therapeutics (P&T) Committee. Final approval from the P&T must be received to add drugs to the Formulary. CalOptima Formulary is available on the CalOptima website or in hard copy upon request.

Pharmacy Benefit Manager
The PBM is responsible for pharmaceutical administrative and clinical operations, including pharmacy network contracting and credentialing, pharmacy claims processing system and data operations, customer service, pharmacy help desk, prior authorization, clinical services and quality improvement functions. The PBM makes denial decisions based on lack of medical necessity, drugs not included in the Formulary, prior authorization not obtained, etc. The PBM follows and maintains compliance with health plan policies and all pertinent state and federal statutes and regulations. As a delegated entity the PBMs monitored according to the Audit and Oversight department's policies and procedures.

Specialty Injectables
CalOptima contracts with community pharmacies for the provision of specialty injectables not available through the delegated Pharmacy Benefit Manager's network.

CalOptima is responsible for medically necessary determinations related to specialty injectables. The pharmacies are not a subcontracted vendor and do not make medical necessity decisions. In the first Quarter of 2015 the responsibility for authorizing specialty injectables will transition from the UM Department to the Pharmacy Management Department to align the authorization process with the most appropriate health care professionals organizationally.

Medical Necessity Review
Covered services are those medically necessary health care services provided to members as outlined in CalOptima's contract with the State of California. Medically necessary means services or supplies that: are appropriate ~~proper~~ and needed for the diagnosis or treatment of a member's medical condition; are provided for the diagnosis, direct care, and treatment of the member's medical condition; meet the standards of good medical practice in the local area; and are not mainly for the convenience of the member or the doctor.

The CalOptima UM process uses an active, ongoing coordination and evaluation of requested or provided health care services, performed by licensed health care professionals, to ensure medically necessary, appropriate health care or health services are rendered in the most cost efficient manner, without compromising quality. Physicians, or other appropriate healthcare professionals, review and determine all final denial decisions for requested medical and behavioral health care services. The review of the denial of a pharmacy prior authorization, however, may be carried out by a qualified Physician or Pharmacist.

The Medical Directors are responsible for providing clinical expertise to the Utilization Management staff and exercising sound professional judgment during review determinations regarding health care and services. The CMO and Medical Directors, with the support of the UMC, have the authority, accountability and responsibility for denial determinations. For those contracted delegated PMGs that are delegated UM responsibilities, that entity's Medical Director, or designee, has the sole responsibility and authority to deny coverage. The Medical Director may also provide clarification of policy and procedure issues, and communicate with delegated entity practitioners regarding referral issues, policies, procedures, processes etc.

CalOptima's Utilization Management Department is responsible for the review and authorization of health care services for CalOptima Direct members utilizing the following medical determination review processes:

- Referral/Prior Authorization for selected conditions/services;
- Admission Review;
- Concurrent/Continued Stay Review for selected conditions;
- Discharge Planning Review;
- Retrospective Review;
- Emergency Service Authorization is not required but may be reviewed;
- Identification of Opportunities for Case Management, Disease Management or Health Education of CalOptima members;
- Evaluation for potential transplant services for health network members;

The following standards are applied to all prior authorization, concurrent review, and respective review determinations:

- Qualified health care professionals supervise review decisions, including care or service reductions, modifications, or termination of services;
- There is a set of written criteria or guidelines for Utilization Review that is based on sound medical evidence, is consistently applied, regularly reviewed, and updated;
- Member characteristics are considered when applying criteria in order to address the individual needs of the member. These characteristics include, but are not limited to:
    - Age
    - Co-morbidities
    - Complications
    - Progress of treatment
    - Psychological situation
    - Home environment, when applicable;

- Availability of facilities and services in the local area to address the needs of the members are considered when making determinations consistent with the current benefit set. In the event that member circumstances or the local delivery system prevent the application of approved criteria or guidelines in making an organizational determination, the request is forwarded to the Utilization Management Medical Director to determine an appropriate course of action;
- Reasons for decisions are clearly documented in the medical management system;
- Notification to Members regarding denied, deferred, or modified referrals is made in accordance with mandated regulatory and accreditation agency timeframes, and members and providers are notified of appeals and grievance procedures;
- Decisions related to appeals or grievances are made in a timely manner in accordance with timelines established by CalOptima's Grievance and Appeals Resolution process, and as the member's condition requires, for medical conditions requiring time sensitive services;
- Prior Authorization requirements are not applied to Emergency Services, Minor Consent/Sensitive Services, Family Planning, Preventive Services, basic Prenatal Care, Sexually Transmitted Disease services, and HIV testing;

- Records, including an oral or written Notice of Action, are retained for a minimum of five (5) years from the end of the fiscal year in which the date of service occurred, unless a longer period is required by law;
- Requesting provider is notified, orally or in writing, of any decision to deny, approve, modify, or delay a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested;
- All members are notified in writing of any decision to deny, modify, or delay a service authorization request.
- All providers are encouraged to request information regarding the criteria used in making a determination. Contact can be made directly to the Medical Director involved in the decision, utilizing the contact information included in the Notice of Action. A provider may request a discussion with the Medical Director, or a copy of the specific criteria utilized.

The following is appropriate clinical information used to make medical necessity determinations and includes, but is not limited to:

- Office and hospital records
- A history of the presenting problem
- A clinical examination
- Diagnostic test results
- Treatment plans and progress notes
- Patient's psychological history
- Information on consultations with the treating provider
- Evaluations from other health care providers
- Photographs
- Operative and pathological experts
- Rehabilitation evaluations
- A printed copy of criteria related to the request
- Information regarding benefits for services or procedures
- Information regarding the local delivery system
- Patient characteristics and information
- Information from responsible family members

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

Appropriate Professionals for UM Decision Process
The UM decision process requires that qualified, licensed health professionals assess the clinical information used to support UM decisions. If the clinical information included with a request for services does not meet the appropriate clinical criteria, the Utilization Management Nurse Case

Managers and Medical Authorization Assistants are instructed to forward the request to the appropriate qualified, licensed health practitioner for a determination. Only practitioners or pharmacists can make decisions/determinations for denial, or modification of care based on medical necessity, and must have education, training, and professional experience in medical or clinical practice and have an unrestricted license to practice in the specific discipline for which an adverse determination is being rendered.

CalOptima distributes a statement to all members in the Member Handbook, and at least annually to all practitioners and employees who make UM decisions, affirming that UM decision making is based only on appropriateness of care and services and existence of coverage. The organization does not specifically reward practitioners or other individuals for issuing denials of coverage of service or care, and CalOptima ensures that UM decision makers are not unduly influenced by fiscal and administrative management by requiring that UM decisions be based on evidence-based clinical criteria, the member's unique medical needs, and benefit coverage.

Authorization Review Roles				
Authorization Type*	**Criteria Utilized**	**Medical Assistant**	**Nurse**	**Medical Director / Physician Reviewer**
Chemotherapy	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines		X	X
DME (Custom & Standard)	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals		X	X
Diagnostics	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals		X	X
Dialysis	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals	X	X	X
Hearing Aids	Medi-Cal and Medicare Manuals	X	X	X
Home Health	InterQual / MCG / Medi-Cal and Medicare Manuals		X	X
Imaging	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals		X	X
In Home Nursing (EPSDT)	Medi-Cal and Medicare Manuals		X	X
Incontinence Supplies	Medi-Cal and Medicare Manuals	X	X	X
Injectables	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals		X	X
Medical Supplies (DME Related)	Medi-Cal and Medicare Manuals	X	X	X
NEMT	Title 22 Criteria		X	X
Office Consultations	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals	X	X	X
Office Visits (Follow-up)	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals	X	X	X
Orthotics	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals		X	X
Pharmaceuticls	CalOptima Pharmacy Authorization Guidelines	Pharmacy Technician		Pharmacits Physician Reviewer
Procedures	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals		X	X
Prosthetics	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals		X	X
Radiation Oncology	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals		X	X
Therapies (OT/PT/ST)	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals	RCOC Referral	X	X

		s		
Transplants	DHCS Guidelines	Referral	X	X
Administrative Denial	CalOptima Policy	X	X	
Medical Necessity Denial	~~InterQual /~~ MCG / Medi-Cal and Medicare Manuals / CalOptima Pharmacy Authorization Guidelines			X

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

Long Term Services and Supports

Authorization Type*	**Criteria Utilized**	**Medical Assistant**	**Nurse**	**Medical Director / Physician Reviewer**
Community Based Adult Services (CBAS)	DHCS CBAS Eligibility Determination Tool (CEDT)		**X**	**X**
Long Term Care: Nursing Facility B Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services / Title 22, CCR, Section 51335		**X**	**X**
Long Term Care: Nursing Facility A Level	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services / Title 22, CCR, Section 51334		**X**	**X**
Long Term Care: Subacute	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services / Title 22, CCR, Sections 51003 and 51303		**X**	**X**
Long Term Care: Intermediate Care Facility / Developmentally Disabled	Medi-Cal Criteria Manual Chapter 7: Criteria for Long Term Care Services / Title 22, CCR, Sections 51343 and 51164	X DDS or DMH Certified	**X**	**X**
Hospice Services	Medi-Cal Criteria Manual Chapter 11: Criteria for Hospice Care / Title 22, California Code of Regulations	**X**	**X**	**X**

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

Board Certified Clinical Consultants

In some cases, such as for authorization of a specific procedure or service or certain appeal reviews, the clinical judgment needed for a UM decision is specialized. In these instances, the Medical Director may consult with a board certified physician from the appropriate specialty for

additional or clarifying information when making medical necessity determinations or denial decisions. Clinical experts outside CalOptima may be contacted, when necessary to avoid a conflict of interest. CalOptima defines conflict of interest to include situations in which the practitioner who would normally advise on a UM decision made the original request for authorization or determination or is in, or is affiliated with the same practice group as the practitioner who made the original request or determination.

For the purposes of Behavioral Health review and oversight as a delegated vendor, College Health IPA (CHIPA) ensures there are Peer Reviewers/Clinical Consultants. Peer Reviewers are behavioral health professionals who are qualified, as determined by CHIPA's Medical Director, to render a clinical opinion about the behavioral health condition, procedure, and/or treatment under review. Peer reviewers must hold a current unrestricted California license to practice medicine in the appropriate specialty to render an opinion about whether a requested service meets established medical necessity criteria.

New Technology Review

Medi-Cal, OneCare, OneCare Connect

CalOptima's Pharmacy and Therapeutics Committee and Benefit Management Subcommitee shall study the medical, social, ethical, and economic implications of new technologies in order to evaluate the safety and efficacy of use for Members in accordance with policy GG.1534

~~Medi-Cal:~~

~~For Medi-Cal, CalOptima is not responsible for review and approval of new technology. This function is the contractual responsibility of the State of California.~~

~~OneCare:~~

~~A request for experimental or new medical technology for a OneCare member follows the process outlined in OneCare policy MA.7005: Evaluation of New Medical Technologies and Uses. In cases where it is not covered under Medicare, it follows procedures for Medi-Cal.~~

Preventive and Clinical Practice Guidelines (CPG)

Clinical Guidelines are developed and implemented via the QIC, and assist in making health care decisions and improving the quality of care provided to members. Medication use guidelines have been developed that are reviewed by the Pharmacy & Therapeutics Committee, which includes outside physician and pharmaceutical participants, whose recommendations are forwarded to the QIC for review and approval. These guidelines are posted on the CalOptima website. Additional condition specific guidelines are in development, and are based on a compilation of current medical practices researched from current literature and professional expert consensus documents. Guidelines are reviewed and updated at least annually by the respective committees. These standards for patient care are to be used as guidelines, and are not intended to replace the clinical medical judgment of the individual physician. CPGs are shared with the delegated HMOs, PHCs, SRGs and PMGs as they are approved.

While clinical practice guidelines (such as those distributed by American Diabetes Association, American Academy of Pediatrics and the American College of Obstetrics and Gynecology) are not used as criteria for medical necessity determinations, the Medical Director and UM staff make UM decisions that are consistent with guidelines distributed to network practitioners. Such guidelines

include, but are not limited to, Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Immunizations, and ADHD/ADD Guidelines for both adults and children.

UM criteria are nationally recognized, evidence based standards of care and include input from recognized experts in the development, adaption and review of the criteria. UM criteria and the policies for application are reviewed and approved at least annually and updated as appropriate.

CalOptima uses the following criteria sets for all medical necessity determinations:

- Medi-Cal and Medicare Manual of Criteria;
- National Comprehensive Cancer Network (NCCN) Guidelines;
- Centers of Excellence guidelines;
- Specialty Guidelines such as the American Academy of Pediatric Guidelines (AAP) and American Heart Association;
- Evidence- based nationally recognized criteria such as MCG and InterQual;
- CalOptima Level of Care Criteria for outpatient behavioral health services;
- CalOptima Medical Policy and Medi-Cal Benefits Guidelines;
- National (CMS) and Local (State) Determination Guidelines.
- National Guideline Clearinghouse

Delegated HMOs, PHCs, SRGs and PMGs must utilize the same or similar nationally recognized criteria.

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

Practitioner and Member Access to Criteria

At any time, members or treating practitioners may request UM criteria pertinent to a specific authorization request by contacting CalOptima's Utilization Management Department or may discuss the UM decision with CalOptima Medical Director. Each contracted practitioner receives a Provider Manual, a quick reference guide, and a comprehensive orientation that contains critical information about how and when to interact with the Utilization Management Department. The manual also outlines CalOptima's Utilization Management policies and procedures. Similar information is found in the Member Handbook and on the CalOptima website at www.caloptima.org.

Inter-Rater Reliability

At least annually, the CMO and Executive Director of Clinical Operations assess the consistency with which Medical Directors and other UM staff making clinical decisions apply UM criteria in decision-making. The assessment is performed as a periodic review by the Executive Director of Clinical Operations or designee to compare how staff members manage the same case or some forum in which the staff members and physicians evaluate determinations, or they may perform periodic audits against criteria. When an opportunity for improvement is identified through this

process, CalOptima's Utilization Management leadership takes corrective action. New UM staff is required to successfully complete inter-rater reliability testing prior to being released from training oversight.

Communication

Members and practitioners can access UM staff through a toll free telephone number (1-888-587-8088) at least eight hours a day during normal business hours for inbound or outbound calls regarding UM issues or questions about the UM process. TDD/TTY services for deaf, hard of hearing or speech impaired members are available at 1-800-735-2929. The phone numbers for these are included in the member handbook, on the web, and in all member letters. Additionally, language assistance for members to discuss UM issues is provided either by bilingual staff or through Language Line services.

Inbound and outbound communications may include directly speaking with practitioners and members, or faxing, electronic or telephone communications (e.g. sending email messages or leaving voicemail messages). Staff identifies themselves by name, title and CalOptima UM Department when both making and receiving phone calls regarding UM processes. After normal business hours and on holidays, calls to the UM department are automatically routed to an on-call contracted vendor. The vendor is not a delegated UM entity and therefore does not make authorization decisions. The vendor staff takes authorization information for the next business day response by CalOptima or notifies CalOptima on-call nurse in cases requiring immediate response. A log is forwarded to the UM Department daily identifying those issues that need follow-up by the UM staff the following day.

Access to Physician Reviewer

The CalOptima Medical Director or appropriate practitioner reviewer (behavioral health and pharmacy) serves as the point of contact for practitioners calling in with questions about the UM process and/or case determinations. Providers are notified of the availability of the appropriate practitioner reviewer to discuss any UM denial decisions through the Provider Manual, New Provider Orientation, and the Provider Newsletter. Notification of the availability of an appropriate practitioner reviewer to discuss any UM denial decision, and how to contact a reviewer for specific cases, is also provided verbally and/or in the written notification at the time of an adverse determination. The CalOptima Medical Director may be contacted by calling CalOptima's main toll-free phone number and asking for the CalOptima Medical Director. A CalOptima Case Manager may also coordinate communication between the CalOptima Medical Director and requesting practitioner.

Requesting Copies of Medical Records

Utilization Management staff does not routinely request copies of medical records on all patients reviewed. During prospective and concurrent telephonic review, copies of medical records are only required when difficulty develops in certifying the medical necessity or appropriateness of the admission or extension of stay during a verbal review. In those cases, only the necessary or pertinent sections of the record are required. Medical records may also be requested to complete an investigation of a member grievance or when a potential quality of care issue is identified through the UM process. Confidentiality of information necessary to conduct UM activities is maintained at all times. Members requesting a copy of CalOptima's designated record set are not charged for the copy.

Sharing Information
CalOptima's Utilization Management staff share all clinical and demographic information on individual patients among various divisions (e.g. discharge planning, case management, disease management, health education, etc.) to avoid duplicate requests for information from members or practitioners.

Provider/Member Communication
CalOptima's UM program in no way prohibits or otherwise restricts a healthcare professional acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

- The member's health status, medical care or treatment options, including any alternative treatments that may be self-administered;
- Any information the member needs in order to decide among all relevant treatment options;
- The risks, benefits and consequences of treatment or absence of treatment;
- The member's right to participate in a decision regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Timeliness of UM Decisions
Utilization management decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Established timelines are in place for providers to notify CalOptima of a service request and for the health plan to make UM decisions and subsequent notifications to the member and practitioner.

UM Decision and Notification Timelines

Medi-Cal and OneCare Connect	OneCare (Medicare)
Medical and Pharmaceutical - Decision Making	Medical and Pharmaceutical - Decision Making
• Processed by CalOptima Utilization Management Department for members in direct or non-delegated network • Processed by Utilization Management Department at the Physician Medical Groups • Qualified physician review for any modifications or denials • Qualified pharmacist review for any modifications of denials	• Processed by Utilization Management Department at the Physician Medical Groups • Processed by Case Management Department at CalOptima for out of area and Medi-Cal wrap authorizations • Processed by Pharmacy Management Department at CalOptima or Pharmacy Benefits Manager for pharmaceutical prior authorizations • Qualified physician review for any modifications or denials • Qualified pharmacists or physician review for any pharmaceutical partial approvals or denials
Timeframes for Determinations: • Routine 5 business days • Urgent 72 hours • Retrospective 30 days Timeframes for Notification: Authorization Request Type: Routine (Non-Urgent) Pre-Service: (Oral or Electronic) Provider: Initial within 24 hours of the decision Member: None specified Provider: Within 2 working days of making the decision Member: Within 2 working days of making the decision not to exceed 14 calendar days from the receipt of the request Routine (Non-Urgent): Pre-Service Extension Needed: Provider: Within 24 hours of making the	Timeframes for Determinations (non-Part B): Routine 14 calendar~~business~~ days • Urgent 72 hours • Retrospective 30 days Timeframes for Determinations (Part D): • Routine: 72 hours • Urgent: 24 hours • Retrospective: 14 days Timeframes for Notification (non-Part D) Authorization Request Type:: For Expedited requests, oral notification to the member must be made within 72 hours from the receipt of the request and must include expedited appeal rights. Written notification must be sent to the member and provider within three days of oral notification For standard determinations the member must be notified of the decision no later than 14 days after receipt of the request.

decision Member: None specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision Member: Within 14 calendar of making the decision, not to exceed 28 calendar days from receipt of the request Expedited Authorization (Pre-Service): (Oral or Electronic) Provider: Within 24 hours of making the decision Member: None specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision. Member: Within 2 working days of making the decision. Expedited Authorization (Pre-Service) – Extension Needed: (Oral or Electronic) Provider: Within 24 hours of making the decision Member: None specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision Member: Within w working days of making the decision. Concurrent: (Oral or Electronic) Practitioner: Within 24 hours of making the decision (for approvals and denials). Member: None Specified Written Notification of Denial or Modification: Provider: Within 2 working days of making the decision. Member: Within 2 working days of making the	If an extension is requested the member must be notified no later than the expiration of the request (28 days maximum.) Notification includes the reason for the delay and their right to file an expedited grievance if they disagree with the extension request. Pharmaceutical - Timeframes for Notification (Part D) Authorization Request Type: For expedited requests, written notification must be provided to the member within 24 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification. For standard requests, written notification must be provided to the member within 72 hours from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification. For retrospective requests, written notification must be provided to the member within 14 calendar days from the receipt of the request. If initial notification is made orally, then written notification must be provided within 3 calendar days of the oral notification.

decision. NOTE: For Provider and Member: If oral notification is given within 24 hours of request, written notification must be given no later than 3 working days after the oral notification. Post Service – Retrospective Review: (Oral or Electronic) Member and Provider: None specified Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of request. Post- Service – Extension Needed: (Oral or Electronic) Provider and Member: None specified Written Notification of Denial or Modification: Provider and Member: Within 30 calendar days of receipt of the information necessary to make the determination	
Denial Letter/Member Notification State mandated "Notice of Action"	Denial Letter/Member Notification CMS mandated "Medicare Notice of Non-Coverage" including specific language for expedited appeal for expedited initial organization determination

Urgent/Expedited Prior Authorization Services
For all pre-scheduled services requiring prior authorization, the provider must notify CalOptima within five (5) days prior to the requested service date. Prior authorization is never required for emergent or urgent care services. Facilities are required to notify CalOptima of all inpatient admissions and long-term care facility admissions within one (1) business day following the admission. Post-stabilization services (at out of network facilities) require authorization. Once the member's emergency medical condition is stabilized, certification for hospital admission or authorization for follow-up care is required.

Routine/Standard Prior Authorization Services
CalOptima makes determinations for standard, non-urgent, pre-service prior authorization requests within five (5) business~~calendar~~ days of receipt of necessary information, not to exceed 14 calendar days of receipt of the request. A determination for urgent pre-service care (expedited prior authorization) will be issued within 72 hours of receiving the request for service. CalOptima makes a determination for urgent concurrent, expedited continued stay, post stabilization review or in cases for ongoing ambulatory care or if the lack of treatment may result in an emergency visit or emergency admission within 24 hours of receipt of the request for services. A request made

while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by CalOptima. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., pre-service and post-service). Medical necessity of post service decisions (retrospective review) and subsequent member/practitioner notification will occur no later than 30 calendar days from receipt of request.

Nurse Advice Line

It is expected that CalOptima haswill implement a twenty-four hour, seven days per week NCQA accredited Nurse Advice Line accessible to all lines of business in 2015. The health line is designed to reduce unwarranted ER visits and associated costs; elevate member knowledge, engagement, health and satisfaction; and boost clinical, financial and operational outcomes. Multiple communication options allow the member access by web, email, and phone.

Bilingual staffs of Registered Nurses (RNs) assess and triage symptoms, make urgent and non urgent care recommendations using evidence based guidelines and resources, give provider and facility referrals and educate members on diagnoses, conditions and medications. The Advise Line also helps support CalOptima member's comprehensive needs by cross referring members to existing programs such as case or disease management, Pre-Natal Support Services, In Home Support Services, Multipurpose Senior Services, Health Education, and local resources available in the community.

Emergency Services

Emergency room services are available 24 hours/day 7days/week. Prior authorization is not required for emergency services and coverage is based on the severity of the symptoms at the time of presentation. Emergency services are covered inpatient and outpatient services when furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition. CalOptima covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An emergency medical condition is not defined on the basis of lists of diagnoses or symptoms.

Emergency services are covered when furnished by a qualified practitioner, including non-network practitioners, and are covered until the member is stabilized. CalOptima also covers any screening examination services conducted to determine whether an emergency medical condition exists.

If a Plan network practitioner, or Plan representative, instructs a member to seek emergency

services, the medical screening examination and other medically necessary emergency services are covered without regard to whether the condition meets the prudent layperson standard. Once the member's emergency medical condition is stabilized, certification for hospital admission or prior authorization for follow-up care is required as previously stated.

Although CalOptima may establish guidelines and timelines for submittal of notification regarding the provision of emergency services, including emergent admissions, CalOptima does not refuse to cover an emergency service based on the practitioner's or the facility's failure to notify CalOptima of the screening and treatment within the required timeframes, except as related to any claim filing timeframes. Members who have an emergency medical condition are not required to pay for subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

Admission/Concurrent Review Process

The admission/concurrent review process assesses the clinical status of the member and verifies the need for continued hospitalization and facilitates the implementation of the practitioner's plan of care, validates the appropriateness of the treatment rendered and the level of care, and monitors the quality of care to verify professional standards of care are met. Information assessed during the review includes:

- Clinical information to support the appropriateness and level of service proposed,
- Validating the diagnosis;
- Assessment of the clinical status of the member to determine special requirements to
- facilitate a safe discharge to another level of care;
- Additional days/service/procedures proposed, and
- Reasons for extension of the treatment or service.

Concurrent review for inpatient hospitalization is conducted throughout the inpatient stay, with each hospital day approved based on review of the patient's condition and evaluation of medical necessity. Concurrent review can occur on-site or telephonic. The frequency of reviews is based on the severity/complexity of the member's condition and/or necessary treatment and discharge planning activity.

If, at any time, services cease to meet inpatient criteria, discharge criteria are met, and/or alternative care options exist, the nurse case manager contacts the attending physician and obtains additional information to justify the continuation of services. When the medical necessity for a continued inpatient stay cannot be determined, the case is referred to the Medical Director for review. When an acceptable discharge plan is mutually agreed upon by the attending physician and the Utilization Management Medical Director, a Notice of Action (NOA) letter is issued immediately by fax or via overnight Certified Mail to the attending physician, hospital and the member.

The need for case management, disease management, or discharge planning services is assessed during the admission review and each concurrent review, meeting the objective of planning for the most appropriate and cost efficient alternative to inpatient care. If at any time the UM staff become aware of potential quality of care issues, the concern is referred to CalOptima Quality Improvement Department for investigation and resolution.

Hospitalist/SNFist Program

The goal of the Hospitalist/SNFist Program is for early identification and management of members, either in the Emergency Room or Inpatient setting, with prompt linkage to an identified hospitalist/SNFist to ensure that the member receives the appropriate care in the most appropriate setting. Appropriate setting is determined by medical providers using established evidence based clinical and administrative criteria. Other program objectives include:

Initiate appropriate care plan consistent with:

- Established estimated length of stay criteria
- Medical necessity criteria to establish appropriate level of care
- Member psychosocial needs impacting ongoing care
- Communication of current and ongoing needs impacting discharge planning and after-care requirements to PCP and others involved in the members care
- Facilitation of transfer of members from non-contracted facilities to facilities with a contracted hospitalist team

Contracted hospitalist groups, facilities case management staff, and Emergency Room personnel receive training from CalOptima staff on:

- Early identification of CalOptima Direct (COD) members
- Process for notification of Hospitalists
- Face sheet and/or telephonic notification to CalOptima
- Care Plan development and implementation
- Discharge Planning

The role of the hospitalist is to work together with the Emergency Department team to determine the optimal location and level of care for the member's treatment needs. If, based on clinical information and medical necessity criteria, the member requires admission to the facility; the hospitalist assumes primary responsibility for the member's care as the admitting physician and will coordinate the member's care together with CalOptima medical management staff. If at any time the member is appropriate for transfer to a lower level of care, whether directly from the emergency room or after admission, the hospitalist will facilitate the transfer to the appropriate setting, in concert with the accepting facility and with CalOptima staff.

Discharge Planning Review

Discharge planning begins within 48 hours of an inpatient admission, and is designed to identify and initiate a cost effective, quality driven treatment intervention for post-hospital care needs. It is a cooperative effort between the attending physician, hospital discharge planner, UM staff, health care delivery organizations, and community resources to coordinate care and services.

Objectives of the Discharge Planning Review are:

- Early identification during a member's hospitalization of medical/psycho-social issues with potential for post-hospital intervention;

- Development of an individual care plan involving an appropriate multi-disciplinary team and family members involved in the members care;
- Communication to the attending physician and member, when appropriate, to suggest alternate health care resources;
- Communication to attending physician and member regarding covered benefits, to reduce the possibility of a financial discrepancy regarding non-covered services and denied days of hospitalization;
- Coordination of care between the member, PCP, attending physician, specialists, hospital UM/Discharge Planning staff, and UM staff.

The UM staff obtains medical record information and identifies the need for discharge to a lower level of care based on discharge review criteria/guidelines. If the attending physician orders discharge to a lower level of care, the UM staff assists the hospital UM/Discharge Planner in coordinating post-hospital care needs. The same process is utilized for continued stay approval or denial determinations by the Utilization Medical Director as previously noted in the Concurrent Review Process.

Denials

A denial of services, also called an adverse organization determination, is a reduction, modification, suspension, denial or termination of any service based on medical necessity or benefit limitations. Upon any adverse determination for medical or behavioral health services made by CalOptima Medical Director or other appropriately licensed health care professional (as indicated by case type) a written notification, at a minimum, will be communicated to the member and requesting practitioner. Verbal notification of any adverse determination is provided when applicable.

All notifications are provided within the timeframes as noted in the Referral/Authorization Processing Policy and Procedure. The written notification is easily understandable and includes the member specific reason/rationale for the determination, specific criteria and availability of the criteria used to make the decision as well as the availability, process and timeframes for appeal of the decision. All templates for written notifications of decision making are DHCS approved prior to implementation.

Practitioners are provided with the opportunity to discuss any medical or behavioral health UM denial decisions with a physician or other appropriate reviewer. CalOptima Medical Director or appropriate practitioner reviewer (behavioral health practitioner, pharmacist, etc.) serves as the point of contact the peer to peer discussion. This is communicated to the practitioner at the time of verbal notification of the denial, as applicable, and is included in the standard denial letter template.

Utilization Management Appeals Process

CalOptima has a comprehensive review system to address matters when Medi-Cal or OneCare members wish to exercise their right to review of a utilization management decision to deny, delay, terminate or modify a request for services. This process is initiated by contact from a member, a member's representative, or practitioner to CalOptima. Appeals for members enrolled in COD, or one of the contracted HMOs, PHCs, SRGs and PMGs, are submitted to CalOptima's Grievance and

Appeals Resolution Services (GARS). The process is designed to handle individual disagreements in a timely fashion, and to ensure an appropriate resolution. The appeals process is in accordance with CalOptima Policy and Procedure HH.1102: Grievance and Appeals Resolution Services. This process includes:

- Collection of data
- Communication to the member and provider
- Thorough evaluation of the substance of the appeal
- Resolution of operational or systems issues
- Referral to an appropriately licensed professional in Medical Affairs for evaluation and further management of clinical issues, such as timeliness of care, access to care, and appropriateness of care, including review of the clinical judgments involved in the case

The UM appeal process for COD, HMOs, PHCs and SRGs is handled by the CalOptima Grievance and Appeals Resolution Services (GARS). CalOptima works collaboratively with the delegated entity in the gathering of information and supporting documentation. If a member is not satisfied with the initial decision, he/she may file for a State Hearing with the California Department of Social Services.

UM Appeals can be initiated by a member, a member's representative or a practitioner. Pre-service appeals may be processed as expedited or standard appeals, while post-service appeals will be processed as standard appeals only.

All medical necessity decisions are made by a licensed physician reviewer. -Appeals are reviewed by an objective reviewer, other than the reviewer who made the initial denial determination; however, the initial reviewer may participate in the appeal process if new or additional information is submitted.

The UM or CM Medical Director or designee evaluates appeals regarding the denial, delay, termination, or modification of care or service. The UM Medical Director or designee may request a review by a board-certified, specialty-matched Peer Reviewer to evaluate the determination. An "Expert Panel" roster is maintained from which, either via Letter of Agreement or Contract, a Board Certified Specialist reviewer is engaged to complete a review and provide a recommendation regarding the appropriateness of a pending and/or original decision that is now being appealed.

CalOptima sends written notification to the member and/or practitioner of the outcome of the review within the required timelines. If the denial was upheld, even in part, the letter includes the appropriate appeal language to comply with applicable regulations.

When quality of care issues are identified during the investigation process, further review of the matter is indicated. This portion of the review is conducted under the Peer Review process.

Upon request, members can have access to and copies of all documents relevant to the member's appeal by calling the CalOptima Customer Service Department.

Expedited Appeals

A member or member's representative may request the appeal process to be expedited if it is felt that there is an imminent and serious threat to the health of the member, including, but not limited to, severe pain, or potential loss of life, limb, or major bodily function. All expedited appeal requests shall be reviewed and resolved in as expeditious a manner as the matter requires, but no later than 72 hours after receipt.

At the time of the request, the information is reviewed and a decision is made as to whether or not the appeal meets the expedited appeal criteria. Under certain circumstances, where a delay in an appeal decision may adversely affect the outcome of treatment, or the member is terminally ill, an appeal may be determined to be urgent in nature, and will be considered expedited. These appeals are managed in an accelerated fashion in an effort to provide appropriate, timely care to members when the regular timeframes of the review process could seriously jeopardize the life or health of the member, or could jeopardize the member's ability to regain maximum functionality.

Provider Preventable Conditions (PPCs)

The federal Affordable Care Act (ACA) requires that providers report all Provider Preventable Conditions (PPCs) that are associated with claims for Medi-Cal payment or with courses of treatment furnished to a Medi-Cal patient for which Medi-Cal payment would otherwise be available. The ACA also prohibits Medi-Cal from paying for treatment of PPCs.
There are two types of PPCs health care acquired conditions (HCAC), 1). Those occurring in inpatient acute care hospitals, and 2) Provider-preventable conditions (OPPC), which are reported when they occur in any health care setting.

Once identified the PPC is reported to CalOptima's Quality Improvement Division for further research and reporting to government and/or regulatory agencies.

Long Term Support Services (LTSS)

Long Term Care

The Long Term Care case management program includes authorizations for the following facilities: skilled nursing, intermediate care, sub-acute care, intermediate care–developmentally disabled, intermediate care–developmentally disabled—habilitative, and intermediate care–developmentally disabled—nursing. It excludes institutions for mental disease, special treatment programs, residential care facilities, board and care, and assisted living facilities. Facilities are required to notify CalOptima of admissions within 21 days. An on-site visit is scheduled to assess patient's needs through review of the Minimum Data Set, member's care plan, medical records, and social service notes, as well as bedside evaluation of the member and support system. Ongoing case management is provided for members whose needs are changing or complex. LTC services also include coordination of care for members transitioning out of a facility, such as education regarding community service options, or a referral to the Multipurpose Senior Services Program (MSSP), In Home Supportive Services (IHSS) program or to a Community Based Adult Services (CBAS) facility. In addition, the LTC staff provides education to facilities and staff through monthly onsite visits, quarterly and annual workshops, or in response to individual facility requests, and when new programs are implemented.

Community Based Adult Services (CBAS)

An outpatient, facility based program offering daytime care and health and social services to frail

seniors and adults with disabilities to enable participants to remain living at home instead of a nursing facility.
Services may include: health care coordination, meal service (at least one per day at center), medication management, mental health services, nursing services, personal care and social services, physical, occupational, and speech therapy, recreational activities, training and support for family and caregivers, and transportation to and from center.

Multipurpose Senior Services Program (MSSP)
~~Effective July 1, 2015~~ CalOptima has ~~will assume~~ responsibility for the payment of the MSSP in the County of Orange for individuals who have Medi-Cal. The program provides services and support to help persons 65 and older who have a disability that puts them at risk of going to a nursing home. Services include, but are not limited to: senior center programs, case management, money management and counseling, respite, housing assistance, assistive devices, legal services, transportation, nutrition services, home health care, meals, personal care assistance with hygiene, personal safety and activities of daily living.

In Home Supportive Services (IHSS)
~~Effective July 1, 2015~~ CalOptima has~~will assume~~ responsibility of the payment of services for CalOptima members who receive services from the IHSS program which is operated by the County of Orange. The program provides services to those members who are disabled, blind, or 65 years of age or older and are unable to live safely at home without help who meet the financial need requirement. Services are provided by a caretaker that the member hires. The County will still make the determination of eligibility under the program as well as determine the number of hours that an individual will be receiving services. Under an MOU with the county, CalOptima will be working collaboratively to ensure that referrals are being made and to involve members and their caregivers, when agreed to, in the care planning process.

Retrospective Review
Retrospective review is an initial review of services that have already been rendered. This process encompasses services performed by a participating or non-participating provider without CalOptima notification and/or authorization and when there was no opportunity for concurrent review. The Director of Utilization Management, or designee, reviews the request for retrospective authorization. If supporting documentation satisfies the administrative waiver of notification the request is reviewed utilizing the standard medical necessity review process. If the supplied documentation meets medical necessity criteria, the request is authorized. If the supporting documentation is questionable, the Director of Utilization Management or designee requests a Medical Director review. The request for a retrospective review must be made within 60 days of the service provided. The decision, to authorize or deny, is made within thirty (30) calendar days of receipt.

Transitions of Care (TOC)
TOC is a 4-week patient-centered intervention, managed by the Case Management Department, which employs a coaching, rather than doing, approach. It provides patients or caregivers with tools and support to encourage and sustain self-management skills in an effort to minimize a possible readmission and optimize the member's quality of life.

TOC focuses on four conceptual areas determined to be crucial in preventing readmission. These are:

- Knowledge of Red Flags: Patient is knowledgeable about indications that their condition is worsening and how to respond;
- Medication Self-Management: Patient is knowledgeable about medications and has a medication management system;
- Patient-Centered Health Record: Patient understands and uses a Personal Health Record (PHR) to facilitate communication with their health care team and ensure continuity of care across providers and settings;
- Physician Follow-Up: Patient schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.

The program is introduced by the TOC coach, typically, at four touch points over one month: a pre-discharge hospital visit, a post-discharge home visit, and two follow-up phone calls. Coaches are typically community workers, social workers or nurses.

Complex Case Management

The Case Management Program is an ongoing outpatient collaborative process that strives to assure the delivery of health care services in a responsible, optimally cost-efficient manner. Case Management is a distinct and unique program that identifies eligible persons, with specific health care needs, in order to facilitate the development and implementation of a care plan to efficiently use health care resources to achieve optimum member outcomes. Case Management activities are complimentary, not duplicative, of Utilization Management activities.

Case Managers are licensed Nurses with caseloads that are variable, depending on the complexity of the cases managed.

The case management program includes:

- Standardized mechanisms for member identification through use of data;
- Multiple avenues for referrals to case management;
- Following members across the continuum of health care from outpatient or ambulatory to inpatient settings;
- Use of evidence-based clinical practice guidelines or algorithms;
- Initial assessment and ongoing management process;
- Developing, implementing and modifying an individualized care plan through an interdisciplinary and collaborative team process, in conjunction with the member and/or his or her family and/or care giver(s);
- Developing comprehensive long and short term goals;
- Analyzing all data for formulating appropriate recommendations;
- Coordinating services for members for appropriate levels of care and resources;
- Documenting all findings;
- Monitoring, reassessing, and modifying CalOptima of care to ensure quality, timeliness, and effectiveness of services;
- Mechanism for identification and referral of quality of care issues to QI Department;

- Assessing the outcomes of case management and presenting findings to the Medical Director of Case Management.

Case Management Process

- Referral/Case Identification
- Intake
- Assessment
- Risk Stratification
- Care Plan development, with long and short term goals

For further details of the structure, process, staffing, and overall program management please refer to the 2016~~5~~ Case Management Program document.

Transplant Program

The CalOptima transplant program is coordinated by CalOptima's medical director and managed by the Case Management Department's collaboration. Transplants are ~~and is not~~not delegated to the HMOs, PHCs, SRGs and PMGs, other than Kaiser Foundation Health Plan. It provides the resources and education needed to proactively manage members identified as potential transplant candidates. The CalOptima Case Management Department works in conjunction with the contracted practitioners and the DHCS Center(s) of Excellence, or CMS Center(s) of Excellence for OneCare, as needed to assist members through the transplant review process. Patients are monitored on an inpatient and outpatient basis, and the member, physician, and facilities are assisted in order to assure timely, efficient, and coordinated access to the appropriate level of care and services within the member's benefit structure. In this manner, the transplant program benefits the member, the community of transplant staff, and the facilities. CalOptima monitors and maintains oversight of the transplant program, and reports to the UM Committee to oversee the accessibility, timeliness and quality of the transplant process across networks.

Coordination of Care ~~Services~~

Coordination of services and benefits is a key function of case management both during inpatient acute episodes of care as well as for complex or special needs cases which are referred to the Case Management and/or Disease Management Department for follow-up after discharge. Coordination of care encompasses synchronization of medical, social, and financial services and may include management across payer sources. The Case Manager must promote continuity of care by ensuring appropriate referrals and linkages are made for the member to the applicable provider or community resource, even if these services are outside of the required core benefits of the health plan or the member has met the benefit limitation. Because Medicaid is always the payer of last resort, CalOptima must coordinate benefits with other payers including Medicare, Worker's Compensation, commercial insurance, etc. in order to maintain access to appropriate services.

Other attempts to promote continuity and coordination of care include member notifications to those affected by a PCP or practice group termination from CalOptima. CalOptima assists the member as needed to choose a new PCP and transfer the medical records to the new PCP. If the provider is not termed due to a quality issue, the health plan may also authorize continued treatment with the provider under certain situations. CalOptima also coordinates continuity of care with other

Medicaid health plans when a new member comes onto CalOptima or a member terminates from CalOptima to a new health plan.

Disease Management (DM)

Disease Management is a multidisciplinary, continuum-based approach to healthcare delivery that proactively identifies populations with, or at risk for, chronic medical conditions. CalOptima's Disease Management Program is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant. The diagnosis based programs are offered telephonically, involving interaction with a trained healthcare professional, and require an extended series of interactions, including a strong educational element. CalOptima's disease management programs emphasize prevention and members are expected to play an active role in managing their diseases.

Disease Management Process

CalOptima's DM programs are disease specific and evaluated for relevance to CalOptima's membership demographics and utilization patterns. DM programs may include, but are not limited to: Asthma, Chronic Kidney Disease, COPD, Diabetes, Pregnancy Management, and Depression. The major components of each disease management program include:

- Identification of members with specified diagnosis;
- Stratification or classification of these members according to the severity of their disease, the appropriateness of their treatment, and the risk for complications and high resource utilization;
- Provision of proven interventions that will improve the clinical status of the member and reduce the risk for complications and long-term problems;
- Involvement of the member, family/caregiver(s), and physician to promote appropriate use of resources;
- Education of patient and family/caregiver(s) to promote increased understanding of the disease and increase self-management of the disease in an effort to decrease exacerbations;
- Ongoing measurement of the process and its outcomes in order to document successes and/or identify necessary revisions of the program.

Members with a potential diagnosis applicable to the specific DM program are identified through various sources, including, but not limited to: inpatient census reports, medical claims data (office, emergency department, outpatient, and inpatient levels of care), pharmaceutical claims data, health risk assessments (HRA) results, laboratory reports, data from UM/CM processes, new member welcome calls, member self-referral, and physician referral.

Based on the data received during the identification phase, members are stratified into risk groups that guide the care coordination interventions provided. Members are stratified into Low, Moderate, or High Risk categories. Definitions for each risk category are program specific and are outlined in the program's description document. Members may change between risk groups based on data retrieved during each reporting period, as well as through collaboration/interaction with the member or PCP.

Members enrolled into a disease management program receive some level of intervention, which may include, but is not limited to: identification, assessment, disease specific education,

reminders about preventive/monitoring services, assistance with making needed appointments and transportation arrangements, referral to specialists as needed, authorization for services and/or medical equipment, coordination of benefits, and coordination with community based resources. Education is a crucial component of the disease management program. Education is presented to members and their treating physician(s) and may be provided through mailings, telephone calls, or home visits.

High-risk members are referred to CalOptima's complex case management program for development of an individualized care plan. Both the member/family/caregiver(s) and the physician will be included in the development of the care plan. Including the member/family/caregiver(s) in the development of the individualized goals and interventions promotes ownership of the program and stimulates a desire for success. Care plan goals and interventions are reviewed routinely and CalOptima of care is adjusted as necessary by the care coordinator to assure an optimal outcome for the member.

Measuring Effectiveness

Effectiveness of both the complex case management and disease management programs are measured on, at a minimum, an annual basis. Methods of evaluation include condition specific indicators (e.g. HEDIS measures for Comprehensive Diabetes Care), utilization data, such as frequency of ER visits or inpatient admissions, and self-reported member information such as satisfaction with the program, level of understanding of the disease, or improvement in life impact, such as days of school or work missed. This measurement and analysis is documented as part of the annual UM program evaluation.

State Fair Hearing (Medi-Cal Line of Business Only)

CalOptima Medi-Cal members have the right to request a State Fair Hearing from the California Department of Social Services at any time during the appeals process, or within 90 days of an adverse decision. A member may file a request for a State Fair Hearing and a request for an appeal at the same time. CalOptima and the HMOs, PHCs and SRGs comply with State Aid Paid Pending requirements, as applicable. Information on filing a State Fair Hearing is included annually in the member newsletter, in the member's evidence of coverage, and with each resolution letter sent to the member or the member's representative.

Independent Medical Review

OneCare and OneCare Connect members have a right to request an independent review if they disagree with the termination of services from a skilled nursing facility (SNF), home health agency (HHA) or a comprehensive outpatient rehabilitation facility (CORF). The Center for Medicare and Medicaid Services (CMS) contracts with a Quality Improvement Organizations (QIO) to conduct the reviews. OneCare is notified when a requests is made by a member or member representative. OneCare supports the process with providing the medical records for the QIC's review. The QIO notifies the member or member representative and OneCare of the outcome of their review. If the decision is overturned, OneCare complies by issuing a reinstatement notice ensuring services will continue as determined by the QIO.

Program Evaluation

The UM Program is evaluated at least annually, and modifications made as necessary. The CMO

and Executive Director of Clinical Operations evaluate the impact of the UM program by using:

- Member complaint, grievance and appeal data
- The results of member satisfaction surveys
- Practitioner complaint, and practitioner satisfaction surveys
- Relevant UM data
- Practitioner profiles
- Drug Utilization Review (DUR) profiles (where applicable)

The evaluation covers all aspects of the UM Program. Problems and/or concerns are identified and recommendations for removing barriers to improvement are provided. The evaluation and recommendations are submitted to the UMC for review, action and follow-up. The final document is then submitted to the Board of Directors through the QIC for approval.

Satisfaction With the UM Process

CalOptima provides an explanation of the grievance and appeal process, Administrative Hearing, Independent Review, and DHCS Board of Appeals review processes to newly enrolled members upon enrollment and annually thereafter. The process is explained in the Member Handbook and Provider Manual and may also be highlighted in member newsletter articles, member educational flyers, postings at provider offices. Complaints or grievances regarding potential quality of care issues are referred to CalOptima Quality Improvement Department for investigation and resolution.

Annually, CalOptima evaluates both members' and providers' satisfaction with the UM process. Mechanisms of information gathering may include, but are not limited to: member satisfaction survey results (CAHPS), member/provider complaints and appeals that relate specifically to UM, provider satisfaction surveys with specific questions about the UM process, and soliciting feedback from members/providers who have been involved in appeals related to UM. When analysis of the information gathered indicates that there are areas of dissatisfaction, CalOptima develops an action plan and interventions to improve on the areas of concern which may include staff retraining and member/provider education.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

Chet Uma, Chief Financial Officer, (714) 246-8400
Silver Ho, Executive Director, Compliance, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute Amendment to the Primary and Secondary Agreements between DHCS and CalOptima related to:

- Rate Changes;
- Extension of the Termination Date of the Agreements; and
- Incorporation of language to the Primary Agreement related to Provider-Preventable Conditions (PPC)

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 25, which extends the agreement through December 31, 2016. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

On October 3, 2016, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will revise CalOptima's Intergovernmental Transfer (IGT) rate range for the period of July 2014 to June 2015, update the Classic Medi-Cal rates for the period of July 2014 to June 2015, and update Optional Expansion rates for the period July 2014 to December 2014 under Senate Bill (SB) 239. The amendment also seeks to incorporate language related to Provider-Preventable Conditions (PPC).

DHCS has also notified Plans that amendments will be forthcoming to extend the termination dates of the Primary and Secondary Agreements to December 31, 2020.

Rate Changes

On August 19, 2016, CalOptima received draft rate changes from DHCS. Specifically, the amendment seeks to make rate changes related to:

- IGT rate range for the period July 2014 to June 2015;
- Classic Medi-Cal rates for the period July 2014 to June 2015 under SB 239; and
- Optional Expansion rates for the period July 2014 to December 2014 under SB 239.

Back to Agenda

The changes to the IGT rate range for the period July 2014 to June 2015 are a result of CalOptima's IGT 5 initiatives, as described to and approved by the CalOptima Board of Directors during its March 3, 2016 meeting. Expenditures of IGT funds are for restricted, one-time purposes for providing enhanced benefits to existing CalOptima Medi-Cal members, and do not commit CalOptima to future budget allocations.

The changes to Medi-Cal rates under SB 239 relate to the Hospital Quality Assurance Fee (QAF). SB 239 imposes a QAF from January 1, 2014 to December 31, 2016, and authorizes the framework for the existing QAF built into CalOptima's rates, which have been approved numerous times by the CalOptima Board of Directors, including most recently in May 2015. By statute, CalOptima will pass through to hospitals the full amount of supplemental hospital funds it receives from DHCS.

Of note, this amendment revises Classic Medi-Cal rates for QAF for the entire Fiscal Year 2014/15, or July 2014 to June 205. However, the amendment seeks to only revise Optional Expansion rates for the QAF for the period July 2014 to December 2014, meaning that the Optional Expansion rates will be further amended in the future for the QAF for the remainder of Fiscal Year 2014/15.

The anticipated impact of these proposed rate changes is summarized below in the Fiscal Impact section.

Extension of the Termination Date of the Agreements

DHCS will request CalOptima's execution of amendments to extend the termination date of CalOptima's Primary and Secondary Agreements to December 31, 2020 from the current termination date of December 31, 2016. DHCS has historically extended the termination date of its agreements with CalOptima by a single calendar year, but it informed CalOptima on November 9, 2016 that it has reached an agreement with the Centers for Medicare & Medicaid Services (CMS) that allows DHCS to extend the term of CalOptima's contract for a longer term.

The CalOptima Board previously authorized and directed the Board Chair to execute an extension to the Primary and Secondary Agreements to December 31, 2017 during its June 2, 2016 meeting. Because the term of the extension has changed (i.e., from December 31, 2017 to December 31, 2020), Staff is requesting that the Board provide updated authority and direction to the Chair to execute amendments to the Primary and Secondary agreements reflective of the updates covered by the amendment now being proposed by DHCS.

Provider Preventable Conditions

DHCS's proposed amendment adds language regarding PPCs. Specifically, the amendment defines PPCs as "a condition occurring in an inpatient hospital setting, or a condition occurring in any health care setting, that meets the criteria as stated in 42 CFR 447.26(b)," and states that CalOptima shall not pay provider claims or reimburse a provider for a PPC, and requires CalOptima and its contracted providers to report PPCs to DHCS in a format required by DHCS.

The addition of this contract language is consistent with current DHCS All Plan Letter (APL) guidance, which provides further detail and description of PPCs. DHCS 16-011 identifies PPCs as either Health Care-Acquired Conditions in inpatient hospital settings (such as blood incompatibility,

air embolism, or surgical site infection following certain procedures) or Other Provider Preventable Conditions in any health care setting (such as performing the wrong surgery or performing surgery on the wrong body part or patient).

This new contract language is also intended to bring CalOptima's contract into alignment with certain requirements set forth in the Medicaid and CHIP Managed Care Final Rule (Final Rule), as published in the Federal Register in May 2016. This contract language is intended by DHCS to meet the Final Rule requirement in 42 Code of Federal Regulations (CFR) Section 438.3(g) that Plans must report all identified provider-preventable conditions in a form and frequency as specified by the State.

Once CMS concludes its review of DHCS's proposed amendment, DHCS will provide the amendment to CalOptima for prompt execution and return. If the amendment is not consistent with Staff's understanding as presented in this document or if it includes significant unexpected language changes, Staff will return to the Board of Directors for further consideration.

Fiscal Impact

The IGT rate range for the period of July 2014 through June 2015 is budget neutral to CalOptima. Expenditures of IGT funds are for restricted, one-time purposes for providing enhanced benefits to existing CalOptima Medi-Cal members, and do not commit CalOptima to future budget allocations.

The revised capitation rates for Classic Medi-Cal for the period of July 2014 through June 2015 under SB 239 and Optional Expansion rates for the period of July 2014 through December 2014 under SB 239 result in an average per member per month increase of $21.29. By statute, CalOptima will pass through to hospitals the full amount of supplemental hospital funds it receives from DHCS.

The contract language revisions related to PPCs is budget neutral to CalOptima. The CalOptima Fiscal Year 2016-17 Consolidated Operating Budget included a revenue adjustment for PPCs.

Rationale for Recommendation

CalOptima's 2013-14 operating budget was based on the anticipated rates for FY 2014-15. CalOptima's 2014-15 operating budget was based on the anticipated rates for FY 2015-16. Therefore, execution of the rate amendment will ensure revenues and payments consistent with the approved budget.

The extensions of the Primary and Secondary Agreements with DHCS for Medi-Cal are necessary for the continued operation of CalOptima's Medi-Cal program.

The addition of the PPC language to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of the Medicaid and CHIP Managed Care Final Rule.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

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

/s/ Michael Schrader *11/22/2016*
Authorized Signature **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 7

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

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

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 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language.	April 2, 2015

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

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) Ratification of rates requested April 7, 2016

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Consider Authorizing Proposed Budget Allocation Changes in the CalOptima Fiscal Year (FY) 2016-2017 Operating Budget

Contact

Katia Taylor, Interim Director, Human Resources, (714) 246-8400

Recommended Actions

1. Authorize reallocation of budgeted but unused funds of $500,000 from Salaries, Wages and Benefits to Purchased Services, to fund the use of executive search consultants and/or executive temporary staffing firm(s) to assist in filling hard to fill vacancies; and
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to contract with such firms consistent with CalOptima's Board-approved purchasing policy.

Background/Discussion

On March 1, 2012, the CalOptima Board of Directors adopted CalOptima Resolution No. 12-0301-01, which includes provisions that delegate authority to the Chief Executive Officer to make budget allocation changes within certain parameters. Pursuant to this resolution, budget allocation changes (i.e., movement of unexpended budgeted dollars from one Board-approved program, item, or activity to another within the same expense category) of $100,000 or more require Board approval.

To ensure that difficult to fill positions at the department director level and above are filled in timely manner, management recommends that the Board authorize the reallocation and use of currently unexpended budgeted dollars from Salaries, Wages and Benefits to fund executive search consultant(s) and/or executive temporary staffing agency(ies) to assist in filling those positions either permanently, or on a temporary basis while seeking a permanent replacement.

Fiscal Impact

The fiscal impact for this recommended action is budget neutral. Unspent budgeted funds from Salaries, Wages and Benefits approved in the CalOptima FY 2016-17 Operating Budget on June 2, 2016, will fund the total cost of up to $500,000 for the recommended actions.

Rationale for Recommendation

Staff recommends approval of the recommended action as a budget-neutral way to fill certain hard-to-fill management-level positions.

Concurrence

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

Back to Agenda

Attachments
None

/s/ Michael Schrader *11/22/2016*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
9. Approve CalOptima Strategic Plan for 2017-2019

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

Recommended Action
Adopt CalOptima's Strategic Plan: 2017-2019, and direct the Chief Executive Officer (CEO) to implement, providing regular progress reports to the Board of Directors over the course of its implementation.

Background
CalOptima's previous 2013-2016 Strategic Plan expired in June 2016. The plan included CalOptima's goals of launching new programs and products, such as PACE and OneCare Connect. Over the last three years, these programs have successfully launched and continue to grow.

Due to the expiration of the 2013-2016 Strategic Plan, a new draft strategic plan has been developed.

Discussion
CalOptima staff completed preliminary work on the strategic plan through a facilitated process, including review of the prior strategic plan and accomplishments. As a result, three priority areas were identified: Innovation, Value, and Partnerships and Engagement, and two foundational building blocks were developed to support these priorities: Workforce Performance and Financial strength.

A joint Ad-Hoc meeting of the Provider Advisory Committee, Member Advisory Committee, and OneCare Connect Member Advisory Committee was held to vet the draft plan and provide feedback. This feedback was incorporated into the draft plan.

A Strategic Planning workshop was conducted during the Board of Directors meeting on November 3, 2016, and comments and feedback from this session have also been incorporated into the final draft of the 2017-2019 Strategic Plan. Staff is now requesting final approval of the new Strategic Plan for calendar years 2017-2019.

Fiscal Impact
The recommended action to adopt CalOptima's 2017-2019 Strategic Plan may include budgeted and unbudgeted initiatives/programs. Unbudgeted initiatives/programs for Fiscal Year 2016-17 will be presented to the CalOptima Board of Directors for approval. Management plans to include new initiatives/programs related to 2018-19 strategic plan years in the CalOptima FY 2017-18 and FY 2018-19 Operating Budgets.

Back to Agenda

Rationale for Recommendation
Development of the proposed Strategic Plan is consistent with direction provided by the Board of Directors.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation - Strategic Plan Update
2. CalOptima CY 2017 – 2019 Organizational Strategic Plan (draft)

/s/ Michael Schrader *11/22/2016*
Authorized Signature **Date**

Back to Agenda

Strategic Plan Update

Board of Directors Meeting

December 1, 2016

Back to Agenda

2013 – 16 Strategic Plan Priorities

Quality Programs and Services	Financial Stability
Strong Internal Processes	Culture, Learning and Innovation

Back to Agenda

CalOptima
A Public Agency
Better. Together.

2017 – 19 Strategic Priorities

Innovation	Value	Partnerships and Engagement
Workforce Performance	Financial Strength	

Back to Agenda

CalOptima
A Public Agency
Better. Together.

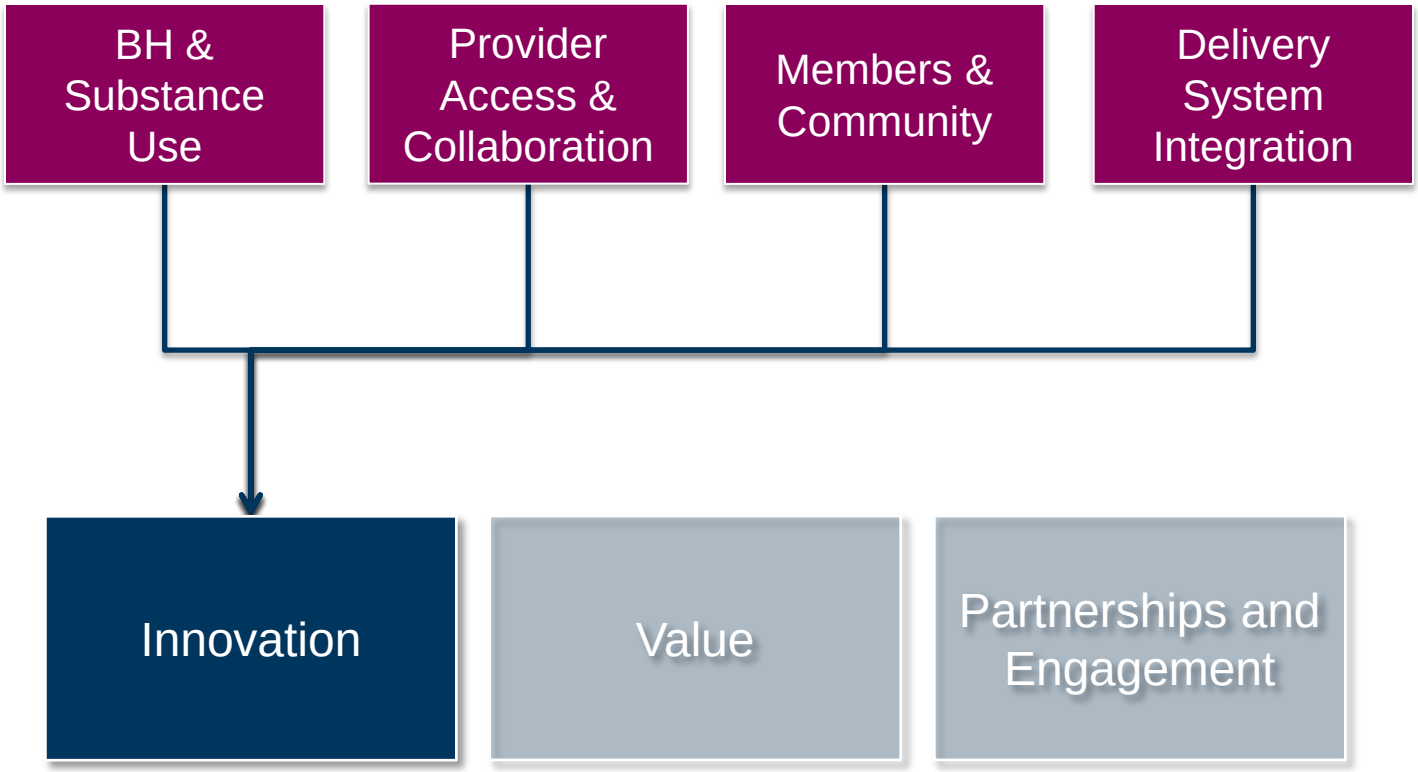
Board Input

- BH & Substance Use
- Provider Access & Collaboration
- Members & Community
- Delivery System Integration

- Innovation
- Value
- Partnerships and Engagement

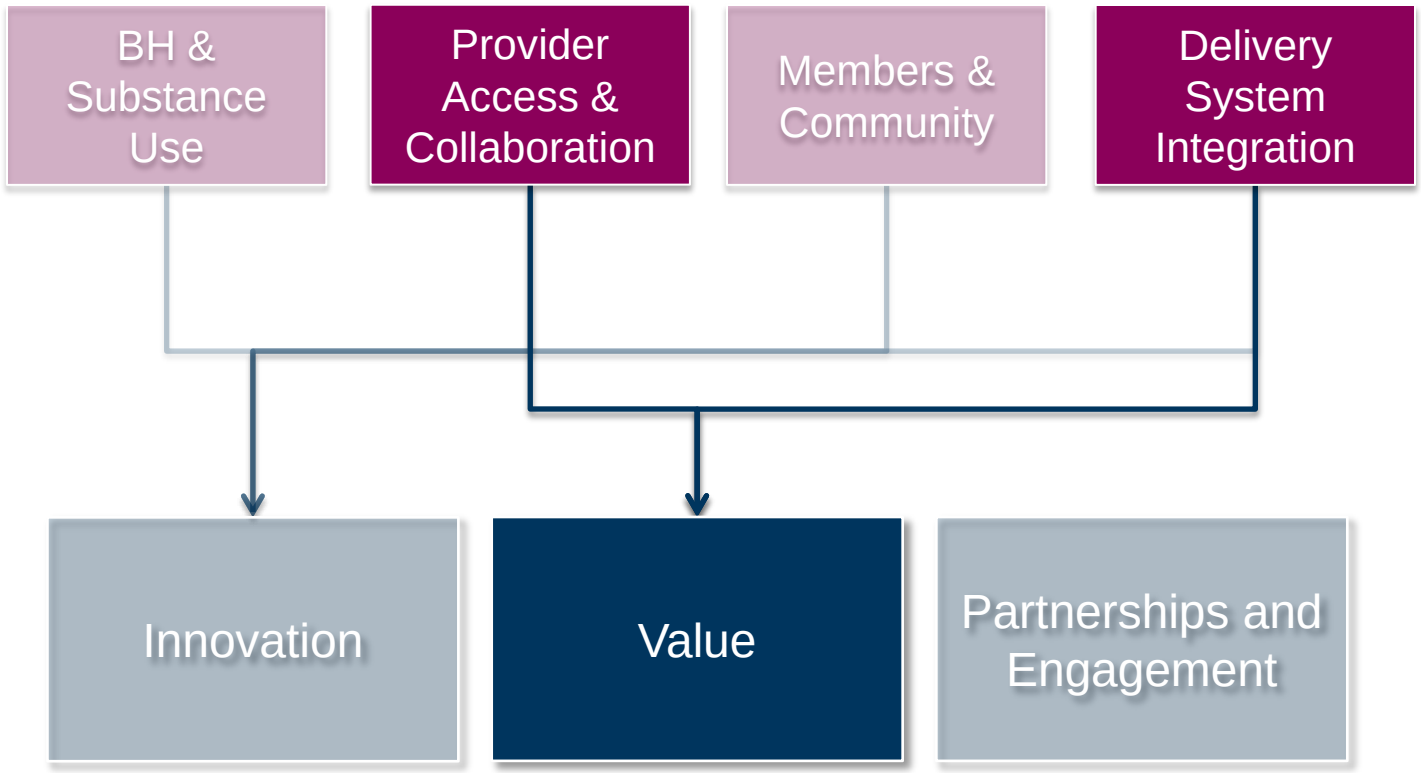
Back to Agenda

Board Input



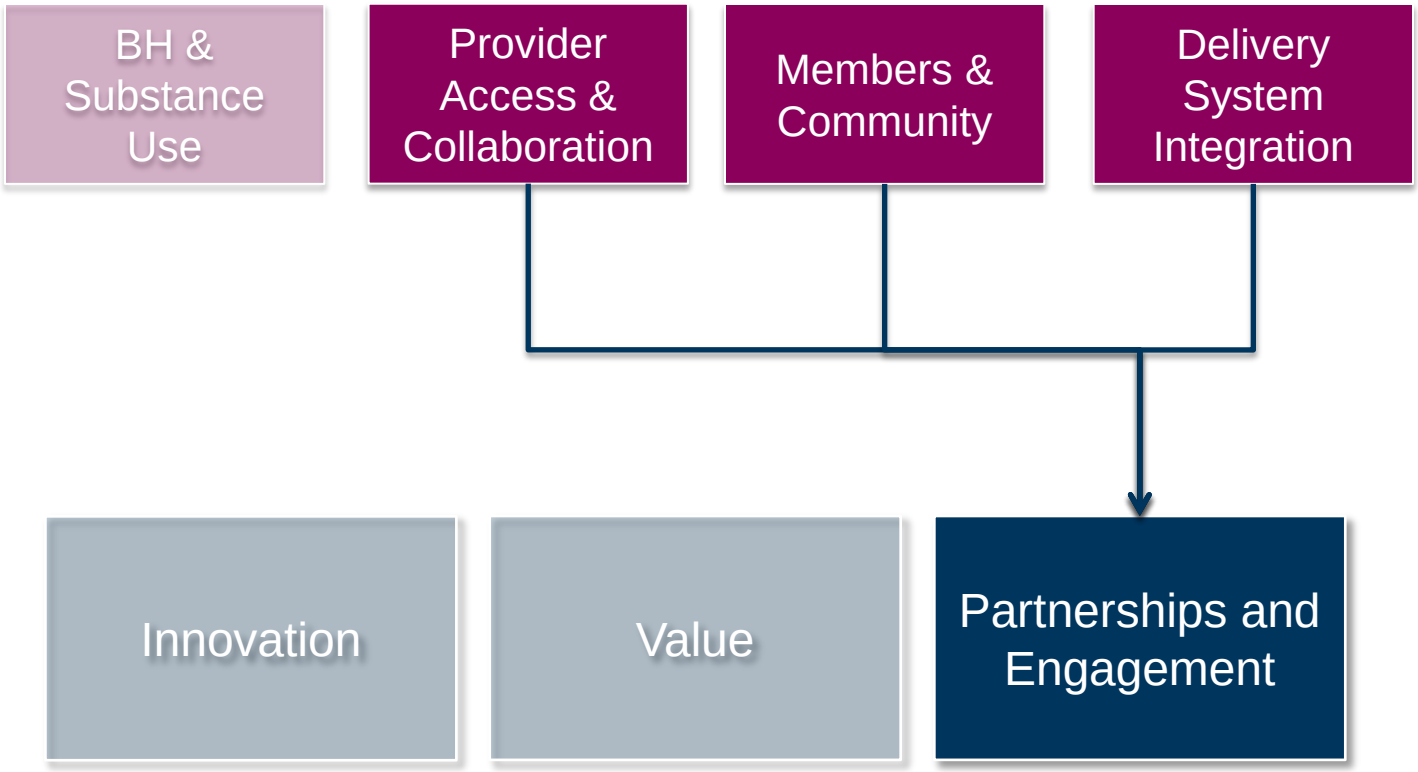
Back to Agenda

Board Input



Back to Agenda

Board Input



Back to Agenda

Innovation

- **Delivery System Innovation**
- **Program Integration**
- **Program Incubation**

1. ***Delivery System Innovation.*** Utilize pay-for-performance, **creative partnerships**, sponsored initiatives and **technology** to **empower networks and providers to drive innovation** and improve **member access**.
2. ***Program Integration.*** Implement programs and services that create an integrated service experience for members, including **an integrated physical and behavioral health service model**.
3. ***Program Incubation.*** Incubate new programs and pursue service approaches to address unmet member needs by sponsoring program pilots addressing areas such as **substance abuse, behavioral health services, childhood obesity and complex conditions**.

Back to Agenda

Value

- **Data Analytics Infrastructure**
- **Pay for Value**
- **Cost-Effectiveness**

1. ***Data Analytics Infrastructure.*** Establish robust IT infrastructure and **integrated data** warehouse to enable predictive modeling, effective performance accountability and data-based decision making.
2. ***Pay for Value.*** Launch pay-for-performance and quality incentive initiatives that **encourage provider participation**, facilitate accurate encounter data submissions, improved clinical quality and member experience outcomes, and the spread of best practices.
3. ***Cost-Effectiveness.*** Implement **efficient** systems and processes to facilitate better understanding of internal cost drivers, eliminate administrative redundancies, and promote effective and standardized internal practices

Back to Agenda

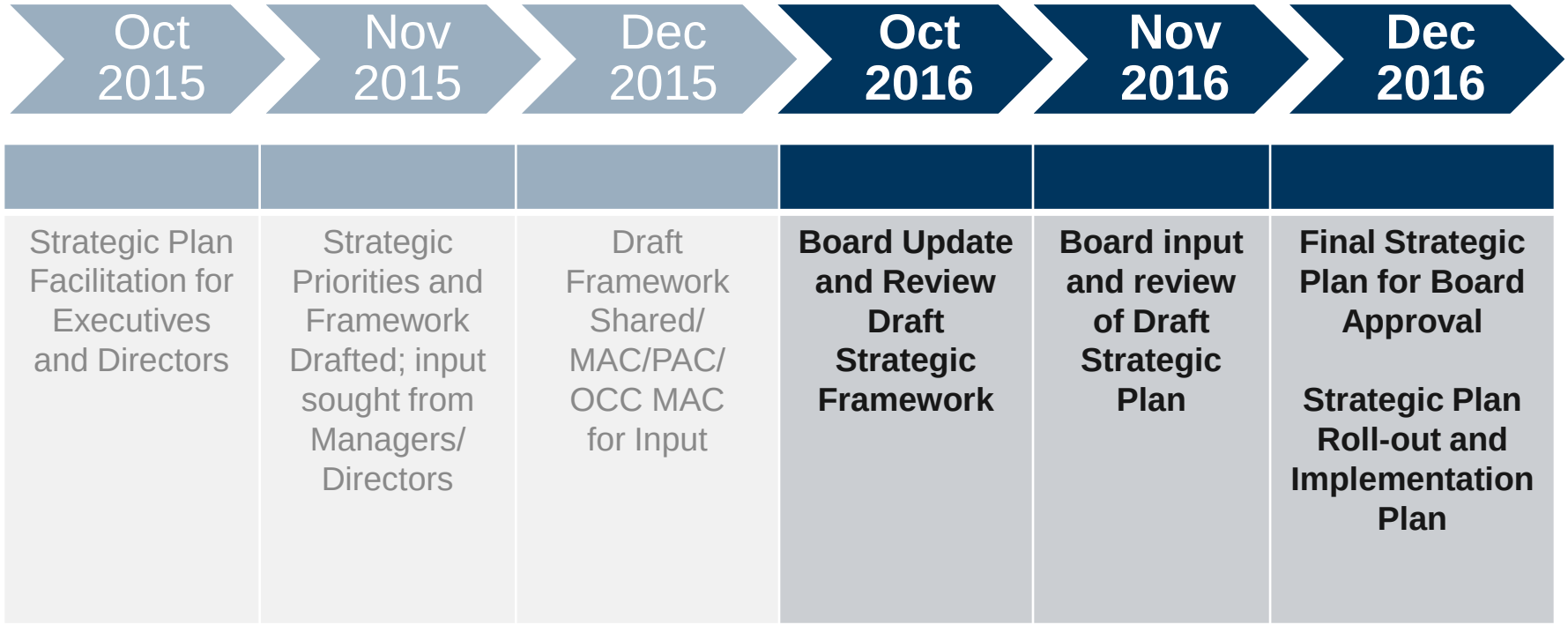
Partnership and Engagement

- **Provider Collaboration**
- **Member Engagement**
- **Community Partnerships**
- **Shared Advocacy**

1. ***Provider Collaboration.*** **Enhance partnerships** with networks, physicians and the Provider Advisory Committee to improve service to providers and members, **expand access**, and advance shared health priorities.
2. ***Member Engagement.*** Seek input from the Member Advisory Committee and the plan's diverse membership to **better understand member needs**, and ensure the implementation of services and programs that strengthen member choice and experience and improve health outcomes.
3. ***Community Partnerships.*** Establish new organizational partnerships and collaborations to understand, measure and address **social determinants of health** that lead to health disparities among the plan's **vulnerable populations**.
4. ***Shared Advocacy.*** Utilize provider and community relationships to educate stakeholders about health policy issues impacting the safety-net delivery system and community members, and promote the value of CalOptima to members, providers, and the broader **population health** of the Orange County community.

Back to Agenda

2017-2019 Strategic Planning Timeline



Back to Agenda

2017 – 2019 Organizational Strategic Plan

DRAFT

Our Mission

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

Our Vision

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

Strategic Framework

PRIORITIES

Innovation

Pursue innovative programs and services to optimize member access to care

1. Delivery System Innovation
2. Program Integration
3. Program Incubation

Value

Maximize the value of care for members by ensuring quality in a cost effective way

1. Data Analytics
2. Pay for Value
3. Cost Effectiveness

Partnership and Engagement

Engage providers and community partners in improving the health status and experience of our members

1. Provider Collaboration
2. Member Engagement
3. Community Partnerships
4. Shared Advocacy

BUILDING BLOCKS

Workforce Performance

Attract and retain an accountable and high performing workforce capable of strengthening systems and processes

Financial Strength

Provide effective financial management and planning to ensure long-term financial strength

Back to Agenda

Priorities

Priorities	Strategies
Innovation *Pursue innovative programs and services to optimize member access to care*	1. ***Delivery System Innovation.*** Utilize pay-for-performance, **creative partnerships**, sponsored initiatives and **technology** to **empower networks and providers to drive innovation** and improve **member access**. 2. ***Program Integration.*** Implement programs and services that create an integrated service experience for members, including **an integrated physical and behavioral health service model**. 3. ***Program Incubation.*** Incubate new programs and pursue service approaches to address unmet member needs by sponsoring program pilots addressing areas such as **substance abuse, behavioral health services, childhood obesity and complex conditions**.
Value *Maximize the value of care for members by ensuring quality in a cost effective way*	1. ***Data Analytics Infrastructure.*** Establish robust IT infrastructure and **integrated data** warehouse to enable predictive modeling, effective performance accountability and data-based decision making. 2. ***Pay for Value.*** Launch pay-for-performance and quality incentive initiatives that **encourage provider participation**, facilitate accurate encounter data submissions, improved clinical quality and member experience outcomes, and the spread of best practices. 3. ***Cost-Effectiveness.*** Implement **efficient** systems and processes to facilitate better understanding of internal cost drivers, eliminate administrative redundancies, and promote effective and standardized internal practices
Partnership and Engagement *Engage providers and community partners in improving the health status and experience of our members*	1. ***Provider Collaboration.*** **Enhance partnerships** with networks, physicians and the Provider Advisory Committee to improve service to providers and members, **expand access**, and advance shared health priorities. 2. ***Member Engagement.*** Seek input from the Member Advisory Committee and the plan's diverse membership to **better understand member needs**, and ensure the implementation of services and programs that strengthen member choice and experience and improve health outcomes. 3. ***Community Partnerships.*** Establish new organizational partnerships and collaborations to understand, measure and address **social determinants of health** that lead to health disparities among the plan's **vulnerable populations**. 4. ***Shared Advocacy.*** Utilize provider and community relationships to educate stakeholders about health policy issues impacting the safety-net delivery system and community members, and promote the value of CalOptima to members, providers, and the broader **population health** of the Orange County community.

Back to Agenda

Building Blocks

Building Blocks	Strategies
Workforce Performance *Attract and retain an accountable and high performing workforce capable of strengthening systems and processes*	1. ***Employer of Choice.*** Establish a “feedback rich” culture to ensure accountability, optimize performance and retain high performers capable of advancing organizational objectives. 2. ***Collaborative Culture.*** Drive collaboration to strengthen data-informed decision-making, launch innovative member-centered programs and services, and evaluate shared performance. 3. ***Operational Excellence.*** Review, measure, and refine processes to ensure continuous improvement of programs and services for members and ensure regulatory compliance.
Financial Strength *Provide effective financial management and planning to ensure long-term financial strength*	1. ***Strategic Goal Alignment.*** Ensure departmental budgets reinforce the organization’s strategic objectives to advance shared mission and values. 2. ***Fiscal Management.*** Standardize the use of effective financial reporting and forecasting tools to enable directors to develop departmental budgets and promote a culture of transparency and accountability.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Authorize Vendor Contract(s) and/or Contract Amendment(s) for Services Related to CalOptima's Development Rights at the 505 City Parkway Site and Funding to Develop a Site Plan

Contact

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

Recommended Actions

1. Authorize the amendment of CalOptima's contract with real estate consultant Newport Real Estate Services to include site plan development; and
2. Appropriate expenditures from existing reserves of up to $7,000 to provide funding for this contract amendment.

Background

At its January 2011 meeting, the CalOptima Board of Directors authorized the purchase of land and an office building located at 505 City Parkway West, Orange, California, and the assumption of development rights associated with the parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower of up to ten stories and 200,000 square feet of office space, and a parking structure of up to five-levels and 1,528 spaces. The potential second office tower and parking structure are referred to as the 605 Building Site. At the time of CalOptima's purchase of the land and building, the expiration date for the Development Agreement was October 28, 2014.

At its October 2, 2014 meeting, the CalOptima Board of Directors authorized the CEO to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. Assuming CalOptima makes required public benefit fee payments to the City of Orange, the expiration date for the current development agreement is October 28, 2020.

At the August 4, 2016 meeting, the Board authorized a contract with a real estate consultant to assist in evaluating options related to CalOptima's development rights, and approved a budget allocation of $22,602 from existing reserves to fund the contract through June 30, 2017.

Discussion

Site Plan Development

Pursuant to the Board action on August, 4, 2016, CalOptima contracted with real estate consultant, Newport Real Estate Services, to provide market research, evaluate development feasibility and financial feasibility, and recommend options based on CalOptima's development rights. To move forward in exploring options related to the development rights, the consultant has recommended the

Back to Agenda

development of a site plan to further inform the Board of potential opportunities. The projected cost to develop a site plan is $7,000.

Update from the Finance and Audit Committee (FAC)
At the November 17, 2016, meeting, the FAC received presentations from Management and real estate consultant, Newport Real Estate Services. Committee members requested Staff return to the FAC with additional information on the development rights at the next FAC meeting on February 16, 2017. Tentatively, Staff anticipates the FAC's recommendation will be put forward for the full Board's consideration at the March 2, 2017, meeting.

Fiscal Impact
The recommended action to fund the contract with a real estate consultant to develop a site plan is an unbudgeted item. An allocation of $7,000 from existing reserves will fund this action.

Rationale for Recommendation
Management anticipates that CalOptima's space needs will continue to grow in the near term. To accommodate this growth, management recommends that the Board authorize the CEO to fully explore options available with the existing development rights and to ensure that CalOptima's space needs are adequately met in the future.

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Board Action dated August 4, 2016, Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board-approved procurement process; and
2. Approve allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017.

Background

In January 2011, CalOptima purchased land and an office building located at 505 City Parkway West, Orange, California, and assumed development rights for the land parcel pursuant to a 2004 Development Agreement with the City of Orange. The development rights include the possible construction of an office tower up to ten stories and 200,000 square feet of office uses, and a maximum five-level, 1,528 space parking structure which was previously approved in 2001. The second office tower and parking structure are referred to as the 605 Building Site. The expiration date for the initial 10 year Development Agreement was October 28, 2014.

At the October 2, 2014, meeting, the CalOptima Board of Directors (Board) authorized the CEO, with the assistance of legal counsel, to enter into an Amended and Restated development agreement with the City of Orange to extend CalOptima's development rights for up to six years. The extension was approved by the City of Orange Planning Commission on September 15, 2014, and the Orange City Council on November 25, 2014. The Amended and Restated Development Agreement requires CalOptima to make public benefit fee payments to the City of Orange in order to extend the termination date by two year increments. The Board approved funding of $200,000 from existing reserves to make the public benefit fee payments. The following table provides additional information on the public benefit fees.

Payment Amount	Due Date	Agreement Extension Period
First Payment: $50,000	Within forty-five (45) days of mutual execution of the Agreement	Agreement remains in effect for a period of two (2) years from the original termination date
Second Payment: $50,000	No later than fifteen (15) days prior to the expiration of the Initial Term	Extends Agreement for an additional two (2) years from the expiration of the Initial Term

Back to Agenda

Payment Amount	Due Date	Agreement Extension Period
Final Payment: $100,000	No later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term	Extends Agreement for an additional two (2) years from the expiration of the First Automatic Renewal Term

Assuming all payments are made on time, the end date for the Amended and Restated Development Agreement is October 28, 2020.

Discussion

CalOptima's Development Agreement represents a significant value to CalOptima. In order to understand the best strategic use of these rights, CalOptima requires assistance of a real estate consultant who has expertise and specializes in the area of development rights. The real estate consultant will perform market research, explore options for the development rights, evaluate development feasibility and financial feasibility, and provide recommendations to CalOptima. The proposed evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

In light of forthcoming development projects around the 505 City Parkway West building and the number of years remaining under the current Development Agreement, Management believes it is prudent to obtain reliable information expeditiously in order to make a well-informed decision. The CalOptima Fiscal Year (FY) 2016-17 Operating Budget included $7,398 under Professional Fees for a real estate consultant. Management proposes to make an allocation of $22,602 from existing reserves to fund the remaining expenses related to the contract with the real estate consultant through June 30, 2017.

Fiscal Impact

The recommended action to authorize the CEO to contract with a real estate consultant to assist in evaluation of options related to CalOptima's development rights will not exceed $30,000 through June 30, 2017. An allocation of $22,602 from existing reserves will fund this action.

Rationale for Recommendation

The retention of a real estate consultant to evaluate options related to CalOptima's development rights will provide reliable information to the Board and Management to make informed decisions on long term space planning.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachment

Amended and Restated Development Agreement between the City of Orange and Orange County Health Authority dated December 10, 2014

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

Back to Agenda

Ag. 4545.0C

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

Recorded in Official Records, Orange County
Hugh Nguyen, Clerk-Recorder

NO FEE

* $ R 0 0 0 7 1 5 5 2 6 5 $ *

2014000535189 9:23 am 12/11/14
93 413 A17 35
0.00 0.00 0.00 0.00 102.00 0.00 0.00 0.00

(SPACE ABOVE FOR RECORDER'S USE)

CONFORMED COPY

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

Dated as of Dec. 10 **, 2014**

By and Between

City of Orange,
a municipal corporation

and

Orange County Health Authority,
a public agency doing business as CalOptima

Back to Agenda

TABLE OF CONTENTS

Back to Agenda

Ag. 4545.OC

EXEMPT FROM RECORDER'S FEES
Pursuant to Government Code §§ 6103 and 27383

Recording requested by and when recorded return to:

City Clerk
City of Orange
300 East Chapman Avenue
Orange, California 92866

(SPACE ABOVE FOR RECORDER'S USE)

AMENDED AND RESTATED DEVELOPMENT AGREEMENT

This Amended and Restated Development Agreement (the "**Agreement**") is made in Orange County, California as of Dec. 10, 2014, by and between the CITY OF ORANGE, a municipal corporation (the "**City**") and ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima ("**Developer**"). Together, the City and the Developer shall be referred to as the "**Parties**".

1. **Recitals**. This Agreement is made with respect to the following facts and for the following purposes, each of which is acknowledged as true and correct by the Parties:

(a) The City is authorized, pursuant to Government Code §§65864 through 65869.5 (the "**Development Agreement Statutes**") and Chapter 17.44 (Development Agreements) of the Orange Municipal Code to enter into binding agreements with persons or entities having legal or equitable interests in real property for the development of such property in order to establish certainty in the development process.

(b) Developer is the owner of certain real property located in the City and consisting of the parcel commonly referred to the "**605 Building Site**" (legally described on **Exhibit "A"**).

(c) References in this Agreement to the "**Project**" shall mean the 605 Building Site hereinabove described and the development project proposed for such property.

(d) Developer seeks to enhance the vitality of the City by developing additional office and commercial related uses.

(e) Pursuant to Government Code §65867.5 and Orange Municipal Code Section 17.44.100, the City Council finds that: (i) this Agreement and any Future Approvals of the Project implement the goals and policies of the City's General Plan, provide balanced and diversified land uses and impose appropriate standards and requirements with respect to land development and usage in order to maintain the overall quality of life and the environment within the City; (ii) this Agreement is in the best interests of and not in detriment to the public health, safety and general welfare of the residents of the City and the surrounding region; (iii) this

Back to Agenda

Agreement is compatible with the uses authorized in the zoning district and planning area in which the Project site is located; (iv) adopting this Agreement is consistent with the City's General Plan and constitutes a present exercise of the City's police power; and (v) this Agreement is being entered into pursuant to and in compliance with the requirements of Government Code §65867.

(f) Substantial public benefits (as required by Section 17.44.200 of the Orange Municipal Code) will be provided by Developer and the Project to the entire community. These substantial public benefits include, but are not limited to, the following:

(1) By and through its existence, the Project is and, at the completion of the Project, will continue to be, an enormous benefit and resource to the community;

(2) The Project will provide an expanded economic base for the City by generating substantial property tax revenue;

(3) The Project will provide temporary construction employment and permanent office-based jobs for a substantial number of workers;

(4) The Project, consisting of the 605 Building Site, will contribute traffic impact mitigation fees to the City pursuant to the West Orange Circulation Study ("**WOCS Study**"), which will partially fund the completion of traffic and circulation infrastructure in the WOCS Study area that will be needed to accommodate demand from future growth; and

(5) The Project will provide for additional sales/use taxes to the City, as provided in Section 7 hereof.

In exchange for these substantial public benefits, City intends to give Developer assurance that Developer can proceed with the development of the Project for the term and pursuant to the terms and the conditions of this Agreement and in accordance with the Applicable Rules (as hereinafter defined).

(g) The Developer has applied for and the City has approved this Agreement in order to create a beneficial project and a physical environment that will conform to and compliment the goals of the City, create a development project sensitive to human needs and values, facilitate efficient traffic circulation, and develop the Project.

(h) This Agreement will bind the City to the terms and obligations specified in this Agreement and will limit, to the degree specified in this Agreement and under the laws of the State of California, the future exercise of the City's ability to delay, postpone, preclude or regulate development on the Project, except as provided for herein.

(i) In accordance with the Development Agreement Statutes, this Agreement eliminates uncertainty in the planning process and provides for the orderly improvement of the Project. Further, this Agreement provides for appropriate further development of the Project over and above the improvements which currently exist on the Project and generally serves the public interest within the City and the surrounding region.

(j) CA-THE CITY LIMITED PARTNERSHIP (the "**Original Developer**") first filed land use applications in 2001 to entitle four (4) separate development sites which together were to consist of one million one hundred fifty-seven thousand (1,157,000) square feet of office space and a one hundred thirty-seven (137) room hotel (collectively, the "**EOP Projects**"). Those land use applications included applications for a Conditional Use Permit(s) and Major Site Plan Review(s). In addition, the Original Developer filed for negotiations and approval of that certain Development Agreement, dated as of December 13, 2004, by and between the City of Orange and the Original Developer (the "**Original Development Agreement**"). The City processed the various applications and commissioned the preparation of the Final Environmental Impact Report (FEIR) 1612-01 for the Original Development Agreement and the 2001 land use applications (the "**Final EIR**"), which was certified in accordance with the California Environmental Quality Act ("**CEQA**"). On October 9, 2001, the City certified the Final EIR and approved the various applications for the entitlements for the EOP Projects including Resolution No. 9521 with respect to the 605 Building Site.

(1) The Final EIR evaluated the EOP Projects, all of which were located in the area within or adjacent to the former "**The Block at Orange**" which has been rebranded to "**The Outlets at Orange.**" A trip generation survey was conducted and the Final EIR determined that the EOP Projects, upon completion, would generate a total of thirteen thousand eight hundred seventy-six (13,876) average daily trips. The Final EIR designated separate average daily trip generation estimates for each of the EOP Projects based upon the estimated development square footage of each of the EOP Projects.

(2) As part of its approval of the EOP Projects, the City imposed various traffic mitigation conditions, including:

(A) a "fair share" allocation of the cost of certain traffic improvements identified in the WOCS Study (the "**WOCS Improvements**");

(B) the obligation to pay one hundred percent (100%) of the cost of specific traffic improvements at three (3) designated intersections; and

(C) a "fair share" of the cost of widening the Orangewood Avenue bridge over the Santa Ana River.

The traffic improvements described in (B) and (C) are herein referred as the "**Traffic Improvement Conditions**".

(3) The WOCS Study estimated the cost of the WOCS Improvements to be approximately Three Million Five Hundred Thousand Dollars ($3,500,000.00) and assigned "fair share" costs for such improvements to the following projects:

(A) UCI Medical Center Expansion – thirty-two percent (32%);

(B) EOP Projects – thirty-eight percent (38%); and

(C) The Outlets at Orange Expansion – thirty percent (30%).

(4) On March 9, 2004, the City adopted Resolution No. 9843 in which the City determined that the "fair share" of the EOP Projects for the WOCS Improvements and the Traffic Improvement Conditions would be as set forth in Exhibit "A" to Resolution No. 9843. A copy of Resolution No. 9843 is attached hereto as **Exhibit "B"**.

(k) In 2004, in response to the Original Developer's application for the Original Development Agreement, the City felt that it would be helpful to provide the public with information updating and amplifying some of the points raised in the Final EIR as they pertain to the EOP Projects. Accordingly, and as provided in Section 15164 of the State California Environmental Quality Act Guidelines (the **"CEQA Guidelines"**), the City prepared an Addendum to the Final EIR (the "**Addendum**"). On August 16, 2004, the Planning Commission held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, which were approved by Resolution No. PC 33-04 and recommended to the City Council of the City approval. On September 14, 2004, the City Council held a duly noticed public hearing on the Original Developer's application for the Original Development Agreement and the Addendum, and adopted Resolution No. 9909, making certain findings under CEQA and determined that the Addendum is all that is necessary in connection with the Original Development Agreement and the approval thereof. Thereafter, at its regular meeting of September 14, 2004, the City Council adopted its Ordinance No. 19-04 approving the Original Development Agreement.

(l) In January 2006, the City and the Original Developer amended the Original Development Agreement by entering into that certain First Amendment to Development Agreement dated as of January 20, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000051175 on January 24, 2006 (herein referred as the "**First Amendment**").

(m) In October 2006, the City and the Original Developer further amended the Original Development Agreement by entering into that certain Second Amendment to Development Agreement dated as of October 5, 2006, the original of which was recorded in the Official Records as Instrument No. 2006000698031 on October 17, 2006 (herein referred as the "**Second Amendment**").

(n) In January 2007, the City and the Original Developer entered into that certain Operating Memorandum dated as of January 22, 2007 (hereinafter referred as "**First Operating Memorandum**") as it relates to the amendment to certain covenants, conditions and restrictions governing the expansion of the Block at Orange (the "**Block Expansion**").

(o) In 2007, the Original Developer and Maguire Properties-City Plaza, LLC and Maguire Properties-City Parkway, LLC entered into that certain Assignment and Assumption Agreement dated April 23, 2007, the original of which was recorded in the Official Records as Instrument No. 2007000271600 on April 26, 2007 (herein referred as the "**Maguire Agreement**"). The terms of the Maguire Agreement transferred and assigned the development rights related to City Plaza Two Site and 605 Building Site (as defined in the Original Development Agreement) from the Original Developer to Maguire Properties-City Plaza, LLC and Maguire-City Parkway, LLC, respectively.

(p) In August 2008, Maguire Properties-City Plaza, LLC and HFOP City Plaza, LLC ("**HFOP**") entered into that certain Partial Assignment and Assumption of Development Agreement dated August 26, 2008, the original of which was recorded in the Official Records as Instrument No. 2008000406579 on August 27, 2008 (herein referred as the "**HFOP Agreement**"). The terms of the HFOP Agreement transferred and assigned development rights related to City Plaza Two Site from Maguire Properties-City Plaza, LLC to HFOP.

(q) In May 2009, Maguire Properties-City Parkway, LLC and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated May 27, 2009, the original of which was recorded in the Official Records as Instrument No. 2009000268530 on May 28, 2009 (herein referred as the "**AB Agreement**"). The terms of the AB Agreement transferred and assigned development rights related to 605 Building Site from Maguire Properties-City Parkway, LLC to AB-City Parkway, LLC.

(r) In January 2011, Developer and AB-City Parkway, LLC entered into that certain Partial Assignment and Assumption of Development Agreement dated January 7, 2011, the original of which was recorded in the Official Records as Instrument No.2011000013726 on January 7, 2011 (herein referred as the "**CalOptima Agreement**"). The terms of the CalOptima Agreement transferred and assigned development rights related to 605 Building Site from AB-City Parkway, LLC to Developer. The Original Development Agreement, as amended and assigned by the First Amendment, the Second Amendment, the First Operating Memorandum, the Maguire Agreement, the HFOP Agreement, the AB Agreement, and the CalOptima Agreement, is herein referred to as the "**Amended Development Agreement**".

(s) The Developer represents to the City that, as of the date hereof, it is the owner of the Project, subject to encumbrances, easements, covenants, conditions, restrictions, and other matters of record.

(t) The Parties acknowledge and agree that the term of the Amended Development Agreement expires on October 28, 2014 (the "**Original Termination Date**"). Developer has requested, and the City has agreed, to extend the term of the Amended Development Agreement, subject to the terms hereof.

(u) In order to effectuate the extension of the term of the Amended Development Agreement, the Parties hereby agree to amend and restate in its entirety the Amended Agreement as set forth below.

2. **Definitions**. In this Agreement, unless the context otherwise requires:

(a) "**Applicable Rules**" means the development standards and restrictions set forth in Section 5 of this Agreement which shall govern the use and development of the Project and shall amend and supersede any conflicting or inconsistent provisions of zoning ordinances, regulations or other City requirements relating to development of property within the City.

(b) "**Development Agreement Statutes**" means Government Code §§ 65864 to 65869.5.

(c) **"Discretionary Actions"** and **"Discretionary Approvals"** are actions which require the exercise of judgment or a discretionary decision, and which contemplate and authorize the imposition of revisions or additional conditions, by the City, including any board, commission, or department of the City and any officer or employee of the City; as opposed to actions which in the process of approving or disapproving a permit or other entitlement merely requires the City, including any board, commission, or department of the City and any officer or employee of the City, to determine whether there has been compliance with applicable statutes, ordinances, regulations, or conditions of approval.

(d) **"Effective Date"** is the date the ordinance approving the Original Development Agreement became effective, which was October 28, 2004.

(e) **"Future Approvals"** means any action in implementation of development of the Project which requires Discretionary Approvals pursuant to the Applicable Rules, including, without limitation, parcel maps, tentative subdivision maps, development plan and site plan reviews, and conditional use permits. Upon approval of any of the Future Approvals, as they may be amended from time to time, they shall become part of the Applicable Rules, and Developer shall have a "vested right", as that term is defined under California law, in and to such Future Approvals by virtue of this Agreement.

(f) Other terms not specifically defined in this Agreement shall have the same meaning as set forth in Chapter 17.44 (Development Agreements) of the Orange Municipal Code, as the same existed on the Effective Date.

3. **Binding Effect**. This Agreement, and all of the terms and conditions of this Agreement shall, to the extent permitted by law, constitute covenants which shall run with the land comprising the Project for the benefit thereof, and the benefits and burdens of this Agreement shall be binding upon and inure to the benefit of the Parties and their respective assigns, heirs, or other successors in interest.

4. **Negation of Agency**. The Parties acknowledge that, in entering into and performing under this Agreement, each is acting as an independent entity and not as an agent of the other in any respect. Nothing contained herein or in any document executed in connection herewith shall be construed as making the City and Developer joint venturers, partners, agents of the other, or employer/employee.

5. **Development Standards for the Project, Applicable Rules**. The development standards and restrictions set forth in this Section shall govern the use and development of the Project and shall constitute the Applicable Rules, except as otherwise provided herein, and shall amend and supersede any conflicting or inconsistent provisions of existing zoning ordinances, regulations or other City requirements relating to development of the Project and any subsequent changes to the Applicable Rules as specifically described in Section 5(c).

(a) The following ordinances and regulations shall be part of the Applicable Rules:

(1) The City's General Plan as it existed on the Effective Date;

Back to Agenda

(2) The City's Municipal Code relating to Development Agreements which is set forth in Chapter 17.44 of the Orange Municipal Code, as it existed on the Effective Date; and

(3) Such other ordinances, rules, regulations, and official policies governing permitted uses of the Project, density, design, improvement, and construction standards and specifications applicable to the development of the Project in force on the Effective Date, except as they may be in conflict with the provision of Subsection (a)(4) of this Section.

(4) The terms, provisions and conditions of the following with respect to each Project as hereinafter described:

(A) Conditional Use Permit No. 2379-01 and Major Site Plan Review No. 107-99 for the 605 Building Site; and

(B) The "fair share" of the Project for the WOCS Improvements and the Traffic Improvement Conditions as set forth in Resolution No. 9843.

(b) The City acknowledges that the Original Developer sold one (1) of the EOP Projects legally described on **Exhibit "C"** attached hereto and commonly referred to as the **"City Tower Two Site"** to a third party and, the City granted approvals to allow such third party to develop a residential project on the City Tower Two Site. The City further acknowledges that the average daily trips which would be generated by the proposed residential project may be substantially less than the average daily trips that would have been generated by the original project for the City Tower Two Site as identified in the Final EIR. The City hereby agrees and acknowledges that the traffic impacts identified in the Final EIR were studied on an area-wide basis and that the Final EIR adequately studied and determined the traffic impacts and relevant mitigation measures required for such traffic impacts. Accordingly, the City hereby agrees that the difference between the average daily trips allocated to the original City Tower Two Site and the average daily trips which are determined to be generated by the residential project (or other project) located on the City Tower Two Site and approved by the City (the **"Unused Trips"**) may be "transferred" to the Project during the term of this Agreement (it being the intention of the Parties that the Unused Trips shall be reserved for the benefit of Developer and the Project and, without the prior written consent of Developer, such Unused Trips shall not be applied to or reserved for the benefit of any other project that is subject to approval by the City).

(c) The Project shall not be required to pay any portion of the "fair share" of the WOCS Improvements and/or Traffic Improvement Conditions payable by or as a result of any project approved by the City on the City Tower Two Site.

(d) The "fair share" of the Project shall not be increased as a result of the failure by the City to recover (for whatever reason) the "fair share" contributions of the UCI Medical Center Expansion and/or The Block at Orange Expansion, nor shall the cost of the WOCS Improvements and the Traffic Improvement Conditions be deemed to be increased as a result of such failure.

(e) Notwithstanding the provisions of this Agreement, the City reserves the right to apply certain other laws, ordinances and regulations under the certain limited circumstances described below:

(1) This Agreement shall not prevent the City from applying new ordinances, rules, regulations and policies relating to uniform codes adopted by City or by the State of California, such as the Uniform Building Code, National Electrical Code, Uniform Mechanical Code or Uniform Fire Code, as amended, and the application of such uniform codes to the Project at the time of application for issuance of building permits for structures on the Project including such amendments to uniform codes as the City may adopt from time to time.

(2) In the event that State or Federal laws or regulations prevent or preclude compliance with one or more of the provisions of this Agreement, such provisions of this Agreement shall be modified or suspended as may be necessary to comply with such State or Federal laws or regulations; provided, however, that this Agreement shall remain in full force and effect to the extent it is not inconsistent with such laws or regulations and to the extent such laws or regulations do not render such remaining provisions impractical to enforce. Notwithstanding the foregoing, City shall not adopt or undertake any regulation, program or action or fail to take any action which is inconsistent or in conflict with this Agreement until, following meetings and discussions with the Developer, the City Council makes a finding, at or following a noticed public hearing, that such regulation, program actions or inaction is required (as opposed to permitted) to comply with such State and Federal laws or regulations after taking into consideration all reasonable alternatives.

(3) Notwithstanding anything to the contrary in this Agreement, City shall have the right to apply City ordinances and regulations (including amendments to Applicable Rules) adopted by the City after the Effective Date, in connection with any Future Approvals, or deny, or impose conditions of approval on, any Future Approvals in City's sole discretion if such application is required to prevent a condition dangerous to the physical health or safety of existing or future occupants of the Project, or any portion thereof or any lands adjacent thereto.

6. **Right to Develop**. Subject to the terms of this Agreement, and as of the Effective Date, Developer shall have a vested right to develop the Project in accordance with the Applicable Rules.

7. **Acknowledgments, Agreements and Assurances on the Part of the Developer**.

(a) **Developer's Faithful Performance**. The Parties acknowledge and agree that Developer's performance in developing the Project and in constructing and installing certain public improvements and complying with the Applicable Rules will fulfill substantial public needs. The City acknowledges and agrees that there is good and valuable consideration to the City resulting from Developer's assurances and faithful performance thereof and otherwise in this Agreement, and that same is in balance with the benefits conferred by the City on the Project. The Parties further acknowledge and agree that the exchanged consideration hereunder is fair, just and reasonable.

Back to Agenda

(b) **Obligations to be Non-Recourse**. As a material element of this Agreement, and as an inducement to Developer to enter into this Agreement, each of the Parties understands and agrees that the City's remedies for breach of the obligations of Developer under this Agreement shall be limited as described in this Agreement.

(c) **Developer's Commitment Regarding California Sales/Use Taxes**. To the extent permitted by law, Developer will require in its general contractor construction contract that Developer's general contractor and subcontractors exercise their option to obtain a Board of Equalization sales/use tax subpermit for the jobsite at the project site and allocate all eligible use tax payments to the City. Further, to the extent permitted by law, Developer will require in its general contractor construction contract that prior to beginning construction of the project, the general contractor and subcontractors will provide the City with either a copy of the subpermit, or a statement that sales/use tax does not apply to their portion of the job, or a statement that they do not have a resale license which is a precondition to obtaining a subpermit. Further, to the extent permitted by law, Developer will use its best efforts to require in its general contractor construction contract that (1) the general contractor or subcontractor shall provide a written certification that the person(s) responsible for filing the tax return understands the process of reporting the tax to the City and will do so in accordance with the City's conditions of project approval as contained in this Agreement; (2) the general contractor or subcontractor shall, on its quarterly sales/use tax return, identify the sales/use tax applicable to the construction site and use the appropriate Board of Equalization forms and schedules to ensure that the tax is allocated to the City of Orange; (3) in determining the amounts of sales/use tax to be paid, the general contractor or subcontractor shall follow the guidelines set forth in Section 1806 of Sales and Use Tax Regulations; (4) the general contractor or subcontractor shall submit an advance copy of his tax return(s) to the City for inspection and confirmation prior to submittal to the Board of Equalization; and (5) in the event it is later determined that certain eligible sales/use tax amounts were not included on general contractor's or subcontractor's sales/use tax return(s), general contractor and subcontractor agree to amend those returns and file them with the Board of Equalization in a manner that will ensure the City receives such additional sales/use tax as City may be eligible to receive from the project for which that particular contractor and its subcontractors were responsible.

During the term of this Agreement, to the extent permitted by law, Developer shall do one of the following: (1) Developer will review the Direct Payment Permit Process established under State Revenue and Taxation Code Section 7051.3 and, if eligible, acquire and use the permit so that the local share of its sales/use tax payments is allocated to the City; Developer will provide City with either a copy of the direct payment permit or a statement certifying ineligibility to qualify for the permit; Developer will further work with the City to inform all tenants about the Direct Payment Permit Process and encourage their participation, if qualified; or (2) Developer shall make use of its resale license issued by the Board of Equalization to exempt from sales/use taxes Developer's significant equipment purchases relating to the project site from vendors and to direct pay all sales/use tax to the Board of Equalization with the City of Orange as the point of sale for such purchases; in connection with the foregoing, Developer shall provide to the City the vendor names, a description of the equipment to be purchased, the purchase amounts for any out-of-state or out-of-country purchases exceeding $500,000, and a copy of the applicable quarterly sales/use tax reflecting payment of the sales/use tax so long as the confidentiality thereof is protected in a manner consistent with the restrictions imposed by Revenue and Taxation Code Section 7056.

City agrees to cause City's sales and use tax consultant, which is presently the HdL Companies, to reasonably cooperate with Developer, Developer's general contractor(s) and the general contractors' subcontractors to maximize City's receipt of sales/use tax hereunder.

(d) **Limitation on Parking.** Developer acknowledges and agrees that the total amount of parking to be constructed by Developer in connection with the Project shall not exceed the maximum authorized parking set forth in Conditional Use Permit No. 2379-01.

8. **Acknowledgments, Agreements and Assurances on the Part of the City**. In order to effectuate the provisions of this Agreement, and in consideration for the Developer to obligate itself to carry out the covenants and conditions set forth in the preceding Section of this Agreement, the City hereby agrees and assures Developer that Developer will be permitted to carry out and complete the development of the Project in accordance with the Applicable Rules, subject to the terms and conditions of this Agreement and the Applicable Rules. Therefore, the City hereby agrees and acknowledges that:

(a) **Entitlement to Develop**. The Developer is hereby granted the vested right to develop the Project to the extent and in the manner provided in this Agreement, subject to the Applicable Rules and the **Future Approvals.**

(b) **Conflicting Enactments**. Except as provided in Subsection (e) of Section 5 above, any change in the Applicable Rules, including, without limitation, any change in any applicable general area or specific plan, zoning, subdivision or building regulation, adopted or becoming effective after the Effective Date, including, without limitation, any such change by means of a Future Approval, an ordinance, initiative, resolution, policy, order or moratorium, initiated or instituted for any reason whatsoever and adopted by the Council, the Planning Commission or any other board, commission or department of City, or any officer or employee thereof, or by the electorate, as the case may be, which would, absent this Agreement, otherwise be applicable to the Project and which would conflict in any way with or be more restrictive than the Applicable Rules ("Subsequent Rules"), shall not be applied by City to any part of the Project. Developer may give City written notice of its election to have any Subsequent Rule applied to such portion of the Project as it may own, in which case such Subsequent Rule shall be deemed to be an Applicable Rule insofar as that portion of the Project is concerned.

(c) **Permitted Conditions**. Provided Developer's applications for any Future Approvals are consistent with this Agreement and the Applicable Rules, City shall grant the Future Approvals in accordance with the Applicable Rules and authorize development of the Project for the uses and to the density and regulations as described herein. City shall have the right to impose reasonable conditions in connection with Future Approvals and, in approving tentative subdivision maps, impose dedications for rights of way or easements for public access, utilities, water, sewers, and drainage necessary for the Project or other developments on the Project; provided, however, that such conditions and dedications shall not be inconsistent with the Applicable Rules in effect prior to imposition of the new requirement nor inconsistent with the development of the Project as contemplated by this Agreement; and provided further that such conditions and dedication shall not impose additional infrastructure or public improvement obligations in excess of those identified in this Agreement or normally imposed by the City. In connection with a Future Approval, Developer may protest any conditions, dedications or fees to the City Council or as

otherwise provided by City rules or regulations while continuing to develop the Project; such a protest by Developer shall not delay or stop the issuance of building permits or certificates of occupancy unless otherwise provided in the Applicable Rules.

(d) **Timing of Development**. Because the California Supreme Court held in *Pardee Construction Co. v. City of Camarillo*, 37 Ca1.3d 465 (1984) that failure of the parties to provide for the timing of development resulted in a later adopted initiative restricting the timing of development to prevail over the parties' Agreement, it is the intent of Developer and the City to cure that deficiency by acknowledging and providing that Developer shall have the right (without the obligation) to develop the Project in such order and at such rate and at such time as it deems appropriate within the exercise of its subjective business judgment, subject to the terms of this Agreement.

(e) **Moratorium**. No City-imposed moratorium or other limitation (whether relating to the rate, timing or sequencing of the development or construction of all or any part of the Project whether imposed by ordinance, initiative, resolution, policy, order or otherwise, and whether enacted by the Council, an agency of City, the electorate, or otherwise) affecting parcel or subdivision maps (whether tentative, vesting tentative or final), building permits, occupancy certificates or other entitlements to use or service (including, without limitation, water and sewer, should the City ever provide such services) approved, issued or granted within City, or portions of City, shall apply to the Project to the extent such moratorium or other limitation is in conflict with this Agreement and/or the Applicable Rules.

(f) **Permitted Fees and Exactions**. Certain development impact and processing fees have been imposed on the Project as conditions of the Existing Project Approvals (including, by way of example but not limited to, TSIP Fees, park facility fees, library facility fees, policy facility fees and fire facility fees), which impact and processing fees are in existence on the Effective Date ("**Development Project Fees**"). Development Project Fees applicable to the Project, together with any processing fees charged by the City for the City's administrative time and related costs incurred in preparing and considering any application for the Project, shall be assessed in the amount they exist at the time Developer becomes liable to pay such fees, provided that such fees shall not exceed the fees that are charged by the City generally to all other applicants similarly situated, on a non-discriminatory basis for similar approvals, permits, or entitlements granted by City. During the term of this Agreement, the City shall be precluded from applying any development impact fee that does not exist as of the Effective Date, except for an impact fee the City may adopt on a City-wide basis for administrative facility capital improvements. This provision does not authorize City to impose fees on the Project that could not be imposed in the absence of this Agreement. Except as otherwise provided in this Agreement, City shall only charge and impose those fees and exactions, including, without limitation, dedications and any other fees or taxes (including excise, construction or any other taxes) relating to development or the privilege of developing the Project as set forth in the Applicable Rules described in Section 5 of this Agreement; provided, however, that Section 5 shall not apply to the following fees and taxes and shall not be construed to limit the authority of City to:

(1) Impose or levy general or special taxes, including but not limited to, property taxes, sales taxes, parcel taxes, transient occupancy taxes, business taxes, which may be applied to the Project or to businesses occupying the Project; provided, however, that the tax is of

general applicability citywide and does not burden the Project disproportionately to other development within the City; or

(2) Collect such fees or exactions as are imposed and set by governmental entities not controlled by City but which are required to be collected by City.

(g) **Project Mitigation**. The Developer shall undertake and complete the mitigation requirements of the Existing Project Approvals. These requirements shall be satisfied within the time established therefor in the Existing Project Approvals.

9. **Cooperation and Implementation**. The City and Developer agree that they will cooperate with one another to the fullest extent reasonable and feasible to implement this Agreement. Upon satisfactory performance by Developer of all required preliminary conditions of approval, actions and payments, the City will commence and in a timely manner proceed to complete all steps necessary for the implementation of this Agreement and the development of the Project in accordance with the terms of this Agreement. Developer shall, in a timely manner, provide the City with all documents, plans, and other information necessary for the City to carry out its obligations. Additionally:

(a) **Further Assurances: Covenant to Sign Documents**. Each party shall take all actions and do all things, and execute, with acknowledgment or affidavit, if required, any and all documents and writings, including estoppel certificates, that may be necessary or proper to achieve the purposes and objectives of this Agreement.

(b) **Reimbursement and Apportionment**. Nothing in this Agreement precludes City and Developer from entering into any reimbursement agreements for reimbursement to the Developer of the portion (if any) of the cost of any dedications, public facilities and/or infrastructure that City, pursuant to this Agreement, may require as conditions of the Future Approvals agreed to by the Parties, to the extent that they are in excess of those reasonably necessary to mitigate the impacts of the Project or development on the Project.

(c) **Processing**. Upon satisfactory completion by Developer of all required preliminary actions and payments of appropriate processing fees, if any, City shall, subject to all legal requirements, promptly initiate, diligently process, and complete all required steps, and promptly act upon any approvals and permits necessary for the development by Developer in accordance with this Agreement, including, but not limited to, the following:

(1) the processing of applications for and issuing of all discretionary approvals requiring the exercise of judgment and deliberation by City, including without limitation, the Future Approvals;

(2) the holding of any required public hearings; and

(3) the processing of applications for and issuing of all ministerial approvals requiring the determination of conformance with the Applicable Rules, including, without limitation, site plans, grading plans, improvement plans, building plans and specifications, and ministerial issuance of one or more final maps, grading permits, improvement permits, wall permits, building permits, lot line adjustments, encroachment permits, temporary use permits,

Back to Agenda

certificates of use and occupancy and approvals and entitlements and related matters as necessary for the completion of the development of the Project ("**Ministerial Approvals**").

(d) **Processing During Third Party Litigation**. The filing of any third party lawsuit(s) against City and Developer relating to this Agreement or to other development issues affecting the Project shall not delay or stop the development, processing or construction of the Project, approval of the Future Approvals, or issuance of Ministerial Approvals, unless the third party obtains a court order preventing the activity. City shall not stipulate to or fail to oppose the issuance of any such order.

(e) **Defense of Agreement**. City agrees to and shall timely take all actions which are necessary or required to uphold the validity and enforceability of this Agreement and the Applicable Rules, subject to the indemnification provisions of this Section. Developer shall indemnify, protect and hold harmless, the City and any agency or instrumentality thereof, and/or any of its officers, employees, and agents from any and all claims, actions, or proceedings against the City, or any agency or instrumentality thereof, or any of its officers, employees and agents, to attack, set aside, void, annul, or seek monetary damages resulting from an approval of the City, or any agency or instrumentality thereof, advisory agency, appeal board or legislative body including actions approved by the voters of the City, concerning this Agreement. The City shall promptly notify the Developer of any claim, action, or proceeding brought forth within this time period. The Developer and City shall select joint legal counsel to conduct such defense and which legal counsel shall represent both the City and Developer in the defense of such action. The City in consultation with Developer shall estimate the cost of the defense of the action and Developer shall deposit said amount with the City. City may require additional deposits to cover anticipated costs. City shall refund, without interest, any unused portions of the deposit once the litigation is finally concluded. Should the City fail to either promptly notify or cooperate fully, Developer shall not thereafter be responsible to indemnify, defend, protect, or hold harmless the City, any agency or instrumentality thereof, or any of its officers, employees, or agents. Should the Developer fail to post the required deposit within five (5) working days from notice by City, City may terminate this Agreement pursuant to its terms. If City elects to terminate this Agreement pursuant to this Section, it shall do so by written notice to Developer, whereupon this Agreement shall terminate, expire and have no further force or effect as to the Project. Thereafter, the terminating party's indemnity and defense obligations pursuant to this Agreement shall have no further force or effect as to acts or omissions from and after the effective date of said termination.

10. **Compliance; Termination; Modifications and Amendments**.

(a) **Review of Compliance**. The City's Director of Community Development (or designee) shall review this Development Agreement once each year, on or before each anniversary of the Effective Date ("**Periodic Review**"), in accordance with this Section, and the Applicable Rules and the City's Municipal Code in order to determine whether or not Developer is out-of-compliance with any specific term or provision of this Agreement. At commencement of each Periodic Review, the Director shall notify Developer in writing that the Periodic Review will commence or has commenced.

(b) **Prima Facie Compliance**. Within thirty (30) days after receipt of the Director's notice that the Periodic Review will commence or has commenced (and unless

Developer requests and is granted a waiver by the City), Developer shall demonstrate that it has, during the preceding twelve (12) month period, been in reasonable prima facie compliance with this Agreement. For purposes of this Agreement, the phrase "reasonable prima facie compliance" shall mean that Developer has demonstrated that it has acted in accordance with this Agreement.

(c) **Notice of Non-Compliance, Cure Rights**. If during any Periodic Review, the Director reasonably concludes that (i) Developer has not demonstrated that it is in reasonable prima facie compliance with this Agreement, and (ii) Developer is out of compliance with a specific, substantive term or provision of this Agreement, then the Director may issue and deliver to Developer a written notice of non-compliance ("**Notice of Non-Compliance**") detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement and Applicable Rules which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then Developer shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion. Upon completion of each Periodic Review, the Director shall submit a report to the City Council if the Director determines that Developer has not satisfactorily demonstrated reasonable prima facie compliance with this Agreement. The Director shall submit a report to the City Council stating what steps have been taken by the Director or what steps the Director recommends that the City subsequently take with reference to the alleged non-compliance. (If the Director determines that the Developer has demonstrated reasonable prima facie compliance with this Agreement, the Director will not be required to submit a report to the City Council.) Non-performance by either party shall be excused when it is delayed unavoidably and beyond the reasonable control of the Parties as a result of any of the events identified in Section 19 of this Agreement.

(d) **Termination of Development Agreement as to Breaching Party**. If Developer fails to timely cure any item(s) of non-compliance set forth in a Notice of Non-compliance, then the City shall have the right, but not the obligation, to initiate proceedings for the purpose of terminating this Agreement. Such proceedings shall be initiated by notice to the Developer, followed by meetings between the Developer and the City for the purpose of good faith negotiations between the Parties to resolve the dispute. If the City determines to terminate this Agreement following a reasonable number of meetings and a reasonable opportunity for the Developer to cure any non-performance, the City shall give Developer written notice of its intent to so terminate this Agreement, specifying the precise grounds for termination and setting a date, time and place for a public hearing on the issue, all in compliance with the Development Agreement Statutes. At the noticed public hearing, Developer and/or its designated representative shall be given an opportunity to make a full and public presentation to the City. If, following the taking of evidence and hearing of testimony at said public hearing, the City finds, based upon a preponderance of evidence, that the Developer has not demonstrated compliance with this Agreement, and that Developer is out of material compliance with a specific, substantive term or provision of this Agreement, then the City may (unless the Parties otherwise agree in writing) terminate this Agreement.

(e) **Notice and Opportunity to Cure if City Breaches**. If at any time Developer reasonably concludes that (1) City has not acted in prima facie compliance with this Agreement, and (ii) City is out of compliance with a specific, substantive term or provision of this Agreement, then Developer may issue and deliver to City written notice of City's non-compliance, detailing the specific reasons for non-compliance (including references to sections and provisions of this Agreement which have allegedly been breached) and a complete statement of all facts demonstrating such non-compliance. Developer shall also meet with the City as appropriate to discuss any alleged non-compliance on the part of the City. City shall have thirty (30) calendar days following its receipt of the Notice of Non-compliance in which to cure said failure(s); provided, however, that if any one or more of the item(s) of non-compliance set forth in the Notice of Non-compliance cannot reasonably be cured within said thirty (30) calendar day period, then City shall not be in breach of this Agreement if it commences to cure said item(s) within said thirty (30) day period and diligently prosecutes said cure to completion.

(f) **Modification or Amendment, of Development Agreement**. Subject to the notice and hearing requirements of the applicable Development Agreement Statutes, this Agreement may be modified or amended from time to time only with the written consent of Developer and the City or their successors and assigns in accordance with the provisions of the Municipal Code and Government Code §65868.

(g) **No Cross-Default**. Notwithstanding anything set forth in this Agreement to the contrary, in no event shall the breach of or default under this Agreement by Developer with respect to the Project constitute a breach of or default under this Agreement or any other agreement with respect to any other development project. In other words, the Project identified in this Agreement shall stand alone for purposes of its compliance with the terms, provisions and requirements of this Agreement and any other agreement between the City and Developer.

11. **Operating Memoranda**. The provisions of this Agreement require a close degree of cooperation between City and Developer. The anticipated refinements to the Project and other development activity at the Project may demonstrate that clarifications to this Agreement and the Applicable Rules are appropriate with respect to the details of performance of City and Developer. If and when, from time to time during the term of this Agreement, City and Developer agree that such clarifications are necessary or appropriate, they shall effectuate such clarifications through operating memoranda approved in writing by the City and Developer which, after execution, shall be attached hereto and become a part of this Agreement, and the same may be further clarified from time to time as necessary with future written approval by City and Developer. Operating memoranda are not intended to constitute an amendment to this Agreement but mere ministerial clarifications; therefore, no public notice or hearing shall be required. The City Attorney shall be authorized, upon consultation with and approval of Developer, to determine whether a requested clarification may be effectuated pursuant to this Section or whether the requested clarification is of such a character to constitute an amendment hereof which requires compliance with the provisions of Section 10(f) above. The authority to enter into such operating memoranda is hereby delegated to the City Manager and the City Manager is hereby authorized to execute any operating memoranda hereunder without further action by the City Council.

12. **Term of Agreement**. This Agreement shall become operative and shall commence upon the date the ordinance approving this Agreement becomes effective. Subject to payment by

Back to Agenda

Developer of the "**Public Benefit Fees**" that are applicable in the amounts and at the times identified on **Exhibit "D"** attached hereto, this Agreement shall remain in effect for a period of up to six (6) years from the Original Termination Date unless this Agreement is terminated, modified or extended upon mutual written consent of the Parties hereto or as otherwise provided in this Agreement. Unless otherwise agreed to by the City and Developer, Developer's failure to pay any portion of the Public Benefit Fees within the time period set forth on **Exhibit "D"** shall be deemed Developer's election not to extend the term of this Agreement. In no event shall the Public Benefit Fees be supplemented, raised or increased above the amounts identified on **Exhibit "D"**.

(a) **First Payment of Public Benefit Fees**. Within forty-five (45) days of mutual execution of this Agreement by the Developer and the City, Developer shall pay to the City the First Public Benefit Fee (as defined on **Exhibit "D"**). Upon payment by Developer to the City of the First Public Benefit Fee, this Agreement shall remain in effect for a period of two (2) years from the Original Termination Date (such two (2) year period being the "**Initial Term**").

(b) **Second Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to extend this Agreement beyond the Initial Term, then Developer shall pay to the City the Second Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Second Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the Initial Term (such two (2) year period being the "**First Automatic Renewal Term**").

(c) **Final Payment of Public Benefit Fees**. If Developer elects, in its sole and absolute discretion, to further extend this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the Third Public Benefit Fee (as defined on **Exhibit "D"**) no later than the time set forth on **Exhibit "D"**. Upon payment by Developer to the City of the Third Public Benefit Fee, this Agreement shall be automatically extended for an additional two (2) years from the expiration of the First Automatic Renewal Term.

(d) Following expiration or termination of the term hereof, this Agreement shall be deemed terminated and of no further force and effect; provided, however, that no such expiration or termination shall automatically affect any right of the City and Developer arising from City approvals on the Project prior to expiration or termination of the term hereof or arising from the duties of the Parties as prescribed in this Agreement.

13. **Administration of Agreement and Resolution of Disputes**.

(a) **Administration of Disputes**. All disputes involving the enforcement, interpretation or administration of this Agreement (including, but not limited to, decisions by the City staff concerning this Agreement and any of the projects or other matters concerning this Agreement which are the subject hereof) shall first be subject to good faith negotiations between the Parties to resolve the dispute. In the event the dispute is not resolved by negotiations, the dispute shall then be heard and decided by the City Council. Thereafter, any decision of the City Council which remains in dispute shall be appealed to, heard by, and resolved pursuant to the Mandatory Alternative Dispute Resolution procedures set forth in Section 13(b) hereinbelow.

Unless the dispute is resolved sooner, City shall use diligent efforts to complete the foregoing City Council review within thirty (30) days following receipt of a written notice of default or dispute notice. Nothing in this Agreement shall prevent or delay Developer or City from seeking a temporary or preliminary injunction in state or federal court if it believes that injunctive relief is necessary on a more immediate basis.

(b) **Mandatory Alternative Dispute Resolution**. After the provisions of Section 13(a) above have been complied with, and pursuant to Code of Civil Procedure §638, *et seq*., all disputes regarding the enforcement, interpretation or administration of this Agreement (including, but not limited to, appeals from decisions of the City Council, all matters involving Code of Civil Procedure §1094.5, all Ministerial Approvals, Discretionary Approvals, Future Approvals and the application of Applicable Rules) shall be heard and resolved pursuant to the alternative dispute resolution procedure set forth in this Section 13(b). All matters to be heard and resolved pursuant to this Section 13(b) shall be heard and resolved by a single appointed referee who shall be a retired judge from either the California Superior Court, the California Court of Appeals, the California Supreme Court, the United States District Court or the United States Court of Appeals, provided that the appointed referee shall have significant and recent experience in resolving land use and real property disputes. The Parties to this Agreement who are involved in the dispute shall agree and appoint a single referee who shall then try all issues, whether of fact or law, and report in writing to the Parties to such dispute all findings of fact and issues and decisions of law and the final judgments made thereon, in sufficient detail to inform each party as to the basis of the referee's decision. The referee shall try all issues as if he/she were a California Superior Court judge, sitting without a jury, and shall (unless otherwise limited by any term or provision of this Agreement) have all legal and equitable powers granted a California Superior Court judge. Prior to the hearing, the Parties shall have full discovery rights as provided by the California Code of Civil Procedure. At the hearing, the Parties shall have the right to present evidence, examine and cross-examine lay and expert witnesses, submit briefs and have arguments of counsel heard, all in accordance with a briefing and hearing schedule reasonably established by the referee. The referee shall be required to follow and adhere to all laws, rules and regulations of the State of California in the hearing of testimony, admission of evidence, conduct of discovery, issuance of a judgment and fashioning of remedy, subject to such restriction on remedies as set forth in this Agreement. If the Parties involved in the dispute are unable to agree on a referee, any party to the dispute may seek to have a single referee appointed by a California Superior Court judge and the hearing shall be held in Orange County pursuant to California Code of Civil Procedure §640. The cost of any proceeding held pursuant to this Section 13(b) shall initially be borne equally by the Parties involved in the dispute, and each party shall bear its own attorneys' fees. Any referee selected pursuant to this Section shall be considered a temporary judge appointed pursuant to Article 6, Section 21 of the Constitution of the State of California. The cost of the referee shall be borne equally by each party. If any party to the dispute fails to timely pay its fees or costs, or fails to cooperate in the administration of the hearing and decision process as determined by the referee, the referee shall, upon the written request of any party to the dispute, be required to issue a written notice of breach to the defaulting party, and if the defaulting party fails to timely respond or cooperate with the period of time set forth in the notice of default (which in any event may not exceed thirty (30) calendar days), then the referee shall, upon the request of any non-defaulting party, render a default judgment against the defaulting party. At the end of the hearing, the referee shall issue a written judgment (which may include an award of reasonable attorneys' fees and costs as provided elsewhere in this Agreement), which judgment shall be final and binding between the

Parties and which may be entered as a final judgment in a California Superior Court. The referee shall use his/her best efforts to finally resolve the dispute and issue a final judgment within sixty (60) calendar days from the date of his/her appointment. Pursuant to Code of Civil Procedure Section 645, the decision of the referee may be excepted to and reviewed in like manner as if made by the Superior Court.

(1) Any party to the dispute may, in addition to any other rights or remedies provided by this Agreement, seek appropriate judicial ancillary remedies from a court of competent jurisdiction to enjoin any threatened or attempted violation hereof, or enforce by specific performance the obligations and rights of the Parties hereto, except as otherwise provided herein.

(2) The Parties hereto agree that (i) the City would not have entered into this Agreement if it were to be held liable for general, special or compensatory damages for any default under or with respect to this Agreement or the application thereof, and (ii) Developer has adequate remedies, other than general, special or compensatory damages, to secure City's compliance with its obligations under this Agreement. Therefore, the undersigned agree that neither the City nor its officers, employees or agents shall be liable for any general, special or compensatory damages to Developer or to any successor or assignee or transferee of Developer for the City's breach or default under or with respect to this Agreement; and Developer covenants not to sue the City, its officers, employees or agents for, or claim against the City, its officers, employees or agents, any right to receive general, special or compensatory damages for the City's default under this Agreement. Notwithstanding the provisions of this Section 13(b)(2), City agrees that Developer shall have the right to seek a refund or return of a deposit made with the City or fee paid to the City in accordance with the provisions of the Applicable Rules.

(c) In the event Developer challenges an ordinance or regulation of the City as being outside of the authority of the City pursuant to this Agreement, Developer shall bear the burden of proof in establishing that such ordinance, rule, regulation, or policy is inconsistent with the terms of this Agreement and applied in violation thereof.

14. **Transfers and Assignments**.

(a) **Right to Assign**. Developer shall have the right to encumber, sell, transfer or assign all or any portion of the Project which it may own to any person or entity (such person or entity, a "**Transferee**") at any time during the term of this Agreement without approval of the City, provided that Developer provides the City with written notice of the applicable transfer within thirty (30) days of the transfer, along with notice of the name and address of the assignee. Nothing set forth herein shall cause a lease or license of any portion of the Project to be deemed to constitute a transfer of the Project, or any portion thereof. This Agreement may be assigned or transferred by Developer as to and in conjunction with the sale or transfer of all or a portion of the Project, as permitted by this Section 14, provided that the Transferee has agreed in writing to be subject to all of the provisions of this Agreement applicable to the portion of the Project so transferred.

(b) **Liabilities Upon Transfer**. Upon the delegation of all duties and obligations and the sale, transfer or assignment of all or any portion of the Project to a Transferee,

Back to Agenda

Developer shall be released from its obligations under this Agreement with respect to the Project or portion thereof so transferred arising subsequent to the effective date of such transfer if (1) Developer has provided to City thirty (30) days' prior written notice of such transfer and (2) the Transferee has agreed in writing to be subject to all of the provisions hereof applicable to the portion of the Project so transferred. Upon any transfer of any portion of the Project and the express assumption of Developer's obligations under this Agreement by such Transferee, the Transferee becomes a party to this Agreement, and the City agrees to look solely to the Transferee for compliance by such Transferee with the provisions of this Agreement as such provisions relate to the portion of the Project acquired by such Transferee. Any such Transferee shall be entitled to the benefits of this Agreement and shall be subject to the obligations of this Agreement, applicable to the parcel(s) transferred. A default by any Transferee shall only affect that portion of the Project owned by such Transferee and shall not cancel or diminish in any way Developer's rights hereunder with respect to any portion of the Project not owned by such Transferee. The Transferee shall be responsible for the reporting and annual review requirements relating to the portion of the Project owned by such Transferee, and any amendment to this Agreement between City and a transferee shall only affect the portion of the Project owned by such transferee. In the event that Developer retains its obligations under this Agreement with respect to the portion of the Project transferred by Developer, the Transferee in such a transaction (a "**Non-Assuming Transferee**") shall be deemed to have no obligations under this Agreement, but shall continue to benefit from all rights provided by this Agreement for the duration of the term set forth in Section 12. Nothing in this section shall exempt any Non-Assuming Transferee from payment of applicable fees and assessments or compliance with applicable permit conditions of approval or mitigation measures.

15. **Mortgage Protection**. The Parties hereto agree that this Agreement shall not prevent or limit Developer, at Developer's sole discretion, from encumbering the Project or any portion thereof or any improvement thereon in any manner whatsoever by any mortgage, deed of trust, sale/leaseback, synthetic lease or other security device securing financing with respect to the Project. City acknowledges that the lender(s) providing such financing may require certain Agreement interpretations and modifications and agrees, upon request, from time to time, to meet with Developer and representatives of such lender(s) to negotiate in good faith any such request for interpretation or modification; provided, however, that no such interpretations or modifications shall diminish the public benefits received under this Agreement unless the City agrees to the acceptance of such diminished public benefits. City will not unreasonably withhold its consent to any such requested interpretation or modification, provided such interpretation or modification is consistent with the intent and purposes of this Agreement. Any mortgagee of a mortgage or a beneficiary of a deed of trust or landlord under a sale/leaseback, synthetic lease or lender providing secured financing in any manner ("**Mortgagee**") on the Project shall be entitled to the following rights and privileges:

(a) **Mortgage Not Rendered Invalid**. Neither entering into this Agreement nor a breach of this Agreement shall defeat, render invalid, diminish, or impair the lien of any mortgage, deed of trust or other financing documents on the Project made in good faith and for value.

(b) **Request for Notice to Mortgagee**. The Mortgagee of any mortgage, deed of trust or other financing documents encumbering the Project, or any part thereof, who has submitted a request in writing to City in the manner specified herein for giving notices shall be

entitled to receive written notification from City of any default by Developer in the performance of Developer's obligations under this Agreement.

(c) **Mortgagee's Time to Cure**. If City timely receives a request from a Mortgagee requesting a copy of any notice of default given to Developer under the terms of this Agreement, City shall provide a copy of that notice to the Mortgagee within ten (10) days of sending the notice of default to Developer. The Mortgagee shall have the right, but not the obligation, to cure the default during the remaining cure period allowed Developer under this Agreement, as well as any reasonable additional time necessary to cure, including reasonable time for reacquisition of the Project or the applicable portion thereof.

(d) **Project Taken Subject to Obligations**. Any Mortgagee who comes into possession of the Project or any portion thereof, pursuant to foreclosure of the mortgage, deed of trust, or other financing documents, or deed in lieu of foreclosure, shall take the Project or portion thereof subject to the terms of this Agreement; provided, however, that in no event shall such Mortgagee be held liable for any default or monetary obligation of Developer arising prior to acquisition of title to the Project by such Mortgagee, except that no such Mortgagee (nor its successors or assigns) shall be entitled to a building permit or occupancy certificate until all delinquent and current fees and other monetary obligations due under this Agreement for the Project or portion thereof acquired by such Mortgagee have been paid to City.

16. **Notices**. All notices under this Agreement shall be in writing and shall be deemed delivered when personally received by the addressee, or within three (3) calendar days after deposit in the United States mail by registered or certified mail, postage prepaid, return receipt requested, to the following Parties and their counsel at the addresses indicated below; provided, however, if any party to this Agreement delivers a notice or causes a notice to be delivered to any other party to this Agreement, a duplicate of that Notice shall be concurrently delivered to each other party and their respective counsel.

If to City:	City of Orange 300 East Chapman Avenue Orange, CA 92866 Attention: City Manager Facsimile: (714) 744-5147
With a copy to:	Wayne Winthers, Esq. City Attorney City of Orange 300 East Chapman Avenue Orange, California 92866 Facsimile: (714) 538-7157
If to Developer:	ORANGE COUNTY HEALTH AUTHORITY, a public agency doing business as CalOptima 505 City Parkway West Orange, California 92868 Attention: Mr. Mike Ruane

Back to Agenda

Facsimile: (714) 571-2416

Notice given in any other manner shall be effective when received by the addressee. The addresses for notices may be changed by notice given in accordance with this provision.

17. **Severability and Termination**. If any provision of this Agreement is determined by a court of competent jurisdiction to be invalid or unenforceable, or if any provision of this Agreement is superseded or rendered unenforceable according to any law which becomes effective after the Effective Date, the remainder of this Agreement shall be effective to the extent the remaining provisions are not rendered impractical to perform, taking into consideration the purposes of this Agreement.

18. **Time of Essence**. Time is of the essence for each provision of this Agreement of which time is an element.

19. **Force Majeure**. Changed conditions, changes in local, state or federal laws or regulations, floods, earthquakes, delays due to strikes or other labor problems, moratoria enacted by City or by any other governmental entity or agency (subject to Sections 5 and 8 of this Agreement), third-party litigation, injunctions issued by any court of competent jurisdiction, initiatives or referenda, the inability to obtain materials, civil commotion, fire, acts of God, or other circumstances which substantially interfere with the development or construction of the Project, or which substantially interfere with the ability of any of the Parties to perform its obligations under this Agreement, shall collectively be referred to as "**Events of Force Majeure**". If any party to this Agreement is prevented from performing its obligation under this Agreement by any Event of Force Majeure, then, on the condition that the party claiming the benefit of any Event of Force Majeure, (a) did not cause any such Event of Force Majeure and (b) such Event of Force Majeure was beyond said party's reasonable control, the time for performance by said party of its obligations under this Agreement shall be extended by a number of days equal to the number of days that said Event of Force Majeure continued in effect, or by the number of days it takes to repair or restore the damage caused by any such Event to the condition which existed prior to the occurrence of such Event, whichever is longer. In addition, the termination date of this Agreement as set forth in Section 12 of this Agreement shall be extended by the number of days equal to the number of days that any Events of Force Majeure were in effect.

20. **Sole Obligation of Health Authority**. As required by County of Orange Ordinance No. 3896 and amendments thereto, any obligation of the Orange County Health Authority created by this Development Agreement shall not be an obligation of the County of Orange.

21. **Waiver**. No waiver of any provision of this Agreement shall be effective unless in writing and signed by a duly authorized representative of the party against whom enforcement of a waiver is sought.

22. **No Third Party Beneficiaries**. This Agreement is made and entered into for the sole protection and benefit of the Developer and the City and their successors and assigns. Notwithstanding anything contained in this Agreement to the contrary, no other person shall have any right of action based upon any provision of this Agreement.

23. **Attorneys' Fees**. In the event any dispute hereunder is resolved pursuant to the terms of Section 13 (b) hereof, or if any party commences any action for the interpretation, enforcement, termination, cancellation or rescission of this Agreement, or for specific performance for the breach hereof, the prevailing party shall be entitled to its reasonable attorneys' fees, litigation expenses and costs arising from the action. Attorneys' fees under this Section shall include attorneys' fees on any appeal as well as any attorneys' fees incurred in any post judgment proceedings to collect or enforce the judgment.

24. **Incorporation of Exhibits**. The following exhibits which are part of this Agreement are attached hereto and each of which is incorporated herein by this reference as though set forth in full:

(a) Exhibit "A" — Legal Description of the 605 Building Site;

(b) Exhibit "B" — Copy of Resolution No. 9843 of the City Council of the City of Orange;

(c) Exhibit "C" – Legal Description of the City Tower Two Site; and

(d) Exhibit "D" — Public Benefit Fees.

25. **Copies of Applicable Rules**. Prior to the Effective Date, the City and Original Developer prepared two (2) sets of the Applicable Rules, one each for City and Original Developer, so that if it became necessary in the future to refer to any of the Applicable Rules, there would be a common set available to the Parties. The City agrees to deliver to Developer a copy of the Applicable Rules upon request.

26. **Authority to Execute, Binding Effect**. Developer represents and warrants to the City that it has the power and authority to execute this Agreement and, once executed, this Agreement shall be final, valid, binding and enforceable against Developer in accordance with its terms. The City represents and warrants to Developer that (a) all public notices and public hearings have been held in accordance with law and all required actions for the adoption of this Agreement have been completed in accordance with applicable law; (b) this Agreement, once executed by the City, shall be final, valid, binding and enforceable on the City in accordance with its terms; and (c) this Agreement may not be amended, modified, changed or terminated in the future by the City except in accordance with the terms and conditions set forth herein.

27. **Entire Agreement; Conflicts**. This Agreement represents the entire of the Parties. This Agreement integrates all of the terms and conditions mentioned herein or incidental hereto, and supersedes all negotiations or previous s between the Parties or their predecessors in interest with respect to all or any part of the subject matter hereof. Should any or all of the provisions of this Agreement be found to be in conflict with any other provision or provisions found in the Applicable Rules, then the provisions of this Agreement shall prevail.

28. **Remedies**. Upon either party's breach hereunder, the non-breaching party shall be permitted to pursue any remedy provided for hereunder.

[SIGNATURES BEGIN ON FOLLOWING PAGE]

Back to Agenda

IN WITNESS WHEREOF, the Parties have each executed this Agreement on the date first written above.

CITY OF ORANGE:

Teresa E. Smith, Mayor

ATTEST:

chief clerk for

Mary E. Murphy, City Clerk

APPROVED AS TO FORM:

By:

Wayne W. Winthers, City Attorney

Back to Agenda

DEVELOPER:

ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: Michael Schrader
its Chief Executive Officer

By: ORANGE COUNTY HEALTH AUTHORITY,
a public agency doing business as CalOptima
_____
Print Name: _____
its _____

Back to Agenda

ACKNOWLEDGMENTS

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 9 2014, before me, Suzanne M. Turf, Notary Public, personally appeared Michael Schrader, who proved to me on the basis of satisfactory evidence to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he/she/they~~ executed the same in ~~his/her/their~~ authorized capacity~~(ies)~~, and that by ~~his/her/their~~ signature on the instrument, the person~~(s),~~ or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

SUZANNE M. TURF
Commission # 1921663
Notary Public - California
Orange County
My Comm. Expires Jan 14, 2015

(SEAL)

Suzanne M. Turf
Notary Public in and for said State

STATE OF CALIFORNIA)
) ss.
COUNTY OF ORANGE)

On Dec. 10, 2014, before me, Michele E. Day, personally appeared Teresa E. Smith, who proved to me on the basis of satisfactory evidence) to be the person~~(s)~~ whose name~~(s)~~ is subscribed to the within instrument and acknowledged to me that ~~he~~/she/~~they~~ executed the same in ~~his~~/her/~~their~~ authorized capacity~~(ies)~~, and that by ~~his~~/her/~~their~~ signature on the instrument, the person~~(s)~~, or the entity upon behalf of which the person acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

MICHELE E. DAY
COMM. # 1936993
NOTARY PUBLIC - CALIFORNIA
ORANGE COUNTY
My Comm. Expires June 14, 2015

(SEAL)

Michele E. Day
Notary Public in and for said State

Back to Agenda

EXHIBIT "A"

LEGAL DESCRIPTION
605 BUILDING TWO

That certain real property located in the City of Orange, County of Orange, State of California, described as follows:

PARCEL A:

PARCEL 2 OF THE LOT LINE ADJUSTMENT NO. LL94-1, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, RECORDED APRIL 12, 1996 AS INSTRUMENT NO. 96-180461, OFFICIAL RECORDS.

EXCEPT FROM THAT PORTION THEREOF INCLUDED WITHIN THE NORTHWEST QUARTER OF THE SOUTHEAST QUARTER OF FRACTIONAL SECTION 35, TOWNSHIP 4 SOUTH, RANGE 10 WEST, IN THE RANCHO LAS BOLSAS, IN THE CITY OF ORANGE, COUNTY OF ORANGE, STATE OF CALIFORNIA, AS PER MAP RECORDED IN BOOK 51, PAGE 10 OF MISCELLANEOUS MAPS, IN THE OFFICE OF THE COUNTY RECORDER OF SAID COUNTY, ALL OIL AND OTHER MINERAL RIGHTS IN OR UNDER SAID LAND, LYING BELOW A DEPTH OF 500 FEET FROM THE SURFACE THEREOF, BUT WITHOUT THE RIGHT OF ENTRY, AS RESERVED IN THE DEED FROM CHESTER M. BARNES AND OTHERS, RECORDED OCTOBER 2, 1999 IN BOOK 4911, PAGE 214, OFFICIAL RECORDS.

ALSO EXCEPT THEREFROM ALL SUBSURFACE WATER AND SUBSURFACE WATER RIGHTS IN AND UNDER SAID LAND.

PARCEL B:

A NONEXCLUSIVE EASEMENT FOR UTILITY FACILITIES FOR THE BENEFIT OF PARCEL A, IN, ON, OVER, TO, UNDER, THROUGH, UPON AND ACROSS THE REAL PROPERTY DESCRIBED IN THAT CERTAIN DECLARATION OF UTILITY LINE EASEMENT, DATED JULY 11, 1996, AND RECORDED JULY 11, 1996 AS INSTRUMENT NO. 19960354693 OF OFFICIAL RECORDS, AS SET FORTH IN SAID DECLARATION.

Back to Agenda

EXHIBIT "B"

COPY OF RESOLUTION NO. 9843

OF THE CITY COUNCIL OF THE CITY OF ORANGE

Back to Agenda

RESOLUTION NO. 9843

A RESOLUTION OF THE CITY COUNCIL OF THE CITY OF ORANGE AMENDING CONDITIONAL USE PERMIT 2378-01, 2379-01 AND 2380-01; MAJOR SITE PLAN REVIEW NOS. 106-99, 107-99 AND 108-99.

WHEREAS, on October 10, 2001, the City Council adopted resolutions approving the following conditional use permits, major site plan reviews:

1. The Chapman Site consisting of 132,000 square feet of office space and a 137-room hotel (Resolution No. 9519);
2. City Tower Two Site consisting of 465,000 square feet of office space and eight-level parking structure (Resolution No. 9520);
3. 605 Building Site consisting of 200,000 square feet of office space and a five-level parking structure (Resolution No. 9521);
4. City Plaza Two Site consisting of 136,000 square feet of office building and a six-level parking structure (Resolution No. 9522); and

WHEREAS, the foregoing four projects are hereafter referred to as the EOP Projects; and

WHEREAS, the City Council considered and approved Final Environmental Impact Report No. 1612-01 (hereafter, the FEIR) which analyzed the environmental impacts of the EOP Projects; and

WHEREAS, the City commissioned the West Orange Circulation Study (hereafter, WOC Study) to analyze the traffic impacts of the EOP Projects, expansion of The Block at Orange and expansion of UCI Medical Center; and

WHEREAS, the WOC Study identified approximately $3.5 million in traffic improvements and assigned fair share costs of such improvements to the following projects: (1) UCI Medical Center expansion, 32%; (2) EOP Projects 38% (identified in the WOC Study as Spieker Office Properties); and (3) The Block at Orange expansion, 30%; and

WHEREAS, as a result of the WOC Study the FEIR, as well as Resolution Nos. 9519-9522 require the EOP Projects as a mitigation measure to pay 38% of the cost of the traffic improvements identified in the WOC Study as its fair share contribution (hereafter WOC Traffic Improvements); and

WHEREAS, Resolutions Nos. 9519-9522 also require the EOP Projects to fully fund three improvements identified in conditions nos. 32, 34 and 35 of such resolutions and pursuant to condition no. 33, to pay a fair share of the cost of a bridge

Back to Agenda

widening on Orangewood Avenue near its intersection with State Route 57 (hereafter conditions 32-35 are referred to as, Traffic Improvement Conditions); and

WHEREAS, on January 19, 2004, the Planning Commission adopted Resolution No. PC 04-04 approving a new development on the Chapman Site which includes, but is not limited to, 58,260 square feet of commercial space and a fast food restaurant (hereafter, Best Buy Project) which would replace the Chapman Site component (City Council Resolution 9519) of the EOP Projects; and

WHEREAS, CA-The City (Chapman) Limited Partnership is in escrow to sell the Chapman Site to City Town Center, L.P., for development of the Best Buy Project; and

WHEREAS, EOP-The City, L.L.C., has requested that the City proportionally reduce the fair share cost of the WOC Traffic Improvements and Traffic Improvement Conditions to reflect the fact that the Chapman Site is no longer a component of the EOP Projects; and

WHEREAS, City staff has determined that such a reduction is appropriate and will fairly reflect the traffic impacts caused by the EOP Projects, exclusive of the Chapman Site (hereafter, the Remaining EOP Projects).

NOW, THEREFORE, BE IT RESOLVED THAT THE CITY COUNCIL OF THE CITY OF ORANGE FINDS AND DETERMINES as follows:

1. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the WOC Traffic Improvements, as originally identified in the FEIR and the WOC Study. The fair shares of the EOP Projects for the WOC Traffic Improvements, as identified in the FEIR and WOC Study are reflected in the attached **ExhibitA.**

2. The Remaining EOP Projects shall not bear the costs of the Chapman Site's fair share of the Traffic Improvement Conditions as identified in the FEIR. The fair shares of the EOP Projects for the Traffic Improvement Conditions, as identified in the FEIR are reflected in the attached Exhibit A.

3. This Resolution shall only become effective upon City Town Center, L.P., becoming the owner of the Chapman Site.

ADOPTED this 9th day of March, 2004.

ORIGINAL SIGNED BY
MARK A. MURPHY

Mark A. Murphy, Mayor, City of Orange

ATTEST:

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

I, MARY E. MURPHY, City Clerk of the City of Orange, California, do hereby certify that the foregoing Resolution was duly and regularly adopted by the City Council of the City of Orange at a regular meeting thereof held on the 9th day of March, 2004, by the following vote:

AYES:	COUNCILMEMBERS:	Ambriz, Alvarez, Murphy, Coontz
NOES:	COUNCILMEMBERS:	None
ABSENT:	COUNCILMEMBERS:	Cavecche
ABSTAIN:	COUNCILMEMBERS:	None

ORIGINAL SIGNED BY
MARY E. MURPHY

Mary E. Murphy, City Clerk, City of Orange

EXHIBIT "A"

	Intersection Identified in the WOC Study[1]	Chapman Site[2]	City Tower Two	City Plaza 2 Share	605 Bldg. Share	EOP Total
1	State College & Katella	0%	1%	1%	0%	2%
3	SR-57 NB Ramps & Katella	0%	1%	1%	0%	2%
4	State College & Gene Autry Way	0%	0%	0%	0%	0%
5	State College & Orangewood	0%	2%	1%	1%	4%
6	SR-57 SB Ramps & Orangewood	1%	3%	2%	1%	7%
→ 10	Haster & Chapman	6%	10%	8%	5%	29%
→ 11	Lewis & Chapman	15%	22%	24%	14%	75%
→ 13	The City & Chapman	8%	19%	4%	2%	33%
14	I-5 SB Ramp on-Ramp & Chapman	5%	16%	2%	1%	
→ 19	The City Dr. & The City Way	2%	10%	2%	1%	15%
→ 23	Haster & Lampson	4%	7%	14%	8%	33%
27	The City Dr. & SR-22 EB Ramps	1%	9%	4%	2%	
→ 29	Haster & Garden Grove Blvd.	1%	2%	2%	1%	6%
→ 30	Fairview & Garden Grove Blvd.	1%	3%	6%	3%	13%
→ 31	Lewis & Garden Grove Blvd.	1%	3%	15%	9%	28%
→ 32	The City Dr. & Garden Grove Blvd.	1%	7%	5%	3%	16%
34	Howell & Katella	2%	0%	0%	0%	2%

Traffic Improvement Conditions[3]	Intersection	Chapman Site	City Tower	City Plaza	605	EOP Total
32	The City Drive/Garden Grove	10%	90%			100%
33	SR-57/Orangewood Ave.(Bridge Widening)	14%	47%	25%	14%	100%
34	Haster St/Chapman Ave.	21%	36%	27%	16%	100%
35	Lewis St/Garden Grove Blvd.	5%	13%	52%	30%	100%

→ = [1] The shaded intersections are identified in the FEIR and WOC Study and are the only intersections requiring traffic improvements and a fair share contribution.

[2] Referred to as the "North Parcel" in the FEIR tables.

[3] Conditions are those referenced in City Council Resolutions 9519-9522.

EXHIBIT "C"

LEGAL DESCRIPTION
CITY TOWER TWO SITE

Parcel 2 of Parcel Map No. 81-769 recorded in Book 172, Pages 40-42 of Parcel Maps, in the Office of the County Recorder of Orange County, California.

EXHIBIT "D"

PUBLIC BENEFIT FEES

In the event that Developer elects, in accordance with the terms and upon the conditions set forth in Section "**12. Term of Agreement**" of this Agreement, to extend the term of this Agreement, then Developer shall pay the following Public Benefit Fees in the amounts and at the times hereinafter described:

1. Within forty-five (45) days of the mutual execution of this Agreement by Developer and the City, Developer shall pay to the City the sum of $50,000 (such amount being the "**First Public Benefit Fee**").

2. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the Initial Term, then Developer shall pay to the City the sum of $50,000 (such amount being the "**Second Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the Initial Term.

3. If Developer elects, in its sole and absolute discretion, to extend the term of this Agreement beyond the First Automatic Renewal Term, then Developer shall pay to the City the sum of $100,000 (such amount being the "**Third Public Benefit Fee**") no later than fifteen (15) days prior to the expiration of the First Automatic Renewal Term.

For the avoidance of doubt, Developer's election to extend the term of this Agreement shall be in Developer's sole and absolute discretion, and the City's sole remedy for Developer's failure to pay any portion of the Public Benefit Fee within the term periods set forth above shall be to terminate this Agreement.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Consider Recommended Appointment to the CalOptima Board of Directors' Member Advisory Committee (MAC); Consider Recommended Appointments of MAC Chair and Vice Chair

Contact

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

Recommended Actions

The MAC recommends the following actions to be effective December 1, 2016:

1. Appointment of the following individual as Recipients of CalWORKs Representative for the remainder of the term ending June 30, 2017:
    a. Appoint Carlos Robles to serve as Recipients of CalWORKs Representative of the Member Advisory Committee;
2. Reappointment of Mallory Vega, Seniors Representative, as the Chair of the MAC for the remainder of Fiscal Year 2016-17; and
3. Appointment of Patty Mouton, Medi-Cal Beneficiaries Representative, as the Vice Chair of the MAC for the remainder of Fiscal Year 2016-17.

Background

The CalOptima Board of Directors established the Member Advisory Committee (MAC) by resolution on February 14, 1995 to provide input to the Board. The MAC is comprised of fifteen voting members. Pursuant to the resolution, the CalOptima Board appoints each member of the MAC for a two-year term with the exception of the two standing seats, the Orange County Social Services Agency representative and the Orange County Health Care Agency representative, which have an unlimited term. The Board is responsible for the appointment of all MAC members, as well as the chair and vice chair.

Discussion

CalOptima conducted recruitment for candidates following the mid-term resignation of the Recipients of CalWORKs representative. In addition, upon Board approval of the addition of a MAC vice chair position, the MAC reopened nominations for the MAC chair position and opened nominations for the vice chair position. CalOptima staff submitted the applications from interested candidates to the Nominations Ad Hoc Subcommittee for review prior to the subcommittee meeting. The subcommittee, including Members Suzanne Butler, Christine Tolbert and Lisa Workman, met on August 31, 2016 to recommend a candidate for the open seat, as well as the chair and vice chair positions. The Nominations Ad Hoc forwarded the proposed slate of candidates to the MAC for consideration.

The MAC voted to accept the Nominations Ad Hoc Subcommittee's recommended candidates at the November 10, 2016 MAC meeting.

Back to Agenda

Candidates for open positions are as follows:

Recipients of CalWORKs Representative Candidates
Carlos Robles*
Nam Neil Hoang
Mai-Phuong Nguyen, M.D.
Ashley Regan

Carlos Robles is a Program Supervisor for ResCare Workforce Services. ResCare, a subcontractor for the Social Services Administration (SSA), implements Orange County's Welfare to Work program, which is CalWORKs. Mr. Robles helps link CalWORKs' recipients with the appropriate services and resources to assist these individuals achieve self-sufficiency. In addition, he started an outreach organization that assists low-income families by providing resources and necessities to families in need.

Nam Neil Hoang is an Engineering Manager and Chief Executive Officer at BestHomeINC.com. Mr. Hoang has experience working with low income employees. In addition, he feels there is a lack of information on services for individuals from diverse cultural communities and believes his background would add value to the MAC.

Mai-Phuong Nguyen, M.D. is currently practicing Internal Medicine and is the founder and Chief Executive Officer of Karuna Healthcare Consultants, Inc. She has worked for over twenty-five years as a clinician, attending to the underserved. Dr. Nguyen has served in the capacity of physician-leader and patient advocate for over a decade, working on behalf of minority patients for expansion of culturally and linguistically competent health care in California.

Ashley Regan and her three children are CalOptima members. In her employment, she currently works with a diverse population ranging from lower socioeconomic individuals with English as the non-primary language to institutionalized individuals with disabilities. Many of her clients at the facility have Medi-Cal as their primary or secondary health care coverage.

MAC Chair Candidate
Mallory Vega*

Mallory Vega has been the Executive Director of Acacia Adult Day Services for over thirty years, providing adult day care, adult day health care, dementia care, and now Community Based Adult Services to seniors. In addition, she serves on numerous community agency boards that serve this population, including CalOptima's PACE Development Advisory Committee (PDAC).

*Indicates MAC recommendation

Back to Agenda

MAC Vice Chair Candidate
Patty Mouton*

Patty Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County, and has more than 30 years experience in health care. She oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy forming activities. She is involved in the community speaking to community groups about issues of medical coverage and defining the continuum of care, especially with respect to caring for the aged in long-term care.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Pursuant to Resolution No. 021495, the MAC established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the Committee. The MAC concurred with the Ad Hoc's recommended candidate, chair and vice chair positions. The MAC forwards the recommended candidates to the Board of Directors for consideration.

Concurrence
Member Advisory Committee Nominations Ad Hoc
Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

*Indicates MAC recommendation

Back to Agenda

Continued to February 2, 2017 Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
12. Consider Extending the Timeframe for the Qualifying New Network to Complete Readiness Assessment Requirements

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

Recommended Action
Extend the deadline to December 31, 2017 for St. Joseph Heritage Healthcare, selected through the Request for Proposal (RFP) process for health networks, to meet all applicable readiness requirements.

Background/Discussion
On February 7, 2013, the CalOptima Board of Directors authorized the Chief Executive Officer (CEO) to conduct a RFP process for the purpose of exploring the expansion of the delivery system serving CalOptima members. The RFP process gave existing health networks an opportunity to request changes to their business models, and sought the participation of new health network entities in CalOptima's delivery system.

On October 3, 2013, the Board authorized the CEO to enter into Health Network contracts with new entities selected through the RFP process, subject to the successful completion of the readiness assessment process.

On February 6, 2014, the Board authorized an extension of the timeframe within which the CEO had to enter into contracts with new Health Networks selected through the RFP process to no later than December 31, 2014; at its November 6, 2014 meeting, the Board extended the timeframe for meeting all readiness requirements to December 31, 2015, and at the December 3, 2015 Board meeting, the timeframe was further extended through December 31, 2016.

St. Joseph Heritage Healthcare, a new Health Network selected through the RFP process, is currently being evaluated for participation in CalOptima through the readiness review process. In order to provide the new Health Network with the time needed to complete readiness requirements, staff recommends extending the timeframe within which the CEO is authorized to enter into contracts with St. Joseph Heritage Healthcare as a new health network until December 31, 2017.

Fiscal Impact
There is no fiscal impact from the recommended action.

Back to Agenda

Rationale for Recommendation

Staff recommends the extended time period to ensure the successful addition of a new health network. The proposed extension will allow St. Joseph Heritage Healthcare additional time to complete the readiness assessment process for Medi-Cal and Medicare and be able to contract with CalOptima under their preferred risk model no later than December 31, 2017.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated February 7, 2013, Consider Options for Developing a Provider Delivery System in Preparation for Implementation of the Duals Demonstration, Including Related Financial Modeling and Contract Template Development
2. Board Action dated October 3, 2013, Authorize the Chief Executive Officer to Finalize the Duals Delivery System Expansion Request for Proposal Process in Order to Enter into Contracts with Selected New Health Networks for Purposes of Medi-Cal Expansion
3. Board Action dated February 6, 2014, Provide Current and Potentially New Health Networks Involved in the Readiness Assessment Process with Additional Time to Meet Readiness Requirements for Changes to their Proposed Contracting Model, Subject to Meeting Federal, State and CalOptima Requirements
4. Board Action dated November 6, 2014, Extend Timeframe for New and Existing Health Networks to Request Changes to Their Proposed Contracting Models
5. Board Action dated December 3, 2015, Consider Extending the Timeframe for Qualifying New and Existing Health Networks to Request Changes to Their Proposed Contracting Models and Complete Readiness Assessment Requirements

/s/ Michael Schrader — *11/22/2016*

Authorized Signature — **Date**

Back to Agenda

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

Back to Agenda

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)

Back to Agenda

- 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.

RFP and Evaluation Process

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

Back to Agenda

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 October 3, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. E. Authorize the Chief Executive Officer to Finalize the Duals Delivery System Expansion Request for Proposal (RFP) Process in Order to Enter into Contracts with Selected New Health Networks for Purposes of Medi-Cal Expansion

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to finalize the Duals delivery system expansion RFP process for purposes of Medi-Cal Expansion.
2. Authorize the CEO to enter into contracts for Medi-Cal and OneCare with selected new Health Networks that meet all readiness requirements for coordinating delegated services delivered to CalOptima's Medi-Cal and OneCare members.
3. Authorize the CEO to amend the new Health Network contracts to include Cal-Medi-Connect upon approval of that Program and the successful completion of any additional readiness requirements for the Cal-Medi-Connect program.

Background

On March 4, 2013, the CalOptima Board authorized the CEO to explore options for expanding the provider delivery system for the purpose of preparing for the implementation of the Duals Demonstration now known as Cal MediConnect, including conducting related financial modeling, developing contract templates with the assistance of legal counsel, and exploring the option of adding additional health networks selected through a Request for Proposal (RFP) process. At the time the RFP was released, the expectation was that the Duals Demonstration would have already begun so that the Network providers would be in place to accommodate the expected increase membership as a result of Medi-Cal expansion. However, the start date of the Duals Demonstration has been delayed to no earlier than April 1, 2014.

Discussion

CalOptima staff released an RFP on March 11, 2013. In response, CalOptima received 17 proposals by the submission deadline of 2:00 P.M. on April 5, 2013. Twelve proposals were submitted by new networks. Five proposals were submitted by current Health Networks which proposed changing their current contract model (e.g., Shared Risk Group to full risk HMO). New networks were required to meet minimum criteria, which was based on network adequacy and administrative requirements. Current Health Networks were exempt from meeting minimum criteria since they already participate in the CalOptima delivery system.

Back to Agenda

Five of the 12 new network proposals met the minimum criteria in the RFP. Seven of the 12 new networks proposals did not meet the minim criteria and were disqualified from continuing in the RFP process.

Staff has evaluated the qualifications of the five new networks candidates that met the minimum requirements and concluded that the proposals submitted by these networks meet the minimum qualifications to move to the readiness review phase. CalOptima staff has concluded that the RFP process was successful and is recommending completion of the exploratory phase of the delivery system expansion. The five qualified new network candidates would potentially add more than 1,000 primary care and specialist physicians to the CalOptima delivery system in underserved areas and also expand the capability to serve ethnically diverse populations such as Dual eligible members. Following the conclusion of the exploratory RFP process, these five networks will undergo a readiness review to assess their ability to meet all operational, financial, medical management and regulatory requirements. Only those networks that successfully meet the readiness review requirements will be awarded contracts that will be under the same contracting model for all CalOptima Programs.

In addition, CalOptima staff is considering the proposals of the five currently contracted Health Networks that proposed a model change through the RFP process. One of the five Health Networks rescinded its proposal so CalOptima staff is considering the proposals of the remaining four Health Networks. These four Health Networks will undergo a readiness review for their respective proposed new model. CalOptima staff will review the readiness of these networks' ability to meet all operational, financial, medical management and regulatory requirements, including but not limited to Knox-Keene Act licensing (if applicable) and other criteria required under the respective model proposed. Upon successful completion of the readiness process, CalOptima staff proposes to award new contracts that will be under the same contracting model for all CalOptima Programs.

Even though the Duals Demonstration has been delayed, CalOptima still needs to be ready to move forward with Medi-Cal expansion. The Board's approval would allow Staff to complete the RFP process in time to bring on new health networks, ensuring adequate access to providers for purposes of Medi-Cal expansion January 1, 2014. However, even though the new networks are required to meet requirements to serve all CalOptima lines of business, at this time, CalOptima would only enter into contracts for existing Programs upon successful completion of the readiness assessment process.

CalOptima has not yet received the three-way contract between CalOptima, the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS), or rates for the Cal MediConnect program. With regard to that Program, staff will not execute Health Network contract amendments to add the Cal-MediConnect Program until after final Board approval is obtained to participate in the Cal-MediConnect Program. Assuming that the CalOptima Board approves participation

Back to Agenda

in the Cal MediConnect program, new health networks would be required to provide services to all lines of business in order to remain contracted with CalOptima.

Fiscal Impact
The readiness reviews will be conducted by the CalOptima Compliance and Provider Network Department staffs. No significant additional resources are expected to be necessary. CalOptima management expects to execute contracts with selected new Health Networks under the same financial terms as other contracted Health Networks in a similarly contracted model, so no significant additional financial impact is expected.

Rationale for Recommendation
The implementation of the Accountable Care Act's Medicaid Expansion (Medi-Cal Expansion) and the CalOptima's potential participation in the Cal MediConnect Duals Demonstration places significant demand on CalOptima to expand the delivery system to serve the potential influx of new members eligible for CalOptima's Medi-Cal Program and the viability of the OneCare and the future Cal MediConnect Program. CalOptima needs to move forward with expansion of the provider network for the Medi-Cal program. Staff has conducted a successful RFP process that has the potential to add a significant number of providers that will expand access to existing and future members. Staff recommends that the Board authorize it to complete the RFP process and implement the contracting process in two phases. The first phase would allow management to contract with new Health Networks that meet readiness assessment requirements for Medi-Cal expansion and OneCare, as well as enter into amendments and/or new contracts with existing Health Networks which successfully qualify to change their current contract model. The second phase to contract for the Cal MediConnect program would not take place until after the Board approves CalOptima's participation in the Duals Demonstration.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *9/27/2013*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2014
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

V. E. Provide Current and Potentially New Health Networks Involved in the Readiness Assessment Process with Additional Time to Meet Readiness Requirements for Changes to their Proposed Contracting Model, Subject to Meeting Federal, State and CalOptima Requirements

Contact

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

Recommended Action

Authorize the CEO to provide current Health Networks as well as Health Networks in the Duals Delivery System Expansion RFP now participating in the readiness assessment process with additional time to meet the requirements of their preferred network model, provided that these entities successfully complete the readiness assessment for that model no later than December 31, 2014, and for currently contracted Health Networks, that they ensure that the financial, regulatory and contractual obligations of their sun-setting Health Network arrangement are addressed to CalOptima's satisfaction.

Background

CalOptima contracts with Health Networks for the Medi-Cal Program according to three models: capitated Physician Hospital Consortia (PHCs), Shared Risk medical groups (SRGs) and full risk HMOs. In the CalOptima OneCare Program, CalOptima contracts with Physician Medi-Cal Groups (PMGs) on a shared risk basis.

On February 7, 2013, the CalOptima Board of Directors authorized the CEO to conduct a Request for Proposal (RFP) process for the purpose of exploring the expansion of the delivery system serving CalOptima members. The RFP process sought the participation of new entities in CalOptima's delivery system, and also provided existing Health Networks with the opportunity to propose a different contracting model.

On October 3, 2013, the Board authorized the CEO to enter into Health Network contracts with entities selected through the RFP process, subject to the successful completion of the readiness assessment process. Five medical groups qualified for readiness assessment reviews and will be awarded contracts for all lines of business (excluding PACE) if they satisfy all readiness assessment requirements. In addition, four currently contracted Health Networks responded to the RFP with proposals for changing to a different contracting model. Four SRG Health Networks proposed assuming hospital risk either as a PHC or HMO for all lines of business. In some cases, entities are now proposing to change their contracting model or they have indicated they are not appropriately licensed at this time for the identified contracting model.

Discussion

CalOptima has experienced significant changes in the Health Network delivery system over the past five years, as medical groups continue to consolidate, change ownership and evolve into more fully integrated delivery systems. CalOptima has also seen an increase in the number of contracted Health

Back to Agenda

Networks that are applying for licenses to assume "full risk" and have requested changing to CalOptima's standard HMO contracting model. Additionally, some hospitals are considering a risk-shifting model in which they receive capitation for all hospital services. CalOptima and its members benefit from fully integrated delivery models because they align physician and hospital services to improve coordination of care, quality, and cost management for the patients they serve.

The RFP process required that proposals submitted by new entities be based on one of CalOptima's current contracting models (PHC, SRG or HMO). As CalOptima staff conducts readiness assessments, staff has determined that certain medical groups have the desire to change the contracting model proposed in the RFP based on the rapidly changing health care environment in Southern California. One example is a medical group that originally submitted a proposal to participate as a SRG Health Network is now interested and may be qualified to meet the requirements of the PHC model.

With all the changes in healthcare as a result of the implementation of the Affordable Care Act, current Health Networks that requested changing to an HMO model have indicated that they have experienced delays in acquiring the necessary Knox-Keene license to accept full risk. CalOptima staff recommends allowing proposed and current Health Networks pursuing Knox-Keene licenses to have more time to complete this process with the Department of Managed Health Care (DMHC).

If approved, staff's recommendation would allow new medical groups to change to a different model than originally proposed in the Duals Delivery System Expansion RFP and would also allow current Health Networks that proposed changing to a full-risk model additional time to work through the regulatory process to meet the DMHC requirements to be eligible to assume full risk. Consistent with previous Board Actions, if approved, this proposed action would authorize the CEO to enter into contracts with selected new and existing Health Networks provided these entities meet all regulatory and operational readiness requirements associated with the proposed contracting models no later than December 31, 2014. In order to meet this timeframe, Health Networks must initiate the readiness assessment process for the preferred model no later than September 1, 2014.

Any currently contracted Health Networks proposing a change to their network must ensure that the financial, regulatory and contractual obligations of the sunsetting Health Network are adequately addressed.

Fiscal Impact

Allowing contracted Health Networks to take steps to assume additional hospital risk as permissible under applicable requirements can result in less direct financial risk to CalOptima. CalOptima will be responsible for oversight of the additional risk delegated to new and existing Health Networks; however, no additional administrative resources are expected as a result of this action. There is no financial impact expected from the recommended action.

Back to Agenda

Rationale for Recommendation
Staff recommends allowing the extended time period so that currently contracted Health Networks and potentially new Health Networks involved in the readiness assessment process can contract with CalOptima through their preferred model provided they meet all CalOptima medical, operational and financial standards for CalOptima Programs (excluding PACE) under the preferred model and current Health Networks ensure that the financial, regulatory and contractual obligations of the sun setting Health Network are addressed to CalOptima's satisfaction.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *1/31/2014*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 6, 2014
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

VI. C. Extend Timeframe for New and Existing Health Networks to Request Changes to Their Proposed Contracting Models

Contact

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

Recommended Action

Extend the timeframe through December 31, 2015 for current health networks and those identified as part of the Board-approved Request for Proposal (RFP) process to request changes to their proposed contracting models, subject to these entities meeting all applicable readiness requirements. The proposed action is limited to providers qualified through the RFP process and now participating in the readiness assessment.

Revised 11/6/14

Background

On February 7, 2013, the CalOptima Board of Directors authorized the Chief Executive Officer (CEO) to conduct a RFP process for the purpose of exploring the expansion of the delivery system serving CalOptima members. The RFP process sought the participation of new entities in CalOptima's delivery system. Existing Health Networks were given the opportunity to propose a contracting model which differed from their current model.

On October 3, 2013, the Board authorized the CEO to enter into Health Network contracts with entities selected through the RFP process, subject to the successful completion of the readiness assessment process.

On February 6, 2014, the Board agreed to extend the timeframe within which the CEO had to enter into contracts with selected new and existing Health Networks to no later than December 31, 2014.

Discussion

In January of 2014, CalOptima began receiving significant membership increases due Medi-Cal expansion. The membership expansion began with a transition of members from the County of Orange's Medical Services Initiative Program to CalOptima. Additional State initiatives, which streamlined the process for individuals in the CalFresh program to become enrolled in Medi-Cal, also expanded CalOptima membership.

Also in January 2014, CalOptima received the results of an audit conducted by the Center for Medicare & Medicaid Services (CMS). Issues were identified which required remediation. A subsequent audit by the Department of Health Care Services and the Department of Managed Health Care identified additional issues requiring resolution. As a result of the audit findings and sanctions, the implementation of the Cal MediConnect program was delayed.

Back to Agenda

Medi-Cal Expansion and audit remediation placed a strain on CalOptima resources. CalOptima has improved many programs to resolve issues identified in the CMS audit. This included enhanced oversight of the delegated Health Networks and an enhanced OneCare Model of Care. DHCS and DMHC have recently completed a comprehensive audit of CalOptima and CMS will return in January for a reaudit.

Due to initiatives currently underway within CalOptima and the Health Networks, the implementation of the Cal MediConnect program has been delayed to no later than July 1, 2015. Staff recommends extending the timeframe within which the CEO is authorized to enter into contracts with selected new and existing Health Networks provided these entities meet all readiness requirements associated with the proposed contracting models to no later than December 31, 2015.

Any currently contracted Health Networks proposing a change to their network must ensure that all legal, financial, and operational obligations are adequately addressed in conjunction with the proposed change being implemented.

Fiscal Impact
There is no financial impact expected from the recommended action.

Rationale for Recommendation
Staff recommends allowing the extended time period to ensure the completion of current initiatives and audits. As proposed, new and existing Health Networks involved in the readiness assessment process would be able to contract with CalOptima through their preferred model provided they meet all requirements for participation in CalOptima programs (excluding PACE) no later than December 31, 2015.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *10/31/2014*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

13. Consider Extending the Timeframe for Qualifying New and Existing Health Networks to Request Changes to Their Proposed Contracting Models and Complete Readiness Assessment Requirements

Contact

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

Recommended Actions

1. Extend the deadline to June 30, 2016 for Health Networks qualified through the Board approved Request for Proposal (RFP) process to request changes to their proposed contracting models; and
2. Extend the deadline to December 31, 2016 for existing Health Networks requesting changes to their contracting models as well as new networks selected through the RFP process to meet all applicable readiness requirements.

Background/Discussion

On February 7, 2013, the CalOptima Board of Directors authorized the Chief Executive Officer (CEO) to conduct a RFP process for the purpose of exploring the expansion of the delivery system serving CalOptima members. The RFP process sought the participation of new entities in CalOptima's delivery system. Existing Health Networks were also given the opportunity to propose a contracting model which differed from their current model.

On October 3, 2013, the Board authorized the CEO to enter into Health Network contracts with entities selected through the RFP process, subject to the successful completion of the readiness assessment process.

On February 6, 2014, the Board agreed to extend the timeframe within which the CEO had to enter into contracts with selected and existing Health Networks to no later than December 31, 2014. At its November 6, 2014 meeting, the Board further extended the timeframe through December 31, 2015 for providers qualified through the 2013 RFP process and to request changes to their proposed contracting models.

Two existing Health Networks are interested in pursuing full- risk arrangements with CalOptima. In order to provide these Health Networks with additional time to obtain necessary regulatory approvals, staff recommends extending the timeframe within which the CEO is authorized to enter into contracts with selected new and existing Health Networks. As proposed, in order to change models, the qualifying existing Health Networks interested in making a model change will be required to provide a written commitment to CalOptima of their preferred contracting model by June 30, 2016, and to complete all readiness assessment requirements to implement the new model no later than December 31, 2016.

Potential new Health Networks selected through the RFP process are being evaluated for participation in CalOptima through the readiness review process. CalOptima has successfully implemented two of the

Back to Agenda

successful RFP respondents in 2015. Three potential new networks remain from the RFP process. All efforts with the remaining potential networks will be completed by the end of 2016.

Fiscal Impact
There is no fiscal impact expected from the recommended action.

Rationale for Recommendation
Staff recommends the extended time period to ensure the successful addition of new Health Networks and the model conversion of existing Networks. The extension will allow new and existing Health Networks to complete the readiness assessment process for Medi-Cal and Medicare and be able to contract with CalOptima under their preferred risk model no later than December 31, 2016.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/25/2015*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Extending the Timeframe for Qualifying Existing Health Networks that Elected to Change their Contracting Models to Complete Readiness Assessment Requirements

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

Recommended Action
Extend the deadline to December 31, 2017 for existing health networks Monarch HealthCare, A Medical Group, Inc. and Prospect Health Plan, Inc./Prospect Medical Group that requested changes to their contracting models through the Request for Proposal (RFP) process for health networks, to meet all applicable readiness requirements.

Background/Discussion
On February 7, 2013, the CalOptima Board of Directors authorized the Chief Executive Officer (CEO) to conduct a RFP process for the purpose of exploring the expansion of the delivery system serving CalOptima members. The RFP process gave existing health networks an opportunity to request changes to their business models, and sought the participation of new health network entities in CalOptima's delivery system.

On October 3, 2013, the Board authorized the CEO to enter into Health Network contracts with entities selected through the RFP process, subject to the successful completion of the readiness assessment process.

On February 6, 2014, the Board authorized an extension of the timeframe within which the CEO had to enter into updated contracts with selected existing Health Networks seeking to change their business models to no later than December 31, 2014; at its November 6, 2014 meeting, the Board extended the timeframe for meeting all applicable readiness requirements to December 31, 2015; and at the December 3, 2015 Board meeting, the timeframe was further extended through December 31, 2016. This Board action also required qualifying health networks wanting to change models to provide a written commitment to CalOptima of the change by June 30, 2016.

Two existing Health Networks – Monarch Healthcare and Prospect Health Plan – are pursuing full-risk arrangements with CalOptima. At this time, the networks have or are close to completing all applicable readiness requirements. In order to provide these health networks and CalOptima with the time needed to complete the remaining readiness requirements and transition activities, staff recommends extending the timeframe within which the CEO is authorized to enter into contracts with selected existing Health Networks until December 31, 2017.

Back to Agenda

Fiscal Impact
There is no fiscal impact from the recommended action.

Rationale for Recommendation
Staff recommends the extended time period to ensure the successful model conversion of existing Health Networks. The extension will allow the existing Health Networks to complete the readiness assessment process for Medi-Cal and Medicare and be able to contract with CalOptima under their preferred risk model no later than December 31, 2017.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated February 7, 2013, Consider Options for Developing a Provider Delivery System in Preparation for Implementation of the Duals Demonstration, Including Related Financial Modeling and Contract Template Development
2. Board Action dated October 3, 2013, Authorize the Chief Executive Officer to Finalize the Duals Delivery System Expansion Request for Proposal Process in Order to Enter into Contracts with Selected New Health Networks for Purposes of Medi-Cal Expansion
3. Board Action dated February 6, 2014, Provide Current and Potentially New Health Networks Involved in the Readiness Assessment Process with Additional Time to Meet Readiness Requirements for Changes to their Proposed Contracting Model, Subject to Meeting Federal, State and CalOptima Requirements
4. Board Action dated November 6, 2014, Extend Timeframe for New and Existing Health Networks to Request Changes to Their Proposed Contracting Models
5. Board Action dated December 3, 2015, Consider Extending the Timeframe for Qualifying New and Existing Health Networks to Request Changes to Their Proposed Contracting Models and Complete Readiness Assessment Requirements

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

11/22/2016 — **Date**

Back to Agenda

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

Back to Agenda

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)

Back to Agenda

- 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.

RFP and Evaluation Process

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

Back to Agenda

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 October 3, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. E. Authorize the Chief Executive Officer to Finalize the Duals Delivery System Expansion Request for Proposal (RFP) Process in Order to Enter into Contracts with Selected New Health Networks for Purposes of Medi-Cal Expansion

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to finalize the Duals delivery system expansion RFP process for purposes of Medi-Cal Expansion.
2. Authorize the CEO to enter into contracts for Medi-Cal and OneCare with selected new Health Networks that meet all readiness requirements for coordinating delegated services delivered to CalOptima's Medi-Cal and OneCare members.
3. Authorize the CEO to amend the new Health Network contracts to include Cal-Medi-Connect upon approval of that Program and the successful completion of any additional readiness requirements for the Cal-Medi-Connect program.

Background

On March 4, 2013, the CalOptima Board authorized the CEO to explore options for expanding the provider delivery system for the purpose of preparing for the implementation of the Duals Demonstration now known as Cal MediConnect, including conducting related financial modeling, developing contract templates with the assistance of legal counsel, and exploring the option of adding additional health networks selected through a Request for Proposal (RFP) process. At the time the RFP was released, the expectation was that the Duals Demonstration would have already begun so that the Network providers would be in place to accommodate the expected increase membership as a result of Medi-Cal expansion. However, the start date of the Duals Demonstration has been delayed to no earlier than April 1, 2014.

Discussion

CalOptima staff released an RFP on March 11, 2013. In response, CalOptima received 17 proposals by the submission deadline of 2:00 P.M. on April 5, 2013. Twelve proposals were submitted by new networks. Five proposals were submitted by current Health Networks which proposed changing their current contract model (e.g., Shared Risk Group to full risk HMO). New networks were required to meet minimum criteria, which was based on network adequacy and administrative requirements. Current Health Networks were exempt from meeting minimum criteria since they already participate in the CalOptima delivery system.

Back to Agenda

Five of the 12 new network proposals met the minimum criteria in the RFP. Seven of the 12 new networks proposals did not meet the minim criteria and were disqualified from continuing in the RFP process.

Staff has evaluated the qualifications of the five new networks candidates that met the minimum requirements and concluded that the proposals submitted by these networks meet the minimum qualifications to move to the readiness review phase. CalOptima staff has concluded that the RFP process was successful and is recommending completion of the exploratory phase of the delivery system expansion. The five qualified new network candidates would potentially add more than 1,000 primary care and specialist physicians to the CalOptima delivery system in underserved areas and also expand the capability to serve ethnically diverse populations such as Dual eligible members. Following the conclusion of the exploratory RFP process, these five networks will undergo a readiness review to assess their ability to meet all operational, financial, medical management and regulatory requirements. Only those networks that successfully meet the readiness review requirements will be awarded contracts that will be under the same contracting model for all CalOptima Programs.

In addition, CalOptima staff is considering the proposals of the five currently contracted Health Networks that proposed a model change through the RFP process. One of the five Health Networks rescinded its proposal so CalOptima staff is considering the proposals of the remaining four Health Networks. These four Health Networks will undergo a readiness review for their respective proposed new model. CalOptima staff will review the readiness of these networks' ability to meet all operational, financial, medical management and regulatory requirements, including but not limited to Knox-Keene Act licensing (if applicable) and other criteria required under the respective model proposed. Upon successful completion of the readiness process, CalOptima staff proposes to award new contracts that will be under the same contracting model for all CalOptima Programs.

Even though the Duals Demonstration has been delayed, CalOptima still needs to be ready to move forward with Medi-Cal expansion. The Board's approval would allow Staff to complete the RFP process in time to bring on new health networks, ensuring adequate access to providers for purposes of Medi-Cal expansion January 1, 2014. However, even though the new networks are required to meet requirements to serve all CalOptima lines of business, at this time, CalOptima would only enter into contracts for existing Programs upon successful completion of the readiness assessment process.

CalOptima has not yet received the three-way contract between CalOptima, the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS), or rates for the Cal MediConnect program. With regard to that Program, staff will not execute Health Network contract amendments to add the Cal-MediConnect Program until after final Board approval is obtained to participate in the Cal-MediConnect Program. Assuming that the CalOptima Board approves participation

Back to Agenda

in the Cal MediConnect program, new health networks would be required to provide services to all lines of business in order to remain contracted with CalOptima.

Fiscal Impact
The readiness reviews will be conducted by the CalOptima Compliance and Provider Network Department staffs. No significant additional resources are expected to be necessary. CalOptima management expects to execute contracts with selected new Health Networks under the same financial terms as other contracted Health Networks in a similarly contracted model, so no significant additional financial impact is expected.

Rationale for Recommendation
The implementation of the Accountable Care Act's Medicaid Expansion (Medi-Cal Expansion) and the CalOptima's potential participation in the Cal MediConnect Duals Demonstration places significant demand on CalOptima to expand the delivery system to serve the potential influx of new members eligible for CalOptima's Medi-Cal Program and the viability of the OneCare and the future Cal MediConnect Program. CalOptima needs to move forward with expansion of the provider network for the Medi-Cal program. Staff has conducted a successful RFP process that has the potential to add a significant number of providers that will expand access to existing and future members. Staff recommends that the Board authorize it to complete the RFP process and implement the contracting process in two phases. The first phase would allow management to contract with new Health Networks that meet readiness assessment requirements for Medi-Cal expansion and OneCare, as well as enter into amendments and/or new contracts with existing Health Networks which successfully qualify to change their current contract model. The second phase to contract for the Cal MediConnect program would not take place until after the Board approves CalOptima's participation in the Duals Demonstration.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *9/27/2013*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 6, 2014
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

V. E. Provide Current and Potentially New Health Networks Involved in the Readiness Assessment Process with Additional Time to Meet Readiness Requirements for Changes to their Proposed Contracting Model, Subject to Meeting Federal, State and CalOptima Requirements

Contact

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

Recommended Action

Authorize the CEO to provide current Health Networks as well as Health Networks in the Duals Delivery System Expansion RFP now participating in the readiness assessment process with additional time to meet the requirements of their preferred network model, provided that these entities successfully complete the readiness assessment for that model no later than December 31, 2014, and for currently contracted Health Networks, that they ensure that the financial, regulatory and contractual obligations of their sun-setting Health Network arrangement are addressed to CalOptima's satisfaction.

Background

CalOptima contracts with Health Networks for the Medi-Cal Program according to three models: capitated Physician Hospital Consortia (PHCs), Shared Risk medical groups (SRGs) and full risk HMOs. In the CalOptima OneCare Program, CalOptima contracts with Physician Medi-Cal Groups (PMGs) on a shared risk basis.

On February 7, 2013, the CalOptima Board of Directors authorized the CEO to conduct a Request for Proposal (RFP) process for the purpose of exploring the expansion of the delivery system serving CalOptima members. The RFP process sought the participation of new entities in CalOptima's delivery system, and also provided existing Health Networks with the opportunity to propose a different contracting model.

On October 3, 2013, the Board authorized the CEO to enter into Health Network contracts with entities selected through the RFP process, subject to the successful completion of the readiness assessment process. Five medical groups qualified for readiness assessment reviews and will be awarded contracts for all lines of business (excluding PACE) if they satisfy all readiness assessment requirements. In addition, four currently contracted Health Networks responded to the RFP with proposals for changing to a different contracting model. Four SRG Health Networks proposed assuming hospital risk either as a PHC or HMO for all lines of business. In some cases, entities are now proposing to change their contracting model or they have indicated they are not appropriately licensed at this time for the identified contracting model.

Discussion

CalOptima has experienced significant changes in the Health Network delivery system over the past five years, as medical groups continue to consolidate, change ownership and evolve into more fully integrated delivery systems. CalOptima has also seen an increase in the number of contracted Health

Back to Agenda

Networks that are applying for licenses to assume "full risk" and have requested changing to CalOptima's standard HMO contracting model. Additionally, some hospitals are considering a risk-shifting model in which they receive capitation for all hospital services. CalOptima and its members benefit from fully integrated delivery models because they align physician and hospital services to improve coordination of care, quality, and cost management for the patients they serve.

The RFP process required that proposals submitted by new entities be based on one of CalOptima's current contracting models (PHC, SRG or HMO). As CalOptima staff conducts readiness assessments, staff has determined that certain medical groups have the desire to change the contracting model proposed in the RFP based on the rapidly changing health care environment in Southern California. One example is a medical group that originally submitted a proposal to participate as a SRG Health Network is now interested and may be qualified to meet the requirements of the PHC model.

With all the changes in healthcare as a result of the implementation of the Affordable Care Act, current Health Networks that requested changing to an HMO model have indicated that they have experienced delays in acquiring the necessary Knox-Keene license to accept full risk. CalOptima staff recommends allowing proposed and current Health Networks pursuing Knox-Keene licenses to have more time to complete this process with the Department of Managed Health Care (DMHC).

If approved, staff's recommendation would allow new medical groups to change to a different model than originally proposed in the Duals Delivery System Expansion RFP and would also allow current Health Networks that proposed changing to a full-risk model additional time to work through the regulatory process to meet the DMHC requirements to be eligible to assume full risk. Consistent with previous Board Actions, if approved, this proposed action would authorize the CEO to enter into contracts with selected new and existing Health Networks provided these entities meet all regulatory and operational readiness requirements associated with the proposed contracting models no later than December 31, 2014. In order to meet this timeframe, Health Networks must initiate the readiness assessment process for the preferred model no later than September 1, 2014.

Any currently contracted Health Networks proposing a change to their network must ensure that the financial, regulatory and contractual obligations of the sunsetting Health Network are adequately addressed.

Fiscal Impact

Allowing contracted Health Networks to take steps to assume additional hospital risk as permissible under applicable requirements can result in less direct financial risk to CalOptima. CalOptima will be responsible for oversight of the additional risk delegated to new and existing Health Networks; however, no additional administrative resources are expected as a result of this action. There is no financial impact expected from the recommended action.

Back to Agenda

Rationale for Recommendation
Staff recommends allowing the extended time period so that currently contracted Health Networks and potentially new Health Networks involved in the readiness assessment process can contract with CalOptima through their preferred model provided they meet all CalOptima medical, operational and financial standards for CalOptima Programs (excluding PACE) under the preferred model and current Health Networks ensure that the financial, regulatory and contractual obligations of the sun setting Health Network are addressed to CalOptima's satisfaction.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *1/31/2014*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 6, 2014
Regular Meeting of the CalOptima Board of Directors

Consent Calendar
VI. C. Extend Timeframe for New and Existing Health Networks to Request Changes to Their Proposed Contracting Models

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

Recommended Action
Extend the timeframe through December 31, 2015 for current health networks and those identified as part of the Board-approved Request for Proposal (RFP) process to request changes to their proposed contracting models, subject to these entities meeting all applicable readiness requirements. The proposed action is limited to providers qualified through the RFP process and now participating in the readiness assessment.

Revised 11/6/14

Background
On February 7, 2013, the CalOptima Board of Directors authorized the Chief Executive Officer (CEO) to conduct a RFP process for the purpose of exploring the expansion of the delivery system serving CalOptima members. The RFP process sought the participation of new entities in CalOptima's delivery system. Existing Health Networks were given the opportunity to propose a contracting model which differed from their current model.

On October 3, 2013, the Board authorized the CEO to enter into Health Network contracts with entities selected through the RFP process, subject to the successful completion of the readiness assessment process.

On February 6, 2014, the Board agreed to extend the timeframe within which the CEO had to enter into contracts with selected new and existing Health Networks to no later than December 31, 2014.

Discussion
In January of 2014, CalOptima began receiving significant membership increases due Medi-Cal expansion. The membership expansion began with a transition of members from the County of Orange's Medical Services Initiative Program to CalOptima. Additional State initiatives, which streamlined the process for individuals in the CalFresh program to become enrolled in Medi-Cal, also expanded CalOptima membership.

Also in January 2014, CalOptima received the results of an audit conducted by the Center for Medicare & Medicaid Services (CMS). Issues were identified which required remediation. A subsequent audit by the Department of Health Care Services and the Department of Managed Health Care identified additional issues requiring resolution. As a result of the audit findings and sanctions, the implementation of the Cal MediConnect program was delayed.

Back to Agenda

Medi-Cal Expansion and audit remediation placed a strain on CalOptima resources. CalOptima has improved many programs to resolve issues identified in the CMS audit. This included enhanced oversight of the delegated Health Networks and an enhanced OneCare Model of Care. DHCS and DMHC have recently completed a comprehensive audit of CalOptima and CMS will return in January for a reaudit.

Due to initiatives currently underway within CalOptima and the Health Networks, the implementation of the Cal MediConnect program has been delayed to no later than July 1, 2015. Staff recommends extending the timeframe within which the CEO is authorized to enter into contracts with selected new and existing Health Networks provided these entities meet all readiness requirements associated with the proposed contracting models to no later than December 31, 2015.

Any currently contracted Health Networks proposing a change to their network must ensure that all legal, financial, and operational obligations are adequately addressed in conjunction with the proposed change being implemented.

Fiscal Impact
There is no financial impact expected from the recommended action.

Rationale for Recommendation
Staff recommends allowing the extended time period to ensure the completion of current initiatives and audits. As proposed, new and existing Health Networks involved in the readiness assessment process would be able to contract with CalOptima through their preferred model provided they meet all requirements for participation in CalOptima programs (excluding PACE) no later than December 31, 2015.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *10/31/2014*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

13. Consider Extending the Timeframe for Qualifying New and Existing Health Networks to Request Changes to Their Proposed Contracting Models and Complete Readiness Assessment Requirements

Contact

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

Recommended Actions

1. Extend the deadline to June 30, 2016 for Health Networks qualified through the Board approved Request for Proposal (RFP) process to request changes to their proposed contracting models; and
2. Extend the deadline to December 31, 2016 for existing Health Networks requesting changes to their contracting models as well as new networks selected through the RFP process to meet all applicable readiness requirements.

Background/Discussion

On February 7, 2013, the CalOptima Board of Directors authorized the Chief Executive Officer (CEO) to conduct a RFP process for the purpose of exploring the expansion of the delivery system serving CalOptima members. The RFP process sought the participation of new entities in CalOptima's delivery system. Existing Health Networks were also given the opportunity to propose a contracting model which differed from their current model.

On October 3, 2013, the Board authorized the CEO to enter into Health Network contracts with entities selected through the RFP process, subject to the successful completion of the readiness assessment process.

On February 6, 2014, the Board agreed to extend the timeframe within which the CEO had to enter into contracts with selected and existing Health Networks to no later than December 31, 2014. At its November 6, 2014 meeting, the Board further extended the timeframe through December 31, 2015 for providers qualified through the 2013 RFP process and to request changes to their proposed contracting models.

Two existing Health Networks are interested in pursuing full- risk arrangements with CalOptima. In order to provide these Health Networks with additional time to obtain necessary regulatory approvals, staff recommends extending the timeframe within which the CEO is authorized to enter into contracts with selected new and existing Health Networks. As proposed, in order to change models, the qualifying existing Health Networks interested in making a model change will be required to provide a written commitment to CalOptima of their preferred contracting model by June 30, 2016, and to complete all readiness assessment requirements to implement the new model no later than December 31, 2016.

Potential new Health Networks selected through the RFP process are being evaluated for participation in CalOptima through the readiness review process. CalOptima has successfully implemented two of the

Back to Agenda

successful RFP respondents in 2015. Three potential new networks remain from the RFP process. All efforts with the remaining potential networks will be completed by the end of 2016.

Fiscal Impact
There is no fiscal impact expected from the recommended action.

Rationale for Recommendation
Staff recommends the extended time period to ensure the successful addition of new Health Networks and the model conversion of existing Networks. The extension will allow new and existing Health Networks to complete the readiness assessment process for Medi-Cal and Medicare and be able to contract with CalOptima under their preferred risk model no later than December 31, 2016.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/25/2015*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

14. Consider Approval of Unbudgeted Expenses Related to Member Focused Communications for OneCare Connect

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Authorize expenditures of up to $75,000 from existing reserves to fund member focused communications for OneCare Connect.

Background/Discussion

On December 5, 2013, the CalOptima Board of Directors (BOD) authorized execution of the Three-Way Agreement between the California Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS) and CalOptima for implementation of Cal MediConnect (CMC), branded CalOptima OneCare Connect Plan (Medicare-Medicaid Plan) (OCC) in Orange County. OCC is a managed care plan that combines Medicare and Medi-Cal, including long-term services and supports (such as In-Home Supportive Services, Multipurpose Senior Services Program, Community-Based Adult Services, and long-term care). Enrollment into OCC began on July 1, 2015. As of October 10, 2016 there were 17,444 members enrolled in OCC.

Since the inception of the program, CalOptima has engaged in various marketing activities primarily focused on new member enrollment, in accordance with CMS and DHCS marketing guidelines. These include transit advertising, print advertisement, radio campaigns, and informational brochure stands in provider offices. CalOptima has mailed informational brochures and business reply cards to potentially eligible members. In the community, CalOptima has increased its presence in community-based organizations, and faith-based organizations in both marketing and informational activities.

For members already enrolled in OCC, CalOptima has launched member outreach initiatives. A telephonic outreach is conducted 45 days after enrollment and yearly during the member's birthday month to discuss the OCC program and respond to member questions. CalOptima also hosts in-person new member orientation events and provides assistance to retain Medi-Cal eligibility. Activities have also been implemented to promote a positive member experience when interacting with CalOptima's Customer Service staff. This includes providing continuous customer service training, performing quality audits of the call center, and conducting an optional member satisfaction survey after each call. Grievances, member and provider feedback, and disenrollment reasons are also monitored to develop member outreach strategies.

To further increase member interactions and provide plan benefit information, staff plans to conduct telephonic outreach to promote the new gym and taxi benefits to members who have historically utilized those benefits. CalOptima staff also recommends increasing the number of member touch points through member mailings. These member mailings will provide additional information

Back to Agenda

regarding OCC plan benefits, contact information to address concerns, and member rights and responsibilities. One member newsletter and a limited number of disease management mailings for OCC members with specific medical conditions were budgeted for FY16-17. To increase the number of touch points CalOptima staff recommends adding the following member communications: two additional newsletters ($31,500), four health promotion mailings ($23,500), and a new year's card ($20,000). All member materials will follow the appropriate regulatory review and approval process, as required by CMS and DHCS.

Fiscal Impact
The recommended action to authorize expenditures to fund increased member communications for OCC is an unbudgeted item. An allocation of up to $75,000 from existing reserves will fund this action.

Rationale for Recommendation
Increasing the number of mailings to OCC members will provide additional benefit and plan information. CalOptima recognizes that OCC members have many health plan options and wants to provide information that can assist members in making informed decisions regarding their health care and take full advantage of benefits and services available through their existing coverage.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

11/22/2016 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

15. Consider Authorization of the Expenditure Plan for Available Intergovernmental Transfer (IGT) Funds, Including Reallocation of Dollars from IGT 1, IGT 2 and IGT 3, and Allocation of Dollars from IGT 4 and IGT 5

Contact

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

Recommended Actions

1. Approve expenditure plan for reallocation of IGT 1-3 funds in the amount of $5,820,020 and allocation of IGT 4 and 5 funds in the amount of $21,966,208 to include projects consistent with the original CMS-approved expenditure categories, and that support CalOptima Board-approved funding categories;
2. Authorize the CEO to execute agreements as necessary to distribute IGT funds for Board approved projects and initiatives supporting the approved funding priorities;
3. Authorize a timeline extension for the expenditure of $50,000 in IGT 1 funds for OneCare Personal Care Coordinators (PCC) through June 30, 2017 or until funds have been exhausted, whichever occurs earlier; and
4. Direct staff to return to the Board with further IGT expenditure recommendations as they are developed; all IGT specific programs and initiatives remain subject to Board approval.

Background/Discussion

CalOptima began participating in the rate range IGT program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. Including the estimated amount of the currently pending IGT 5 transaction, CalOptima's share of the five IGT transactions will total approximately $48 million. Numerous Board-approved projects have been launched with IGT 1-3 funds within the regulator-approved categories, and most have been completed or are on track for completion. There are a small number of projects that have been postponed or eliminated and these dollars are available for the Board's reallocation. Allocations for IGT 4 and IGT 5 funds have yet to be approved by the Board.

1. Staff has developed recommendations to reallocate $5.8 million in unspent funds from IGTs 1-3. Recommendations have also been developed for expenditure of the $22 million in available funds from IGT 4 and IGT 5.
2. The proposed $27.8 million in recommended expenditures will be utilized to support one or more of the original CMS-approved and CalOptima Board-approved expenditure categories (see Attachment 2. IGT 1 – 5 Summary Tables of Expenditures by CMS/DHCS (and CalOptima Board) Approved Funding Categories) as appropriate.

Back to Agenda

IGT Ad Hoc Committee

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on November 14, 2016, to review the IGT expenditure plan as recommended by staff. The ad hoc committee consists of Supervisor Do, Director Nguyen, and Director Schoeffel. Recommendations from the Ad Hoc committee include the following:

1. Approve $12.8 million for projects within the approved funding categories as listed below, to improve services and quality of care for Medi-Cal member, support providers, and make infrastructure investments for the benefit Medi-Cal members.

2. Complete a comprehensive Member Health Needs Assessment, results of which will be used to inform development of Community Grant RFPs.
    a. Member Health Needs Assessment to be conducted within a 3-6 month timeframe, with the assistance of a consultant (procured according to appropriate policy and RFP processes).

3. Staff will return with recommendations for Board approval on specific programs and initiatives on the expenditure of an additional $15 million in IGT funds following completion of the Member Health Needs Assessment;

Funding Allocations and Projects to be Supported

The table below illustrates the recommended funding reallocations from IGTs 1-3 projects and allocation of IGT 4 and 5 funds:

FROM (Project/IGT)	Amount to be (Re)allocated	TO Recommended Projects	Project Funding Amount
Telemedicine/ IGT 1 *(Enhance provider reimbursement rates)*	$1,000,000	Depression Screenings	$1,000,000
Telemedicine/ IGT 1 *(Strengthen delivery system)*	$69,190	Provider Portal Communications & Interconnectivity	$1,500,000
IGT 4	$1,430,810		
IGT 4	$250,000	Member Health Homes	$250,000
IGT 4	$750,000	UCI Observation Stay Payment Pilot	$750,000
IGT 4	$500,000	Member Health Needs Assessment	$500,000
IGT 4	$3,550,000	Personal Care Coordinators (PCCs)	$7,000,000
Pay-for-Performance for PCPs/ IGT 3 *(Care Coordination)*	$3,450,000		
Pay-for-Performance for PCPs/ IGT 3 *(Improve information services infrastructure)*	$750,000	Data Warehouse Expansion	$750,000
Case Management System/ IGT1 *(Strengthen delivery system)*	$3,620	Facets System Upgrade and Reconfiguration	$506,620
Provider Network Management Solution/	$500,000		

Back to Agenda

FROM (Project/IGT)	Amount to be (Re)allocated	TO Recommended Projects	Project Funding Amount
IGT 2 *(Enhance information technology infrastructure)*			
Security Audit Remediation/ IGT2 *(Enhance information technology infrastructure)*	$3,000		
Additional Unallocated Funds/ IGT 1	$28,231	IGT Program Administration (Grants Management Software, staffing and administrative costs)	$529,608
Additional Unallocated Funds/ IGT 2	$427		
Additional Unallocated Funds/ IGT 3	$15,552		
IGT 4	$485,398		
		Subtotal	**$12,786,228**
IGT 5 (Anticipated amount)	$15,000,000	Community Grants (pending completion of Member Health Needs Assessment)	$15,000,000
		Total	**$27,786,228**

The details of the above recommended projects are as follows:

- Depression Screenings (up to $1,000,000): Physician incentive payment program to increase the rate of depression screenings conducted during annual wellness visits for members ages 12-18 over two years. Subject to regulator approval, as applicable, incentive payments per screening will be $30 and made directly to primary care providers. Beginning with Year 2 of the project, and again, subject to regulator approval as appropriate, a sufficient process/infrastructure must be in place to collect depression screening scores in addition to the claims from providers in order for incentive payment to be made. This project addresses the "Children's Mental Health" funding category.

- Provider Portal Communications and Interconnectivity (up to $1,500,000): Develop and implement a web-based provider portal strategy that will support real time bi-directional electronic communication between CalOptima and community partners/providers. Project includes an initial pilot with designated community agencies to evaluate and incorporate feedback prior to implementation with CCN Network Providers. This project addresses the "Pilot Program Planning and Implementation" funding category, as bi-directional data sharing and exchange between CalOptima and providers is a required component of the Whole Person Care pilot in which CalOptima is a key participant, and will be an important asset to the upcoming Health Homes Program.

- Health Homes Program (HHP) (up to $250,000): CalOptima is implementing the "Health Homes for Patients with Complex Needs Program" (HHP), a new DHCS program for Medi-Cal and Cal Medi-Connect plans. This program requires plans to engage Community-Based

Care Management Entities (CB-CMEs) to provide HHP services. DHCS requires plans to assess organizations in the community that may offer HHP services and use this information in development of the local delivery model. Health Homes Program payments do not cover the cost of such activities, and IGT funds will be used to complete this one-time environmental assessment and development of tools to select, contract and determine readiness of organizations to provide HHP services. These activities may be conducted by a consultant, temporary staff or other resource (procured according to appropriate policy and RFP processes). This project addresses the "Pilot Program Planning and Implementation" funding category.

- UCI Observation Stay Payment Pilot (up to $750,000): Assuming terms and can be reached with UCI within 90 days, funds will support a pilot project with UC Irvine Health to test cost effectiveness of emergency department observation unit (EDOU) care and demonstrate potential return on investment for such care. This project will include tracking of specific CalOptima member information, including diagnosis, protocol, time in EDOU, discharge diagnosis, discharge status and readmission rates. UCI and CalOptima will conduct monthly utilization review. If terms cannot be reached within this time period, staff will return to the Board with further recommendations. This project addresses the "Pilot Program Planning and Implementation" funding category.

- Member Health Needs Assessment (up to $500,000): Conduct a county-wide Medi-Cal member health needs assessment. Funds will support assistance from a consultant (procured according to appropriate policy and RFP processes) and associated costs for assessment activities such as surveys, focus group meetings and survey completion incentives etc. Results and recommendations from the completed assessment will inform RFP development of targeted Community Grant funding to support the needs of Medi-Cal beneficiaries in Orange County. This project addresses the "Strengthening the Safety Net" funding category by providing information that will more effectively align funding investments with the needs of our Medi-Cal members.

- Personal Care Coordinators (PCCs) (up to $7,000,000): Funds will support Health Network and CalOptima PCCs to assist members in navigating the health care system. Funding covers PCCs for the following member populations: duals (OneCare and OneCare Connect), Medi-Cal Seniors and Persons with Disabilities, and other vulnerable populations (e.g, homeless, those with serious and persistent mental illness, transitioning from Regional Center services, etc.). Funding includes support for the cost of services to complete an evaluation of the PCC program, to be completed no later than June 2018. Evaluation activities may be conducted by a consultant, temporary staff or other resource (procured according to appropriate policy and RFP processes). This project addresses the "Strengthening the Safety Net" funding category as PCCs assist members in navigating the health care system.

- Data Warehouse Expansion ($750,000): Integrate various data sources (e.g. pharmacy, claims, case management system, accounting and budget data) into the Clinical Data Warehouse to provide the capability to build complete member claims and pharmacy histories, analyze data

and produce an integrated performance/financial impact analysis package. This project is anticipated to be completed in two years or less and may include the use of contract services and information systems upgrades procured according to appropriate policy and RFP processes. This project addresses the "Pilot Program Planning and Implementation" funding category, as data integration is a fundamental component of the Whole Person Care pilot, Health Homes Program, and Whole Child initiatives.

- Facets System Upgrade and Reconfiguration (up to $506,620): Improve operational efficiencies of Facets claims and member management system with additional hardware and vendor service purchases. This work supports optimizing data storage requirements and prevents data loss, adding test environments for program implementation to mitigate negative impact to production, system load balancing to support growth in membership and claims data, and improving performance and batch processing to optimize server distribution. This project addresses the "Enhance core data analysis and exchange systems" funding category, being continued from IGT 2.

- IGT Program Administration (up to $529,608): Funds will support purchase and ongoing maintenance of Grant Administration software (procured according to appropriate policy and RFP processes) to facilitate management and oversight of IGT projects and community grants. Funding will also support staffing and administrative costs to manage the IGT transaction process, and provide IGT project and expenditure oversight over two years. Administrative functions are an allowable use of IGT funds and support the funding category of "Strengthening the Safety Net" by providing oversight of the entire IGT process and ensuring that funding investments are effectively aligned with the needs of our members.

- Addressing Gaps and Barriers facing Orange County Medi-Cal members (approximately $15,000,000): $15,000,000 in anticipated funds from IGT 5 to be allocated for targeted community needs in one or more of the funding priority areas above after completion of a Member Health Needs Assessment. Staff will return to the Board with recommendations following completion of the Health Needs Assessment.

IGT 1 Project Timeline Extension

As part of this expenditure plan recommendation, staff also requests a timeline extension for an expenditure of $50,000 in IGT 1 funds for OneCare Personal Care Coordinators (PCC) which was authorized through December 31, 2016 (see Attachment 14, Board Action dated March 3, 2016 - Authorize Extension and Reallocation of OneCare PCC Funds for CY 2016). Extension for use of these funds is requested through June 30, 2017 or until funds have been exhausted, whichever occurs earlier.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future budget allocations.

Back to Agenda

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: IGT Update and Expenditure Plan
2. IGT 1 – 5 Summary Tables of Expenditures by CMS/DHCS (and CalOptima Board) Approved Funding Categories
3. Board Action dated March 7, 2013: Approve Proposed Use of $12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2011-12 IGT Funds and Execute Required IGT Documents
4. Board Action dated June 6, 2013: Approve Work Plan and Timeline for Implementation of FY 2010-11 Intergovernmental Transfer (IGT) Funds
5. Board Action dated March 6, 2014: Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents
6. Board Action dated September 4, 2014: Authorize and Direct the Chairman of the Board of Directors to Enter into the Necessary Agreements with the University of California at Irvine (UCI) and the California Department of Health Care Services (DHCS) to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2012-13, Including Approval of Proposed Funding Categories; Recommend Board of Directors Approval of an Updated Expenditure Plan for FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of $900,000 of IGT 2 Funds and Authorize Procurement Process for School-Based Vision and Dental Wraparound Services
7. Board Action dated October 2, 2014: Approve Grant Awards to Designated Organizations in Support of New and Prospective Federally Qualified Health Centers (FQHCs)
8. Board Action dated December 4, 2014: Authorize Grant Awards in Support of Prospective Federally Qualified Health Centers (FQHCs) and Funding for Expert Consultation to Manage and Ensure Satisfactory Progress on Clinic Grants
9. Board Action dated December 4, 2014: Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation
10. Board Action dated April 2, 2015: Authorize Reallocation of OneCare Personal Care Coordinator (PCC) Funding to Cover the Cost of the Program
11. Board Action dated April 2, 2015: Approve the Allocation of Intergovernmental Transfer (IGT) Funds for Personal Care Coordinators (PCC) for the OneCare Connect (OCC) Program Including for OCC Members in the CalOptima Community Network

Back to Agenda

12. Board Action dated May 7, 2015: Authorize Agreements Necessary to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2013-14 (IGT 4); Consider Approval of a Modification of Eligible Use for IGT 2 Funds Allocated to Support Federally Qualified Health Centers (FQHCs)
13. Board Action dated October 1, 2015: Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects
14. Board Action dated March 3, 2016: Authorize Extension of Expenditures of Fiscal Year 2010-11 Intergovernmental Transfer Funds for OneCare Personal Care Coordinators (PCC) through December 31, 2016; and Authorize the Reallocation of OneCare Connect PCC Funding to Cover the Cost of the OneCare PCC Program through Calendar Year 2016

/s/ Michael Schrader *11/23/2016*

Authorized Signature **Date**

Back to Agenda

IGT Update & Expenditure Plan

Board of Directors Meeting
December 1, 2016

Cheryl Meronk
Director, Strategic Development

Back to Agenda

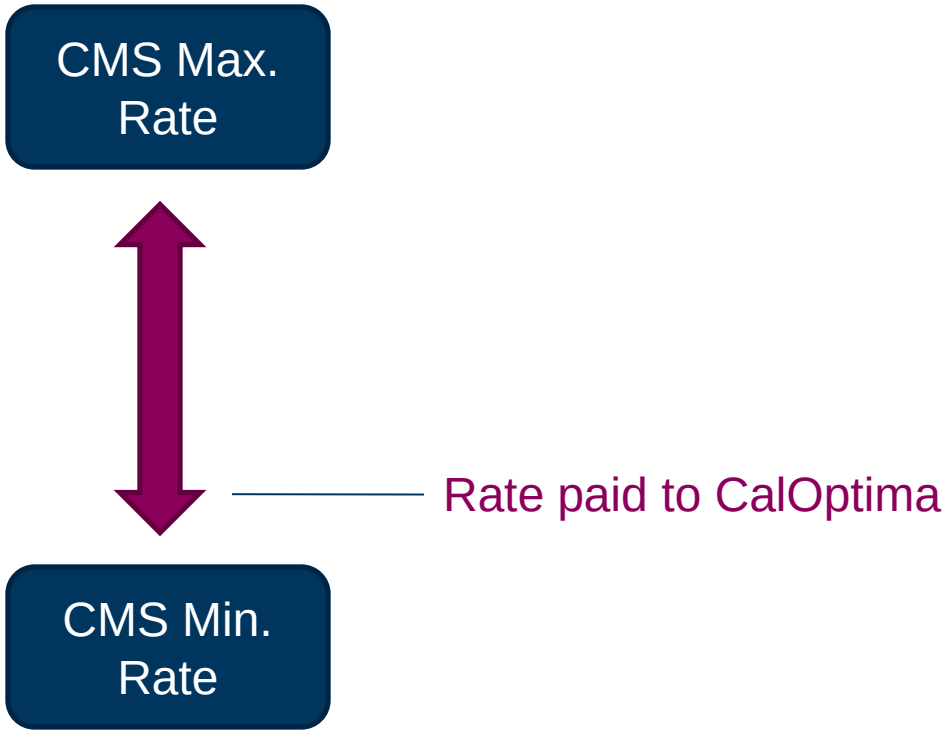
Intergovernmental Transfers (IGT) Background

- Medi-Cal program is funded by state and federal funds
- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
- Funds must be used to deliver enhanced services for the Medi-Cal population

Back to Agenda

Low Medi-Cal Managed Care Rates

- CMS approves a rate range for Medi-Cal managed care
- California pays near the bottom of the range



Back to Agenda

IGT Funds Availability and Process

- Available pool of dollars based on difference paid to CalOptima and the maximum rate
- Access to IGT dollars is contingent upon eligible government entities contributing dollars to be used as match for federal dollars
- Funds secured through cooperative transactions among eligible governmental funding entities, CalOptima, DHCS and CMS

Back to Agenda

CalOptima Share Totals for IGT 1–5

IGTs	CalOptima Share
IGT 1	$12.52 M
IGT 2	$8.60 M
IGT 3	$4.88 M
IGT 4	$7 M
IGT 5	≈$15 M
Total	**$48 M***

**Estimated total*

Back to Agenda

IGT 1 Status*

Project	Budget	Balance	Notes
Personal Care Coordinators	$3,850,000	$110,000	Complete by 2/28/2017
Case Management System	$2,099,000	$3,500	Completed
Strategies to Reduce Readmissions	$533,585	$443,000	Complete by 12/1/2016
Program for High-Risk Children	$500,000	$500,000	Complete by 10/31/2018
Telemedicine	$1,100,000	$1,100,000	To be reallocated
Case Management System Consulting	$866,415	$218,000	Complete by 12/31/2017
OCC PCC Program	$3,550,000	$2,085,000	Complete by 2/28/2017
Total	**$12.5 M**	**$4.4 M**	**Total Reallocation Amount: $1.1 M**

**As of 8/31/2016 – balance figures rounded*

Back to Agenda

IGT 2 Status*

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	$1,250,000	$265,000	Complete by 12/31/2016
Security Audit Remediation	$101,000	$0	Completed
Continuation of COREC	$1,000,000	$517,000	Complete by 6/30/2017
OCC PCC Program	$2,400,000	$2,400,000	Complete by 3/31/2018
Children's Health/ Safety Net Services	$1,300,000	$126,000	Complete by 5/31/2017
Wraparound Services	$1,400,000	$487,000	Complete by 11/1/2017
Recuperative Care	$500,000	$318,500	Complete by 3/1/2017
Provider Network Management Solution	$500,000	$500,000	To be reallocated
Project Management	$100,000	$17,000	Complete by 9/30/2016
PACE EHR System	$50,000	$1,000	Complete by 12/31/2016
Total	**$8.6 M**	**$4.6 M**	**Total Reallocation Amount: $0.5 M**

**As of 8/31/2016 – balance figures rounded*

Back to Agenda

IGT 3 Status*

Project	Budget	Balance	Notes
Pay for Performance for PCPs	$4,200,000	$4,200,000	To be reallocated
Recuperative Case (Phase 2)	$500,000	$500,000	Complete by 6/30/2018
Project Management	$165,000	$165,000	Complete by 12/31/2017
Total	**$4.8 M**	**$4.8 M**	**Total Reallocation Amount: $4.2 M**

**As of 8/31/2016 – balance figures rounded*

Back to Agenda

IGT 4 Status*

Project	Budget	Balance	Notes
Unallocated Funds	$7,000,000	$7,000,000	To be allocated
Total	**$7 M**	**$7 M**	**Total Allocation Amount: $7 M**

**As of 8/31/2016 – balance figures rounded*

Back to Agenda

IGT 5 Status*

Project	Budget	Balance	Notes
Unallocated Funds	≈$15,000,000	≈$15,000,000	To be allocated
Total	**≈$15 M**	**≈$15 M**	**Total Allocation Amount: ≈$15 M**

**Not yet received*

Back to Agenda

Total Funds to Reallocate or Allocate

IGT	Funds Available
IGT 1	$1.1 M
IGT 2	$0.5 M
IGT 3	$4.2 M
IGT 4	$7 M
IGT 5	≈$15 M
Total	**$27.8 M***

**Estimate dependent on total IGT 5 amount*

Back to Agenda

IGT Approved Funding Categories*

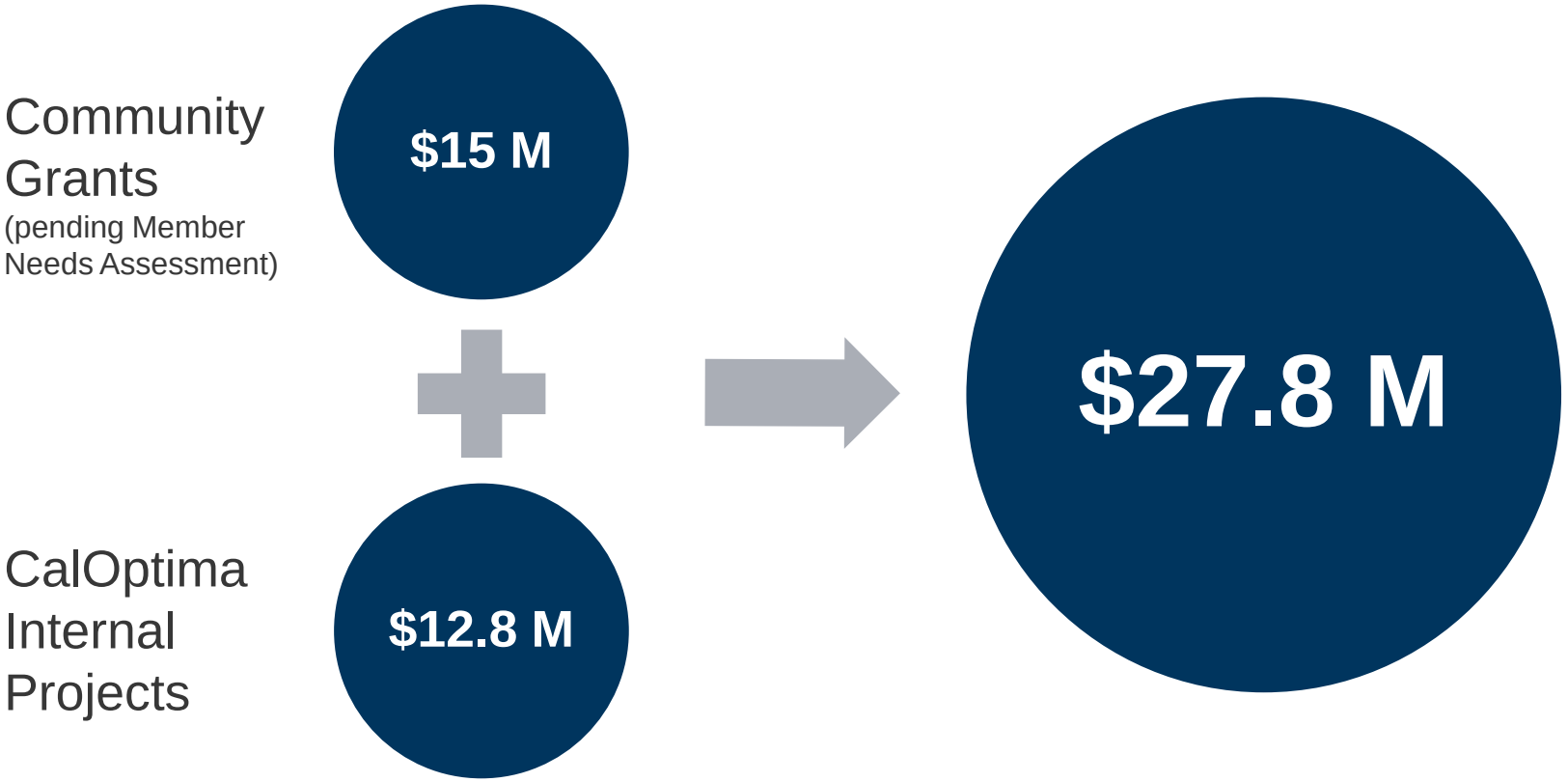
- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Strengthening the Safety Net
- Improving Children's Health
- Pilot Program Planning & Implementation

**IGTs 4 and 5 only*

Back to Agenda

Purpose of IGT Funds

- Funds must be used to deliver enhanced services for the Medi-Cal population



Back to Agenda

Recommended Internal Expenditures

Expenditures	Funding Amount
Data Warehouse Expansion	$750,000
Depression Screenings Ages 12–18	$1,000,000
Facets System Upgrade and Reconfiguration	$500,000
Health Homes Program	$250,000
Health Needs Assessment	$500,000
IGT Program Administration (grant management software, staff and administrative costs over two years)	$530,000
Personal Care Coordinators (PCCs) • Duals (OneCare and OneCare Connect) • Medi-Cal Seniors and Persons with Disabilities • Other Populations (Homeless/SPMI, RCOC, etc.)	$7,000,000
Provider Portal Communications and Interconnectivity	$1,500,000
UCI Observation Stay Payment Pilot	$750,000
Total	**$12,780,000**

Back to Agenda

External Community Grant Support

- Comprehensive Member Health Needs Assessment to inform Grant RFP development
  - Fill gaps in services and improve health outcomes for CalOptima members
  - Improve access to services
  - Address social determinants of health
- Orange County's Medi-Cal delivery system relies heavily on safety net system
  - Community health centers
  - Community-based organizations

Back to Agenda

IGT Timeline

Date	Activity
September 15	FAC Update and Review
September 21	QAC Update and Review
November 10 and 17	PAC/MAC/OCC MAC Review
November 14	IGT Ad Hoc
December 1	Board of Directors Presentation
January – June 2017	Conduct Member Health Needs Assessment
Fall 2017	Development and Release of Community Grant RFPs

Back to Agenda

IGT 1-5 Summary Tables of Expenditure by CMS/DHCS (and CalOptima Board) Approved Funding Categories

IGT 1 Funding Categories: (CalOptima Board Approved on March 7, 2013)

- Enhance provider reimbursement rates based on rewards for increased access, which includes, but is not limited to, the following:
  - Open access scheduling
  - Same day appointment availability
  - Participation in medical homes
  - Specialist recruitment for increased access
- Strengthen the delivery system to include, but no be limited to, increased member education and previously unused or underused resources such as the following:
  - 24/7 clinical call center
  - Minute clinics
  - Telemedicine
  - E-consults
  - Complex case management

Project	Amount	Funding Category
OneCare Personal Care Coordinators	$3,850,000	Strengthen the delivery system
Case Management System	$2,099,000	Strengthen the delivery system
Strategies to Reduce Re-admissions	$533,585	Strengthen the delivery system
Program for High Risk Children	$500,000	Strengthen the delivery system
Telemedicine	$1,100,000	Enhance provider reimbursement rates
Case Management System Consulting	$866,415	Strengthen the delivery system
OCC PCC Program	$3,550,000	Strengthen the delivery system
Total Allocation	**$12.5 M**	

IGT 2 Funding Categories: (CalOptima Board Approved on March 6, 2014)

- Enhance CalOptima's core data analysis and exchange systems and management information technology infrastructure to facilitate improved coordination of care for Medi-Cal members;
- Continue and/or expand on services and initiatives developed with 2010-11 IGT funds;
- Provided wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health integration, preventative dental services and supplies, and incentives to encourage members to participate in initial health assessment and preventative health programs.

Back to Agenda

Project	Amount	Funding Category
Facets System Upgrade & Reconfiguration	$1,250,000	Enhance information technology infrastructure
Security Audit Remediation	$101,000	Enhance information technology infrastructure
Continuation of COREC	$1,000,000	Enhancement to core data systems
OCC PCC Program	$2,400,000	Strengthen the delivery system
Children's Health/Safety Net Services	$1,300,000	Strengthen the delivery system
Wraparound Services	$1,400,000	Wraparound services
Recuperative Care	$500,000	Strengthen the delivery system
Provider Network Management Solution	$500,000	Enhancement to core data systems
Project Management	$100,000	Administration
PACE EHR System	$50,000	Enhance information technology infrastructure
Total Allocation	**$8.6 M**	

IGT 3 Funding Categories: (CalOptima Board Approved on September 4, 2014)

- Services related to care coordination and case management for CalOptima members;
- Expansion of optional benefits for CalOptima members potentially including but not limited to vision, dental, and prevention and treatment of chronic disease;
- Innovation and enhancement of the health care delivery model
- Continuing improvements to information services infrastructure and applications to enhance services to CalOptima members.

Project	Amount	Funding Category
Pay for Performance for PCPs	$4,200,000	Care coordination
Recuperative Case (Phase 2)	$500,000	Strengthen the delivery system
Project Management	$165,000	Administration
Total Allocation	**$4.8 M**	

IGT 4 Funding Categories: (CalOptima Board Approved on May 7, 2015)

- Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health;
- Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver initiatives. This would be one-time funding allocation for planning and implement pilot programs as required.

Project	Amount	Funding Category
Unallocated Funds	$7,000,000	To be distributed across categories
Total Allocation	**$7 M**	

Back to Agenda

IGT 5 Funding Categories: (CalOptima Board Approved on April 7, 2016)

- Adult Mental Health
- Childhood Obesity
- Children's Mental Health
- Improving Children's Health
- Strengthening the Safety Net
- Pilot Program Planning and Implementation

Project	Amount	Funding Category
Unallocated Funds	$15,000,000	To be distributed across categories
Total Allocation	**$15 M**	

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

VII. A. Approve Proposed Use of $12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2011-12 IGT Funds and Execute Required IGT Documents

Contact

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

Recommended Actions

1. Approve proposed use of $12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds; and
2. Authorize the CEO to initiate the required process for FY 2011-12 IGT funds and execute required IGT documents.

Background

On March 3, 2011, the CalOptima Board approved staff to enter into agreements to secure an IGT with the Regents of the University of California/University of California, Irvine (UCI) for Fiscal Year (FY) 2010-11. CalOptima retained $12.4 million through the IGT transaction. The funds were received in late August 2012, and UCI's portion was disbursed in September.

IGTs are transfers of public funds between governmental entities. The revenue generated through IGTs is potentially non-recurring since there is no guarantee of future IGT agreements. Thus, funds are best suited for one-time investments or as seed capital for new services or initiatives. Ultimately, IGT-funded programs or services must be self-sustaining and not reliant on IGT funds for ongoing operation.

In approving the IGT, the Centers for Medicare & Medicaid Services (CMS) authorized the use of IGT funds to fulfill one or more of the options under the following categories, as approved by the CalOptima Board of Directors:

Category 1: Enhance provider reimbursement rates based on rewards for increased access, which includes, but is not necessarily limited to, the following:

a. Open access scheduling
b. Same day appointment availability
c. Participation in medical homes
d. Specialist recruitment for increased access

Category 2: Strengthen the delivery system to include, but not be limited to, increased member education and previously unused or underused resources such as the following:

a. 24/7 clinical call center
b. Minute clinics
c. Telemedicine

Back to Agenda

d. e-Consult
e. Complex case management

Discussion

CalOptima sought input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the relative priority of each potential use. In response to a request from both committees for a cost analysis of the CMS-approved uses, Manatt, an interdisciplinary policy and business advisory consultancy firm, was engaged to research and prepare the requested analyses within an accelerated timeframe. A copy of Manatt's analysis is attached.

The MAC and the PAC met twice and formed ad hoc groups to review Manatt's analysis and provide recommendations for use of the funds. Based on this input, staff developed a proposal that is presented in the attached presentation.

Prior to moving forward, staff will return to the Board for approval of a proposed implementation plan.

Proposed Uses	Recommended Allocation
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical needs	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

UCI has indicated interest in entering into an agreement for a second IGT for FY 2011-12. As proposed, CalOptima plans to begin working with UCI on the required process.

Fiscal Impact

FY 2010-11 IGT funding provides $12.4 million to improve the quality of care and cost effectiveness of CalOptima and its delegated network. Potential funds for FY 2011-12 are unknown at this time.

Rationale for Recommendation

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

Back to Agenda

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

Attachments
FY 2010-11 IGT Recommendations Presentation
Manatt Cost Analysis dated January 10, 2013

/s/ Michael Schrader — *3/1/2013*
Authorized Signature — **Date**

Back to Agenda

Recommendations for FY 2010-11 Intergovernmental Transfer (IGT) Funds

Board of Directors Meeting
March 7, 2013

Ilia Rolon, MPH
Manager, Strategic Operations

Back to Agenda

Planning Process

- Engaged Manatt Consulting to:
  - Estimate upfront costs, costs to sustain
  - Identify implementation barriers and opportunities
- Presented analysis to Provider Advisory Committee (PAC) and Member Advisory Committee (MAC) in January 2013
- PAC and MAC
  - Held ad hoc meetings in January to review analysis in more depth and receive staff input
  - Met in February to vote on priority of options and finalize recommendations to CalOptima Board
  - Consensus reached between PAC and MAC regarding top four priorities

Options

Previous Name	New Name
Complex case management	•Complex case management
Open access scheduling	•Extended hours
Same day appointment availability	•Combined with above
Participation in medical homes	•Medical home infrastructure support
Specialist recruitment	•Specialist recruitment and retention
24/7 clinical call center	•Clinical call center
Minute clinics	•Alternative access points
Telemedicine	•Remote visits •Telemonitoring
E-Consults	•Specialty Care Consults

CalOptima
A Public Agency
Better. Together.

Back to Agenda

Comparison of Recommendations

Priority	Provider Advisory Committee	Member Advisory Committee
1	**Complex Case Management**	**Complex Case Management**
2	**Specialty Care Access -- Planning & Pilots**	**Extended Hours**
3	**Extended Hours Access**	**Alternative Access Points**
4	**Alternative Access Points – Planning and Pilots**	**Specialty Care Access – Planning & Pilots**
5		Remote Visits
6		Medical Home Infrastructure Support
7		Telemonitoring

* Bold type indicates consensus

Back to Agenda

Staff Recommendations

Proposed Uses	Recommended Allocation
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical risk	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented ROI, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

CalOptima
A Public Agency
Better. Together.

Back to Agenda

Complex Case Management – Part 1

- Recommended Allocation: $9.3 Million
- Description
  - Case management and care coordination services for high-need members across various provider settings (e.g., primary and specialty care, inpatient, skilled nursing)
  - A platform for IGT-funded services: Case Management team determines which other services the member needs
- Pricing Elements
  - Approximately 15 positions (HIT staff, RNs, data analysis, patient navigators)
  - New or enhanced technology for:
    - care coordination
    - clinical decision support
    - data repository
    - electronic health record (EHR) integration
    - predictive modeling

Complex Case Management – Part 2

- Recommended Allocation: $2 Million
- Description
  - Improvement of Health Networks' ability to accurately document clinical need
- Pricing Elements
  - Gap analysis
  - Risk documentation software
  - Staffing for provider technical assistance and education

Expanded Access Pilots

- Proposed Allocation: $1.1 Million
- Objectives
  - Reduction in visits to emergency departments
  - Decreased wait times for specialty care
  - Improved member satisfaction
- Potential Pilots
  - E-Consultation: Enables PCP to meet and share information with specialist via web connection and refer electronically for treatment, thus reducing need for specialty care
  - Incentivizing providers to see patients during evening and weekend hours
  - Developing alternative access points
  - Telemonitoring

Back to Agenda

Next Steps

- Approve Staff Recommendation for use of IGT funds
- Receive implementation plan in April / May 2013

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 6, 2013
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. E. Approve Work Plan and Timeline for Implementation of FY 2010-11 Intergovernmental Transfer (IGT) Funds

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

Recommended Action
Approve work plan and timeline for proposed use of $12.4 million of FY 2010-11 Intergovernmental Transfer (IGT) funds.

Background
On March 3, 2011, the CalOptima Board authorized staff to enter into agreements to secure an IGT with the Regents of the University of California/University of California, Irvine (UCI) for Fiscal Year (FY) 2010-11. CalOptima retained $12.4 million through the IGT transaction.

Subsequent to receiving the funds in late August 2012, CalOptima sought input from the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) regarding the relative priority of each CMS-approved potential use. In response to a request from both committees for a cost analysis of the potential uses, Manatt, an interdisciplinary policy and business advisory consulting firm, was engaged to research and prepare the requested analyses. The MAC and the PAC reviewed Manatt's analysis and provided recommendations for use of the funds. Based on this input, staff developed a proposal for best use of the funds.

On March 7, 2013, the CalOptima Board approved three main uses of the funds to improve the quality of care and cost effectiveness of CalOptima and its delegated network, as shown in the table below. The approved uses are expected to generate the most positive impact on members, CalOptima and its delegated networks, while also providing a sustainable return on investment for the future.

Approved Uses	Allocation
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical needs	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

Back to Agenda

Discussion
The largest portion of FY 2010-11 IGT funds is allocated to the enhancement of complex case management services for high-risk members across various care settings. Per the medical literature, the success of such programs is highly dependent on who is targeted, the program's design, and how success is measured. To derive maximum benefit from its investment in disease and case management services, CalOptima will first seek to strengthen the existing infrastructure in the following two areas: 1) improvement of data integrity and completeness; and, 2) implementation of predictive modeling to further inform the enrollment of members in disease and complex case management programs. In Phase Two, staff will use improved data to design complex case management program enhancements and determine the optimal delegation arrangement for these services.

IGT funds were also earmarked for pilot projects that expand access to healthcare services, particularly for medically vulnerable members. In FY 2013-14, CalOptima will implement a pilot to enhance communication between primary and specialty care providers through electronic referrals and consultations. The goals of the pilot are to mitigate specialty care service capacity issues and increase the ease and efficiency with which members who need specialty care services are able to access those services.

A more detailed work plan and timeline is included in the attached presentation. Staff will provide quarterly reports on the implementation progress.

Fiscal Impact
Implementation plan is consistent with previously approved IGT for FY 2010-11.

Rationale for Recommendation
The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

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

Attachment
FY 2010-11 Intergovernmental Transfer (IGT) Implementation Plan

/s/ Michael Schrader — *5/31/2013*
Authorized Signature — **Date**

Back to Agenda

FY 2010-11 Intergovernmental Transfer (IGT) Implementation Plan

Board of Directors Meeting

June 6, 2013

Ilia Rolon, MPH

Director, Strategic Development

Back to Agenda

Background

March 2013 Board Actions

- Approved use of IGT funds as follows:
  - Complex Case Management (CCM) 1: Case management for high-risk members across various care settings
    - Year 1: $5.1M
    - Year 2: $4.2M
  - CCM 2: Improved health network documentation of clinical risk
    - Year 1: $1.8M
    - Year 2: $200K
  - Pilot selected expanded access strategies such as e-consults, telemonitoring, and alternative access points
    - Year 1: $450K
    - Year 2: $650K
- Directed staff to return with implementation plan

Key Planning Assumptions

- Success of case and disease management programs is highly dependent on who is targeted, how program is designed and how success is measured*
- Allocation of funding should be data-driven
    - Begin by strengthening CalOptima's ability to accurately identify patients that fall within targeted risk score range
- Resources should follow the critical mass of at-risk members

* *Source: "Complex Puzzle: How Payers are Managing Complex and Chronic Care," Issue Brief, California Healthcare Foundation, April 2013*

Back to Agenda

Work Plan and Timeline

- **Strengthen complex case management infrastructure**
  - Improve data integrity and completeness
    - **Q3 2013** Assess current CalOptima data integrity; Issue RFP for vendor to provide technical assistance to health networks (HN) and providers for improved documentation of risk (CCM 1 & 2)
    - **Q4 2013** Upon selection of vendor, enroll interested HNs and conduct assessments (CCM 2)
    - **Q1 2014** Based on assessment results, identify opportunities for improvement and offer consultative assistance to HNs (CCM 2)
    - **Q2 2014** Use improved data to design, implement CCM program enhancements and determine delegation arrangement (CCM1)
  - Implement predictive modeling to further inform enrollment in complex case management programs (CCM 1)
    - **Q2 2014** Issue RFP
    - **Q3 2014** Select vendor and begin implementation and training
    - **Q4 2014** Implement enhancements to member enrollment

Work Plan and Timeline (Cont.)

- **Enhance referral and consultation communication between primary and specialty care providers**
  - **Q3 2013** Assess current health information exchange capabilities (CalOptima web portal, OCPRHIO*) and determine buy or build
  - **Q4 2013** Issue RFP for e-consult platform, if needed
  - **Q1 2014** Install components
  - **Q2 2014** Pilot with 1 health network and select CCN providers
  - **Q2-Q3 2014** Enroll other interested health networks and CCN providers

* Orange County Partnership Regional Health Information Organization

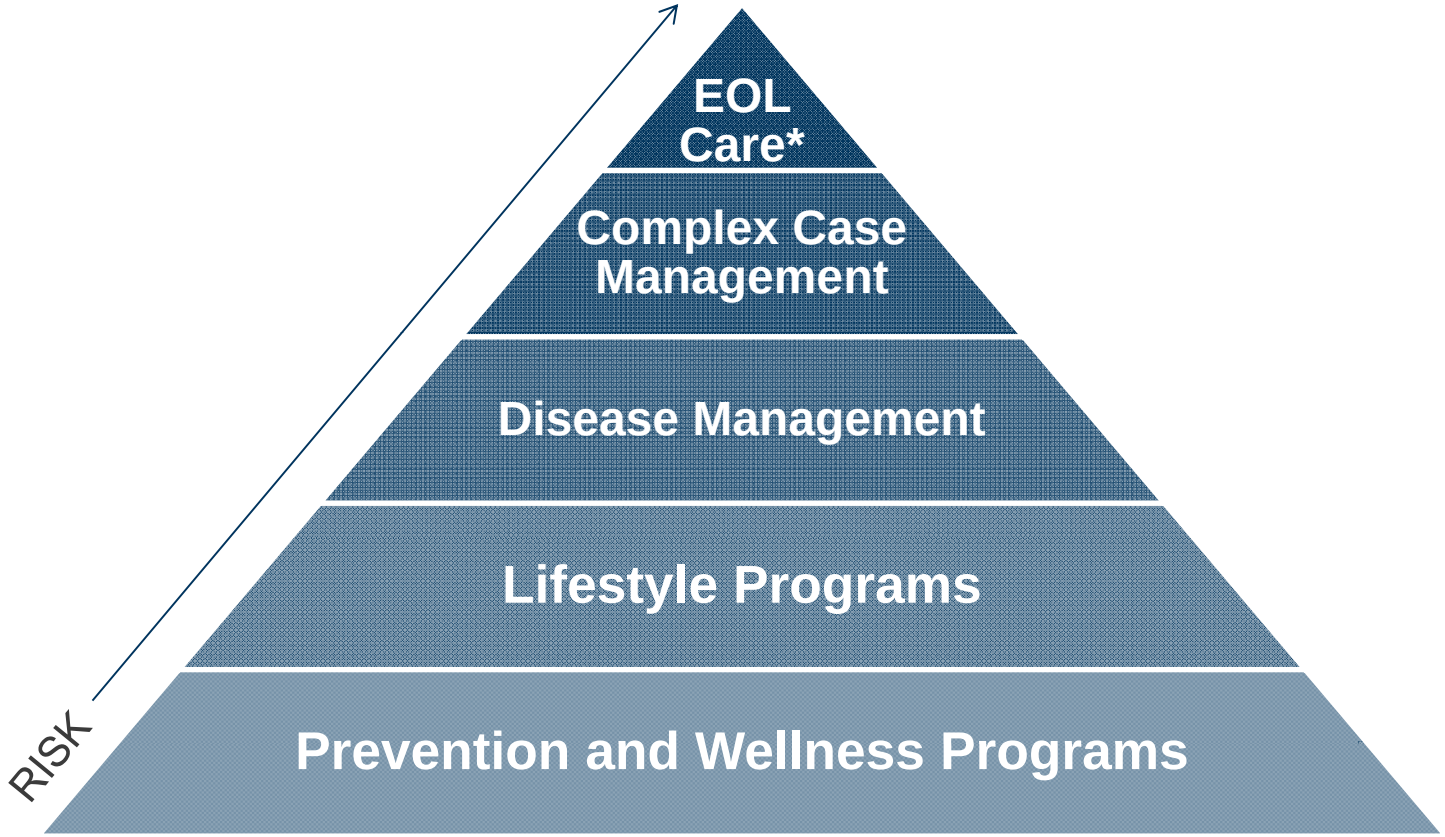
Back to Agenda

Appendix

- Types of Care Management Programs
- California Healthcare Foundation Recommendations

Back to Agenda

Types of Care Management Programs



* End-of-life care (may be considered part of complex case management or may be separate program)

Source: Booz Allen Hamilton, 2012

Back to Agenda

California Healthcare Foundation Recommendations

- Use analytic tools to better identify the population that would most benefit from interventions
  - *Predictive modeling*: Statistical technique of analyzing data to predict which members may be at greater risk for high-cost care, esp. hospitalization
- Adjust program design to engage and activate the patient by experimenting with a wide range of tools
  - "Low-touch": Tech solutions such as mobile apps, text messaging
  - "High-touch": Coaching or case management
- Better integrate disease management and complex case management programs with the treating provider or PCP
  - Use contracting arrangements to better align financial incentives and outcome measurement
  - Test a range of provider engagement tools, such as health information exchanges (HIEs), provider portals and embedding of care managers

Source: "Complex Puzzle: How Payers are Managing Complex and Chronic Care," Issue Brief, California Healthcare Foundation, April 2013

Intergovernmental Transfers (IGT)

Board of Directors Meeting
March ~~7~~ 6, 2014

Ilia Rolon
Director, Strategic Development

Back to Agenda

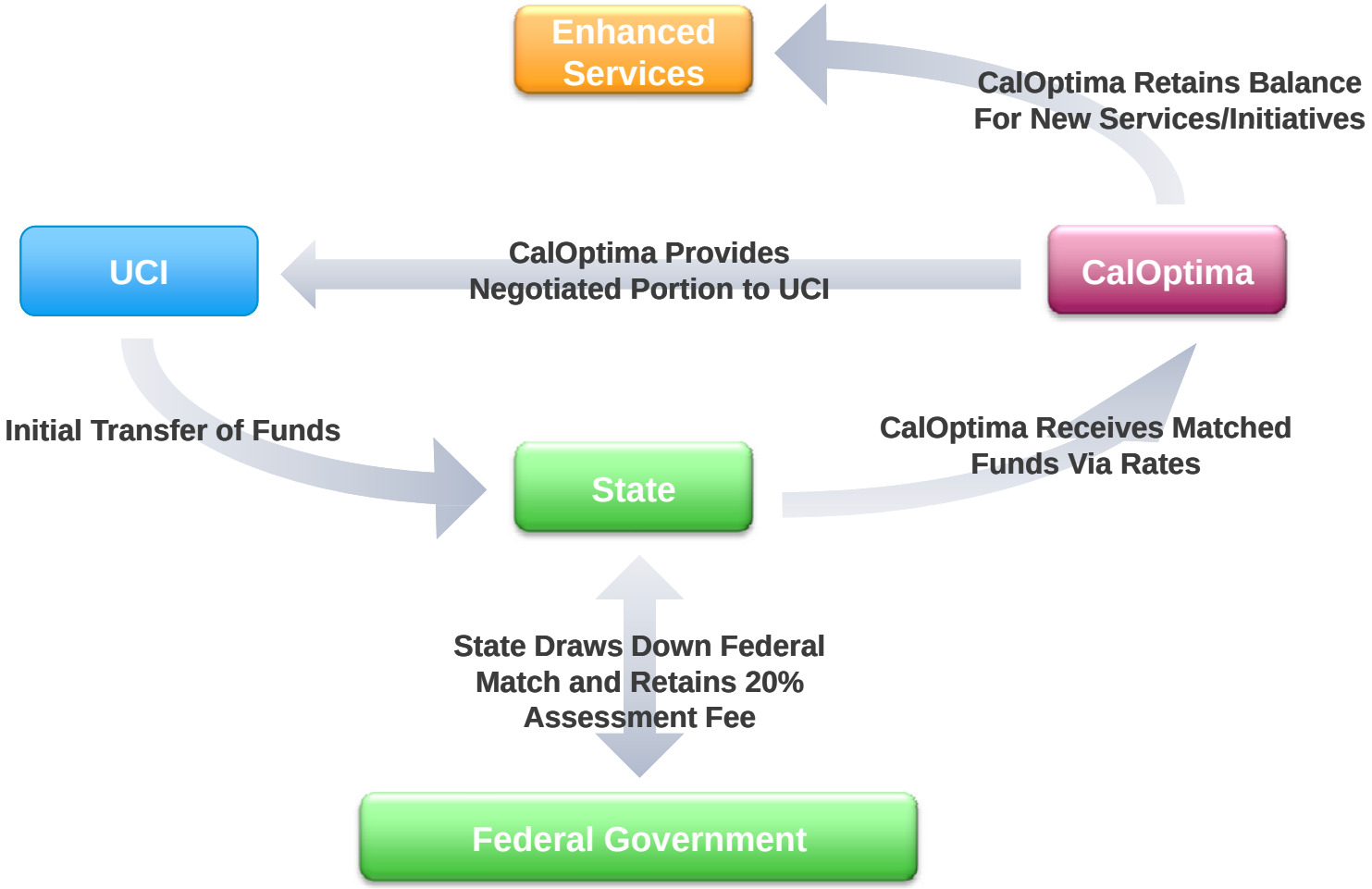
Background

Back to Agenda

About IGTs

- Intergovernmental Transfers (IGTs) are transfers of public funds between governmental entities
- Extensive precedent of IGTs among managed care plans in California
- California managed care plans have historically saved state/federal governments millions in health care costs
  - Federal Medical Assistance Percentage (FMAP): Amount of federal match for states' expenditures on social, medical services
    - California: 50%
    - Mississipi: 73%
- IGTs are a means of leveling the field and ensuring continued investment in our healthcare systems

IGT Transaction Overview



Back to Agenda

Use of Funds

- Revenue must be used to finance improvements in services for Medi-Cal beneficiaries
- No guarantee of future IGT agreements -- thus funds are best suited for one-time investments or as seed capital for new services or initiatives
- Budgeted uses for current IGTs are consistent with system improvements that will support successful response to OneCare audit
- Agreements are silent on deadline for use of funds

IGTs Received to Date

Funding Source	Claim Year	Year Received	CalOptima Amount	UCI Amount	State Amount	Total
IGT 1	FY 10-11	2012	**$12.4 M**	**$8.4 M***	$3.1 M	$23.9 M
IGT 2	FY 11-12	2013	**$7.4 M**	**$4.8 M**	$5.4 M	$17.6 M
Total Funds			**$19.8 M**	**$13.2 M**	$8.5 M	$41.5 M

- IGT 1 included a one-year community vetting process; proposed uses for IGTs 2 and 3 are consistent with results of this earlier process
- Status of IGT Year 1 expenditures: $2 M contract award for new case management system; agreements with health networks for approximately $2 M in funding for personal care coordinators pending

* UCI's net revenue was $3.4 Million due to exclusion from approximately $5.0 million in state disproportionate share (DSH) payments

Back to Agenda

Proposal

Back to Agenda

IGT 1 Expenditure Plan

Proposed Uses	Year 1	Year 2	Impacted Programs	Timing	Description
Complex Case Management I	$5.1 M	$4.2 M	–	–	
Personal Care Coordinators	$1.85 M	$1.95 M	CMC	CY 14	Additional PMPM line item payment to networks
Case Management System	$2.0 M	$0	All	CY 14	Replace existing case management system
Strategies to Reduce Readmission	$1.0 M	$2.0 M	MC, CMC OneCare	CY 14	Post-discharge follow up; transitions of care
Program for High-Risk Children	$250 K	$250 K	MC	FY 14/15	Services for children affected by both obesity and asthma
Complex Case Management II	**$1.8 M**	**$200,000**	**N/A**	**N/A**	**Merge this category with CCM 1**
Access Strategies	$450,000	$650,000	–	–	
e-Referral/ Telemedicine	TBD	TBD	All	CY 14	Dermatology project in development
Total Funds	$7.35 M	$5.05 M			

Back to Agenda

Proposed IGT 2 Expenditure Plan

CMS and CalOptima Board Approved Categories	Proposed Allocation
Enhanced Core Systems • Facets system upgrade and reconfiguration • Provider network management solution • Security audit remediation • Funding to continue COREC services for two years	**$3.0 M**
Continued / Expanded IGT 1 Services •Personal care coordinators •Strategies to reduce hospital readmissions	**$3.0 M**
Wraparound Services & Optional Benefits • To be developed further. • May include: school-based vision and dental services for children; recuperative care for homeless members discharged from hospital; and/or backfilling Medi-Cal cuts to payments and/or benefits.	**$1.4 M**
Total Funds	**$7.4 M**

60% for direct services

Back to Agenda

Next Steps

- Execute approved expenditure plan for IGT 1
- Begin implementation of IGT 2 funded activities
- Initiate process to explore feasibility of securing third IGT
- Periodic Board updates on progress

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. C. Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

Contact

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

Recommended Actions

1. Approve final expenditure plan for $12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds;
2. Approve expenditure plan for $7.4 Million in FY 2011-12 IGT funds;
3. Authorize the CEO to initiate the required process for FY 2012-13 IGT and execute the required application documents consistent with Board approved terms.

Background

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date. The two transactions are summarized below:

- IGT 1 was authorized by the CalOptima Board on March 3, 2011, and covers the claiming period of Fiscal Year (FY) 2010-11. CalOptima retained $12.4 Million, UCI retained $8.4 Million, and the state disbursed the funds in August 2012.
- IGT 2 was authorized by the CalOptima Board on March 7, 2013 for the FY 2011-12 claiming period. CalOptima retained $7.4 million, UCI retained $4.8 Million, and the state disbursed the funds in June 2013.

IGTs are transfers of public funds between governmental entities. The revenue generated through the CalOptima /UCI IGTs must be used to finance improvements in services for Medi-Cal beneficiaries. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives for Medi-Cal beneficiaries.

The present item seeks: 1) authorization to adjust the expenditure plan for IGT 1 to reflect the final funding distribution needed to fully implement the approved uses; 2) approval of the proposed expenditure plan for IGT 2; and 3) authorization to initiate the process to secure a third IGT.

Discussion

Final Expenditure Plan for IGT 1

On March 7, 2013, the CalOptima Board approved the following expenditure plan for IGT 1:

Back to Agenda

Table 1. Approved Expenditure Plan for IGT 1	**Budget**
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical needs	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

As reported at the February 2014 CalOptima Board meeting, recent data analyses indicate that the need for improved health network documentation of clinical needs (i.e., Complex Case Management – Part 2 in the above table) is not consistent among the networks, and thus will not require the entire budgeted amount. At the same time, full implementation of the uses proposed under Complex Case Management – Part 1, including reimbursement of health networks for enhanced care coordination, requires more funding than originally budgeted. To allow for greater efficiency and ensure that funds are used most effectively, staff recommends merging the two Complex Case Management budget categories, as reflected in Table 2 below.

Table 2. Final Expenditure Plan for IGT 1	**Budget**
Complex Case Management • Case management for high-risk members across various care settings, including improved documentation of clinical risk	Year 1: $6.9M Year 2: $4.4M
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

Proposed Expenditure Plan for IGT 2
As previously stated, CalOptima retained $7.4 million from the second IGT. Per the state's agreement with the Centers for Medicare and Medi-Cal (CMS), funds must be used for any of three Board-approved general purposes:

1. Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care;
2. Continue and/or expand on services and initiatives developed with FY 2010-11 IGT funds; and/or
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health, preventive dental services and supplies, and incentives to encourage members to participate in preventive health programs.

Based on an analysis of current and emerging priorities, staff proposes the budget allocation plan presented in the attached presentation and summarized below:

Table 3. Proposed Expenditure Plan for IGT 2	**Budget**
Enhancement of Core Data Systems	$3.0 M
Continuation/Expansion of IGT 1 Initiatives	$3.0 M
Wraparound Services/Optional Benefits to Address Critical Gaps	$1.4 M
Total Budget	**$7.4 M**

Proposed FY 2012-13 IGT

UCI has notified CalOptima of its interest to secure a third IGT for FY 2012-13. The Department of Health Care Services (DHCS) is in the process of calculating the amount of funds that would be available for this transaction. Authorization is requested to begin working with UCI to determine feasibility of securing a third IGT under the same general terms as the prior two IGTs, and to initiate the process. If IGT 3 is secured, funds will be applied to uses consistent with the categories outlined in Table 3 above.

Fiscal Impact

The recommended action is to be funded from DHCS capitation receipts which are currently reserved. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. It should be noted that the proposed expenditures under IGTs 1 and 2 are aligned with many of the system improvements required in response to the recent CMS audit.

Rationale for Recommendation

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

2/28/2014 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

VII. B. Authorize and Direct the Chairman of the Board of Directors to Enter into the Necessary Agreements with the University of California at Irvine (UCI) and the California Department of Health Care Services (DHCS) to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2012-13, Including Approval of Proposed Funding Categories; Recommend Board of Directors Approval of an Updated Expenditure Plan for FY 2011-12 IGT (IGT 2) Funds; and Consider Allocation of $900,000 of IGT 2 Funds and Authorize Procurement Process for School-Based Vision and Dental Wraparound Services

Contact

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

Recommended Actions

1. Authorize the Chairman of the Board of Directors to execute an amendment to the primary agreements among DHCS, UCI, and CalOptima for the upcoming FY 2012-13 IGT (IGT 3), including approval of proposed general use categories;
2. Approve final IGT 2 budget of $8.7 million and allocate the additional $1.3 Million to children's health and/or safety net services; and
3. Consider proposal for school-based vision and dental wraparound services for children enrolled in Medi-Cal, in amounts not to exceed $500,000 for vision services and $400,000 for dental services.

Background

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date, with a third IGT pending for FY 2012-13.

Presently staff recommends two actions related to the pending IGT 3 transaction, and two pertaining to FY IGT 2 revenue. Approval of these recommendations is requested in order to implement programmatic priorities.

Discussion

IGT 3 Application
On June 20, 2014, CalOptima and UCI submitted a proposal to DHCS for a third IGT. If approved, the proposed IGT will result in revenue of approximately $4.8 million each to UCI and CalOptima. Our understanding is that DHCS anticipates disbursement of an IGT payment to CalOptima in September 2014. At this time, staff requests authorization to amend the primary agreement between the DHCS and CalOptima for purposes of accepting an increased rate that includes IGT 3 funding. Additionally, consistent with the proposal to DHCS submitted in June 2014, staff requests approval of four general categories of uses for IGT 3 revenue as follows:

1. Services related to care coordination and case management for CalOptima members;
2. Expansion of optional benefits for CalOptima members potentially including but not limited to vision, dental, and prevention and treatment of chronic disease;

Back to Agenda

3. Innovation and enhancement of the health care delivery model;
4. Continuing improvements to information services infrastructure and applications to enhance services to CalOptima members.

A budget allocation for the proposed categories will be presented at a future Board meeting after the transaction has received federal approval and funds have been received from the state.

Additional IGT 2 Revenue
The current Board approved budget for IGT 2 is based on an original revenue estimate of $7.4 million, while actual revenue received was $8.7 million. Based upon discussion and direction provided at the August 27, 2014, Quality Assurance Committee, staff recommends allocating the additional $1.3 million for children's health and/or support of the safety net. For children's health services, priority could be given to addressing pediatric obesity and expanding access to children's health services. Safety net support could include, but not limited to, assisting safety net provider in their sustainability efforts.

Staff will present a proposed plan and recommendations for the additional funding allocation for Board consideration at a future meeting.

Plan for Wraparound Services
As discussed above, the Board-approved IGT 2 budget includes an allocation of $1.4 million for wraparound services and optional benefits for CalOptima members. The intent of these funds is to help address recognized gaps in services, as well as barriers to accessing preventive care and treatment.

The Board previously identified children's dental and vision services as priorities for this category of IGT funding, given the historically low utilization of these services. For example, only 54% of the nearly 190,000 Orange County children enrolled in Denti-Cal, which is administered directly by the state on a fee for service basis, had a dental visit in the previous year.[1] Similarly, only 52% of CalOptima's population under 19 years of age received a vision screening through a CalOptima provider in 2011. Lack of transportation; language barriers; inconvenient office hours; difficulty locating a provider that accepts Denti-Cal or Medi-Cal/Vision Services Plan (VSP); and parental beliefs regarding the timing of the first dental visit or vision screening are some reasons for the low utilization rates.

To help inform a funding plan to begin addressing these gaps, staff consulted with Kids Vision for Life, a non-profit dedicated to prevention of vision problems in children; Dr. Marc Lerner, Medical Officer, Center for Healthy Kids and Schools, Orange County Department of Education; and the

[1] "Why kids in Denti-Cal are feeling the pain," Children Now, 2013.

Children and Families Commission of Orange County, all of which have extensive expertise in these subjects, as well as deep knowledge regarding service gaps and access barriers affecting Orange County children.

At this time, staff recommends the Board consider expenditure of $900,000 for school-based children's dental and vision services, in amounts not to exceed $500,000 for vision services and $400,000 for dental. If approved, the recommended action will be accomplished in accordance with approved CalOptima Procurement Policy. Conditions for selection will include previous experience providing services at Orange County schools in high-need areas, as well as willingness to partner and coordinate with other providers for co-deployment of vision and dental services.

Children's Vision Services – $500,000

- Conduct school-based vision screening and assessment and supply eyeglasses to children with vision problems as medically recommended, with priority given to schools with the highest concentration of Medi-Cal eligible pupils;
- Provide referrals to local vision care providers and conduct follow-up to encourage families to connect with these providers for their children's ongoing vision care.

Children's Dental Services – $400,000

- Conduct school-based dental screening, education and preventive care, with priority given to schools with the highest concentration of Medi-Cal eligible pupils;
- Provide referrals to local dentists and conduct follow-up to encourage families to connect with these providers for their children's ongoing dental care.

If approved, staff anticipates selection of service providers, and inception of services, during the current (2014-15) school year. Moreover, staff will work with the selected vision and dental health partners to monitor and evaluate outcomes, and evaluation reports will be submitted to the Board's Quality Assurance Committee (QAC) for review. Upon completion of both programs, proof of concept data will be submitted to the Department of Health Care Services for its consideration of future reimbursement to providers of school-based vision and dental care.

As a separate but complementary effort, staff is also exploring opportunities to pilot incentives for pediatric primary care providers to provide basic oral health education and make timely referrals for dental care.

Another wraparound service being explored is pediatric obesity prevention and treatment. FY 2010-11 (IGT 1) funds were set aside for this purpose by prior Board action. However, given the complexity of this health issue and the dearth of effective models, staff brought this topic to the August meeting of the Board's QAC for discussion and direction. Dr. Candice Taylor Lucas, a noted expert on pediatric

obesity, provided guidelines and recommendations to the QAC. Based on input from this group, staff anticipates presenting funding recommendations for the Board's consideration in October.

Quality Assurance Committee Action
At its August meeting, the Board's Quality Assurance Committee approved the recommended Board of Directors approval of requested actions, but did not take action on proposed school-based services due to lack of consensus regarding whether schools are the most effective platform for children's vision and dental services, and whether IGT funds should be expended on these services.

Fiscal Impact
The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Rationale for Recommendations
The final budget for IGT 2 incorporates additional funds received in a manner consistent with prior Board actions. Funding for vision and dental wraparound service was approved by prior Board action and will provide enhanced services to current CalOptima members not available through current covered benefits, a key requirement for the use of IGT funds. Proposed funding categories for IGT 3 allow for continued support of key organizational priorities and programs.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *8/29/2014*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. E. Approve Grant Awards to Designated Organizations in Support of New and Prospective Federally Qualified Health Centers (FQHCs)

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

Recommended Actions
Approve grant awards in the aggregate amount of up to $200,000 to designated community health centers to support new and prospective Federally Qualified Health Centers (FQHCs) in Orange County, to be funded with Intergovernmental Transfer (IGT) 2 funds.

Background
Through recent discussions with representatives of Orange County's community health centers, CalOptima learned that several health centers have an urgent need for specialized technical assistance to ensure successful attainment of, and transition to, Federally Qualified Health Center (FQHC) designation. FQHCs are vital to Orange County's safety net because they provide comprehensive healthcare for low-income residents, including a significant number of current and future CalOptima Medi-Cal members. There are currently 10 FQHCs in the county, and collectively they operate 26 sites.

To qualify for FQHC designation, clinics must be located in or serve a community that has been designated a Medically Underserved Area or Population by the federal government; be governed by a community board; provide comprehensive primary health care; and provide services to all, with fees adjusted based on ability to pay. Prospective FQHCs often begin by applying to become a Non-grant-supported Health Center, more commonly known as an FQHC "look-alike." This interim designation confers many of the same benefits as full FQHC status, with the exception of the annual $650,000 grant that full FQHCs receive from the Health Resources and Services Administration (HRSA) to offset the cost of uncompensated care. Additional benefits of FQHC status are listed in the attachment to this item.

According to the Coalition of Orange County Community Health Centers, there are currently two look-alikes in the county; both are preparing to submit an application for full designation by the October 7th federal deadline. Existing FQHCs are also required to submit an application in order to expand to new sites; three Orange County FQHCs plan to apply for a New Access Points grant in October, with new sites planned for Tustin, Santa Ana and Lake Forest.

Prospective FQHCs, and those that wish to expand, must submit a successful application to HRSA's Bureau of Primary Health Care. There is typically no more than one application cycle per year. During the rigorous federal application process, prospective FQHCs often need specialized technical assistance to prepare the required application, and to conduct thorough financial analysis and planning to avoid adverse fiscal impact during the implementation period. In addition, newly-designated FQHCs derive long-term benefit from technical assistance with state and federal rate setting negotiations,

Back to Agenda

which help ensure a sustainable business model. Centers also need infrastructure support, such as information technology consultation and capital support, to meet more stringent federal guidelines.

Discussion

Five (5) Orange County health centers are preparing to submit applications by the next federal deadline of October 7, 2014. Clinics will be notified of the application outcome no later than June 30, 2015, and most likely in the Spring. A total of eight (8) grant recipients are proposed. Of those, six (6) are prospective FQHCs, applicants for new access points, or "look-alikes" upgrading to full FQHC status, as follows:

1. VNCOC Southland Health Center: FQHC "look-alike" applying for full designation;
2. North Orange County Regional Health Foundation: "look-alike" applying for full designation;
3. Camino Health Center: Full FQHC applying for a new access point in Lake Forest;
4. Friends of Family Health Center: Full FQHC applying for a new access point in Tustin;
5. Share Our Selves (SOS): Full FQHC applying for a new access point in Santa Ana; and
6. La Amistad / Puente a la Salud: New applicant.

In addition, two other clinics that received FQHC designation in 2013, Nhan Hoa Comprehensive Health Care Clinic and Serve the People, are scheduled for HRSA site visits in late 2014, which they must pass in order to successfully complete the federal designation process.

At this time, staff recommends a grant to up to eight (8) community health centers for an individual allocation not to exceed $30,000 per organization and a total aggregate amount not to exceed $200,000. In approving the staff recommendation, the Board would be making a finding that the proposed expenditures are in the public good and consistent with CalOptima's statutory purpose. The proposed grants are to be used to assist new and prospective FQHCs with consulting costs, such as for rate negotiations and HRSA site visit preparation, but shall not be used for centers' administrative costs or staff time. The proposed grants are expected to lead to enhancements to the safety net and its ability to serve the Orange County Medi-Cal population. In addition, terms of the funding agreements will require a detailed scope of services and prior approval of all contracts and subcontractors utilized for the specialized technical assistance.

CalOptima is committed to working with community health centers to explore additional opportunities to support the safety net during this period of rapid change and increased demand in the healthcare sector, and will return to the Board with recommendations at a future meeting.

Fiscal Impact

The recommended action is consistent with the Board's previously approved IGT 2 allocation of $1.3 million for children's health or support of the safety net. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

FQHCs are vital to Orange County's safety net; the proposed support for new and prospective FQHCs has the potential to enhance access to comprehensive health services for current CalOptima Medi-Cal members.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
Benefits of FQHC Status

/s/ Michael Schrader — *9/26/2014*
Authorized Signature — **Date**

Back to Agenda

Benefits of Federally Qualified Health Center (FQHC) Designation

- Section 330 grant funds to offset the costs of uncompensated care and other key enabling services (Health Center Program grantees receive these grant funds. Look-alikes are eligible to compete for them.)
- Access to medical malpractice coverage under Federal Tort Claims Act (FTCA) (Look-alikes are not eligible for this benefit.)
- Prospective Payment System reimbursement for services to Medicaid patients
- Cost-based reimbursement for services to Medicare patients
- PHS Drug Pricing Discounts for pharmaceutical products under the 340B Program Federal loan guarantees for capital improvements (Look-alikes are not eligible for this benefit.)
- Access to on-site eligibility workers to provide Medicaid and Child Health Insurance Program (CHIP) enrollment services
- Reimbursement by Medicare for "first dollar" of services because deductible is waived if FQHC is providing services
- Access to Vaccines for Children Program for uninsured children
- The National Health Service Corps (NHSC) can help health centers, look-alikes, and free clinics recruit and retain qualified providers who care about communities in need and choose to work where they are needed most.

Source: U.S. Department of Health and Human Services, Health Resources and Services Administration. *Primary Care: The Health Center Program: Program Benefits*. Downloaded from http://bphc.hrsa.gov/about/benefits/.

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
VII. C. Authorize Grant Awards in Support of Prospective Federally Qualified Health Centers (FQHCs) and Funding for Expert Consultation to Manage and Ensure Satisfactory Progress on Clinic Grants

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

Recommended Actions
1. Authorize grant awards in the aggregate amount of up to $200,000 to eligible community health centers for Phase 2 of the Safety Net Program to support prospective Federally Qualified Health Centers (FQHCs) in Orange County, to be funded with Intergovernmental Transfer (IGT) 2 funds; and
2. Approve $25,000 for an expert consultant to monitor grant recipients' performance and assess progress toward FQHC designation, to be funded with Intergovernmental Transfer (IGT) 2 funds.

Background
In October 2014, the CalOptima Board of Directors approved grant awards for specified new and prospective community health centers to address clinics' need for specialized technical assistance to attain, or transition to, Federally Qualified Health Center (FQHC) designation. A total of $200,000 in FY 2012-13 Intergovernmental Transfer (IGT 2) funds was approved for eight (8) centers for Phase I of this initiative.

For Phase 2 of CalOptima's safety net support initiative, staff proposes grant awards for clinics that are interested in applying for FQHC designation, but were not ready for the 2014 cycle and would benefit from funding support to assist with costs related to feasibility analysis; FQHC application development; and/or capital improvements to meet more stringent federal requirements (such as implementation of an electronic health record system or improvements to clinics' waiting rooms).

FQHCs are vital to Orange County's safety net because they provide comprehensive healthcare for low-income residents, including a significant number of current and future CalOptima members. There are currently 10 FQHCs in the county, and collectively they operate 26 sites. To qualify for FQHC designation, clinics must be located in or serve a community that has been designated a Medically Underserved Area or Population by the federal government; be governed by a community board; provide comprehensive primary health care; and provide services to all, with fees adjusted based on ability to pay.

Prospective FQHCs must submit a successful application to HRSA's Bureau of Primary Health Care. There is typically no more than one application cycle per year. During the rigorous federal application process, prospective FQHCs often need specialized technical assistance to prepare the required application, and to conduct thorough financial analysis and planning to avoid adverse fiscal

Back to Agenda

impact during the implementation period. Centers also need infrastructure support, such as information technology consultation and capital support, to meet more stringent federal guidelines.

Discussion

Based on discussions with the Coalition of Orange County Community Health Centers, it is understood that at least three (3) Orange County health centers are interested in pursuing FQHC designation. Hence, for Phase 2 of CalOptima's safety net support initiative, staff recommends grant awards for up to four (4) community health centers for an individual allocation not to exceed $50,000 per organization, and a total aggregate amount not to exceed $200,000.

At this time, Sierra Health Center, Korean Community Services and Laguna Beach Clinic would be eligible for Phase 2 support. The final selection of health centers would be based upon a staff assessment of readiness and a commitment by the health center to undertake the necessary process for the grant award. However, community health centers currently included in Phase 1 would not be eligible for Phase 2 support.

The proposed grants are to be used to assist prospective FQHCs with consulting costs, such as for feasibility assessment and financial analysis, work plan development, and formulation of HRSA application, or for infrastructure or capital improvements that may be needed for readiness to submit a HRSA application. Funds shall not be used for general operating support. A key early deliverable for these grants will be a clinic self-assessment and written plan for moving toward FQHC designation. The proposed grants are expected to lead to enhancements to the safety net and its ability to serve the Orange County Medi-Cal population.

Staff also recommends that an additional $25,000 of IGT 2 funds be set aside for a consultant with expertise in FQHCs to assist CalOptima in monitoring grant recipients' performance toward grant objectives; assessing grantees' progress toward attainment of FQHC designation; and making recommendations for any needed future support to prospective FQHCs. Qualified consultants are currently conducting the work required for Phase I of the Safety Net FQHC support and staff would procure needed services from one or more of the current vendors consistent with CalOptima procurement policy.

In approving the staff recommendations, the Board would be making a finding that the proposed expenditures are in the public interest and consistent with CalOptima's statutory purpose.

Fiscal Impact

The recommended action is consistent with the Board's previously approved IGT 2 allocation of $1.3 million for children's health or support of the safety net. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations or expenditures.

Back to Agenda

Rationale for Recommendation
FQHCs are vital to Orange County's safety net; the proposed support for prospective FQHCs has the potential to enhance access to comprehensive health services for current CalOptima Medi-Cal members.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature Date

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
VII. F. Authorize Expenditure of Intergovernmental Transfer (IGT) Funds for Post Acute Inpatient Hospital Recuperative Care for Members Enrolled in CalOptima Medi-Cal; Authorize Amendments to CalOptima Medi-Cal Hospital Contracts as Required for Implementation

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

Recommended Actions
1. Authorize expenditures of up to $500,000 in Fiscal Year (FY) 2011- 12 Intergovernmental Transfer Funds (IGT 2) for the provision of Recuperative Care to homeless members enrolled in CalOptima Medi-Cal after discharge from an acute care hospital facility, subject to required regulator approval(s), if any; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend Medi-Cal Hospital contracts covering Shared Risk Group, Physician Hospital Consortia, CalOptima Direct and CalOptima Care Network members, to include Recuperative Care services.

Revised 12/4/14

Background
At the November 6, 2014 meeting of the CalOptima Board of Directors, staff presented an overview of a proposed program to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but who are not ill enough to be hospitalized. This program is to be funded with IGT 2 revenue.

Recuperative care currently exists in Orange County and received partial funding from the MSI program. With Medi-Cal expansion, many of the MSI members were transitioned to CalOptima and no longer have access to these services.

Proposed services to be included in the Recuperative Care Program include: housing in a motel; nurse-provided medical oversight; case management/social services; food and supplies; warm handoff to safe housing or shelters upon discharge; and communication and follow-up with referring hospitals.

Staff now requests the Board authorize the expenditure of IGT 2 funding for recuperative care services for Medi-Cal members and amending hospital contracts to facilitate referrals to and payment of this program.

Discussion
Staff requests authority by the Board of Directors to allocate up to $500,000 of IGT 2 funds to a Recuperative Care services funding pool. Funding is a continuation of IGT 1 initiatives intended to reduce hospital readmissions and reduce inappropriate emergency room use by CalOptima members experiencing homelessness.

Back to Agenda

CalOptima staff proposes to amend existing hospital contracts to allow reimbursement for hospital discharges for recuperative care services for Medi-Cal homeless members that qualify for such service. Hospitals will be required to contract and refer homeless members who can benefit from this service to a Recuperative Care provider of the hospital's choice. The hospital will facilitate the transfer of the members to the appropriate Recuperative Care provider. The referring hospital will pay the Recuperative Care provider for services rendered based on need to facilitate a safe hospital discharge as determined by the hospital and the provider.

Contracted hospitals will be required to invoice CalOptima for services rendered, CalOptima will, in turn, reimburse contracted hospitals from the Recuperative Care fund pool for services rendered. Reimbursement by CalOptima to hospitals for Recuperative Care services will stop when the $500,000 recuperative services pool has been depleted. Staff will provide oversight of the program and will implement a process to track the utilization of funds.

Fiscal Impact

A total of up to $500,000 in IGT 2 funds are proposed for this initiative. Based on an estimate of $150 per day for recuperative for up to a 10 day stay per member, this funding is expected to fund approximately 330 cases. The proposed funding level is a cap. If exhausted prior to the end of FY 2014-15, no additional funding for recuperative care will be available without further Board approval. Should the proposed IGT 2 funds not be exhausted on services provided during FY 2014-15, the remaining funds will be carried over to the following fiscal year.

The recommended actions are consistent with the Board's previously identified funding priorities for use of IGT 2 funds. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations

Rationale for Recommendation

With Medi-Cal expansion, CalOptima is serving more members who are homeless. These members experience twice as many readmissions and twice as many inpatient days when discharged to the street rather than to respite or recuperative care. In addition, homeless members remain in acute care hospitals longer rather than being discharged due to a lack of residential beds.

Evaluation by the U.S. Department of Health and Human Services Agency for Healthcare Research and Quality of an existing program administered by the Illumination Foundation, showed: decreased emergency room use; reduced inpatient stays; and stable medical condition for homeless members post discharge. These results are consistent with the IGT 2, as a continuation of IGT 1 funding initiatives, to reduce readmissions to hospitals.

Concurrence

Gary Crockett, Chief Counsel

Back to Agenda

Attachments
None

/s/ Michael Schrader *11/26/2014*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

VII. G. Authorize Reallocation of OneCare Personal Care Coordinator (PCC) Funding to Cover the Cost of the Program

Contact

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

Recommended Action

Authorize the reallocation of OneCare PCC funds from Year 2 to Year 1 in order to compensate delegated OneCare Physician Medical Groups (PMGs) for the month of March 2015.

Background

At its March 6, 2014, meeting, the CalOptima Board of Directors (Board) approved the final expenditure plan for $12.4 million in Fiscal Year (FY) 2010-11 Intergovernmental Transfer (IGT) funds. The expenditure plan included an initiative, Complex Case Management – Part 1, to provide case management for high-risk members across various care setting. As part of this initiative CalOptima and PMGs would hire PCCs for up to two (2) years. Within the PMG, PCCs would serve as a single point of contact for OneCare members and assist members in navigating the healthcare delivery system, facilitating access to care and services.

On April 3, 2014, the Board authorized the CEO, with the assistance of legal counsel, to execute OneCare PMG contract amendments to provide funding to PMGs to hire and retain PCCs. The Board authorized the expenditure of FY 2010-11 IGT funds over a two-year period, with a total of up to $1.85 million expended in Year 1, and up to $1.95 million expended in Year 2 as authorized by the Board in March 2014.

Discussion

The Board authorized $1.85 million to fund PCCs in Year 1. However, due to a higher than expected retention of membership in OneCare, the funding allocation was depleted when the February 2015 PCC capitation payment was made to contracted OneCare PMGs.

Management requests that the Board approve a budget reallocation of approximately $200,000 from the $1.95 million budget allocation in Year 2 to make the March 2015 PCC capitation payment. Staff estimates that the remaining funding for the PCC program in Year 2, which was authorized through March 31, 2016, will be sufficient since OneCare members will transition to OneCare Connect in December 2015.

Fiscal Impact

The recommended action will reallocate $200,000 in FY 2010-11 IGT funds from Year 2 to Year 1, and is consistent with the expenditure plan previously approved by the Board on March 6, 2014. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Back to Agenda

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

3/27/2015 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

VII. H. Approve the Allocation of Intergovernmental Transfer (IGT) Funds for Personal Care Coordinators (PCC) for the OneCare Connect (OCC) Program Including for OCC Members in the CalOptima Community Network

Contact

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

Recommended Actions

1. Approve $3.6 million in Fiscal Year (FY) 2010-11 IGT funds for Complex Case Management for PCCs in the OneCare Connect Program, including for OCC members in the CalOptima Community Network:
    a. Allocate $1.15 million from 'PCC supplemental';
    b. Allocate $500,000 from 'General Contingency'; and
    c. Reallocate $1.95 million from "Strategies to Reduce Readmissions."

2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to execute OneCare Connect Health Network contracts that include funding to hire, train and retain PCCs for the period of July 1, 2015, through June 30, 2016.

3. Authorize CalOptima staff to hire, train and retain PCCs to support OneCare Connect members in the CalOptima Community Network during the July 1, 2015 through June 30, 2016 period.

Background

In actions taken at the January 3, 2013, February 7, 2013, and December 5, 2013, meetings, the CalOptima Board of Directors (Board) authorized the CEO to develop a provider delivery system for implementation of the Duals Demonstration, also now known in the state as the Cal MediConnect Program and branded by CalOptima as OneCare Connect.

At its March 6, 2014, meeting, the Board authorized the expenditure of IGT funds to support the hiring of PCCs by both CalOptima and Physician Medical Groups (PMGs) for up to two (2) years to provide services to OneCare members. Within the PMG, PCCs would serve as a single point of contact for OneCare members and help members navigate the healthcare delivery system, facilitating access to care and services.

Subsequently, at the April 3, 2014, meeting, the Board authorized the CEO, with the assistance of legal counsel, to execute amendments to OneCare PMG contracts to include funding for hiring, training, and retention of PCCs. The Board approved funding for the PCCs at a rate of $14.53 per member per month (PMPM). PCC payments rates are further adjusted according to performance metrics established by CalOptima and described in a CalOptima PCC Policy and Procedure.

Back to Agenda

Discussion

The Board has authorized the use of up to $3.8 million in FY 2010-11 IGT funds over a two-year period to hire PCCs to support the execution of the OneCare Model of Care by delegated PMGs. The creation of the position proved to be an integral part of the remediation of the OneCare audit findings. CMS found CalOptima's PCC Program to be a best practice among Medicare Advantage plans. The PCC program launch has exceeded expectations, and is an integral feature of the approved Model of Care for OneCare Connect, and is no longer an optional component.

Management recommends the Board to approve this action to effectuate the implementation of the successful PCC program for the Cal MediConnect Program, which CalOptima has branded as OneCare Connect. CalOptima would require OneCare Connect contracted Health Networks to hire and retain PCCs. The OneCare Connect contracts will stipulate the conditions for the funding of the PCC positions and will provide the parameters and expectations of the PCC program. Management is requesting $3.6 million in total FY 2010-11 IGT funds for PCCs for OneCare Connect Program from the following:

- Allocate $1.15 million from 'PCC supplemental';
- Allocate $500,000 from 'General Contingency'; and
- Reallocate $1.95 million from "Strategies to Reduce Readmissions."

Management requests funding the program with IGT funds for FY 2015-16, with additional funding subject to future Board approval and IGT fund availability. Funds will be used for the creation of the PCC position by the delegated health networks and the CalOptima Community Network in order to execute the OneCare Model of Care for OneCare Connect and provide ongoing funding of the PCC positions for the next year of the OneCare Connect program. After this time, CalOptima will evaluate if these positions will be self-funding following the first year based upon improved clinical outcomes and lower utilization costs. In addition, the PCCs will support preventive and chronic disease services that results in improvement in HEDIS scores and an anticipated improvement in OneCare Connect's quality rating. Finally, PCCs will improve data capture that support appropriate Hierarchical Condition Category (HCC) scores for OneCare Connect.

The PCC positions hired by CalOptima to serve OneCare Connect members in the CalOptima Community Network will be funded in the same manner as CalOptima's delegated Health Networks.

Fiscal Impact

The recommended action will result in the expenditure of IGT funds in FY 2015-16 of $3.6 million in FY 2010-11 IGT funds. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

CalOptima staff recommends this action in support of the expenditure of IGT funds as approved at the March 2014 Board Meeting. In addition, the PCCs are an integral component of the enhanced Model of Care that has been a successful program in OneCare and will an important component of the OneCare Connect Program that will expand CalOptima's ability to apply best practices in care coordination for CalOptima's members eligible for Medi-Cal and Medicare.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *3/27/2015*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. B. Authorize Agreements Necessary to Secure Additional Medi-Cal Funds Through an Intergovernmental Transfer (IGT) for Fiscal Year (FY) 2013-14 (IGT 4); Consider Approval of a Modification of Eligible Use for IGT 2 Funds Allocated to Support Federally Qualified Health Centers (FQHCs)

Contact

Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions

1. Authorize and direct the Board Chair to execute an amendment to the primary agreements among the California Department of Health Care Services (DHCS), the Regents of the University of California on behalf of the University of California, Irvine, and CalOptima for the purpose of securing an IGT for the upcoming Rate Year 2013-14 IGT (IGT 4); and
2. Approve modification in eligible uses for IGT 2 funds designated to support Federally Qualified Health Centers in Orange County.

Background

CalOptima began participating in the rate range IGT program for its rate year that began July 1, 2010. This IGT arrangement involves an approved government entity ("funding entity") providing non-federal funds to serve as a match to allow the State to draw down the difference between the highest and lowest actuarially approved Medi-Cal reimbursement rate from the Center for Medicare and Medicaid Services (CMS). Management's understanding is that rate range IGTs are currently in place in all managed care counties in California. Eligible funding entities include but are not limited to county governments, district hospitals, and UC hospitals. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives, which enhance care to Medi-Cal members.

CalOptima has partnered with the Regents of the University of California on behalf of UCI to secure three IGTs to date, and staff has started the process for a fourth proposed IGT for Rate Year 2013-14. This IGT arrangement involves UCI providing the non-federal funds for the rate increase to CalOptima and the administrative fee charged by DHCS. A high-level progress update for each of these IGTs is attached.

The CalOptima Board approves all proposed uses and authorizes the plan to participate in each available IGT. Per the State's agreement with the Centers for Medicare and Medi-Cal (CMS), funds must finance improvements in services for Medi-Cal members. The approved uses are intended to generate a positive impact on members, CalOptima and its delegated networks, while also providing a sustainable return on investment for the future.

Presently, staff recommends one action related to the proposed IGT 4 transaction and one modification to a program funded by IGT 2 revenue. Approval of these recommendations is requested in order to implement programmatic priorities.

Back to Agenda

IGT	Rate Year	IGT Funds Received by CalOptima ($)
IGT 1	2010-2011	12.4M
IGT 2	2011-2012	8.7M
IGT 3	2012-2013	4.8M
IGT 4	2013-2014	5.5M (projected)

Discussion

IGT 4 Application

On April 24, 2015, CalOptima and UCI submitted a proposal to DHCS for a fourth IGT. If approved, the proposed IGT will result in revenue of approximately $5.5 million each to UCI and CalOptima. Our understanding is that DHCS anticipates disbursement of an IGT payment to CalOptima in or about September 2015. At this time, staff requests authorization to amend the primary agreement between the DHCS and CalOptima for purposes of accepting an increased rate that includes IGT 4 funding. Additionally, consistent with the proposal to DHCS submitted in April 2015, staff recommends two general categories of use for IGT 4 revenue as follows:

1. Community health investments to improve adult mental health, children's mental health, reduce childhood obesity, strengthen the safety net, and improve children's health, consistent with the Board's March 2015 approval of these five priority areas;
2. Planning and implementing innovative programs required under the Health Homes and the 1115 Waiver initiatives. This would be one-time funding allocation for planning and to implement pilot programs as required.

Staff will develop a budget allocation for the proposed categories to be presented at a future Board meeting after the transaction has received federal approval and funds have been received from the State. Staff will continue to gather information on whether there may be additional acceptable funding entities in Orange County with the capacity to partner to participate in future rate range transfer processes. The intent is to allow CalOptima to draw down maximum available rate range eligible funding to support Medi-Cal enrollees. For example, in the most recently proposed IGT 4, the State indicated that funding entities in Orange County could provide up to $28M as the non-federal source; UCI Health was able to provide $13.7M tied to uncompensated care rendered by UCI Physicians to CalOptima members. After factoring in the available federal match and required state fees, it is possible that CalOptima could have accessed an additional $11M in net revenue to support Medi-Cal members for this rate year.

Potential IGT 4 Funding Needs/Priorities

Health Homes

The Medicaid Health Home State Plan Option, under the Affordable Care Act (Section 2703), enables states to design health homes to provide comprehensive care coordination for Medicaid beneficiaries

with chronic conditions, including homelessness and/or mental illness. California's Health Homes Program is intended to serve eligible Medi-Cal beneficiaries with multiple chronic conditions who are frequent utilizers and may benefit from enhanced care management and coordination. On April 20th, 2015, the DHCS indicated its intent to require participation from all counties effective 2016, with the benefit implemented through the managed care organizations who will then contract with community organizations. Staff is monitoring the development of final program regulations and will provide details on specific projects in the future as additional information becomes available.

1115 Waiver
California's existing Bridge to Reform 1115 Waiver expires on October 31, 2015. DHCS will seek approval of the new Waiver by November 2015 from CMS. At this time, the State's Waiver application proposes key delivery system transformations, including but not limited to changes for counties with public hospitals, regional incentives among managed care organizations, providers and counties behavioral health systems, workforce development initiatives, access to housing and supportive services, and whole person care pilots to improve and integrate physical and behavioral health. Staff will continue to monitor the development of final program regulations and will keep the Board apprised as new information becomes available.

As additional details become available, staff will return to the Board as appropriate with recommendations on the possible use of one-time IGT funded to launch potential early implementation projects to prepare for these critical programmatic changes.

Approve modification of IGT 2 funds designated to support Federally Qualified Health Centers (FQHC)
The Board approved $200,000 in funding in the *Strengthening the Safety Net* priority area at its October 2014 meeting. Specifically, the funding was designated to support engagements with qualified consultants/vendors to partner with up to eight named Orange County community clinics to support their conversion to FQHC status from FQHC "look-alike" status. To date, staff have received formal submissions from seven eligible clinics, with an additional application in progress. The ultimate goal was to contribute to a robust and sustainable system of care for vulnerable CalOptima members who access care at community clinics. Receipt of FQHC status will allow clinics to receive critical and stabilizing federal funds. A second cycle of funding (FQHC Phase 2) was designated for clinics in earlier stages of readiness to apply. The status of IGT-funded Safety Net projects is listed in the attachment.

At this time, staff recommends broadening eligible expenses to include permitting funding for one-time costs associated with merging with an existing FHQC or consulting costs associated with adding a critical new service that will facilitate greater access to care and a more robust reimbursement rate.

No funds will be used to support staff costs or recurring expenses. Currently, funds are designated for consulting services only. Specifically, staff has learned that one area clinic has elected to merge with an existing FQHC to achieve its sustainability goals. Effective May 2015, L'Amistad Health Center will be part of St. Jude Neighborhood Centers, which was not named as one of the eight clinics in the original Board approval. What is being proposed is a modification to enable St. Jude's to receive

support in lieu of L'Amistad. This funding will address the project management expense associated with bringing L'Amistad on to St. Jude Neighborhood Center existing electronic health record at a cost of $12,000, an expense within the maximum amount allowable for each clinic under the grant program. This modification is recommended as the expense is consistent with the Board's intent of accelerating sustainability and access. Likewise, a modification is recommended to enable clinics to allocate eligible consulting hours to prepare for a scope of service request in conjunction with preparation for new access point submission. This proposed change will provide an avenue for greater access to critical services such as dental or behavioral health in underserved communities.

Fiscal Impact

Fiscal Year (FY) 2013-14 IGT (IGT 4)
The recommended action to execute the FY 2013-14 IGT will provide approximately $5.5 million in one-time IGT revenue. Management will present an expenditure plan for Board approval at an upcoming meeting.

FY 2011-12 IGT (IGT 2)
The recommended action to permit St. Jude's to act as an eligible recipient under the Phase 1 FQHC program is budget neutral, as St. Jude's Neighborhood Clinic will replace L'Amistad as one of the eight eligible grantees. Expenditure of IGT funds is for restricted, one-time purposes, and does not commit CalOptima to future budget allocations.

Rationale for Recommendations

Proposed funding categories for IGT 4 would allow for continued support of key organizational priorities and programs. Modification to IGT 2 is proposed to ensure broad participation from area community clinics in the FQHC grant cycle.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Presentation: IGT Progress Report

_____ _____

Authorized Signature **Date**

Back to Agenda

Intergovernmental Transfers (IGT): Progress

Board of Directors Meeting

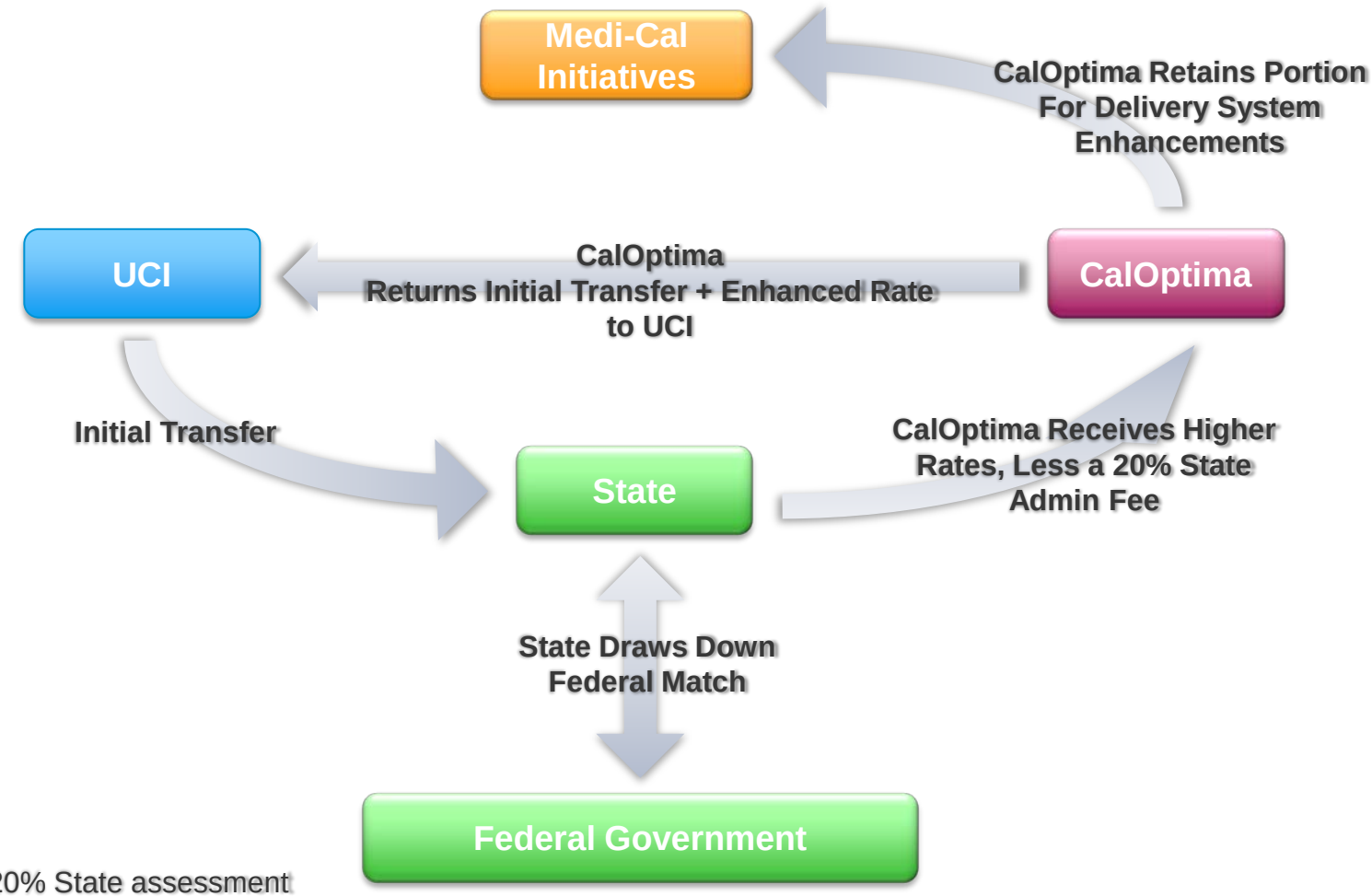
May 7, 2015

Lindsey Angelats

Director, Strategic Development

Back to Agenda

Overview of CalOptima/UC Irvine IGT



* Includes 20% State assessment fee

Back to Agenda

IGTs Purpose and Restrictions

- Revenue generated through IGTs must be used to finance enhancements in services for Medi-Cal members
  - Support enhanced Medi-Cal program
  - Enable CalOptima to pay providers designated by the funding entity (UCI is currently the only funding entity used)

- Funds are potentially non-recurring, since there is no guarantee of future IGT agreements; funds are suited for one-time investments or as seed capital for new initiatives for members

- CalOptima is only plan allowed to retain funds. This process is consistent with state and federal rules and was approved by DHCS and CMS.

Back to Agenda

IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount
IGT 1	12-13	$12.4 M
IGT 2	13-14	$8.7 M
IGT 3	14-15	$4.8 M
IGT 4	15-16*	(Est. $5.5 M)*
Total Funds Received		$25.9 M

* Transaction has received state and federal approval but funds have not been received yet.

Back to Agenda

IGT Presentation Timeline

	May	June	July	Aug	Sept	Oct
Board		IGT 3 Budgeting; IGT 1-2 Progress Report				IGT 3 Budgeting; IGT 1-3 Progress Report
QAC	IGT 3 Budgeting				IGT 4 Budgeting	
FAC	IGT 3 Budgeting				IGT 4 Budgeting	

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 1, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. D. Consider Updated Revenue Expenditure Plans for Intergovernmental Transfer (IGT) 2 and IGT 3 Projects

Contact
Lindsey Angelats, Director of Strategic Development, (714) 246-8400

Recommended Actions
1. Approve updated expenditure plan for IGT 2 projects, including investments in personal care coordinators (PCC), grants to Federally Qualified Health Centers (FQHC), and autism screenings for children, and authorize expenditure of $3,875,000 in IGT 2 funds to support this purpose; and
2. Approve expenditure plan for IGT 3 projects, including investments in recuperative care and provider incentive programs, and authorize expenditure of $4,880,000 in IGT 3 funds to support this purpose.

Background / Discussion
To date, CalOptima has partnered with the University of California, Irvine (UCI) Medical Center on a total of four IGTs. These IGTs generate funds for special projects that benefit CalOptima members. A progress report detailing the use of funds is attached. Three IGTs have been successfully completed, securing $26.0 million in project funds, and a fourth IGT is pending, which is estimated to secure an additional $5.5 million in project funds. Collectively, the four IGTs represent $31.5 million in available funding. A breakdown of the total amount of IGT funds is listed below:

All IGTs	Total Amount
IGT 1	$12.4 million
IGT 2	$8.7 million
IGT 3	$4.9 million
IGT 4	*$5.5 million**
Total	$31.5 million

*The IGT 4 funds figure is an estimate. These funds have not yet been received by CalOptima.

As part of this proposed action, staff is requesting Board approval of the updated expenditure plan for IGT 2, as well as the expenditure plan for IGT 3. The allocation of these funds will be in accordance with the Board's previously approved funding categories for both IGT 2 and IGT 3, and will support staff-identified projects, as specified.

IGT 2 Updated Expenditure Plan
At its September 4, 2014, meeting, the Board approved the final expenditure plan for IGT 2. Since that time, staff has been able to identify further detailed projects to implement the Board approved allocations. Staff recommends the use of $3,875,000 in IGT 2 funds to support the following projects:

Back to Agenda

- $2,400,000 previously approved for the 'Expansion of IGT 1 Initiatives' will be used to sustain the use of PCCs in the OneCare Connect program in FY 2016-17. Current funding for PCCs expires at the end of the 2015-16fiscal year. This proposed action will extend funding for PCCs for one additional year and allow CalOptima and the health networks to better evaluate the long-term sustainability of PCCs for members.

- $100,000 previously approved for the 'Expansion of IGT 1 Initiatives' will provide IGT project administration and oversight through a full-time staff person and/or consultant for FY 2015-16.

- $875,000 previously approved for 'Children's Health/Safety Net Services' will be used for grant funding for the expansion of behavioral health and dental services at FQHCs and FQHC look-alikes. Grant funding will be awarded to up to five eligible organizations for a two-year period in order to launch the new services.

- $500,000 previously approved for 'Wraparound Services' will be used to support a provider incentive program for autism screenings for children. It is estimated that up to 3,600 screenings could be covered with this funding, in addition to costs of training for providers to deliver the screenings.

- Staff also request a modification to the Board's December 4, 2014 action, which allocated grant funding in support of community health centers. Specifically, staff requests an increase in the maximum threshold for clinic grants from $50,000 up to $100,000. No new funds will be utilized for this change, but this change will allow two existing grantees (Korean Community Services and Livingstone) to double their grant award amounts from $50,000 to $100,000. Staff recommends this modification to address the fact that while the previously approved IGT 2 expenditure plan allowed up to four clinics to receive grants, only the two aforementioned organizations formally submitted grant proposals. If the proposed increase is approved, the additional funds will be used for consulting services to finalize the clinics' FQHC Look-Alike applications as well as upgrades to their IT systems to meet FQHC requirements.

IGT 3 Expenditure Plan

For the $4,865,000 funds remaining under IGT 3, staff proposes to support ongoing projects as follows:

- $4,200,000 to support a pay-for-performance program for physicians serving vulnerable Medi-Cal members, including seniors and person with disabilities (SPD). The program will offer incentives for primary care providers to participate in interdisciplinary care teams and complete an individualized care plan for SPD members, in accordance with CalOptima's Model of Care.

  $500,000 to continue funding and broaden recuperative care for homeless Medi-Cal members. This proposed action would provide an additional investment in recuperative care in addition to the Board's previously approved funding. In addition, going forward, hospitals would be eligible to receive reimbursement for recuperative care for homeless patients following an emergency department visitor observation stay; currently, reimbursement is limited to services following an inpatient stay only. As proposed, the maximum duration for recuperative care will increase from 10 days up to 15 days to more effectively link patients to needed services.

Back to Agenda

These recuperative care services would be made available subject to required regulator approval(s), if any.

- $165,000 to provide IGT project administration and oversight through a full-time Manager, Strategic Development for FY 2016-17. The manager will project manage IGT-funded projects, complete regular progress reports, and submit required documents to DHCS.

Staff is not proposing use of IGT 4 funds at this time, but will return to the Board at a later date for approval of an expenditure plan after funds have been received from the state.

Finally, the requests outlined above have been thoroughly vetted by the CalOptima Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) during their respective meetings on September 10, 2015.

Fiscal Impact
The recommended action implement an updated expenditure plan for the FY 2011-12 IGT is budget neutral. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima members, and does not commit CalOptima to future expenditures.

The recommended action to approve the expenditure plan of $4,865,000 from the FY 2012-13 IGT is consistent with the general use categories previously approved by the Board on August 7, 2014.

Rationale for Recommendation
Staff recommends approval of the proposed expenditure plans for IGT 2 and IGT 3 in order to continue critical funding support of projects that benefit CalOptima Medi-Cal members by addressing unmet needs. Approval will help ensure the success of ongoing and future IGT projects.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. IGT Expenditure Plan (PowerPoint presentation)
2. IGT Progress Report

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

9/25/2015 — **Date**

Back to Agenda

IGT Progress Report and Proposal

Board of Directors Meeting
October 1, 2015

Lindsey Angelats
Dir, Strategic Development

Back to Agenda

IGTs Completed and In Progress

All IGTs	Fiscal Year Received	CalOptima Amount	% Amount Programmed
IGT 1	12-13	$12.4 M	100%
IGT 2	13-14	$8.7 M	55%
IGT 3	14-15	$4.8 M	0%
IGT 4	15-16*	(Est. $5.5 M)*	NA
Total Funds Received or Anticipated		$31.4 M	

* Transaction has received state and federal approval but funds have not yet been received

Back to Agenda

Considerations for IGT Outstanding Funds

- **New or pending State and Federal initiatives increasingly focused on integration and coordination**
  - 1115 Waiver and Whole Person Care
  - Behavioral Health Integration
  - Health Homes
  - Capitation Pilot for Federally Qualified Health Centers

- **Value in supporting providers serving more vulnerable members with greater needs:** *(examples)*
  - Investment in ICTs for providers serving Seniors and Persons with Disabilities
  - Continuation/expansion of Personal Care Coordinators

Back to Agenda

IGT Investment Parameters and Requirements

- IGTs must be used to finance enhancements in services for Medi-Cal beneficiaries

- Projects must be one-time investments or as seed capital for new services or initiative, since there is no guarantee of future IGT agreements

Back to Agenda

Recommended Use of IGT 2 Funds ($3.875M Outstanding)

Category	Board Approval Date of Category	Proposed Project	Proposed Investment	Regulatory Driver	Anticipated Impact
Continuation of IGT 1 Initiatives	03/06/14	Sustain Personal Care Coordinators (PCCs) for the One Care Connect program in FY16-17	$2.4M	**Coordinated Care Initiative**	Providers and members receive timely support
Children's Health/Safety Net Services	10/02/14; 12/04/14	Supporting behavioral health and dental service expansion at FQHC and FQHC look-a-likes via one-time competitive grants	$875K	**Alternative Payment Pilot**	FQHCs launch critical services that can be sustained through higher PPS rates
Wraparound Services	8/7/14	Provider incentive for Autism Screening and provider training to promote access to care	$500K	**Autism Benefits in Managed Care**	Earlier identification and treatment for the 1 in 68 children with autism
Continuation of IGT 1 Initiatives	03/06/14	Full-time IGT project administrator/ benefits (pro-rated for 11/1/15 start; represents 23% admin costs)	$100K	**Intergovernmental Transfers**	Faster launch of IGT funded projects to support members and physicians

Back to Agenda

CalOptima A Public Agency Better. Together.

Recommended Use of IGT 3 Funds ($4.88M Outstanding)

Regulatory Driver	CalOptima Priority Area	Proposed Project	Proposed Investment	Anticipated Impact
1115 Waiver	**Adult Mental Health**	Continue recuperative care to reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	Support for improved and integrated care for vulnerable members
Integrated Care	**Support Primary Care Access**	Support increased funding (pay for performance) for physicians serving vulnerable members, including Seniors and Persons with Disabilities (ICPs + Integrated Health Assessments for new SPDs)	$4.2M	Support for improved and integrated care for vulnerable members
Intergovernmental Transfers		Full-time IGT project administrator (represents 2% admin costs)	$165K	Faster launch of IGT funded projects to support members and physicians

Back to Agenda

Recommended Next Steps

- **Timing**
  - November: Development of project plans and launch
- **Accountability**
  - Staff provide quarterly Board reports sharing progress and outcomes for current and new projects; Jan 2016
- **Engagement**
  - Review IGT 4 with PAC/MAC in October; Staff proposes options focus on improved care for those with serious mental illness and support for providers to screen adolescents for depression
- **Maximization/Leverage**
  - ➢ In Fall 2015, staff will pursue additional Funding Entity partnerships with eligible organizations (County, Children and Families Commission, others) to draw down additional funds in 2016, based on recommendation from consultant Mr. Stan Rosenstein

Back to Agenda

Board of Directors Meeting
October 1, 2015

Intergovernmental Transfer (IGT) Funds Progress Report

Discussion

To date, CalOptima has participated in four IGT transactions with the University of California, Irvine; at this time, IGT 1 and IGT 2 funds are supporting Board-designated projects to improve care for members. Staff presented the following information on the status IGT-funded projects to the Provider Advisory Committee and Member Advisory Committee on September 10, 2015.

IGT 1 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
New Case Management System	To enhance management and coordination of care for vulnerable members	$2M	03/06/14	2 years	75%
Personal Care Coordinators for OneCare members	To help OneCare members navigate healthcare services and to facilitate timely access to care	$3.8M	04/03/14	3 years	50%
OneCare Connect Personal Care Coordinators	To help OneCare Connect members navigate health services and to facilitate timely access to care	$3.6M	04/02/15	1 year	25%
Strategies to Reduce Readmission	To reduce 30-day all cause (non maternity related) avoidable hospital readmissions	$1.05 M	03/06/14	2 years	25%
Complex Case Management Consulting	Staffing and data support for case management system	$350K	03/06/14	2 years	50%
Telemedicine	Expand access to specialty care	$1.1M	03/07/13	2 years	25%
Program for High Risk Children	CalOptima pediatric obesity and pediatric asthma planning and evaluation	$500K	03/06/14	3 years	25%

Back to Agenda

IGT 2 Active Projects					
Description	Objective	Budget	Board Action	Duration	% Complete
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
Continuation of the CalOptima Regional Extension Center	Sustain initiative to assist in the implementation of EHRs for individual and small group local providers	$1M	04/03/14	3 years	25%
Enhancing the Safety Net	To assist health centers to apply for and prepare for Federally Qualified Health Center (FQHC) designation or expansion	$200K	10/02/14	2 years	50%
Enhancing the Safety Net	To support an FQHC readiness analysis for community health centers to enhance the Orange County safety net and its ability to serve Medi-Cal beneficiaries	$225K	12/04/14	2 years	25%
Recuperative Care	To help reduce hospital readmissions by providing safe housing, temporary shelter, food and supplies to homeless individuals	$500K	12/04/14	1 year	25%
Facets System Upgrade & Reconfiguration	Upgrade and reconfigure software system used to manage key aspects of health plan operations, such as claims processing,	$1.25M	03/06/14	2 years	75%
School-Based Vision	Increase access to school-based vision, which can be difficult for Medi-Cal beneficiaries to access	$500K	09/04/14	2 years	25%
School-Based Dental	Increase access to school-based dental, which can be difficult for Medi-Cal beneficiaries to access	$400K	09/04/14	2 years	25%
Provider Network Management Solution	Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care	$500K	03/06/14	1 year	25%
Security Audit Remediation	To increase protection of CalOptima member data	$200K	03/06/14	1 year	85%

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contact

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

Recommended Actions

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

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

Background

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

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

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

Back to Agenda

Discussion

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

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

Attachments

None

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

02/26/2016 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

16. Consider Adoption of Resolution Approving CalOptima Updated 2017 Compliance Plan and Authorizing the Chief Executive Officer (CEO) to Approve New, Revised, and Retired Office of Compliance Policies and Procedures

Contact

Silver Ho, Compliance Officer, (714) 246-8400

Recommended Actions

1. Adopt Resolution No.16-1201-01, Approving CalOptima Updated 2017 Compliance Plan; and
2. Authorize the CEO and/or his designee to amend Office of Compliance Policies and Procedures and/or create new ones, as necessary to implement the updated Compliance Plan.

Background

CalOptima is committed to conducting its operations in compliance with ethical standards and all applicable laws, regulations, and rules, including those pertaining to its Federal and State health care program operations. As part of that commitment, on December 4, 2014, the CalOptima Board of Directors reviewed and approved the updated Compliance Plan, which incorporated the Code of Conduct and the Fraud, Waste, and Abuse (FWA) Plan into the Compliance Plan. The Compliance Plan comprehensively addresses the fundamental elements necessary for an effective compliance program including those elements identified by the Office of Inspector General (OIG) of the Department of Health and Human Services (DHHS) and the Centers for Medicare & Medicaid Services (CMS).

Discussion

CalOptima regularly reviews the Compliance Plan to ensure it is up-to-date and aligned with Federal and State health care program requirements and laws and as well as CalOptima operations. CalOptima's Executive Director of Compliance (Compliance Officer) has reviewed and updated the Compliance Plan and compliance policies and procedures to ensure consistency with applicable Federal and State health care program laws, regulations, and/or guidance.

Compliance Program Elements

Federal laws and regulations (including the federal U.S. Sentencing Guidelines, CMS Medicare Advantage regulations) and the OIG compliance guidance require that compliance programs be reasonably designed, implemented, and enforced, in order to ensure the Compliance Program is effective in preventing and detecting violations of standards or law. CalOptima's Compliance Program addresses each of the seven (7) fundamental elements of an effective compliance program, in addition to FWA detection, prevention, and remediation.

Back to Agenda

Written Standards
As part of the Compliance Program, CalOptima develops, maintains, and distributes to its Board Members, Employees, and First Tier, Downstream or Related Entities (FDRs) written standards in the form of the Compliance Plan, a Code of Conduct, and written Policies and Procedures, as further detailed in the Compliance Plan. The Compliance Plan incorporates all of the elements of an effective compliance program as recommended by OIG and required by CMS regulations. The Compliance Plan incorporates a comprehensive FWA Detection and Prevention section, which establishes guidelines and procedures designed to detect, prevent, and remediate FWA in CalOptima Programs.

Oversight
The CalOptima Board of Directors (the "Board"), the governing body of CalOptima, is responsible for ensuring and overseeing the implementation, effectiveness, and continued operation of the Compliance Program. The Board delegates to the CEO, who then delegates to the Compliance Officer, a CalOptima Employee, the administration of the Compliance Program's development, maintenance, implementation, monitoring, and enforcement activities. The Compliance Officer, in conjunction with the Compliance Committee, are both accountable for the oversight and reporting roles and responsibilities as set forth in the Compliance Plan. The Audit & Oversight Committee (AOC), a subcommittee of the Compliance Committee, chaired by the Director of Audit & Oversight, is responsible for overseeing the internal business and delegated activities.

Training and Education
Utilizing web-based training courses, as well as distribution of guidelines and publications, the Compliance Program incorporates training and educational courses governing CalOptima's compliance standards and requirements, as well as specialized educational courses assigned to individuals based on their respective roles, or positions, within, or with, CalOptima's departments and its programs. CalOptima Board Members, Employees, and FDRs receive copies of CalOptima's Code of Conduct and are required to complete comprehensive training covering compliance obligations and applicable laws, FWA (where applicable), and Health Insurance Portability and Accountability Act (HIPAA) privacy and security requirements, upon appointment, hire, or commencement of a contract, as applicable, and annually thereafter.

Lines of Communication and Reporting
CalOptima utilizes various methods to communicate general information, regulatory updates, and process changes from the Compliance Officer to CalOptima Board Members, Employees, FDRs, and members, including, but not limited to, presentations at meetings and updates in print and/or electronic form, including information on how to identify, report, and prevent compliance issues and FWA. CalOptima Board Members, Employees, FDRs, and/or Members receive information and reminders to report compliance concerns, questionable conduct or practices, and suspected, or actual, non-compliance issues, or FWA incidents, through one (1) of CalOptima's multiple reporting mechanisms. These reporting options, which are outlined in greater detail below, provide for anonymity and confidentiality (to the extent permitted by applicable law and circumstances). CalOptima maintains and supports a no retaliation policy governing good-faith reports of suspected, or actual, non-compliance and/or FWA.

Back to Agenda

Enforcement and Disciplinary Standards
Board Members, Employees, and FDRs are subject to appropriate disciplinary and/or corrective actions for non-compliance with CalOptima's standards, requirements, or applicable laws as specified in the Compliance Program documents and related Policies and Procedures, including, but not limited to, CalOptima's Progressive Discipline Policy, Corrective Action Plans and/or sanctions. Consistent, timely, and effective enforcement of CalOptima's standards are implemented when non-compliance, or unethical behavior, is determined, and appropriate disciplinary action is implemented to address improper conduct, activity, and/or behavior.

Monitoring, Auditing, and Identification of Risks
CalOptima has implemented and continues to implement comprehensive monitoring and auditing activities related to its operations and those of its FDRs. The purpose of CalOptima's monitoring and auditing activities is to test and confirm compliance with all applicable regulations, contractual agreements, and Federal and State laws, as well as applicable Policies and Procedures established to protect against noncompliance and potential FWA in CalOptima Programs. The Compliance Plan and related Policies and Procedures, address the monitoring and auditing processes that are carried out by CalOptima.

Response and Remediation
Once a violation, or an offense, has been detected or reported, CalOptima initiates all necessary steps to investigate, identify, and respond appropriately to the violation, or offense, and to prevent similar violations and offenses from occurring. As described in the Compliance Plan, CalOptima will conduct a timely and documented investigation, and undertake appropriate corrective actions where appropriate, including, but not limited to, modifying its Compliance Program and its Policies and Procedures to prevent the same, or similar, violation or offense, from occurring in the future.

Summary of Changes
The Compliance Plan has been updated and revised as follows:

- Incorporated the Pharmacy Benefits Manager (PBM) to those entities for which CalOptima provides oversight and monitoring;
- Revised the discussion of the overall Compliance Program to include regulatory risk as an area for compliance monitoring;
- Amended the monitoring and auditing activities to describe and delineate CalOptima's oversight of internal and delegated operations and functions, risk assessment process, and other monitoring and auditing activities;
- Modified the roles and responsibilities of the Audit & Oversight Committee;
- Updated the roles and responsibilities of the Compliance Committee;
- Adjusted the timeframe by which Employees are required to complete compliance training courses and clarified the scope of training;
- Updated compliance reporting, review and recordkeeping schedules;
- Added provisions related to CalOptima operational areas that are deemed high-risk, included additional monitoring for FDRs, and included the role of the Compliance Officer, as well as the Audit & Oversight and Compliance Committees, in the risk assessment process;
- Updated the list of CalOptima metrics tracked as part of the monitoring dashboard;

Back to Agenda

- Updated the provisions regarding consulting with legal counsel, as appropriate, for compliance violations;
- Added language regarding a potential source of FWA; and
- Revised the defined terms, methods of communicating and receiving compliance actions, Employee titles, CalOptima departments and Committees, and descriptions of respective roles in Compliance Program.

Policies and Procedures
To align with the revised Compliance Plan, and consistent with applicable Federal and State health care program laws, regulations and/or guidance, the Compliance Officer, with support of the Office of Compliance staff, drafted new policies and updated related Policies and Procedures. For those Policies and Procedures where requirements or operational processes are consistent across CalOptima Programs, staff combined program-specific policies into a policy that is applicable to multiple CalOptima Programs. The summary of changes is included in Attachment ~~[X]~~ 3.

Fiscal Impact
There is no anticipated fiscal impact based on the adoption of the updates to the 2017 Compliance Plan and its related Policies and Procedures. To the extent that there is any fiscal impact due to increases in Compliance Program resources, such impact will be addressed in separate Board actions or the CalOptima Fiscal Year 2017-18 Operating Budget.

Rationale for Recommendation
To ensure CalOptima's continuing commitment to conducting its operations in compliance with ethical and legal standards and all applicable laws, regulations, and rules, CalOptima staff recommends that the Board approve and adopt CalOptima's updated 2017 Compliance Plan, and related Policies and Procedures. The updated 2017 Compliance Plan will supersede the prior updated Compliance Plan and Fraud, Waste, and Abuse Plan approved on December 4, 2014. No changes have been made to the Code of Conduct, last updated and approved by the Board on October 3, 2013. Staff also recommends that the Board authorize the CEO to approve new, revised, and retired related Policies and Procedures to implement the updated 2017 Compliance Plan.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 16-1201-01, Resolution Approving CalOptima's Updated 2017 Compliance Plan.
2. Draft 2017 Compliance Plan (redlined and clean versions).
3. Summary of Proposed Actions to CalOptima Office of Compliance Policies and Procedures.
4. Office of Compliance Policies and Procedures (redlined and clean versions)

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

11/22/2016 — **Date**

Back to Agenda

RESOLUTION NO. 16-1201-01

RESOLUTION OF THE BOARD OF DIRECTORS OF ORANGE COUNTY HEALTH AUTHORITY dba CalOptima

APPROVING CALOPTIMA'S UPDATED 2017 COMPLIANCE PLAN

WHEREAS, Section 4.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provides that the Board of Directors is the governing body of CalOptima, and except as otherwise provided by the Bylaws or by Ordinance, the powers of CalOptima shall be exercised, its property controlled and its business and affairs conducted by or under the direction of the Board; and

WHEREAS, the Board of Directors has responsibility for approving, implementing, and monitoring a Compliance Program governing CalOptima's operations consistent will all applicable laws, regulations, and guidelines; and

WHEREAS, the Board of Directors supports CalOptima's commitment to compliant, lawful and ethical conduct and values the importance of compliance and ethics in Caloptima's operations; and

WHEREAS, the Board of Directors last reviewed and approved the Compliance Program on December 4, 2014,including the Compliance Plan, Code of Conduct, and Fraud, Waste, and Abuse Plan; and

WHEREAS, the Board of Directors reviews the Compliance Program documents on a periodic basis to ensure the Compliance Program is consistent with and updated to reflect applicable laws, regulations and guidelines and to demonstrate the Board of Director's commitment to an effective Compliance Program.

NOW THEREFORE, BE IT RESOLVED:

Section 1. The Board of Directors hereby approves the 2017 Compliance Plan.

Section 2. The Compliance Plan adopted on December 4, 2014, is hereby superseded by the attached 2017 Compliance Plan.

Section 3. The Board of Directors hereby approves and adopts the new, revised, and retired Office of Compliance Policies and Procedures and authorizes the Chief Executive Officer or his/her designee to amend the Policies and Procedures and/or create new ones, as necessary to implement the updated Compliance Plan.

Section 4. The Chief Executive Officer or his/her designee is hereby authorized and directed to implement, monitor, and enforce the Compliance Program.

Section 5. These actions are effective upon the date of adoption of this Resolution.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, dba CalOptima, this 1st day of December 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

Agenda Item 16

Consider Adoption of Resolution Approving CalOptima Updated 2017 Compliance Plan and Authorizing the Chief Executive Officer (CEO) to Approve New, Revised, and Retired Office of Compliance Policies and Procedures

The following attachments are available for viewing at the following link:

- Attachment 2, Draft 2017 Compliance Plan (redlined and clean versions); and
- Attachment 4, Office of Compliance Policies and Procedures (redlined and clean versions).

Back to Agenda

Attachment 3: Summary of Proposed Actions for Office of Compliance Policies and Procedures

Table 1: Revisions to the Office of Compliance Policies and Procedures

The following table lists the proposed revisions to the CalOptima Office of Compliance policies and procedures by department.

Department	Policy	Summary of Change(s)	Reason for Change(s)
Audit & Oversight	HH.2025: Health Network Sub-delegation and Sub-contracting	▪ Added provisions regarding regulatory entities permitted to inspect and audit records ▪ Incorporated MA.5004: Health Network Sub-delegation and Sub-contracting ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Audit & Oversight	HH.2026: Claims Delegation and Oversight	▪ Incorporated MA.9112: Claims Delegation and Oversight ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Audit & Oversight	HH.2027: Annual Risk Assessment (Delegate)	▪ Updated the roles and responsibilities with the Audit & Oversight Department ▪ Incorporated MA.9117: Annual Risk Assessment ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Audit & Oversight	HH.4001Δ: Audit &Oversight Committee	▪ Updated the roles and responsibilities with the Audit & Oversight Department ▪ Incorporated MA.9127: Audit & Oversight Committee ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Fraud, Waste, and Abuse (FWA)	HH.1105Δ: Fraud, Waste, and Abuse Detection	▪ Incorporated MA.9107: Fraud, Waste, and Abuse Detection ▪ Updated defined terms, references, and CalOptima Departments and Committees ▪ Attachment "Suspected Fraud or Abuse Referral Form" updated to include the new fax number (translated versions all contain the new fax number)	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
FWA	HH1107Δ: Fraud, Waste, and Abuse Investigation and Reporting	▪ Clarified provisions of the roles and responsibilities of the departments responsible for tracking FWA case information ▪ Updated provision regarding the data used to investigate FWA ▪ Added provision regarding reporting and referring potential FWA to the Department of Health Care Services (DHCS) ▪ Incorporated MA.9108: Fraud, Waste, and Abuse Investigation and Reporting ▪ Updated defined terms, references, and CalOptima Departments and Committees ▪ Attachment "Suspected Fraud or Abuse Referral Form" updated to include the new fax number (translated versions all contain the new fax number)	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3000Δ: Notice of Privacy Practices	▪ Added provisions in accordance with the 2013 Omnibus Rule ▪ Added provisions regarding National Committee on Quality Assurance (NCQA) requirements ▪ Incorporated MA.9202: Notice of Privacy Practices ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3001Δ: Member Access to Designated Record Set	▪ Added provision regarding the timeframe for notification to a member of a designated record set (DRS) request ▪ Updated record retention requirements ▪ Added provision to exclude case or medical management notes created by providers or health networks ▪ Incorporated MA.9203: Member Access to Designated Record Set ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	HH.3002Δ: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	▪ Added provisions regarding NCQA requirements ▪ Deleted obsolete references to CalOptima Programs ▪ Incorporated MA.9204: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information	▪ Incorporated MA.9205: Verification of Identity for Disclosures of Protected Health Information ▪ Updated defined terms, references, and CalOptima ▪ Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3004Δ: Member Request to Amend Records	▪ Clarified the role and responsibility of the Privacy Officer in receiving, processing, and responding to requests for Protected Health Information (PHI)-related inquiries ▪ Updated provisions regarding timeframes for notifications to members ▪ Updated record retention requirements ▪ Added provisions regarding NCQA requirements ▪ Incorporated MA.9207: Member Request to Amend Record ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3005Δ: Member Request for Accounting of Disclosures	▪ Updated record retention requirements ▪ Added provisions regarding NCQA requirements ▪ Incorporated MA.9209: Member Request for Accounting of Disclosures ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information	▪ Updated provision regarding the routine disclosures that are tracked by CalOptima ▪ Incorporated MA.9210: Tracking and Reporting Disclosures of Protected Health Information ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	HH.3007Δ: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	▪ Incorporated MA.9206: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3008Δ: Member Right to Request Confidential Communications	▪ Updated provision regarding how a member may deliver a request to CalOptima ▪ Incorporated MA.9211: Member Right to Request Confidential Communications ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3009Δ: Access by Member's Authorized Representative	▪ Added provision regarding adhering to state/federal regulations for use/disclosure of PHI ▪ Incorporated MA.9212: Access by Member's Authorized Representative ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3010Δ: Protected Health Information Disclosures Required by Law	▪ Clarified provisions regarding applicability to specific health care programs ▪ Incorporated MA.9213: Protected Health Information Disclosures Required by Law ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3011Δ: Use and Disclosure for Treatment, Payment, and Health Care Operations	▪ Incorporated: – HH.3017: Use and Disclosure of PHI for Research – MA.9214: Use and Disclosure for Treatment, Payment, and Health Care Operations – MA.9215: Use or Disclosure of Protected Health Information (PHI) for Research ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	HH.3014Δ: Use of Electronic Mail with Protected Health Information	▪ Incorporated HH.9218: Use of Electronic Mail with Protected Health Information ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3015Δ: Authorization for Release of Protected Health Information	▪ Added provision regarding mailing and receipt of Authorization for Release of Information form ▪ Updated record retention requirements ▪ Added provision regarding NCQA requirements ▪ Added provision regarding non-CalOptima HIPAA release of information forms ▪ Incorporated: – HH.3021: Disclosure of Information to Family Members or Friends Involved in Member Care – MA.9219: Authorization for Release of Protected Health Information – MA.9224: Disclosure of Information to Family Members or Friends Involved in Member Care ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3016Δ: Guidelines for Handling Protected Health Information Offsite	▪ Clarified applicability to Business Associates ▪ Incorporated MA.9220: Guidelines for Handling Protected Health Information Offsite ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Privacy	HH.3019Δ: De-identification of Protected Health Information	▪ Incorporated MA.9221: De-identification of Protected Health Information ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	HH.3020Δ: Reporting and Providing a Notice of Security Incidents, Breaches of Unsecured PHI/PI, or other Unauthorized Use of Disclosure of PHI/PI	▪ Added provision regarding CalOptima's breach mitigation policy ▪ Added provision regarding notification to regulatory agencies and individuals of breaches based on the size of the breach ▪ Incorporated provision to include social media as a manner in which PHI could be posted and result in a breach ▪ Updated timeframes ▪ Updated regulatory agencies to which CalOptima reports breaches ▪ Added provision regarding the obligation of Business Associates to immediately report breaches when there is a direct contract with DHCS ▪ Incorporated: – HH.3013: Mitigation – MA.9217: Mitigation – MA.9222: Reporting an Unauthorized Use or Disclosure of Protected Health Information (PHI), or Breach of Data, Security, or Intrusion ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2002Δ: Sanctions	▪ Clarified provisions regarding corrective action plans as well as penalties for First Tier Entities ▪ Incorporated MA.9105: Sanctions ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	HH.2005Δ: Corrective Action Plan	▪ Clarified provisions regarding responsibilities for corrective actions plans. ▪ Added provisions regarding responses to Immediate Corrective Action Plan due to regulatory findings ▪ Revised provisions regarding CalOptima's compliance communication methods ▪ Incorporated MA.9104: Corrective Action Plan ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2007Δ: Compliance Committee	▪ Added provisions regarding components of the Compliance Plan that are monitored for effectiveness ▪ Added provisions regarding the analysis of federal and state programs to ensure adequacy of the Compliance program ▪ Incorporated MA.9123: Compliance Committee ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2014Δ: Compliance Program	▪ Added provisions regarding the responsibility of the CalOptima Board of Directors for overseeing the implementation and effectiveness of the Compliance Program and approving the Compliance Plan and Code of Conduct ▪ Clarified the role and responsibilities of the CalOptima Compliance Officer ▪ Incorporated MA.9101: Compliance Program ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	HH.2018Δ: Compliance and Ethics Hotline	▪ Clarified provisions regarding responsibilities of the Office of Compliance to maintain confidentiality to the extent possible ▪ Added provisions regarding the third party vendor's responsibilities for receipt and documentation of a call ▪ Incorporated MA.9113: Compliance and Ethics Hotline ▪ Updated defined terms, references, employee titles, and CalOptima Departments	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2019Δ: Reporting Suspended Misconduct or Violation	▪ Clarified provisions regarding CalOptima's compliance communication methods ▪ Incorporated MA.9114: Reporting Suspected Misconduct or Violation ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2020Δ: Conducting Compliance Investigations	▪ Clarified the role and responsibilities of the CalOptima Security Officer ▪ Added provisions regarding self-disclosure of incidents to CMS ▪ Incorporated MA.9125: Conducting Compliance Investigations	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2021Δ: Exclusion Monitoring	▪ Clarified the role and responsibilities of the departments responsible for exclusion monitoring activities ▪ Incorporated MA.9121: Exclusion Monitoring ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2022Δ: Record Retention and Access	▪ Updated provisions regarding record retention requirements ▪ Incorporated MA.9106: Record Retention and Access ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	HH.2023Δ: Compliance Training	▪ Updated provisions to clarify that FDRs who have met the FWA training and education certification requirements through enrollment into Parts A or B of the Medicare program, or through accreditation as a supplier of Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS), are NOT exempt from the general compliance training requirement ▪ Updated timeframe for completion of compliance training ▪ Incorporated MA.9119: Compliance Training ▪ Updated defined terms, references, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2028Δ: Code of Conduct	▪ Added provisions regarding the distribution of the Code of Conduct to the CalOptima Board of Directors and associated monitoring activities ▪ Incorporated MA.9120: Code of Conduct ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.2029Δ: Annual Compliance Program Effectiveness Audit	▪ Added provision regarding the timing of the CalOptima self-assessment ▪ Incorporated MA.9116: Annual Compliance Program Effectiveness Audit ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations
Regulatory Affairs & Compliance	HH.3012Δ: Non-Retaliation for Reporting Violations	▪ Added communication method for reporting suspected violations ▪ Incorporated MA.9223: Non-Retaliation for Reporting Violations ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	MA.9124: CMS Self-Disclosure	▪ Added provision regarding reporting to DHCS ▪ Incorporated provision regarding department designees ▪ Updated defined terms, references, employee titles, and CalOptima Departments and Committees	Annual review to include revisions to align with the 2017 Compliance Plan and current operations

Table 2: New Office of Compliance Policies and Procedures

The following table contains the proposed list of new policies for the CalOptima Office of Compliance, by department.

Department	Policy	Summary of Change(s)	Reason for Change(s)
Audit & Oversight	HH.4002: CalOptima Internal Oversight	▪ New policy to describe the oversight activities of internal CalOptima Departments ▪ Incorporated MA.9118: Internal Auditing and Monitoring	N/A
Audit & Oversight	HH.4003: Annual Risk Assessment (Internal)	▪ New policy to describe the describe the annual internal risk assessment process ▪ Incorporated MA.9117: Annual Risk Assessment	N/A
FWA	HH.5000Δ: Provider Overpayment Investigation and Determination	▪ This policy describes the process for reviewing suspect claims to detect and prevent FWA within a CalOptima program.	N/A

Table 3: Retiring Office of Compliance Policies and Procedures

The following table contains the proposed list of policies and procedures to be retired within the CalOptima Office of Compliance, by department.

Department	Policy	Summary of Change(s)	Reason for Change(s)
Audit & Oversight	MA.5004: Health Network Sub-delegation and Sub-contracting	▪ Requesting retirement of this policy.	Policy was incorporated within incorporated within HH.2025: Health Network Sub-delegation and Sub-contracting

Department	Policy	Summary of Change(s)	Reason for Change(s)
Audit & Oversight	MA.9112: Claims Delegation and Oversight	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2026: Claims Delegation and Oversight
Audit & Oversight	MA.9117: Annual Risk Assessment	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2027: Annual Risk Assessment (Delegate)
Audit & Oversight	MA.9118: Internal Auditing and Monitoring	▪ Requesting retirement of this policy.	Policy was incorporated within HH.4002: CalOptima Internal Oversight
Audit & Oversight	MA.9127: Audit and Oversight Committee	▪ Requesting retirement of this policy.	Policy was incorporated within HH.4001Δ: Audit and Oversight Committee
FWA	MA.9107: Fraud, Waste, and Abuse Detection	▪ Requesting retirement of this policy.	Policy was incorporated within HH.1105Δ: Fraud, Waste, and Abuse Detection
FWA	MA.9108: Fraud, Waste, and Abuse Investigation and Reporting	▪ Requesting retirement of this policy.	Policy was incorporated within HH.1107Δ: Fraud, Waste, and Abuse Investigation and Reporting
Privacy	HH.3013: Mitigation	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
Privacy	HH.3017: Use and Disclosure of PHI for Research	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3011Δ: Use and Disclosure for Treatment, Payment, and Health Care Operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	HH.3021: Disclosure of Information to Family Members or Friends Involved in Member Care	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3015Δ: Authorization for Release of Protected Health Information
Privacy	MA.9202: Notice of Privacy Practices	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3000Δ: Notice of Privacy Practices
Privacy	MA.9203: Member Access to Designated Record Set	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3001Δ: Member Access to Designated Record Set
Privacy	MA.9204: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3002Δ: Minimum Necessary Uses and Disclosure of Protected Health Information and Document Controls
Privacy	MA.9205: Verification of Identity for Disclosures of Protected Health Information	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3003Δ: Verification of Identity for Disclosures of Protected Health Information
Privacy	MA.9206: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3007Δ: Member Right to Request Restrictions on Use and Disclosure of Protected Health Information
Privacy	MA.9207: Member Request to Amend Record	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3004Δ: Member Request to Amend Records

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	MA.9209: Member Request for Accounting of Disclosures	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3005Δ: Member Request for Accounting of Disclosures
Privacy	MA.9210: Tracking and Reporting Disclosures of Protected Health Information	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3006Δ: Tracking and Reporting Disclosures of Protected Health Information
Privacy	MA.9211: Member Right to Request Confidential Communications	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3008Δ: Member Right to Request Confidential Communications
Privacy	MA.9212: Access by Member's Authorized Representative	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3009Δ: Access by Member's Authorized Representative
Privacy	MA.9213: Protected Health Information Disclosures Required by Law	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3010Δ: Protected Health Information Disclosures Required by Law
Privacy	MA.9214: Use and Disclosure for Treatment, Payment, and Health Care Operations	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3011Δ: Use and Disclosure for Treatment, Payment, and Health Care Operations
Privacy	MA.9215: Use or Disclosure of Protected Health Information (PHI) for Research	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3011Δ: Use and Disclosure for Treatment, Payment, and Health Care Operations

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	MA.9217: Mitigation	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3020Δ: Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI
Privacy	MA.9218: Use of Electronic Mail with Protected Health Information	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3014Δ: Use of Electronic Mail with Protected Health Information
Privacy	MA.9219: Authorization for Release of Protected Health Information	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3015Δ: Authorization for Release of Protected Health Information
Privacy	MA.9220: Guidelines for Handling Protected Health Information Offsite	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3016Δ: Guidelines for Handling Protected Health Information Offsite
Privacy	MA.9221: De-identification of Protected Health Information	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3019 Δ: De-identification of Protected Health Information
Privacy	MA.9222: Reporting an Unauthorized Use or Disclosure of Protected Health Information (PHI), or Breach of Data, Security, or Intrusion	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3020Δ: Reporting a Breach of Data Security, Intrusion, or Unauthorized Use or Disclosure of Protected Health Information

Department	Policy	Summary of Change(s)	Reason for Change(s)
Privacy	MA.9224: Disclosure of Information to Family Members or Friends Involved in Member Care	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3015Δ: Disclosure of Information to Family Members or Friends Involved in Member Care
Regulatory Affairs & Compliance	MA.9101: Compliance Program	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2014Δ: Compliance Program
Regulatory Affairs & Compliance	MA.9104: Corrective Action Plan	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2005Δ: Corrective Action Plan
Regulatory Affairs & Compliance	MA.9105: Sanctions	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2002Δ: Sanctions
Regulatory Affairs & Compliance	MA.9106: Record Retention and Access	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2022Δ: Record Retention and Access
Regulatory Affairs & Compliance	MA.9113: Compliance and Ethics Hotline	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2018Δ: Compliance and Ethics Hotline
Regulatory Affairs & Compliance	MA.9114: Reporting Suspected Misconduct or Violation	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2019Δ: Reporting Suspected Misconduct or Violation
Regulatory Affairs & Compliance	MA.9116: Annual Compliance Program Effectiveness Audit	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2029Δ: Annual Compliance Program Effectiveness Audit
Regulatory Affairs & Compliance	MA.9119: Compliance Training	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2023Δ: Compliance Training

Department	Policy	Summary of Change(s)	Reason for Change(s)
Regulatory Affairs & Compliance	MA.9120: Code of Conduct	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2028Δ: Code of Conduct
Regulatory Affairs & Compliance	MA.9121: Exclusion Monitoring	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2021Δ: Exclusion Monitoring
Regulatory Affairs & Compliance	MA.9123: Compliance Committee	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2007Δ: Compliance Committee
Regulatory Affairs & Compliance	MA.9125: Conducting Compliance Investigations	▪ Requesting retirement of this policy.	Policy was incorporated within HH.2020Δ: Conducting Compliance Investigations
Regulatory Affairs & Compliance	MA.9223: Non-Retaliation for Reporting Violations	▪ Requesting retirement of this policy.	Policy was incorporated within HH.3012Δ: Non-Retaliation for Reporting Violations

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Adoption of Resolution to Amend CalOptima's Conflict of Interest Code

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

Recommended Actions
1. Adopt Resolution adopting a Conflict of Interest Code ("Code") which supersedes all prior Conflict of Interest Codes and Amendments previously adopted; and
2. Upon adoption, direct the Clerk of the Board to submit the Code to the Orange County Board of Supervisors for review and approval.

Background
The Fair Political Practices Commission (FPPC) adopted a regulation, Title 2, California Code of Regulations, Section 18730, which contains terms for a standard Model Conflict of Interest Code ("Model Code") that, together with amendments thereto, may be adopted by local public agencies and incorporated by reference. The CalOptima Board of Directors adopted the Model Code by reference on January 6, 2011, and amended Exhibit A to CalOptima's Conflict of Interest Code on December 4, 2014.

When designated positions or reporting categories are added or changed, local agencies are required under Government Code section 87306 to make changes to the conflict of interest code to reflect these changed circumstances. On November 3, 2016, the CalOptima Board of Directors adopted a new Salary Schedule with an updated list of CalOptima employee positions and job titles. The proposed amendment to the list of Designated Filer Positions and Disclosure Categories (Exhibit A) reflects positions that make or participate in the making of governmental decisions which may foreseeable have a material financial effect on a financial interest. All individuals in designated positions will still be required to complete CalOptima's Supplement to FPPC Form 700. Changes have been proposed that update certain positions that have been added, deleted, or renamed.

In addition, the General Counsel for the California Fair Political Practices Commission (FPPC) issued several memorandums opining that "conflict of interest code disclosure categories must be narrowly tailored to the type of economic interests that will foreseeably be affected by a designated employee's decision making." (May 7, 2012, Memorandum from Zackery P. Morazzini, General Counsel of FPPC). Furthermore, in 2012, the FPPC adopted Title 2, California Code of Regulations, Section 18730.1, providing that designated positions are not required to report gifts outside an agency's jurisdiction if the purpose of disclosure of the source of the gift does not have some connection with or bearing upon the functions or duties of the position for which the reporting is required. Additional changes are also proposed to CalOptima's Conflict of Interest Code to ensure

Back to Agenda

that disclosure requirements for each position is narrowly tailored to the type of economic interests that will foresee ably be materially affected by a designated employee's decision making.

Rationale for Recommendation

Adoption of Resolution to adopt CalOptima's Conflict of Interest Code which supersedes all prior Conflict of Interest Codes and Amendments previously adopted is necessary to reflect updates to certain positions that have been added, deleted, or renamed. Disclosure categories have been updated to conform with the County of Orange Standard Disclosure Categories and to tailor the disclosure requirements to the type of economic interests that will foreseeably be affected by each position.

Fiscal Impact

There is no fiscal impact.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 16-1201-02, Adopt Exhibit A and B to the Conflict of Interest Code for the Orange County Health Authority, dba CalOptima
2. Draft Conflict of Interest Code – Exhibits A and B

/s/ Michael Schrader — *11/22/2016*

Authorized Signature — **Date**

Back to Agenda

RESOLUTION NO. 16-1201-02

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

ADOPTING A CONFLICT OF INTEREST CODE WHICH SUPERSEDES ALL PRIOR CONFLICT OF INTEREST CODES AND AMENDMENTS PREVIOUSLY ADOPTED

WHEREAS, the Political Reform Act of 1974, Government Code Section 81000 et seq. ("the Act"), requires a local government agency to adopt a Conflict of Interest Code pursuant to the Act and conduct a biennial review of Designated Positions and Disclosure Categories; and,

WHEREAS the Orange County Health Authority, dba CalOptima, has previously adopted a Conflict of Interest Code and that Code now requires updating; and,

WHEREAS, amendments to the Act have in the past and foreseeably will in the future require conforming amendments to be made to the Conflict of Interest Code; and,

WHEREAS, the Fair Political Practices Commission has adopted a regulation, Title 2, California Code of Regulations, Section 18730, which contains terms for a standard model Conflict of Interest Code, which, together with amendments thereto, may be adopted by public agencies and incorporated by reference to save public agencies time and money by minimizing the actions required of such agencies to keep their codes in conformity with the Political Reform Act.

NOW, THEREFORE, BE IT RESOLVED:

Section 1. The terms of Title 2, California Code of Regulations, Section 18730, and any amendments to it duly adopted by the Fair Political Practices Commission, and all additional guidance by the Fair Political Practices Commission, are hereby incorporated by reference, and together, with the attached Exhibits A and B in which members and employees are designated and disclosure categories are set forth, constitute the Conflict of Interest Code of the Orange County Health Authority, dba CalOptima.

Section 2. The provisions of all Conflict of Interest Codes and Amendments thereto previously adopted by the Orange County Health Authority, dba CalOptima are hereby superseded.

Section 3. The CalOptima Clerk of the Board is hereby authorized and directed to forward a copy of this Resolution to the Clerk of the Orange County Board of Supervisors for review and approval by the Orange County Board of Supervisors as required by California Government Code Section 87303.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 1st day of December 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

Conflict of Interest Code
EXHIBIT A (Final Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Associate Director, Customer Service	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Associate Director, Human Resources	OC-11	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Associate Director, Information Services	OC-08	COB	Unchanged
Buyer	OC-01	COB	Unchanged
Buyer, Int.	OC-01	COB	Unchanged
Buyer, Sr.	OC-01	COB	Unchanged
Chief Counsel	OC-01	COB	Unchanged
Chief Information Officer	OC-01	COB	Unchanged
Chief Medical Officer	OC-01	COB	Unchanged
Chief Network Officer	OC-01	COB	Deleted
Reason: Deleting position as it no longer exists in CalOptima.			
Chief of Strategy and Public Affairs	OC-01	COB	Deleted
Reason: Deleting position as it no longer exists in CalOptima.			
Chief Operating Officer	OC-01	COB	Unchanged
Clerk of the Board	OC-06	COB	Unchanged
Clinical Pharmacist	OC-20	COB	Unchanged
Consultant	OC-30	Agency	Unchanged
Contract Administrator	OC-06	COB	Unchanged
Contracts Manager	OC-06	COB	Unchanged
Contracts Specialist	OC-06	COB	Unchanged
Contracts Specialist Int.	OC-06	COB	Unchanged
Contracts Specialist Sr.	OC-06	COB	Unchanged
Controller	OC-01	COB	Unchanged
Deputy Chief Counsel	OC-01	COB	Unchanged
Deputy Chief Medical Officer	OC-01	COB	Unchanged
Director, Accounting	OC-01	COB	Unchanged
Director, Applications Management	OC-08	COB	Unchanged
Director, Audit and Oversight	OC-01	COB	Unchanged
Director, Behavioral Health Services	OC-41	COB	Unchanged
Director, Budget & Procurement	OC-01	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Final Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Director, Business Development	OC-41	COB	Unchanged
Director, Business Integration	OC-41	COB	Unchanged
Director, Case Management	OC-41	COB	Unchanged
Director, Claims Administration	OC-41	COB	Unchanged
Director, Clinical Outcomes	OC-01	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Director, Clinical Pharmacy	OC-01	COB	Unchanged
Director, Coding Initiatives	OC-06	COB	Unchanged
Director, Communications	OC-13	COB	Unchanged
Director, Community Relations	OC-41	COB	Unchanged
Director, Compliance	OC-01	COB	Deleted
Reason: Deleting position as it no longer exists in CalOptima.			
Director, Configuration & Coding	OC-06	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Director, Contracting	OC-01	COB	Unchanged
Director, Contracting & Provider Relations	OC-01	COB	Deleted
Reason: Deleting position as it no longer exists in CalOptima.			
Director, COREC	OC-08	COB	Unchanged
Director, Customer Service	OC-41	COB	Unchanged
Director, Customer Service and GARS	OC-41	COB	Deleted
Reason: Deleting position as it no longer exists in CalOptima.			
Director, Electronic Business	OC-06	COB	Unchanged
Director, Enterprise Analytics	OC-06	COB	Unchanged
Director, Facilities	OC-41	COB	Unchanged
Director, Finance & Procurement	OC-01	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Director, Financial Analysis	OC-01	COB	Unchanged
Director, Financial Compliance	OC-01	COB	Unchanged
Director, Fraud, Waste & Abuse and Privacy	OC-01	COB	Unchanged
Director, Government Affairs	OC-41	COB	Unchanged
Director, Grievance & Appeals	OC-41	COB	Unchanged
Director, Health Education	OC-41	COB	Deleted

Conflict of Interest Code
EXHIBIT A (Final Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Reason: Deleting position as it no longer exists in CalOptima.			
Director, Health Education & Disease Management	OC-41	COB	Unchanged
Director, Health Services	OC-41	COB	Unchanged
Director, Human Resources	OC-11	COB	Unchanged
Director, Information Services	OC-08	COB	Unchanged
Director, Long Term Support Services	OC-41	COB	Unchanged
Director, Medi-Cal Plan Operations	OC-41	COB	Unchanged
Director, Network Management	OC-41	COB	Unchanged
Director, OneCare Operations	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Director, Organizational Training & Education	OC-11	COB	Unchanged
Director, PACE Program	OC-41	COB	Unchanged
Director, Process Excellence	OC-41	COB	Unchanged
Director, Program Implementation	OC-41	COB	Unchanged
Director, Project Management	OC-41	COB	Unchanged
Director, Provider Data Quality	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Director, Provider Relations	OC-41	COB	Deleted
Reason: Deleting position as it no longer exists in CalOptima.			
Director, Provider Services	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Director, Public Policy	OC-41	COB	Unchanged
Director, Quality (LTSS)	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Director, Quality Analytics	OC-06	COB	Unchanged
Director, Quality Improvement	OC-41	COB	Unchanged
Director, Regulatory Affairs	OC-41	COB	Deleted
Reason: Deleting position as it no longer exists in CalOptima.			
Director, Regulatory Affairs and Compliance	OC-01	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Director, Strategic Development	OC-41	COB	Unchanged
Director, Systems Development	OC-08	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Final Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Director, Utilization Management	OC-41	COB	Unchanged
Director, Vendor Management	OC-01	COB	Unchanged
Enterprise Analytics Manager	OC-06	COB	Unchanged
Executive Director, Behavioral Health Integration	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Executive Director, Clinical Operations	OC-01	COB	Unchanged
Executive Director, Compliance	OC-01	COB	Unchanged
Executive Director, Human Resources	OC-01	COB	Unchanged
Executive Director, Information Services	OC-01	COB	Deleted
Reason: Deleting position as it no longer exists in CalOptima.			
Executive Director, Network Operations	OC-01	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Executive Director, Operations	OC-01	COB	Unchanged
Executive Director, Program Implementation	OC-01	COB	Unchanged
Executive Director, Public Affairs	OC-01	COB	Unchanged
Executive Director, Quality Analytics	OC-06	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Financial Analyst	OC-01	COB	Unchanged
Financial Analyst, Sr.	OC-01	COB	Unchanged
Financial Reporting Analyst	OC-01	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
General Counsel	OC-01	COB	Unchanged
Litigation Support Specialist	OC-41	COB	Unchanged
Manager, Accounting	OC-01	COB	Unchanged
Manager, Actuary	OC-01	COB	Unchanged
Manager, Applications Management	OC-08	COB	Unchanged
Manager, Audit and Oversight	OC-01	COB	Unchanged
Manager, Behavioral Health	OC-06	COB	Unchanged
Manager, Biostatistics	OC-01	COB	Deleted
Reason: Deleting position as it no longer exists in CalOptima.			
Manager, Business Integration	OC-06	COB	Unchanged
Manager, Business Intelligence	OC-06	COB	Deleted

Conflict of Interest Code
EXHIBIT A (Final Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Reason: Deleting position as it no longer exists in CalOptima.			
Manager, Case Management	OC-41	COB	Unchanged
Manager, Claims	OC-41	COB	Unchanged
Manager, Clinic Operations	OC-06	COB	Unchanged
Manager, Clinical Pharmacists	OC-20	COB	Unchanged
Manager, Coding Quality	OC-06	COB	Unchanged
Manager, Communications	OC-13	COB	Unchanged
Manager, Community Relations	OC-06	COB	Unchanged
Manager, Compliance	OC-41	COB	Deleted
Reason: Deleting position as it no longer exists in CalOptima.			
Manager, Concurrent Review	OC-06	COB	Deleted
Reason: Deleting position as it no longer exists in CalOptima.			
Manager, Contracting	OC-41	COB	Unchanged
Manager, Creative Branding	OC-13	COB	Unchanged
Manager, Cultural & Linguistics	OC-06	COB	Unchanged
Manager, Customer Service	OC-41	COB	Unchanged
Manager, Decision Support	OC-06	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Manager, Disease Management	OC-41	COB	Unchanged
Manager, Electronic Business	OC-06	COB	Unchanged
Manager, Employment Services	OC-11	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Manager, Encounters	OC-06	COB	Unchanged
Manager, Environmental Health & Safety	OC-06	COB	Unchanged
Manager, Facilities	OC-41	COB	Unchanged
Manager, Finance	OC-01	COB	Unchanged
Manager, Financial Analysis	OC-01	COB	Unchanged
Manager, Government Affairs	OC-41	COB	Unchanged
Manager, Grievance and Appeals	OC-41	COB	Unchanged
Manager, Health Education	OC-41	COB	Unchanged
Manager, HEDIS	OC-06	COB	Unchanged
Manager, Human Resources	OC-11	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Final Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Manager, Information Services	OC-08	COB	Unchanged
Manager, Information Technology	OC-08	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Manager, Integration Government Liaison	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Manager, Long Term Support Services	OC-41	COB	Unchanged
Manager, Marketing and Enrollment	OC-06	COB	Unchanged
Manager, Medical Data Management	OC-06	COB	Unchanged
Manager, Medi-Cal Program Operations	OC-41	COB	Unchanged
Manager, Member Liaison Program	OC-41	COB	Unchanged
Manager, Member Outreach & Education	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Manager, Member Outreach, Education and Provider Relations	OC-41	COB	Unchanged
Manager, MSSP	OC-41	COB	Unchanged
Manager, OneCare (Clinical, Customer Service, or Sales)	OC-41	COB	Unchanged
Manager, OneCare Regulatory	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Manager, Outreach & Enrollment	OC-13	COB	Unchanged
Manager, PACE Center	OC-06	COB	Unchanged
Manager, Payroll & Benefits	OC-01	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Manager, Pharmacy Operations	OC-20	COB	Unchanged
Manager, Prior Authorizations	OC-06	COB	Deleted
Reason: Deleting position as it no longer exists in CalOptima.			
Manager, Process Excellence	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Manager, Program Implementation	OC-06	COB	Unchanged
Manager, Project Management	OC-06	COB	Unchanged
Manager, Provider Data Management Services	OC-41	COB	Unchanged
Manager, Provider Network	OC-41	COB	Unchanged
Manager, Provider Operations	OC-41	COB	Deleted
Reason: Deleting position, no Longer in CalOptima.			

Conflict of Interest Code
EXHIBIT A (Final Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Manager, Provider Relations	OC-41	COB	Unchanged
Manager, Provider Services	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Manager, Purchasing	OC-01	COB	Unchanged
Manager, QI Initiatives	OC-41	COB	Unchanged
Manager, Quality Analytics	OC-06	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Manager, Quality Improvement	OC-41	COB	Unchanged
Manager, Regulatory Affairs	OC-06	COB	Deleted
Reason: Deleting position, no Longer in CalOptima.			
Manager, Regulatory Affairs and Compliance	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Manager, Reporting & Financial Compliance	OC-01	COB	Unchanged
Manager, Strategic Development	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Manager, Strategic Operations	OC-41	COB	Unchanged
Manager, Utilization Management	OC-06	COB	Unchanged
Medical Case Manager	OC-41	COB	Unchanged
Medical Director	OC-01	COB	Unchanged
OneCare Operations Manager	OC-41	COB	Unchanged
Pharmacy Services Specialist	OC-20	COB	Unchanged
Pharmacy Services Specialist, Int.	OC-20	COB	Unchanged
Pharmacy Services Specialist, Sr.	OC-20	COB	Unchanged
Policy Advisor	OC-01	COB	Deleted
Reason: Deleting position, no Longer in CalOptima.			
Program Manager	OC-06	COB	Unchanged
Project Manager	OC-06	COB	Unchanged
Project Manager, Lead	OC-06	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Project Manager, Sr.	OC-06	COB	Unchanged
QI Nurse Specialist (RN or LVN)	OC-06	COB	Unchanged
Regulatory Affairs and Compliance Analyst	OC-41	COB	Added

Conflict of Interest Code
EXHIBIT A (Final Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Regulatory Affairs and Compliance Analyst Sr	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Regulatory Affairs and Compliance Lead	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Senior Manager, Government Affairs	OC-06	COB	Unchanged
Special Counsel	OC-01	COB	Unchanged
Staff Attorney	OC-01	COB	Unchanged
Supervisor, Social Work (PACE)	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor, Accounting	OC-01	COB	Unchanged
Supervisor, Audit and Oversight	OC-01	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor, Budgeting	OC-01	COB	Unchanged
Supervisor, Case Management	OC-41	COB	Unchanged
Supervisor, Claims	OC-06	COB	Unchanged
Supervisor, Coding Initiatives	OC-06	COB	Unchanged
Supervisor, Compliance	OC-06	COB	Deleted
Reason: Deleting position, no Longer in CalOptima.			
Supervisor, Customer Service	OC-06	COB	Unchanged
Supervisor, Data Entry	OC-06	COB	Unchanged
Supervisor, Day Center (PACE)	OC-06	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor, Encounters	OC-06	COB	Unchanged
Supervisor, Facilities	OC-41	COB	Unchanged
Supervisor, Finance	OC-01	COB	Unchanged
Supervisor, Grievance and Appeals	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor, Health Education	OC-06	COB	Unchanged
Supervisor, Health Services	OC-06	COB	Unchanged
Supervisor, Information Services	OC-08	COB	Unchanged
Supervisor, Long Term Support Services	OC-41	COB	Unchanged

Conflict of Interest Code
EXHIBIT A (Final Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Position	Disclosure Category	Files With	Status
Supervisor, Member Outreach and Education	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor, MSSP	OC-06	COB	Unchanged
Supervisor, OneCare Customer Service	OC-06	COB	Unchanged
Supervisor, Payroll	OC-06	COB	Unchanged
Supervisor, Pharmacist	OC-20	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor, Pharmacy Services	OC-20	COB	Unchanged
Supervisor, Provider Enrollment	OC-06	COB	Unchanged
Supervisor, Quality Analytics	OC-06	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor, Quality Improvement	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor, Regulatory Affairs and Compliance	OC-06	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor, Systems Development	OC-08	COB	Unchanged
Supervisor, Therapy Services (PACE)	OC-41	COB	Added
Reason: Adding new position/category with job duties requiring completion of Form 700 to the designated filer's list.			
Supervisor, Utilization Management	OC-06	COB	Unchanged

Total: 217

OFFICIALS WHO ARE SPECIFIED IN GOVERNMENT CODE SECTION 87200

Officials who are specified in Government Code section 87200 (including officials who manage public investments, as defined by 2 Cal. Code of Regs. § 18701 (b)), are NOT subject to the Agency's Conflict of Interest Code, but are subject to the disclosure requirements of the Political Reform Act, Government Code section 87100, et seq. Gov't Code § 87203. These positions are listed here for informational purposes only.

The positions listed below are officials who are specified in Government Code section 87200:

Alternate Member of the Board of Directors	Files with	COB	Unchanged
Chief Executive Officer	Files with	COB	Unchanged
Chief Financial Officer	Files with	COB	Unchanged
Member of the Board of Directors	Files with	COB	Unchanged

The disclosure requirements for these positions are set forth in Government Code section 87200, et. seq. They require the

disclosure of interests in real property in the agency's jurisdiction, as well as investments, business positions and sources of income (including gifts, loans and travel payments).

Disclosure Descriptions
EXHIBIT B (Final Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Disclosure Category	Disclosure Description	Status
87200 Filer	Form 87200 filers shall complete all schedules for Form 700 and disclose all reportable sources of income, interests in real property, investments and business positions in business entities, if applicable, pursuant to Government Code Section 87200 *et seq.*.	Unchanged
OC-01	All interests in real property in Orange County, the authority or the District as applicable, as well as investments, business positions and sources of income (including gifts, loans and travel payments).	Unchanged
OC-06	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide leased facilities and goods, supplies, equipment, vehicles, machinery or services (including training and consulting services) of the types used by the County Department, Authority or District, as applicable.	Unchanged
OC-08	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that develop or provide computer hardware/software, voice data communications, or data processing goods, supplies, equipment, or services (including training and consulting services) used by the County Department, Authority or District, as applicable.	Unchanged
OC-11	All interests in real property in Orange County or located entirely or partly within the Authority or District boundaries as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that are engaged in the supply of equipment related to recruitment, employment search & marketing, classification, training, or negotiation with personnel; employee benefits, and health and welfare benefits.	Unchanged
OC-13	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that produce or provide promotional items for public outreach programs; present, facilitate, market or otherwise act as agent for media relations with regard to public relations; provide printing, copying, or mail services; or provide training for or development of customer service representatives.	Unchanged
OC-20	All investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide pharmaceutical services, supplies, materials or equipment.	Unchanged
OC-30	Consultants shall be included in the list of designated employees and shall disclose pursuant to the broadest category in the code subject to the following limitation: The County Department Head/Director/General Manager/Superintendent/etc. may determine that a particular consultant, although a "designated position," is hired to perform a range of duties that is limited in scope and thus is not required to fully comply with the disclosure requirements in this section. Such written determination shall include a description of the consultant's duties and, based upon that description, a statement of the extent of disclosure required. The determination of disclosure is a public record and shall be filed with the Form 700 and retained by the Filing Officer for public inspection.	Unchanged

Disclosure Descriptions
EXHIBIT B (Final Draft)

Entity: **Other misc authorities, districts and commissions**

Agency: **CalOptima**

Disclosure Category	Disclosure Description	Status
OC-41	All interests in real property in Orange County, the District or Authority, as applicable, as well as investments in, business positions with and income (including gifts, loans and travel payments) from sources that provide services, supplies, materials, machinery, vehicles, or equipment (including training and consulting services) used by the County Department, Authority or District, as applicable.	Unchanged

Grand Total: 9

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
18. Consider Adoption of Resolution Approving Updated Human Resources Policies and Amendment to Executive Employment Agreement

Contact
Amelia Huckabee, Interim Human Resources Director, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400
Chet Uma, Chief Financial Officer, (714) 246-8400

Recommended Actions
1. Adopt Resolution Approving CalOptima's Updated Human Resources Policies;
2. Direct staff to revise CalOptima's Employee Handbook consistent with the updated Human Resources policies; and
3. Approve Amendment III to Executive Employment Agreement with the Chief Executive Officer to provide discretionary contributions to the PARS Retirement Plan consistent with prior Board action and to ensure full compliance with Internal Revenue Code limits.

Background

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

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

The following table lists existing Human Resources policies that have been updated and are being presented for review and approval. Staff will make corresponding changes to CalOptima's Employee Handbook and will present those changes to the Board of Directors at the February 2017 Board Meeting.

	Policy No./Name	Summary of Changes	Reason for Change
1.	GA.8019: Promotions and Transfers	• Minor language and formatting change. • Change the procedure to reflect	-Annual review with minor updates and formatting changes.

Back to Agenda

	Policy No./Name	Summary of Changes	Reason for Change
		process changes and use of an electronic applicant tracking system. • Added definition.	- System process change
2.	GA.8020: 9/80 Work Schedule	• Minor language and formatting change. • Limit eligibility for employees to participate in either 9/80 schedule or Telework, but not both. • Added definition	-Annual review with minor updates and formatting changes. - Deloitte audit findings/recommendation (May 19, 2016) - To be consistent with changes made in December 2015 to Policy GA. 8044: Telework Program
3.	GA.8033: License and Certification Tracking	• Minor language and formatting change.	-Annual review with minor formatting changes
4.	GA.8047: Reduction in Force	• Minor language and formatting change. • Expand use of this policy for separations other than RIF, at the discretion of the CEO. • Updates to standard Separation Agreement templates	-Annual review with minor updates and formatting changes. - Broaden the policy for other types of separations. - Update standard Separation Agreement templates to provide greater protections to CalOptima
5.	GA.8048: Restrictions on Smoking and Unregulated Nicotine Products	• Minor language and formatting change. • Transfer this policy to Environmental Health and Safety (EHS) Department.	- Annual review with minor updates and formatting changes. - Scope of the policy is more appropriate within EHS Department's jurisdiction.
6.	GA.8050: Confidentiality	• Minor language and formatting change. • Updates to include broader definition of use of confidential information and expanded locations where information should not be shared.	- Annual review with minor updates and formatting changes. - Update to prevent and address HIPAA breach
7.	GA.8051: Hiring Relatives	• Minor language and formatting change.	-Annual review with minor formatting changes
8.	GA. 8058: Salary	• This policy focuses solely on	- Pursuant to CalPERS

Back to Agenda

	Policy No./Name	Summary of Changes	Reason for Change
	Schedule	CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment 1 – Salary Schedule, has been revised in order to reflect recent changes to the Salary Schedule, including changes to, and the addition and deletion of positions. A summary of the changes to the Salary Schedule is included for reference.	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 3 positions indicated on the attached revised Salary Schedule. New Position: Creation of a new Job Title typically due to a change in the scope of a current position or the addition of a new level in a job family. (1 position) Remove Position: Elimination of a Job Title typically due to a change in the scope of a current position or the elimination of position in a job family. (2 positions)

Amendment to Executive Employment Agreement

At its November 1, 2012, meeting, the CalOptima Board of Directors authorized and directed the Board Chairman to enter into an employment with the current Chief Executive Officer, Michael Schrader. An Executive Employment Agreement was executed on December 6, 2012, and has since been amended two times to revise the effective date, eliminate reference to incentive compensation, adjust the base salary, and provide for automatic salary increases consistent with action by the Board of Directors on February 5, 2015.

While regular employees are generally eligible to receive certain CalOptima's Public Agency Retirement Services (PARS) retirement plan and California Public Employees' Retirement System (CalPERS) contributions made by CalOptima on their behalf, it is recommended that the Chief Executive Officer's (CEO) Executive Employment Agreement be updated to ensure full compliance with applicable Internal Revenue Code (IRS) limitations. Specifically, IRS rules prevent CalPERS and PARS plans from recognizing compensation above a specified limit in calculating the benefits. In order to address the IRS limits and to ensure that the CEO is not at a relative disadvantage to other employees, staff recommends that the Board of Directors approve additional discretionary contributions to the PARS retirement plan for the CEO equal to the maximum contribution allowed

by Internal Revenue Code Section 415 and any other applicable provisions of the law, and authorized the contributions to continue from year to year until discontinued by action of the Board of Directors. While the CEO is authorized pursuant to Policy GA. 8042: Supplemental Compensation to provide additional discretionary contributions to the PARS retirement plan for executive 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 for CEO compensation. Accordingly, to ensure that the CEO is not at a relative disadvantage to other employees and to ensure the Executive Employment Agreement is in full compliance with the IRS requirements, staff recommends that the CEO's Executive Employment Agreement be amended. The proposed changes to the current language are shown in redline below, which will be incorporated as presented in the attached Amendment III to the Executive Employment Agreement.

> 3.d.i. To the extent permitted under applicable law, (a) Employer will pay for Employee's portion of contributions to his CalPERS ("PERS") retirement plan; and (b) Employer will make supplemental Public Agency Retirement System ("PARS") retirement contributions ~~to allow Employee to accrue retirement benefits up to the amount equal to his full PERS pension benefit based on his total base compensation~~ equal to the maximum contribution allowed by Internal Revenue Code Section 415 and any other applicable provisions of the law, reduced by the contributions that are already made by CalOptima into the PARS plan under the generally applicable retirement contribution arrangements made for employees. These PARS retirement contributions are to continue from year to year until discontinued by the Board. These supplemental PARS retirement contributions are discretionary and the Board has the power to discontinue these supplemental contributions at any time.

Fiscal Impact

The recommended action to amend the Executive Employment Agreement will result in an additional $5,312.00 in PARS retirement contribution expenditures for plan year 2016. Because the IRS limit on PARS contributions is indexed for inflation, this amount may increase in future years. Unspent budgeted funds for salaries and benefits approved in the CalOptima FY 2016-17 Operating Budget on June 2, 2016, will fund the amendment to the Executive Employment Agreement.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 16-1201-03, Approve Updated Human Resources Policies
2. Revised CalOptima Policies:
   a. GA.8019: Promotions and Transfers
   b. GA.8020: 9/80 Work Schedule (redlined and clean versions) – with Attachments
   c. GA. 8033: License and Certification Tracking
   d. GA. 8047: Reduction in Force (redlined and clean versions) – with revised Attachments
   e. GA. 8050: Confidentiality
   f. GA. 8051: Hiring Relatives
   g. GA.8058: Salary Schedule (redlined and clean versions) – with revised Attachment

Back to Agenda

3. Summary of Changes to the Salary Schedule
4. Board Action dated October 3, 2006, Approve Discretionary Supplemental PARS Retirement Plan Contribution
5. Board of Directors Meeting Minutes dated October 3, 2006
6. Draft Amendment III to Executive Employment Agreement

/s/ Michael Schrader — *11/23/2016*

Authorized Signature — **Date**

Back to Agenda

RESOLUTION NO. 16-1201-03

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

APPROVE UPDATED HUMAN RESOURCES POLICIES

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

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

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 1st day of December, 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

Back to Agenda

Policy #:	GA.8019
Title:	**Promotions and Transfers**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	01/05/12 Revised 8/07/14
Last Review Date:	TBD12/01/16
Last Revised Date:	TBD12/01/16

I. PURPOSE

This policy To establishes a consistent method of considering current employees for internal promotions and transfers.

II. DEFINITIONS

Hiring Manager: Person responsible for making final hiring decision.

Promotion: Occurs when a current employee advances to an open position at a higher classification and salary range from the employee's previous position.

Transfer: Occurs when an employee moves into a new position that is equivalent in its classification and salary range to the employee's previous position.

III.II. POLICY

A. CalOptima supports the development and advancement of its employees from within the organization.

B. CalOptima encourages employees to apply for promotions or transfers to open positions for which they meet the qualifications and minimum requirements.

C. CalOptima will normally post open positions internally for five (5) business days, allowing current employees who possess the necessary education, skills, and experience for the job position and who are in good standing to apply for the open positions.

D. To express interest in an open position, current employees must complete and submit an iInternal Job job Application application and attach an updated resume. An employee may also attach a cover letter.

E. An employee may be considered for an internal promotion, or transfer, only if the following conditions are met:

1. The employee's work performance is in good standing with a minimum of, "Fully Meets Expectations" for the most current review period.

2. The employee must meet the qualifications and minimum requirements required for the position to which the transfer, or promotion, is sought.

3. The employee is not on a formal Performance Improvement Plan and/or has not received a Performance Improvement Plan, or a written, or final, warning within the last six (6) months.

~~4.~~ The employee has been employed in his or her current position for a minimum of six (6) months.

~~5.~~4.

a. Qualified internal applicants will be considered using the same process followed with external candidates, including interview questions, bilingual screening, and other skills tests, as appropriate.

F. On rare occasions, there may be situations where a position is not posted, or a transfer or promotion is granted due to a sensitive business need or where necessitated by other requirements. The Chief Executive Officer (CEO) must approve these exceptions.

G. If a job offer is extended and accepted by a current employee, subject to the background check and/or any other required medical examinations, if applicable, the start date and transition to the new position will be coordinated between the employee, the new supervisor, and the current supervisor. The employee may need to be available to orient and train a replacement.

~~IV.~~III. PROCEDURE

Responsible Party	Action
Employee	1. The employee is responsible for reviewing the job description and/or job posting and ensuring that he or she meets the qualifications and minimum requirements for the job **before** submitting an application. 2. In order to express interest in an open position, employees are responsible for taking ownership of their own career by completing an ~~Internal~~ internal ~~Job~~ job ~~Application~~application, attaching an updated resume, and submitting the complete package to the Human Resources (HR) Department. 3. Employees participate in the same process followed with external candidates, including an interview, bilingual screening, if applicable, and other skills tests applicable to the selection process.

Hiring Manager ~~(HM)~~	1. Review ~~Internal~~ internal ~~Job~~ job ~~Application~~ application with updated resume and notify HR to schedule an interview if the applicant is qualified. 2. Interview the internal applicant. 3. Once a qualified~~-~~ internal applicant has been identified and the Hiring Manager is interested in selecting that applicant to fill an open position, the Hiring Manager shall speak~~s~~ to internal applicant's immediate supervisor as a reference, and review~~s~~ the internal applicant's personnel files for past and current performance reviews with HR. 4. Discuss salary offer with HR. 5. The Hiring Manager will work with the selected employee's current manager to establish a fair start date for both departments.
~~Human Resources (~~HR~~)~~	1. Review internal applicant resumes. 2. Review personnel files for rating of employee for the most current review period and ~~to check~~verify if the employee received a Performance Improvement Plan, or a written or final warning within the last six (6) months. 3. If internal applicant appears to meet qualifications and minimum requirements, HR will send the application to Hiring Manager. At the request of the Hiring Manager, HR shall schedule~~s~~ an interview with the internal applicant. If appropriate, the Hiring Manager will conduct a second interview with additional staff members. If the internal applicant is not selected, HR will notify internal applicant of the decision. 4. If an internal applicant is selected to fill an open position, HR will extend an offer, in consultation with the Hiring Manager, based on the employee's experience and skill level, current pay, classification of the open position, and CalOptima's Compensation Program and Salary Schedule. 5. HR will ~~administer~~ process an Action Form, which is an internal document used by HR in a form similar to the sample form attached hereto and which may be updated from time to time.

~~V.~~IV. ATTACHMENTS

~~A. Internal Job Application~~
~~B.~~A. Action Form (S~~s~~ample)

~~VI.~~V. REFERENCES

~~A.~~ CalOptima Employee Handbook
~~B. CalOptima Policy GA.8057: Compensation Program and Salary Schedule~~
~~C.~~A. ~~CalOptima Employee Handbook~~

VI. REGULATORY AGENCY APPROVALS ~~OR~~

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	01/05/2012	GA.8019	Promotions and Transfers	Administrative
~~Revision Date 1~~Revised	08/07/2014	GA.8019	Promotions and Transfers	Administrative
Revised~~Revision Date 2~~	12/01/2016	GA.8019	Promotions and Transfers	Administrative

IX. GLOSSARY

Term	Definition
Hiring Manager	Person responsible for making final hiring decision.
Performance Improvement Plan	A developmental coaching tool used to improve employee behavior and/or to address performance deficiencies identified in the annual performance review. The plan includes measurable expectations and accountability meetings.
Promotion	Occurs when a current employee -advances to an open position at a higher classification and salary range from the employee's previous position.
Transfer	Occurs when an employee moves into a new position that is equivalent in its classification and salary range to the employee's previous position.

~~Not Applicable~~

~~IX. KEYWORDS~~

~~Promotion~~
~~Transfer~~

Policy #:	GA.8019
Title:	**Promotions and Transfers**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	01/05/12
Last Review Date:	12/01/16
Last Revised Date:	12/01/16

I. PURPOSE

This policy establishes a consistent method of considering current employees for internal promotions and transfers.

II. POLICY

A. CalOptima supports the development and advancement of its employees from within the organization.

B. CalOptima encourages employees to apply for promotions or transfers to open positions for which they meet the qualifications and minimum requirements.

C. CalOptima will normally post open positions internally for five (5) business days, allowing current employees who possess the necessary education, skills, and experience for the job position and who are in good standing to apply for the open positions.

D. To express interest in an open position, current employees must complete and submit an internal job application and attach an updated resume. An employee may also attach a cover letter.

E. An employee may be considered for an internal promotion, or transfer, only if the following conditions are met:

1. The employee's work performance is in good standing with a minimum of "Fully Meets Expectations" for the most current review period.

2. The employee must meet the qualifications and minimum requirements required for the position to which the transfer, or promotion, is sought.

3. The employee is not on a formal Performance Improvement Plan and/or has not received a Performance Improvement Plan, or a written, or final, warning within the last six (6) months.

4. The employee has been employed in his or her current position for a minimum of six (6) months.

    a. Qualified internal applicants will be considered using the same process followed with external candidates, including interview questions, bilingual screening, and other skills tests, as appropriate.

F. On rare occasions, there may be situations where a position is not posted, or a transfer or promotion is granted due to a sensitive business need or where necessitated by other requirements. The Chief Executive Officer (CEO) must approve these exceptions.

G. If a job offer is extended and accepted by a current employee, subject to the background check and/or any other required medical examinations, if applicable, the start date and transition to the new position will be coordinated between the employee, the new supervisor, and the current supervisor. The employee may need to be available to orient and train a replacement.

III. PROCEDURE

Responsible Party	Action
Employee	1. The employee is responsible for reviewing the job description and/or job posting and ensuring that he or she meets the qualifications and minimum requirements for the job **before** submitting an application. 2. In order to express interest in an open position, employees are responsible for taking ownership of their own career by completing an internal job application, attaching an updated resume, and submitting the complete package to the Human Resources (HR) Department. 3. Employees participate in the same process followed with external candidates, including an interview, bilingual screening, if applicable, and other skills tests applicable to the selection process.
Hiring Manager	1. Review internal job application with updated resume and notify HR to schedule an interview if the applicant is qualified. 2. Interview the internal applicant. 3. Once a qualified internal applicant has been identified and the Hiring Manager is interested in selecting that applicant to fill an open position, the Hiring Manager shall speak to internal applicant's immediate supervisor as a reference, and review the internal applicant's personnel files for past and current performance reviews with HR. 4. Discuss salary offer with HR. 5. The Hiring Manager will work with the selected employee's current manager to establish a fair start date for both departments.
HR	1. Review internal applicant resumes. 2. Review personnel files for rating of employee for the most current review period and verify if the employee received a Performance Improvement Plan, or a written or final warning within the last six (6) months. 3. If internal applicant appears to meet qualifications and minimum requirements, HR will send the application to Hiring Manager. At the request of the Hiring Manager, HR shall schedule an interview with the internal applicant. If appropriate, the Hiring Manager will conduct a

	second interview with additional staff members. If the internal applicant is not selected, HR will notify internal applicant of the decision. 4. If an internal applicant is selected to fill an open position, HR will extend an offer, in consultation with the Hiring Manager, based on the employee's experience and skill level, current pay, classification of the open position, and CalOptima's Compensation Program and Salary Schedule. 5. HR will process an Action Form, which is an internal document used by HR in a form similar to the sample form attached hereto and which may be updated from time to time.

IV. ATTACHMENTS

A. Action Form (Sample)

V. REFERENCES

A. CalOptima Employee Handbook

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8019	Promotions and Transfers	Administrative
Revised	08/07/2014	GA.8019	Promotions and Transfers	Administrative
Revised	12/01/2016	GA.8019	Promotions and Transfers	Administrative

IX. GLOSSARY

Term	Definition
Hiring Manager	Person responsible for making final hiring decision.
Performance Improvement Plan	A developmental coaching tool used to improve employee behavior and/or to address performance deficiencies identified in the annual performance review. The plan includes measurable expectations and accountability meetings.
Promotion	Occurs when a current employee advances to an open position at a higher classification and salary range from the employee's previous position.
Transfer	Occurs when an employee moves into a new position that is equivalent in its classification and salary range to the employee's previous position.

CalOptima
A Public Agency
Better. Together.

ACTION FORM

EMPLOYEE INFORMATION

NAME:	EE ID:	PC #:	EFFECTIVE DATE:

LEVEL:	☐ EMP	☐ SUP	☐ MGR	☐ DIR	☐ X - EXEC	Serves OneCare members?	☐ Yes	OCC Members?	☐ Yes	☐ Neither			
LOB:	☐ 1 MEDI-CAL	☐ 2 OCC	☐ 3 PACE	☐ 4 ASO	☐ 6 ONECARE	☐ 7 MSSP	☐ 9 COREC						
SOURCE:	☐ CALOPTIMA WEBSITE	☐ CAREER FAIR	☐ EE REFERRAL	☐ INTERNET	☐ RECRUITER SOURCED	☐ AGENCY	☐ OTHER						
SOURCE NAME:													

REASON

☐ DEMOTION	☐ C&L TRANSLATION	☐ EQUITY ADJUSTMENT	☐ MARKET ADJUSTMENT	☐ NEW HIRE
☐ PC #	☐ PROMOTION	☐ RECLASSIFICATION	☐ REHIRE	☐ RESTRUCTURE
☐ SEPARATION	☐ SHIFT CHANGE	☐ TEMPORARY INCENTIVE	☐ TRANSFER	☐ OTHER _____

ACTION

	CURRENT	CHANGE TO
STATUS	☐ Exempt ☐ Non-Exempt ☐ FT ☐ PT ☐ As-Needed ☐ Limited Term ☐ Active ☐ Inactive w/ Benefits ☐ Inactive w/o Benefits	☐ Exempt ☐ Non-Exempt ☐ FT ☐ PT ☐ As-Needed ☐ Limited Term ☐ Active ☐ Inactive w/ Benefits ☐ Inactive w/o Benefits
POSITION TITLE		
DEPARTMENT		
COST CENTER #		
SUPERVISOR		
SALARY	$	$
SHIFT		
BILINGUAL PAY		
CCM PAY		

SEPARATION

INVOLUNTARY	☐ END OF ASSIGNMENT	☐ JOB ELIMINATION	☐ DECEASED	☐ PERFORMANCE	☐ ATTENDANCE
	☐ POLICY VIOLATION	☐ JOB ABANDONMENT	☐ I-9 VIOLATION	☐ SAM / OIG VIOLATION	☐ OTHER _____
VOLUNTARY	☐ CAREER CHANGE	☐ AUTONOMY	☐ COMMUTE	☐ PAY	☐ MANAGEMENT
	☐ WORKLOAD	☐ ADVANCEMENT	☐ PERSONAL REASONS	☐ RELOCATION	☐ RETIREMENT
	☐ CHANGE FROM AN	☐ UNABLE TO RET LOA	☐ *OTHER* _____		

LAST DAY WORKED:	FINAL PAY CHECK:	☐ FED-EX	☐ EE TO PICK UP	☐ MAIL HOME	☐ *OTHER* _____

COMMENTS

☐ EMPLOYEE COPY SENT

PAYROLL USE

ADJUSTED PTO ACCRUAL RATE: ( ): _____ x _____ = _____

ADDITIONAL CHECK:	REGULAR PAYOUT:	PTO PAYOUT:
	FLEX PAYOUT:	OTHER:

HUMAN RESOURCES USE

HR RECEIVED:
HR ENTERED:
SENT TO PAYROLL:

APPROVAL

CHIEF SIGNATURE:	PRINT NAME:	DATE:
DIRECTOR/MANAGER SIGNATURE:	PRINT NAME:	DATE:
HR EXECUTIVE SIGNATURE:	PRINT NAME:	DATE:
HR MGR SIGNATURE:	PRINT NAME:	DATE:
COMPENSATION ANALYST SIGNATURE:	PRINT NAME:	DATE:
HR PERSONNEL SIGNATURE:	PRINT NAME:	DATE:

Back to Agenda

Policy #:	GA.8020
Title:	**9/80 Work Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	01/05/12
Last Review Date:	~~10/1/14T~~ ~~BD~~12/01/16
Last Revised Date:	~~10/1/14T~~ ~~BD~~12/01/16

~~*Board Required Policy*~~

I. PURPOSE

~~To~~ This policy outlines how CalOptima will establish and administer an alternate workweek schedule commonly referred to as a 9/80 work schedule.

~~II. DEFINITIONS~~

~~III.~~II. POLICY

A. CalOptima offers employees a compressed work schedule known as a 9/80 work schedule. This alternate work schedule provides employees with another way to manage work and non-work responsibilities by giving an additional day off of work while still achieving a full-time schedule (eighty (80) hours in a two (2) week work period).

B. Eligibility: After completing the initial training requirements, all full-time CalOptima employees may, or may not, be eligible to participate in the 9/80 work schedule. An employee must obtain supervisory approval to participate in the 9/80 work schedule. Initial training requirements vary by department, but typically do not exceed ninety (90) calendar days. Individual schedules are set based on the pre-determined schedules for payroll and at the discretion of the department manager who will designate the hours for each day, as well as the day off, based on business needs, which shall be consistent with the 9/80 Federal Labor Standards Act (FLSA) Workweek definition. Employees not meeting job standards or expectations and/or on a P~~p~~erformance I~~i~~mprovement P~~p~~lan may not participate in the compressed work schedule until performance standards are met. Managers will review such exceptions with Human Resources (HR) before denying the option. Individuals who do not wish to participate may continue to work a standard forty (40) hour week, eight (8) hours a day. Employees will not be eligible to participate in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one (1) alternative at a time.

C. Approval: Before beginning participation in the 9/80 work schedule, an employee must complete a 9/80 Workweek Request Form and acknowledge that they received and read this policy. An employee must obtain supervisory approval before submitting the form to HR. Non-exempt employees cannot begin their 9/80 work schedule until they have received formal approval from HR that outlines the approved 9/80 schedule start date.

D. Transitioning to the 9/80 work schedule: When an employee transitions from an eight (8) hour per day workweek to a 9/80 work schedule, there will be a necessary change in the beginning of the workweek. This results in a situation in which some of the hours fall into both the old workweek and the new workweek. This could result in fewer or more than eighty (80) hours on an employee's paycheck for that transitional period. If the result is more than eighty (80) hours, a calculation of overtime will be made for employees eligible for overtime by Payroll which includes those hours in both the old and new workweeks, and the greater of the two (2) amounts will be paid to the employee at time and a half. When possible, HR may require a non-exempt employee to work a half (½) day during the transition week to both minimize overtime worked and ensure that the employee receives a full paycheck.

E. Hours of Work: CalOptima daily start times will continue to be flexible with each employee committing to a starting time no earlier than 6:00 a.m. and a scheduled ending time no later than 6:30 p.m. Lunch breaks are pre-approved for one-half (1/2) hour. The option to extend to one (1) hour is based on manager's approval.

F. Paid Time Off (PTO): PTO accrual will remain the same for participating employees. When an employee takes a day off pursuant to CalOptima Policy GA.8018: Paid Time Off, the accrual will be depleted by the number of scheduled hours for that day. For example, if an employee takes a PTO day on one (1) of their nine (9) hour days, nine (9) hours of PTO time will be removed from their total available PTO hours. Holiday pay shall remain at eight (8) hours. When a holiday falls on a regular nine (9) hour work day for a non-exempt employee, the employee has the option of using one (1) hour of accrued PTO time, or if approved by their supervisor, the option of working one (1) hour of make-up time. Should a holiday fall on an employee's scheduled day off, the employee will be permitted to take another day off in the same workweek.

G. Overtime: An employee's 9/80 work schedule may not generally correspond with CalOptima's pay periods. Therefore, adjustments to overtime compensation due cannot be calculated until the completion of the employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

H. Customer Service Remains a Priority: The 9/80 work schedule is not an entitlement and will not be provided at the expense of service to the public and must not adversely affect the organization's or a department's ability to provide coverage and maintain service levels. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the 9/80 work schedule based on business needs.

I. Employee Conduct: Failure to adhere to assigned work hours, tardiness, and excessive absenteeism will lead to revocation of the benefit for the individual. If necessary, as a condition of participating in the 9/80 work schedule, employees must agree to work on a scheduled day off for an urgent situation, or as compelled by business needs as determined by the employee's manager. Employees are encouraged to use days off to attend to personal business like medical/dental appointments for themselves and family members.

J. Termination of Program: The 9/80 work schedule is an optional program. CalOptima reserves the right to discontinue the entire program or an individual employee's participation in the program at any time for any reason at management discretion. Should a Manager choose to remove an employee from participating in the 9/80 work schedule, the Manager must consult with HR in

advance to develop a transition plan. Employees are not allowed to change their schedules without prior approval from HR and their Manager. ~~-~~Any changes in schedules by Non-Exempt employees must be within the same workweek.

~~IV.~~III. PROCEDURE

Responsible Party	Action
Employee	Complete the 9/80 Workweek Request Form and forward to supervisor for review and approval. ~~●~~▪ Non-exempt employees must submit the applicable request form to HR no less than two (2) weeks in advance of the requested 9/80 start date. ~~●~~▪ Exempt employees must submit the form one (1) week in advance of the requested 9/80 start date.
Supervisor	Review form and approve or deny. ~~●~~▪ Establish work schedule with the employee. ~~●~~ If approved, supervisor forwards form to HR in advance of the requested 9/80 Work Schedule start date. ~~●~~▪
Human Resources	HR reviews requests, and approves or denies. ~~●~~▪ If approved, HR determines an employee's new workweek and sends an e~~-~~mail to the employee to outline when the new workweek will begin and what hours must be worked in the transition week to minimize overtime.

~~V.~~IV. ATTACHMENTS

A. Friday 9/80 Workweek Request Form~~s~~ (Exempt)
B. Friday 9/80 Workweek Request Form (Non-Exempt)
C. Monday 9/80 Workweek Request Form (Exempt)
~~A.~~D. Monday 9/80 Workweek Request Form (Non-Exempt)

~~VI.~~V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8000: Glossary of Terms
~~C.~~ CalOptima Policy GA.8018: Paid Time Off
~~D.~~C. ~~CalOptima Employee Handbook~~
~~E.~~D. Title 29, Code of Federal Regulations (C.F.R.), ~~C.F.R. section~~§ 778.105

VI. REGULATORY AGENCY APPROVALS ~~OR~~

None to Date

VII. BOARD ACTIONS

A. 12/01/16: Regular Meeting of the CalOptima Board of Directors
B. 12/03/15: Regular Meeting of the CalOptima Board of Directors

~~A.~~C. 11/06/14: Regular Meeting of the CalOptima Board ~~Meeting~~ of Directors
~~B.~~D. 05/01/14: Regular Meeting of the CalOptima Board ~~Meeting~~of Directors
~~C.~~E. 01/05/12: Regular Meeting of the CalOptima Board ~~Meeting~~of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	01/05/2012	GA.8020	9/80 Work Schedule	Administrative
~~Revision Date 1~~Revised	02/01/2014	GA.8020	9/80 Work Schedule	Administrative
~~Revision Date 2~~Revised	10/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	~~TBD~~12/01/2016	GA.8020	9/80 Work Schedule	Administrative

IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
9/80 Federal Labor Standards Act (FLSA) Workweek	Under the Fair Labor Standards Act, the workweek is defined as a fixed and regularly recurring period of seven (7) consecutive twenty-four (24) hour periods, or one hundred sixty-eight (168) hours (29 C.F.R. §778.105). The 9/80 workweek begins on the employee's eight (8) hour day, exactly four (4) hours after the scheduled start time, and ends exactly three (3) hours and fifty-nine (59) minutes after the scheduled start time on the same day the following week. This is commonly referred to as a "day divide," in which four (4) hours of the eight (8) hour day occurs in one (1) week, and four (4) hours occurs in the following week. Department supervisors/managers and HR can answer questions about day divides.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Non-Exempt Employee	Includes all employees who are not identified as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation as required by federal wage and hour laws.
Performance Improvement Plan	A developmental coaching tool used to improve employee behavior and/or to address performance deficiencies identified in the annual performance review. The plan includes measurable expectations and accountability meetings.

~~A. 10/1/14: GA.8020: 9/80 Work Schedule~~
~~B. 2/1/14: GA.8020: 9/80 Work Schedule~~
~~C. 1/5/12: GA.8020: 9/80 Work Schedule~~

Policy #:	GA.8020
Title:	**9/80 Work Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	01/05/12
Last Review Date:	12/01/16
Last Revised Date:	12/01/16

I. PURPOSE

This policy outlines how CalOptima will establish and administer an alternate workweek schedule commonly referred to as a 9/80 work schedule.

II. POLICY

A. CalOptima offers employees a compressed work schedule known as a 9/80 work schedule. This alternate work schedule provides employees with another way to manage work and non-work responsibilities by giving an additional day off of work while still achieving a full-time schedule (eighty (80) hours in a two (2) week work period).

B. Eligibility: After completing the initial training requirements, all full-time CalOptima employees may, or may not, be eligible to participate in the 9/80 work schedule. An employee must obtain supervisory approval to participate in the 9/80 work schedule. Initial training requirements vary by department, but typically do not exceed ninety (90) calendar days. Individual schedules are set based on the pre-determined schedules for payroll and at the discretion of the department manager who will designate the hours for each day, as well as the day off, based on business needs, which shall be consistent with the 9/80 Federal Labor Standards Act (FLSA) Workweek definition. Employees not meeting job standards or expectations and/or on a Performance Improvement Plan may not participate in the compressed work schedule until performance standards are met. Managers will review such exceptions with Human Resources (HR) before denying the option. Individuals who do not wish to participate may continue to work a standard forty (40) hour week, eight (8) hours a day. Employees will not be eligible to participate in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one (1) alternative at a time.

C. Approval: Before beginning participation in the 9/80 work schedule, an employee must complete a 9/80 Workweek Request Form and acknowledge that they received and read this policy. An employee must obtain supervisory approval before submitting the form to HR. Non-exempt employees cannot begin their 9/80 work schedule until they have received formal approval from HR that outlines the approved 9/80 schedule start date.

D. Transitioning to the 9/80 work schedule: When an employee transitions from an eight (8) hour per day workweek to a 9/80 work schedule, there will be a necessary change in the beginning of the workweek. This results in a situation in which some of the hours fall into both the old workweek and the new workweek. This could result in fewer or more than eighty (80) hours on an employee's paycheck for that transitional period. If the result is more than eighty (80) hours, a calculation of overtime will be made for employees eligible for overtime by Payroll which includes those hours in

both the old and new workweeks, and the greater of the two (2) amounts will be paid to the employee at time and a half. When possible, HR may require a non-exempt employee to work a half (½) day during the transition week to both minimize overtime worked and ensure that the employee receives a full paycheck.

E. Hours of Work: CalOptima daily start times will continue to be flexible with each employee committing to a starting time no earlier than 6:00 a.m. and a scheduled ending time no later than 6:30 p.m. Lunch breaks are pre-approved for one-half (1/2) hour. The option to extend to one (1) hour is based on manager's approval.

F. Paid Time Off (PTO): PTO accrual will remain the same for participating employees. When an employee takes a day off pursuant to CalOptima Policy GA.8018: Paid Time Off, the accrual will be depleted by the number of scheduled hours for that day. For example, if an employee takes a PTO day on one (1) of their nine (9) hour days, nine (9) hours of PTO time will be removed from their total available PTO hours. Holiday pay shall remain at eight (8) hours. When a holiday falls on a regular nine (9) hour work day for a non-exempt employee, the employee has the option of using one (1) hour of accrued PTO time, or if approved by their supervisor, the option of working one (1) hour of make-up time. Should a holiday fall on an employee's scheduled day off, the employee will be permitted to take another day off in the same workweek.

G. Overtime: An employee's 9/80 work schedule may not generally correspond with CalOptima's pay periods. Therefore, adjustments to overtime compensation due cannot be calculated until the completion of the employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

H. Customer Service Remains a Priority: The 9/80 work schedule is not an entitlement and will not be provided at the expense of service to the public and must not adversely affect the organization's or a department's ability to provide coverage and maintain service levels. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the 9/80 work schedule based on business needs.

I. Employee Conduct: Failure to adhere to assigned work hours, tardiness, and excessive absenteeism will lead to revocation of the benefit for the individual. If necessary, as a condition of participating in the 9/80 work schedule, employees must agree to work on a scheduled day off for an urgent situation, or as compelled by business needs as determined by the employee's manager. Employees are encouraged to use days off to attend to personal business like medical/dental appointments for themselves and family members.

J. Termination of Program: The 9/80 work schedule is an optional program. CalOptima reserves the right to discontinue the entire program or an individual employee's participation in the program at any time for any reason at management discretion. Should a Manager choose to remove an employee from participating in the 9/80 work schedule, the Manager must consult with HR in advance to develop a transition plan. Employees are not allowed to change their schedules without prior approval from HR and their Manager. Any changes in schedules by Non-Exempt employees must be within the same workweek.

III. PROCEDURE

Responsible Party	Action

Responsible Party	Action
Employee	Complete the 9/80 Workweek Request Form and forward to supervisor for review and approval. ▪ Non-exempt employees must submit the applicable request form to HR no less than two (2) weeks in advance of the requested 9/80 start date. ▪ Exempt employees must submit the form one (1) week in advance of the requested 9/80 start date.
Supervisor	Review form and approve or deny. ▪ Establish work schedule with the employee. ▪ If approved, supervisor forwards form to HR in advance of the requested 9/80 Work Schedule start date.
Human Resources	HR reviews requests, and approves or denies. ▪ If approved, HR determines an employee's new workweek and sends an email to the employee to outline when the new workweek will begin and what hours must be worked in the transition week to minimize overtime.

IV. ATTACHMENTS

A. Friday 9/80 Workweek Request Form (Exempt)
B. Friday 9/80 Workweek Request Form (Non-Exempt)
C. Monday 9/80 Workweek Request Form (Exempt)
D. Monday 9/80 Workweek Request Form (Non-Exempt)

V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8000: Glossary of Terms
C. CalOptima Policy GA.8018: Paid Time Off
D. Title 29, Code of Federal Regulations (C.F.R.), § 778.105

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/01/16: Regular Meeting of the CalOptima Board of Directors
B. 12/03/15: Regular Meeting of the CalOptima Board of Directors
C. 11/06/14: Regular Meeting of the CalOptima Board of Directors
D. 05/01/14: Regular Meeting of the CalOptima Board of Directors
E. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8020	9/80 Work Schedule	Administrative
Revised	02/01/2014	GA.8020	9/80 Work Schedule	Administrative

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	10/01/2014	GA.8020	9/80 Work Schedule	Administrative
Revised	12/01/2016	GA.8020	9/80 Work Schedule	Administrative

1
2

IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
9/80 Federal Labor Standards Act (FLSA) Workweek	Under the Fair Labor Standards Act, the workweek is defined as a fixed and regularly recurring period of seven (7) consecutive twenty-four (24) hour periods, or one hundred sixty-eight (168) hours (29 C.F.R. §778.105). The 9/80 workweek begins on the employee's eight (8) hour day, exactly four (4) hours after the scheduled start time, and ends exactly three (3) hours and fifty-nine (59) minutes after the scheduled start time on the same day the following week. This is commonly referred to as a "day divide," in which four (4) hours of the eight (8) hour day occurs in one (1) week, and four (4) hours occurs in the following week. Department supervisors/managers and HR can answer questions about day divides.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Non-Exempt Employee	Includes all employees who are not identified as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation as required by federal wage and hour laws.
Performance Improvement Plan	A developmental coaching tool used to improve employee behavior and/or to address performance deficiencies identified in the annual performance review. The plan includes measurable expectations and accountability meetings.

Friday 9/80 Workweek Request Form
Declaration of Hours - Exempt Employees

I, the undersigned employee, wish to participate in CalOptima's 9/80 Compressed Work Schedule Program.

I am requesting to work the following schedule, designating this day off:

1st Friday ☐ or 2nd Friday ☐

Lunch Break: ☒ one hour. **From**: 12:00 p.m. **to** 1:00 p.m.

**Fill in below which Friday you'll be off. The hours for the 8-hour Friday worked will be 8:00 a.m. to 5:00 p.m.*

Week 1 of pay period	Monday		Tuesday		Wednesday		Thursday		Friday	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time
	8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm		
Week 2 of pay period	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time
	8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm		

Provisions:

1) The 9/80 program may be modified or discontinued at any time.
2) My participation in the 9/80 Work Schedule is at the discretion of my Supervisor. As a condition of participating in the 9/80 work schedule, I agree to work on a scheduled day off for an urgent situation or as compelled by business needs as determined by my supervisor/manager.
3) The workweek will be subjected to a "Day Divide," meaning that my workweek will begin half-way through my 8 hour day (which is split in half for pay purposes, leaving 4 hours in one week and 4 hours in the following week, ensuring that 40 hours of work are performed in each workweek).
4) **I must notify HR if I plan to permanently change my 9/80 day off or if I end the 9/80 program**.

I, the Employee, acknowledge that I have read and understand all the policy provisions contained in CalOptima Policy #GA. 8020: 9/80 Work Schedule and Employee Handbook and agree to abide by the guidelines and requirements as stated.

Employee Name (*Print*): _____ Employee Name (*Sign*): _____

Date: _____ 4 Digit Employee ID #: _____

I, the Supervisor, acknowledge and understand the above provisions and guidelines as stated.

Supervisor Name (*Print*): _____ Supervisor Name (*Sign*): _____

Date: _____

Please give the original signed form to Human Resources and a copy to your Manager.

Date Requesting to Start (must be beginning of pay period): _____

HR Only
Approved: _____ Date: _____ Date to Start: _____
Denied: _____ Date: _____ Reason: _____

Back to Agenda

Friday 9/80 Workweek Request Form
Declaration of Hours - Non-Exempt Employees

I, the undersigned employee, wish to participate in CalOptima's 9/80 Compressed Work Schedule Program.

- I am currently working a 9/80 schedule: ☐ Yes ☐ No If yes, my current day off is: _____
- I am requesting to work the following schedule, designating this day off: 1st Friday ☐ or 2nd Friday ☐

**Fill in below your work hours according to the schedule options on page 2 and which Friday you'll be off. The opposite Friday must be your 8-hour day.*

- **My Start Time Will Be**: _____ **My End Time Will Be**: _____
- Lunch Break: ☒ half hour. **From**: _____ **To**: _____

Week 1 of pay period	Monday		Tuesday		Wednesday		Thursday		Friday	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time
Week 2 of pay period	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time

Provisions:

1) The 9/80 program may be modified or discontinued at any time.
2) My participation in the 9/80 Work Schedule is at the discretion of my Supervisor. As a condition of participating in the 9/80 work schedule, I agree to work on a scheduled day off for an urgent situation or as compelled by business needs as determined by my supervisor/manager.
3) The workweek will be subjected to a "Day Divide," meaning that my workweek will begin half-way through my 8 hour day (which is split in half for pay purposes, leaving 4 hours in one week and 4 hours in the following week, ensuring that 40 hours of work are performed in each workweek).
4) **I cannot start working a 9/80 schedule, change a 9/80 schedule, or end a 9/80 schedule until Human Resources has confirmed a transition schedule and date for this alternative workweek arrangement.**

I, the Employee, acknowledge that I have read and understand all the policy provisions contained in CalOptima Policy #GA. 8020: 9/80 Work Schedule and Employee Handbook and agree to abide by the guidelines and requirements as stated.

Employee Name (*Print*): _____ Employee Name (*Sign*): _____

Date: _____ 4 Digit Employee ID #: _____

I, the Supervisor, acknowledge and understand the above provisions and guidelines as stated.

Supervisor Name (*Print*): _____ Supervisor Name (*Sign*): _____

Date: _____ Date Requesting to Start (must be beginning of pay period): _____

Please give the original signed form to Human Resources and a copy to your Manager.

HR Only
Approved: _____ Date: _____ Date to Start: _____
Denied: _____ Date: _____ Reason: _____

Friday 9/80 Schedule Options for Non-Exempt Employees

(no exceptions to these schedules are permitted)

Start Time	End Time	Lunch Start Time	Lunch End Time	Notes
6:00 a.m.	3:30 p.m.	10:00 a.m.	10:30 a.m.	2nd Friday off only
7:00 a.m.	4:30 p.m.	11:00 a.m.	11:30 p.m.	1st or 2nd Friday off
7:30 a.m.	5:00 p.m.	11:30 p.m.	12:00 p.m.	1st or 2nd Friday off
8:00 a.m.	5:30 p.m.	12:00 p.m.	12:30 p.m.	1st or 2nd Friday off
8:30 a.m.	6:00 p.m.	12:30 p.m.	1:00 p.m.	1st or 2nd Friday off
9:00 a.m.	6:30 p.m.	1:00 p.m.	1:30 p.m.	1st or 2nd Friday off

Monday 9/80 Workweek Request Form
Declaration of Hours - Exempt Employees

I, the undersigned employee, wish to participate in CalOptima's 9/80 Compressed Work Schedule Program.

I am requesting to work the following schedule, designating this day off:

1st Monday ☐ or 2nd Monday ☐

Lunch Break: ☒ one hour. **From**: 12:00 p.m. **to** 1:00 p.m.

**Fill in below which Monday you'll be off. The hours for the 8-hour Monday worked will be 8:00 a.m. to 5:00 p.m.*

Week 1 of pay period	Monday		Tuesday		Wednesday		Thursday		Friday	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time
			8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm
Week 2 of pay period	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time
			8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm	8:00am	6:00pm

Provisions:

1) The 9/80 program may be modified or discontinued at any time.
2) My participation in the 9/80 Work Schedule is at the discretion of my Supervisor. As a condition of participating in the 9/80 work schedule, I agree to work on a scheduled day off for an urgent situation or as compelled by business needs as determined by my supervisor/manager.
3) The workweek will be subjected to a "Day Divide," meaning that my workweek will begin half-way through my 8 hour day (which is split in half for pay purposes, leaving 4 hours in one week and 4 hours in the following week, ensuring that 40 hours of work are performed in each workweek).
4) **I must notify HR if I plan to permanently change my 9/80 day off or if I end the 9/80 program**.

I, the Employee, acknowledge that I have read and understand all the policy provisions contained in CalOptima Policy #GA. 8020: 9/80 Work Schedule and Employee Handbook and agree to abide by the guidelines and requirements as stated.

Employee Name (*Print*): _____ Employee Name (*Sign*): _____

Date: _____ 4 Digit Employee ID #: _____

I, the Supervisor, acknowledge and understand the above provisions and guidelines as stated.

Supervisor Name (*Print*): _____ Supervisor Name (*Sign*): _____

Date: _____

Please give the original signed form to Human Resources and a copy to your Manager.

Date Requesting to Start (must be beginning of pay period): _____

HR Only
Approved: _____ Date: _____ Date to Start: _____
Denied: _____ Date: _____ Reason: _____

Back to Agenda

Monday 9/80 Workweek Request Form
Declaration of Hours - Non-Exempt Employees

I, the undersigned employee, wish to participate in CalOptima's 9/80 Compressed Work Schedule Program.

- I am currently working a 9/80 schedule: ☐ Yes ☐ No If yes, my current day off is: _____
- I am requesting to work the following schedule, designating this day off: 1st Monday ☐ or 2nd Monday ☐

**Fill in below your work hours according to the schedule options on page 2 and which Monday you'll be off. The opposite Monday must be your 8-hour day.*

- **My Start Time Will Be**: _____ **My End Time Will Be**: _____
- Lunch Break: ☒ half hour. **From**: _____ **To**: _____

Week 1 of pay period	Monday		Tuesday		Wednesday		Thursday		Friday	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time
Week 2 of pay period	**Monday**		**Tuesday**		**Wednesday**		**Thursday**		**Friday**	
	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time	Start Time	End Time

Provisions:

1) The 9/80 program may be modified or discontinued at any time.
2) My participation in the 9/80 Work Schedule is at the discretion of my Supervisor. As a condition of participating in the 9/80 work schedule, I agree to work on a scheduled day off for an urgent situation or as compelled by business needs as determined by my supervisor/manager.
3) The workweek will be subjected to a "Day Divide," meaning that my workweek will begin half-way through my 8 hour day (which is split in half for pay purposes, leaving 4 hours in one week and 4 hours in the following week, ensuring that 40 hours of work are performed in each workweek).
4) **I cannot start working a 9/80 schedule, change a 9/80 schedule, or end a 9/80 schedule until Human Resources has confirmed a transition schedule and date for this alternative workweek arrangement.**

I, the Employee, acknowledge that I have read and understand all the policy provisions contained in CalOptima Policy #GA. 8020: 9/80 Work Schedule and Employee Handbook and agree to abide by the guidelines and requirements as stated.

Employee Name (*Print*): _____ Employee Name (*Sign*): _____

Date: _____ 4 Digit Employee ID #: _____

I, the Supervisor, acknowledge and understand the above provisions and guidelines as stated.

Supervisor Name (*Print*): _____ Supervisor Name (*Sign*): _____

Date: _____ Date Requesting to Start (must be beginning of pay period): _____

Please give the original signed form to Human Resources and a copy to your Manager.

HR Only
Approved: _____ Date: _____ Date to Start: _____
Denied: _____ Date: _____ Reason: _____

Monday 9/80 Schedule Options for Non-Exempt Employees

(no exceptions to these schedules are permitted)

Start Time	End Time	Lunch Start Time	Lunch End Time	Notes
6:00 a.m.	3:30 p.m.	10:00 a.m.	10:30 a.m.	2nd Monday off only
7:00 a.m.	4:30 p.m.	11:00 a.m.	11:30 p.m.	1st or 2nd Monday off
7:30 a.m.	5:00 p.m.	11:30 p.m.	12:00 p.m.	1st or 2nd Monday off
8:00 a.m.	5:30 p.m.	12:00 p.m.	12:30 p.m.	1st or 2nd Monday off
8:30 a.m.	6:00 p.m.	12:30 p.m.	1:00 p.m.	1st or 2nd Monday off
9:00 a.m.	6:30 p.m.	1:00 p.m.	1:30 p.m.	1st or 2nd Monday off

Policy #:	GA.8033
Title:	**License and Certification Tracking**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader: _____
Effective Date:	~~–~~01/05/12
Last Review Date:	~~11/06/14~~1 ~~11/6/14~~ 2/01/16
Last ~~Revision~~ Revised Date:	~~11/06/14~~1 2/01/16 ~~11/6/14~~
~~*Board Required Policy*~~	

I. PURPOSE

~~To~~ This policy describes how CalOptima ensures that all staff, ~~who are~~ required to have active and current licenses and/or certifications, have the appropriate and required licensure(s) and/or certification(s) with proper renewal information.

~~II. DEFINITIONS~~

~~III.~~II. POLICY

A. When Required Licensure and/or Certification is/are mandated as part of a job position or in the performance of an employee's job duties, or where an employee receives supplemental pay for having a particular license and/or certification, ~~-~~the applicant/employee shall have, maintain, and provide proof of the applicable active and current license(s) and/or certification(s). The Human Resources (HR) Department shall verify the license(s) and/or certification(s) of each applicant, including the license/certification number(s) and expiration date(s), through the appropriate licensing/certifying board to ensure primary source verification. A new employee who fails to provide proof of Required Licensure and/or Certification prior to his or her start date shall not be permitted to work until such proof has been submitted and verified by HR. Required Licensures and Certifications are verified at the time of hire and prior to their expiration date.

B. An employee whose job description specifies a Required Licensure and/or Certification, and/or an employee who receives supplemental pay for having a particular license and/or certification, is responsible for maintaining an active and current license and/or certification for the duration of his/her employment at CalOptima. If CalOptima does **not** receive proof of license and/or certification renewal prior to the expiration date, the employee may be subject to suspension without pay effective the following business day. CalOptima will remove the employment suspension when it has obtained proof of an active and current licensure and/or certification. If an employee fails to provide verification of Required Licensure and/or Certification renewal to CalOptima within a reasonable period of time following the expiration date, the employee may be terminated from employment with CalOptima.

C. Employees shall notify the Human Resources Department immediately any time the employee knows, or has reason to know, of any action to be taken on the employee's Required Licensure and/or Certification or an event that occurs that could lead to such actions, including, but not limited to, licensing board investigations, restrictions, allegations, revocations, accidents, DUIs, etc.

~~IV.~~III. PROCEDURE

Responsible Party	Action
Employee	1. Provide proof of active and current license(s) and/or certification(s) upon hire. 2. Renew all Required Licensures and/or Certifications on time. 3. Provide HR with documentation of renewed license(s) and/or certification(s) before license and/or certification expiration date. 4. Notify HR immediately if the employee knows, or has reason to know, of any actual or potential adverse action, or event, impacting the employee's license and/or certification.
Human Resources	1. Verify the validity and date of expiration of the license(s) and/or certification(s) prior to the employee's start date, and prior to the expiration date, and place a copy in the employee's HR file. 2. Track licensures and/or certifications to ensure all required licenses and/or certifications are up to date. 3. Where an employee receives supplemental pay for having a particular license and/or certification, verify and track such license and/or certification to ensure the employee continues to qualify for such supplemental pay.

~~V.~~IV. ATTACHMENTS

Not Applicable

~~VI.~~V. REFERENCES

A. CalOptima Employee Handbook

VI. REGULATORY AGENCY APPROVALS ~~OR~~

None to Date

VII. BOARD ACTIONS

A. 12/01/16: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 11/06/14: Regular Meeting of the CalOptima Board of Directors~~Meeting~~
~~B.~~C. 01/05/12: Regular Meeting of the CalOptima Board ~~Meeting~~of Directors

VIII. REVIEW/REVISION HISTORY

Version	~~Version~~ Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	01/05/2012	GA.8033	Professional License Tracking, changed to License and Certification	Administrative
R~~evision Date~~ 1evised	11/06/2014	GA.8033	License and Certification Tracking~~Professional License Tracking Policy Creation~~	Administrative
~~Reviewed/~~ Revised	~~TBD~~12/01/2016	GA.8033	License and Certification Tracking	Administrative

IX. GLOSSARY

Term	Definition
Required Licensure and/or Certification	Licenses and/or certificates deemed "required" in the applicable job description and/or required in the performance of an employee's job duties, including, but not limited to, professional licenses, driver's licenses, etc.

Policy #: GA.8033
Title: **License and Certification Tracking**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader: _____

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

I. PURPOSE

This policy describes how CalOptima ensures that all staff, required to have active and current licenses and/or certifications, have the appropriate and required licensure(s) and/or certification(s) with proper renewal information.

II. POLICY

A. When Required Licensure and/or Certification is/are mandated as part of a job position or in the performance of an employee's job duties, or where an employee receives supplemental pay for having a particular license and/or certification, the applicant/employee shall have, maintain, and provide proof of the applicable active and current license(s) and/or certification(s). The Human Resources (HR) Department shall verify the license(s) and/or certification(s) of each applicant, including the license/certification number(s) and expiration date(s), through the appropriate licensing/certifying board to ensure primary source verification. A new employee who fails to provide proof of Required Licensure and/or Certification prior to his or her start date shall not be permitted to work until such proof has been submitted and verified by HR. Required Licensures and Certifications are verified at the time of hire and prior to their expiration date.

B. An employee whose job description specifies a Required Licensure and/or Certification, and/or an employee who receives supplemental pay for having a particular license and/or certification, is responsible for maintaining an active and current license and/or certification for the duration of his/her employment at CalOptima. If CalOptima does **not** receive proof of license and/or certification renewal prior to the expiration date, the employee may be subject to suspension without pay effective the following business day. CalOptima will remove the employment suspension when it has obtained proof of an active and current licensure and/or certification. If an employee fails to provide verification of Required Licensure and/or Certification renewal to CalOptima within a reasonable period of time following the expiration date, the employee may be terminated from employment with CalOptima.

C. Employees shall notify the Human Resources Department immediately any time the employee knows, or has reason to know, of any action to be taken on the employee's Required Licensure and/or Certification or an event that occurs that could lead to such actions, including, but not limited to, licensing board investigations, restrictions, allegations, revocations, accidents, DUIs, etc.

III. PROCEDURE

Responsible Party	Action

Responsible Party	Action
Employee	1. Provide proof of active and current license(s) and/or certification(s) upon hire. 2. Renew all Required Licensures and/or Certifications on time. 3. Provide HR with documentation of renewed license(s) and/or certification(s) before license and/or certification expiration date. 4. Notify HR immediately if the employee knows, or has reason to know, of any actual or potential adverse action, or event, impacting the employee's license and/or certification.
Human Resources	1. Verify the validity and date of expiration of the license(s) and/or certification(s) prior to the employee's start date, and prior to the expiration date, and place a copy in the employee's HR file. 2. Track licensures and/or certifications to ensure all required licenses and/or certifications are up to date. 3. Where an employee receives supplemental pay for having a particular license and/or certification, verify and track such license and/or certification to ensure the employee continues to qualify for such supplemental pay.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Employee Handbook

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/01/16: Regular Meeting of the CalOptima Board of Directors
B. 11/06/14: Regular Meeting of the CalOptima Board of Directors
C. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8033	Professional License Tracking, changed to License and Certification	Administrative

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	11/06/2014	GA.8033	License and Certification Tracking	Administrative
Revised	12/01/2016	GA.8033	License and Certification Tracking	Administrative

1
2

IX. GLOSSARY

Term	Definition
Required Licensure and/or Certification	Licenses and/or certificates deemed "required" in the applicable job description and/or required in the performance of an employee's job duties, including, but not limited to, professional licenses, driver's licenses, etc.

Policy #:	GA.8047
Title:	**Reduction In Force**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader ~~Rev ised :~~ ~~8/7/14~~
Effective Date:	02/01/14
Last Review Date:	~~TBD~~12/01/16
Last Revised Date:	~~TBD~~12/01/16

I. PURPOSE

This policy ~~To~~ defines how CalOptima shall administer a Reduction ~~i~~In Force (RIF) program. A RIF occurs when changing priorities, budgetary constraints, or other business conditions require CalOptima to eliminate positions.

~~II. DEFINITIONS~~

~~A. Annual Earnings: The annualized base salary of the employee as of the Separation Date, without regard to overtime, car allowances, bonus, incentive payments or commission payments.~~

~~B. At Will: An employment, having no specified term, may be terminated at the will of employees or employers at any time and with or without cause.~~

~~C. Exempt Employees: Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries, where applicable. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.~~

~~D. Full-Time Employee: An employee who works sixty (60) to eighty (80) hours a pay period.~~

~~E. Limited Term Employees: Employees who are hired to work a full-time schedule on special assignments that last a period of less than six (6) months. Limited Term employees do not become regular employees as a result of the passage of time.~~

~~F. Non-Exempt Employees: Includes all employees who are not identified as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation as required by federal wage and hour laws.~~

~~G. Part-time Employees: Employees that regularly work at least twenty (20) hours per week and no more than thirty (30) hours per week.~~

~~H. Service: All periods of employment with CalOptima, provided that service does not include periods in which an employee is on a Personal leave of absence pursuant to CalOptima Policy GA.8038: Personal Leave of Absence, and service shall not include any period of employment for which the~~

~~employee has received severance pay under the RIF program or under any similar plan of CalOptima's.~~

~~I. Separation Date: The last day of employment with CalOptima.~~

~~III.~~II. POLICY

A. All CalOptima employees are At-Will employees ~~as described in CalOptima Policy #: GA.8028: At-Will~~. An employee is terminated as part of the RIF program through no fault of his or her own. The RIF is considered an involuntary separation of employment that is intended to be permanent as a result of:

1. Lack of work, changing priorities, budgetary constraints or other business reasons; or

2. A determination by management that, due to business reasons, an employee's performance or contribution to the business (although satisfactory) does not meet the needs of the business.

B. As part of the RIF program, CalOptima shall evaluate the business needs of the organization and the need for particular positions. CalOptima shall take into account the relative value of work performed by specific employees, including, but not limited to, performance, qualifications, discipline, attendance, and length of service, so that CalOptima can continue to provide the highest level of service possible with a reduced work force. In implementing an RIF program, CalOptima may consider, depending on the circumstances, various factors, including, but not limited to, the following (which are not presented in any order of importance):

1. CalOptima's need, or lack thereof, for the position occupied by the employee;

2. The contributions which the employee has made to the success of the organization, and the perceived likelihood of contributions to the success of the business in the foreseeable future;

3. Demonstrated high quality performance on the same or related assignments;

4. Versatility and ability in applying pertinent skills and experience to current and expected business requirements;

5. The employee's length of service in the particular position to be retained;

6. The employee's length of service with CalOptima;

7. CalOptima's need to maintain continuity with respect to a particular project or team; and

8. The more recent performance of the employee compared to others in the same classification.

C. In cases where management determines the various factors considered are essentially equal between two (2) or more employees, length of service in the position and/or length of service at CalOptima may be the deciding factor in determining which employee or employees shall be retained. In the

event an employee who is being laid off has greater length of service in the position and/or length of service at CalOptima than an employee or employees being retained within the same classification and specialty in the impacted department, CalOptima must document the basis, in the judgment of management, the employee with less length of service is better suited for retention.

D. The Human Resources Department shall work closely with the Legal Affairs Department to implement the RIF program to ensure compliance with all applicable federal, state and local laws and regulations.

E. An employee terminated as part of the RIF program must continue to perform his or her duties satisfactorily until the Separation Date. Otherwise, the employee may be subject to disciplinary action, up to and including termination, prior to the specified Separation Date, consistent with CalOptima Policy ~~#:~~ GA.8022: Progressive Discipline. An employee terminated as a result of failure to perform duties satisfactorily until the Separation Date shall not be qualified to receive any benefits administered as part of the RIF program.

F. Limitations to Eligibility

1. An employee terminated as part of the RIF program will not be eligible to receive benefits under the plan if the employee:

   a. Is terminated for cause, including but not limited to, failure to meet the performance requirements of the position, policy violation, theft, gross misconduct, etc.; or

   b. Fails or refuses to return all CalOptima property in the employee's possession, and/or fails to clear all expense and other financial accounts, as of the date of termination. (Examples of CalOptima property include, but are not limited to: CalOptima Security badges, office keys any and all CalOptima documents, files, and computers. Examples of accounts to be cleared include, but are not limited to, the completion and reconciliation of expense accounts); or

   c. Resigns or otherwise voluntarily terminates his or her employment; or

   d. Is terminated by temporary layoff or furlough, except that if CalOptima elects to convert the temporary layoff or furlough into a permanent layoff, severance pay may then be payable as of the effective date of permanent layoff, if the employee otherwise is eligible for benefits under the RIF program; or,

   e. Is on a leave of absence, except that if an employee is released to return to work from an approved leave of absence and CalOptima has no assignment for the employee, he/she may be eligible for benefits under the RIF program; or

   f. Is offered a comparable position within CalOptima in lieu of termination, but fails or refuses to accept it; or

   g. Is terminated because of CalOptima's sale or transfer of all or part of its assets and his/her employment continues with the agency or transferee organization after the transfer has been completed; or

h. Is terminated in connection with the "outsourcing" of operational functions, and he/she is offered comparable employment by the outsourcing vendor. For this purpose, comparable employment shall be defined as a position with substantially the same duties, at the same or greater compensation and comparable benefits, which does not require relocation, as defined by the IRS; or

i. Is terminated from employment for failure to return to work following a leave of absence; or

j. Retires; or

k. Is deceased, at which time eligibility for benefits under the RIF program will end and all such benefit payments, if any, will cease; or

l. Is separated from CalOptima because he or she is no longer able to perform the essential functions of his/her job (with or without reasonable accommodation) because of a disability; or

m. Is a temporary employee, intern/volunteer, independent contractor or consultant; or

n. Is an employee employed by CalOptima pursuant to a written contract containing provisions for severance benefits; or

o. Is convicted of a crime involving an abuse of his or her office or position.

G. This policy sets forth general guidelines to observe in the event of a RIF; however, this policy may be subject to change, deviation or modification, without notice, depending on the circumstances. Any decision to deviate from this policy in any particular case shall be subject to the discretion of the Chief Executive Officer (CEO).

~~G.~~H. Applicable provisions of this policy may also be used to address employee separations or terminations, other than a RIF, where appropriate, at the discretion of the CEO.

~~IV.~~III. PROCEDURE

A. Affected Positions: Following an evaluation of CalOptima's business needs, CalOptima, through appropriate Executive Officers and the Human Resources Department (hereinafter referred to as the "management"), will identify and determine the positions that will be eliminated and/or affected by a RIF. ~~-~~Management also has the discretion to determine the manner in which the RIF will occur; however, notification to the Human Resources Department (HR) should precede the implementation of the RIF.

B. Determinations: Determinations concerning the evaluation of employees, the considerations evaluated, and final recommendations should be made by the employee's immediate supervisor and/or manager with the next higher management level. Documentation of all considerations evaluated should be furnished to HR and approved by management prior to any notification to the employee affected by the RIF.

C. Transfers or Downgrades: Depending on CalOptima's business needs, an employee impacted by the RIF may be offered a downgrade (a lower position and/or reduction in base pay) or lateral

transfer (an equivalent position and/or equivalent base pay) to another open job position for which he or she is, in the judgment of management, most qualified even though it is a job position or classification that the employee has not previously held. An employee impacted by the RIF who is offered a lateral transfer or downgrade may be provided the option of layoff. HR shall determine, on a case-by-case basis, the time period appropriate to accept or decline such job offer.

D. Employee Notices: Employees who are to be laid off as a result of the RIF should be notified of such reduction only after all necessary approvals have been obtained. An employee notified of a lay off must continue to work up to the Separation Date specified in the notice, unless management decides otherwise. ~~-~~An employee notified of his or her lay off as a result of the RIF may not subsequently be placed on a leave of absence (LOA) without prior approval of the Executive Director of HR.

E. Severance: Severance Pay may be offered, if approved by the Chief Executive Officer and HR, upon an employee's separation from service when it is deemed appropriate due to special circumstances. If severance pay is authorized and offered, it will be paid in accordance with the following, unless otherwise defined in a separate employee agreement or approved by the CEO:

1. Two (2) weeks of pay at the rate of the Annual Earnings for employees with less than two (2) years of service and more than ninety (90) days; or

2. One (1) week of pay at the rate of the Annual Earnings for each completed year of service, with a maximum of sixteen (16) weeks, for employees with two (2) years or more of service.

F. Employees on a Leave of Absence: If an employee is on a Leave of Absence (LOA), and his or her position is terminated as part of the RIF, CalOptima will not terminate the LOA early to implement the RIF program. The employee will be laid off at the scheduled or required conclusion of the LOA. This paragraph does not apply to employees on Personal LOA pursuant to CalOptima Policy GA.~~-~~8038~~:~~: Personal Leave of Absence.

G. Release Agreement: In order to be eligible for the severance pay, if offered, an eligible employee must fully complete and execute ~~the Release of Claims~~a Separation Agreement provided by CalOptima, in a form approved by the Legal Affairs Department, at or near the time of termination. This ~~Release of Claims~~Separation Agreement includes a release of all known and unknown claims the employee has or may have against CalOptima as well as an agreement of confidentiality, non-disparagement, and non-solicitation. To be eligible for the severance pay, the ~~Release of Claims~~Separation Agreement must be signed by the employee and must become irrevocable, in accordance with applicable law.

H. Payment Method: All wages earned and unpaid, including paid time off (PTO) and flex holidays, on the specified Separation Date will be paid to the employee in accordance with CalOptima's pay schedule and not necessarily on the employee's Separation Date. CalOptima may make payment of severance pay, if an employee is eligible, in accordance with the CalOptima payroll schedule as if the recipient were still employed or in a lump sum payment, following a seven (7) day waiting period, where applicable, and after receipt of the fully executed and irrevocable ~~Release of Claims~~Separation Agreement and/or any other agreement. Payment in installments will be equal to the employee's bi-weekly Annual Earnings wages, less applicable taxes and deductions, including benefits, if applicable, until the agreed upon sum has been distributed. Eligible employees receiving payment in installments shall be required to remain reasonably available during the time period the

employee is receiving periodic severance payments to respond to questions from CalOptima and address work related matters. Payment by lump sum will be distributed on CalOptima's next regularly scheduled payday and will be equal to the amount the employee would have made in wages for the applicable number of weeks of severance pay offered, less applicable taxes and deductions.

I. Taxes: CalOptima shall reduce all severance pay by all applicable federal, state or local tax withholdings.

J. Termination of Severance Pay: If a former employee is receiving severance pay through periodic payments as described in Paragraph H above, severance pay will immediately cease if CalOptima discovers that the employee:

1. Has failed to return all CalOptima property; or

2. Has disclosed or used confidential information about CalOptima for the benefit of a third party; or

3. Has defamed CalOptima; or

4. Has been hired on a full-time basis by another employer; or

5. Has failed to remain reasonably available to respond to CalOptima questions or work related matters.

6. Has attempted to entice other employees of CalOptima to work for a competitor; or

7. Has been convicted of a crime involving an abuse of his or her office or position.

K. Death: ~~-~~If a former employee dies before all payments have been made, severance payments will cease. No benefits will continue to a beneficiary.

L. Returning to Work: If an employee is eligible for and receives benefits under this Policy, and that employee later returns to work for CalOptima before receiving all payments under this Policy, further severance payments will cease effective on the rehire date. If the employee later becomes eligible for benefits under this Policy, the subsequent severance payment calculated based on the total years of service will be reduced by the amount of severance payments previously paid.

M. Retirement Benefits: The receipt of severance pay under this Policy shall have no effect on the employee's right, if any, to retiree benefits under any other employee pension or welfare benefit plan.

N. Other Benefits: ~~-~~Other than Severance pay, employees shall not be offered or provided any other benefits (health, dental, vision, life insurance, or CalPERS/PARS payments). If the employee is being paid by lump sum as described in ~~Paragraph~~ Section III.H., medical, dental, and vision benefits shall cease on the last day of the month in the same month as the Separation Date. All other benefits, including, but not limited to, life insurance and payment towards CalPERS and PARs ends on the Separation Date. If the employee is receiving severance pay through periodic payments as described in ~~Paragraph~~ Section III.H. above, medical, dental, vision, and other applicable

benefits, as determined solely by HR, may cease on the last day of the month in the same month the employee receives his or her last periodic severance payment.

O. Time Limits: All time limits herein refer to calendar days. If the expiration of any time limits of this policy falls on a weekend or a holiday observed by CalOptima, the time limit will be deemed to end on the next workday.

P. Source of Benefits: The benefits provided under this policy shall be unfunded and payable solely from the CalOptima's general fund.

Q. No Individual Liability: It is the express purpose and intention of CalOptima that no individual liability whatsoever shall attach to, or be incurred by, any director, officer, Board Member, executive, employee, representative or agent of CalOptima. This Policy does not guarantee a right to any employee for severance pay, and such benefit shall be offered at the sole discretion of CalOptima.

R. No Employment References: If an employee terminated as part of the RIF program requests an employment reference from CalOptima, CalOptima shall only provide the employee's date(s) of employment and position in response to such requests. All reference requests must be directed to Human Resources.

S. No Vested Right: This Policy does not guarantee a right to any employee for severance pay, and such benefit, if offered, shall be at the sole discretion of CalOptima.

~~V.~~IV. ATTACHMENTS

A. Severance Agreement Under 40 ~~(Single)~~
B. Severance Agreement Over 40 ~~(Multiple)~~

~~VI.~~V. REFERENCES

A. Age Discrimination in Employment Act 29 U.S.C. §621 *et seq.*
B. California Labor Code §1400 *et seq.*
C. CalOptima Employee Handbook
~~A.~~D. CalOptima Policy GA.8000: Glossary of Terms
~~B. CalOptima Policy GA.8028: At-Will~~
~~C.~~E. CalOptima Policy GA.8038: Personal Leave of Absence
~~D.A. CalOptima Employee Handbook~~
~~E. Age Discrimination in Employment Act 29 U.S.C. §621 *et seq.*~~
F. Older Workers Benefit Protection Act 29 U.S.C. §§623, 626 & 630.
G. Worker Adjustment and Retraining Notification Act (WARN) 29 U.S.C. §2101 *et seq.*
~~H.A. California Labor Code §1400 *et seq.*~~

VI. REGULATORY AGENCY APPROVALS ~~OR~~

None to Date

VII. BOARD ACTIONS

A. 12/01/16: Regular Meeting of the CalOptima Board of Directors
B. 06/04/15: Regular Meeting of the CalOptima Board of Directors
~~A.~~C. 05/01/14: Regular Meeting of the CalOptima Board of Directors~~Meeting~~

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/2014	GA.8047	Reduction In Force	Administrative
Revised	08/07/2014	GA.8047	Reduction In Force	Administrative
Revised	~~TBD~~12/01/2016	GA.8047	Reduction In Force	Administrative

~~Not Applicable~~

IX. ~~KEYWORDS~~GLOSSARY

Term	Definition
Annual Earnings	The annualized base salary of the employee as of the Separation Date, without regard to overtime, car allowances, bonus, incentive payments or commission payments.
At-Will	An employment, having no specified term, may be terminated at the will of employees or employers at any time and with or without cause.
Exempt Employees	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries, where applicable. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Full-Time Employee	An employee who works sixty (60) to eighty (80) hours a pay period.
Limited Term Employees	Employees who are hired to work a full-time schedule on special assignments that last a period of less than six (6) months. Limited Term employees do not become regular employees as a result of the passage of time.
Non-Exempt Employees	Includes all employees who are not identified as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation as required by federal wage and hour laws.
Part-time Employees	Employees that regularly work at least twenty (20) hours per week and no more than thirty (30) hours per week.
Service	All periods of employment with CalOptima, provided that service does not include periods in which an employee is on a Personal leave of absence pursuant to CalOptima Policy GA.8038: Personal Leave of Absence, and service shall not include any period of employment for which the employee has received severance pay under the RIF program or under any similar plan of CalOptima's.
Separation Date	The last day of employment with CalOptima.

~~Reduction in force~~
~~The Plan~~
~~Older Worker Benefit Protection Act~~
~~WARN Act~~

Policy #:	GA.8047
Title:	**Reduction In Force**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	02/01/14
Last Review Date:	12/01/16
Last Revised Date:	12/01/16

I. PURPOSE

This policy defines how CalOptima shall administer a Reduction in Force (RIF) program. A RIF occurs when changing priorities, budgetary constraints, or other business conditions require CalOptima to eliminate positions.

II. POLICY

A. All CalOptima employees are At-Will employees. An employee is terminated as part of the RIF program through no fault of his or her own. The RIF is considered an involuntary separation of employment that is intended to be permanent as a result of:

1. Lack of work, changing priorities, budgetary constraints or other business reasons; or

2. A determination by management that, due to business reasons, an employee's performance or contribution to the business (although satisfactory) does not meet the needs of the business.

B. As part of the RIF program, CalOptima shall evaluate the business needs of the organization and the need for particular positions. CalOptima shall take into account the relative value of work performed by specific employees, including, but not limited to, performance, qualifications, discipline, attendance, and length of service, so that CalOptima can continue to provide the highest level of service possible with a reduced work force. In implementing an RIF program, CalOptima may consider, depending on the circumstances, various factors, including, but not limited to, the following (which are not presented in any order of importance):

1. CalOptima's need, or lack thereof, for the position occupied by the employee;

2. The contributions which the employee has made to the success of the organization, and the perceived likelihood of contributions to the success of the business in the foreseeable future;

3. Demonstrated high quality performance on the same or related assignments;

4. Versatility and ability in applying pertinent skills and experience to current and expected business requirements;

5. The employee's length of service in the particular position to be retained;

6. The employee's length of service with CalOptima;

7. CalOptima's need to maintain continuity with respect to a particular project or team; and

8. The more recent performance of the employee compared to others in the same classification.

C. In cases where management determines the various factors considered are essentially equal between two (2) or more employees, length of service in the position and/or length of service at CalOptima may be the deciding factor in determining which employee or employees shall be retained. In the event an employee who is being laid off has greater length of service in the position and/or length of service at CalOptima than an employee or employees being retained within the same classification and specialty in the impacted department, CalOptima must document the basis, in the judgment of management, the employee with less length of service is better suited for retention.

D. The Human Resources Department shall work closely with the Legal Affairs Department to implement the RIF program to ensure compliance with all applicable federal, state and local laws and regulations.

E. An employee terminated as part of the RIF program must continue to perform his or her duties satisfactorily until the Separation Date. Otherwise, the employee may be subject to disciplinary action, up to and including termination, prior to the specified Separation Date, consistent with CalOptima Policy GA.8022: Progressive Discipline. An employee terminated as a result of failure to perform duties satisfactorily until the Separation Date shall not be qualified to receive any benefits administered as part of the RIF program.

F. Limitations to Eligibility

1. An employee terminated as part of the RIF program will not be eligible to receive benefits under the plan if the employee:

   a. Is terminated for cause, including but not limited to, failure to meet the performance requirements of the position, policy violation, theft, gross misconduct, etc.; or

   b. Fails or refuses to return all CalOptima property in the employee's possession, and/or fails to clear all expense and other financial accounts, as of the date of termination. (Examples of CalOptima property include, but are not limited to: CalOptima Security badges, office keys any and all CalOptima documents, files, and computers. Examples of accounts to be cleared include, but are not limited to, the completion and reconciliation of expense accounts); or

   c. Resigns or otherwise voluntarily terminates his or her employment; or

   d. Is terminated by temporary layoff or furlough, except that if CalOptima elects to convert the temporary layoff or furlough into a permanent layoff, severance pay may then be payable as of the effective date of permanent layoff, if the employee otherwise is eligible for benefits under the RIF program; or,

   e. Is on a leave of absence, except that if an employee is released to return to work from an approved leave of absence and CalOptima has no assignment for the employee, he/she may be eligible for benefits under the RIF program; or

   f. Is offered a comparable position within CalOptima in lieu of termination, but fails or refuses to accept it; or

g. Is terminated because of CalOptima's sale or transfer of all or part of its assets and his/her employment continues with the agency or transferee organization after the transfer has been completed; or

h. Is terminated in connection with the "outsourcing" of operational functions, and he/she is offered comparable employment by the outsourcing vendor. For this purpose, comparable employment shall be defined as a position with substantially the same duties, at the same or greater compensation and comparable benefits, which does not require relocation, as defined by the IRS; or

i. Is terminated from employment for failure to return to work following a leave of absence; or

j. Retires; or

k. Is deceased, at which time eligibility for benefits under the RIF program will end and all such benefit payments, if any, will cease; or

l. Is separated from CalOptima because he or she is no longer able to perform the essential functions of his/her job (with or without reasonable accommodation) because of a disability; or

m. Is a temporary employee, intern/volunteer, independent contractor or consultant; or

n. Is an employee employed by CalOptima pursuant to a written contract containing provisions for severance benefits; or

o. Is convicted of a crime involving an abuse of his or her office or position.

G. This policy sets forth general guidelines to observe in the event of a RIF; however, this policy may be subject to change, deviation or modification, without notice, depending on the circumstances. Any decision to deviate from this policy in any particular case shall be subject to the discretion of the Chief Executive Officer (CEO).

H. Applicable provisions of this policy may also be used to address employee separations or terminations, other than a RIF, where appropriate, at the discretion of the CEO.

III. PROCEDURE

A. Affected Positions: Following an evaluation of CalOptima's business needs, CalOptima, through appropriate Executive Officers and the Human Resources Department (hereinafter referred to as the "management"), will identify and determine the positions that will be eliminated and/or affected by a RIF. Management also has the discretion to determine the manner in which the RIF will occur; however, notification to the Human Resources Department (HR) should precede the implementation of the RIF.

B. Determinations: Determinations concerning the evaluation of employees, the considerations evaluated, and final recommendations should be made by the employee's immediate supervisor and/or manager with the next higher management level. Documentation of all considerations

evaluated should be furnished to HR and approved by management prior to any notification to the employee affected by the RIF.

C. Transfers or Downgrades: Depending on CalOptima's business needs, an employee impacted by the RIF may be offered a downgrade (a lower position and/or reduction in base pay) or lateral transfer (an equivalent position and/or equivalent base pay) to another open job position for which he or she is, in the judgment of management, most qualified even though it is a job position or classification that the employee has not previously held. An employee impacted by the RIF who is offered a lateral transfer or downgrade may be provided the option of layoff. HR shall determine, on a case-by-case basis, the time period appropriate to accept or decline such job offer.

D. Employee Notices: Employees who are to be laid off as a result of the RIF should be notified of such reduction only after all necessary approvals have been obtained. An employee notified of a lay off must continue to work up to the Separation Date specified in the notice, unless management decides otherwise. An employee notified of his or her lay off as a result of the RIF may not subsequently be placed on a leave of absence (LOA) without prior approval of the Executive Director of HR.

E. Severance: Severance Pay may be offered, if approved by the Chief Executive Officer and HR, upon an employee's separation from service when it is deemed appropriate due to special circumstances. If severance pay is authorized and offered, it will be paid in accordance with the following, unless otherwise defined in a separate employee agreement or approved by the CEO:

1. Two (2) weeks of pay at the rate of the Annual Earnings for employees with less than two (2) years of service and more than ninety (90) days; or

2. One (1) week of pay at the rate of the Annual Earnings for each completed year of service, with a maximum of sixteen (16) weeks, for employees with two (2) years or more of service.

F. Employees on a Leave of Absence: If an employee is on a Leave of Absence (LOA), and his or her position is terminated as part of the RIF, CalOptima will not terminate the LOA early to implement the RIF program. The employee will be laid off at the scheduled or required conclusion of the LOA. This paragraph does not apply to employees on Personal LOA pursuant to CalOptima Policy GA.8038: Personal Leave of Absence.

G. Release Agreement: In order to be eligible for the severance pay, if offered, an eligible employee must fully complete and execute a Separation Agreement provided by CalOptima, in a form approved by the Legal Affairs Department, at or near the time of termination. This Separation Agreement includes a release of all known and unknown claims the employee has or may have against CalOptima as well as an agreement of confidentiality, non-disparagement, and non-solicitation. To be eligible for the severance pay, the Separation Agreement must be signed by the employee and must become irrevocable, in accordance with applicable law.

H. Payment Method: All wages earned and unpaid, including paid time off (PTO) and flex holidays, on the specified Separation Date will be paid to the employee in accordance with CalOptima's pay schedule and not necessarily on the employee's Separation Date. CalOptima may make payment of severance pay, if an employee is eligible, in accordance with the CalOptima payroll schedule as if the recipient were still employed or in a lump sum payment, following a seven (7) day waiting period, where applicable, and after receipt of the fully executed and irrevocable Separation Agreement and/or any other agreement. Payment in installments will be equal to the employee's bi-

weekly Annual Earnings wages, less applicable taxes and deductions, including benefits, if applicable, until the agreed upon sum has been distributed. Eligible employees receiving payment in installments shall be required to remain reasonably available during the time period the employee is receiving periodic severance payments to respond to questions from CalOptima and address work related matters. Payment by lump sum will be distributed on CalOptima's next regularly scheduled payday and will be equal to the amount the employee would have made in wages for the applicable number of weeks of severance pay offered, less applicable taxes and deductions.

I. Taxes: CalOptima shall reduce all severance pay by all applicable federal, state or local tax withholdings.

J. Termination of Severance Pay: If a former employee is receiving severance pay through periodic payments as described in Paragraph H above, severance pay will immediately cease if CalOptima discovers that the employee:

1. Has failed to return all CalOptima property; or

2. Has disclosed or used confidential information about CalOptima for the benefit of a third party; or

3. Has defamed CalOptima; or

4. Has been hired on a full-time basis by another employer; or

5. Has failed to remain reasonably available to respond to CalOptima questions or work related matters.

6. Has attempted to entice other employees of CalOptima to work for a competitor; or

7. Has been convicted of a crime involving an abuse of his or her office or position.

K. Death: If a former employee dies before all payments have been made, severance payments will cease. No benefits will continue to a beneficiary.

L. Returning to Work: If an employee is eligible for and receives benefits under this Policy, and that employee later returns to work for CalOptima before receiving all payments under this Policy, further severance payments will cease effective on the rehire date. If the employee later becomes eligible for benefits under this Policy, the subsequent severance payment calculated based on the total years of service will be reduced by the amount of severance payments previously paid.

M. Retirement Benefits: The receipt of severance pay under this Policy shall have no effect on the employee's right, if any, to retiree benefits under any other employee pension or welfare benefit plan.

N. Other Benefits: Other than Severance pay, employees shall not be offered or provided any other benefits (health, dental, vision, life insurance, or CalPERS/PARS payments). If the employee is being paid by lump sum as described in Section III.H., medical, dental, and vision benefits shall cease on the last day of the month in the same month as the Separation Date. All other benefits, including, but not limited to, life insurance and payment towards CalPERS and PARs ends on the Separation Date. If the employee is receiving severance pay through periodic payments as

described in Section III.H. above, medical, dental, vision, and other applicable benefits, as determined solely by HR, may cease on the last day of the month in the same month the employee receives his or her last periodic severance payment.

O. Time Limits: All time limits herein refer to calendar days. If the expiration of any time limits of this policy falls on a weekend or a holiday observed by CalOptima, the time limit will be deemed to end on the next workday.

P. Source of Benefits: The benefits provided under this policy shall be unfunded and payable solely from the CalOptima's general fund.

Q. No Individual Liability: It is the express purpose and intention of CalOptima that no individual liability whatsoever shall attach to, or be incurred by, any director, officer, Board Member, executive, employee, representative or agent of CalOptima. This Policy does not guarantee a right to any employee for severance pay, and such benefit shall be offered at the sole discretion of CalOptima.

R. No Employment References: If an employee terminated as part of the RIF program requests an employment reference from CalOptima, CalOptima shall only provide the employee's date(s) of employment and position in response to such requests. All reference requests must be directed to Human Resources.

S. No Vested Right: This Policy does not guarantee a right to any employee for severance pay, and such benefit, if offered, shall be at the sole discretion of CalOptima.

IV. ATTACHMENTS

A. Severance Agreement Under 40
B. Severance Agreement Over 40

V. REFERENCES

A. Age Discrimination in Employment Act 29 U.S.C. §621 *et seq*.
B. California Labor Code §1400 *et seq*.
C. CalOptima Employee Handbook
D. CalOptima Policy GA.8000: Glossary of Terms
E. CalOptima Policy GA.8038: Personal Leave of Absence
F. Older Workers Benefit Protection Act 29 U.S.C. §§623, 626 & 630.
G. Worker Adjustment and Retraining Notification Act (WARN) 29 U.S.C. §2101 *et seq*.

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 12/01/16: Regular Meeting of the CalOptima Board of Directors
B. 06/04/15: Regular Meeting of the CalOptima Board of Directors
C. 05/01/14: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/2014	GA.8047	Reduction In Force	Administrative
Revised	08/07/2014	GA.8047	Reduction In Force	Administrative
Revised	12/01/2016	GA.8047	Reduction In Force	Administrative

IX. GLOSSARY

Term	Definition
Annual Earnings	The annualized base salary of the employee as of the Separation Date, without regard to overtime, car allowances, bonus, incentive payments or commission payments.
At-Will	An employment, having no specified term, may be terminated at the will of employees or employers at any time and with or without cause.
Exempt Employees	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries, where applicable. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Full-Time Employee	An employee who works sixty (60) to eighty (80) hours a pay period.
Limited Term Employees	Employees who are hired to work a full-time schedule on special assignments that last a period of less than six (6) months. Limited Term employees do not become regular employees as a result of the passage of time.
Non-Exempt Employees	Includes all employees who are not identified as exempt. Non-Exempt employees are paid on an hourly basis and are eligible for overtime compensation as required by federal wage and hour laws.
Part-time Employees	Employees that regularly work at least twenty (20) hours per week and no more than thirty (30) hours per week.
Service	All periods of employment with CalOptima, provided that service does not include periods in which an employee is on a Personal leave of absence pursuant to CalOptima Policy GA.8038: Personal Leave of Absence, and service shall not include any period of employment for which the employee has received severance pay under the RIF program or under any similar plan of CalOptima's.
Separation Date	The last day of employment with CalOptima.

SEPARATION AGREEMENT AND GENERAL RELEASE

By signing this Settlement Agreement and General Release ("Agreement"), I, _____ ("Employee") acknowledge that CalOptima (hereinafter referred to as "Employer") and I have reached a final and binding agreement concerning my separation from employment with Employer. Specifically, I acknowledge that we have agreed on the following terms and that this document contains our entire agreement.

NOW THEREFORE, for good and sufficient consideration, as set forth below, the parties agree as follows:

AGREEMENT

1. Separation Date. Employee's last day of work will be mm,dd,yyyy ("Separation Date").

2. Consideration To Employee. Employee shall be entitled to the following:

A. Employee shall receive his/her regular pay through Separation Date to the extent any is due. Employee will receive a check for all unused Paid Time Off (PTO) and Flex Holiday time, less deductions required by law, accrued by Employee through the Separation Date.

B. If, and only if, Employee signs this Agreement and complies with its terms, Employee shall receive severance pay in [biweekly installments of $$$$$, less deductions required by law and less deductions for medical, dental and vision coverage and/or other benefits where applicable, from the Separation Date through mm,dd,yyyy] OR [a lump sum payment of $$$$$, which reflects XX weeks of severance pay, less deductions required by law and less deductions for medical, dental and vision where applicable] (the Severance Period). [Add the following when employee receives biweekly installments ONLY: As a condition of receiving biweekly installments, Employee shall be required to remain reasonably available during the time period Employee is receiving periodic severance payments to respond to questions from CalOptima and address work related matters.]

C. Employer shall make payments on behalf of Employee for medical, dental and vision through mm,dd,yyyy. All other benefits shall cease on [the Separation Date] OR [at the end of the Severance Period].

D. Employer will not challenge any applications by Employee for unemployment insurance compensation.

E. Employee will receive optional outplacement services through a designated outplacement firm for a period not to exceed thirty (30) days.

3. Acknowledgement. Employee acknowledges that Employee has reviewed the consideration specified above. Employee agrees that the consideration set forth above represents a complete and final settlement of any and all claims Employee has had, now has or may have up

to the effective date of this Agreement, including, without limitation, claims arising out of or in connection with Employee's employment and/or termination by CalOptima. Employee acknowledges Employer does not owe Employee any additional wages, commissions, bonuses, PTO pay, severance pay, overtime pay, or other compensation, benefits or payments of any kind or nature, other than that specifically stated in this Agreement.

4. Specific Release. In exchange for the receipt of the foregoing consideration, Employee expressly releases and discharges Employer, Employer's board members, officers, directors, agents, employees, representatives, attorneys, successors, and assigns, and each of them, and all persons and/or entities acting by, through, under, or in concert with such persons (collectively, the "Employer Releasees") from claims or causes of action Employee has had, now has, or may have up to the effective date of this Agreement, including, without limitation, claims based upon:

A. Title VII of the Civil Rights Act of 1964;

B. The Americans with Disabilities Act (ADA);

C. The Equal Pay Act (EPA);

D. California statutory, regulatory or decisional law, including the State Fair Employment and Housing Act, pertaining to employment discrimination, failure to prevent discrimination, harassment, retaliation, failure to engage in the interactive process or failure to provide reasonable accommodation, wrongful termination or breach of public policy; ~~and/or~~

E. Any and all State, Federal and local laws as well as common law for claims of breach of implied or express contract, negligent or intentional infliction of emotional distress, defamation, fraud, concealment, false promise, negligent misrepresentation, intentional interference with contractual relations, ~~and~~ breach of the covenant of good faith and fair dealing, wrongful termination in violation of public policy, and constructive discharge;

F. California Labor Code provisions pertaining to whistleblower rights and other benefits and protections set forth therein; and

G. Any and all claims arising from the California Labor Code or the Fair Labor Standards Act.

5. General Release. Employee, on behalf of himself/herself and his/her executors, heirs or assigns, hereby releases and discharges Employer Releasees from any and all actual or potential claims, obligations, and causes of action, known or unknown, which Employee has, may have, or may claim to have up to the effective date of this Agreement against Employer Releasees, without limitation, such claims arising out of or in connection with Employee's employment with, and/or separation from the Employer. Employee acknowledges that he or she may have claims that are covered by the terms of this Agreement herein which have not yet been discovered.

Nevertheless, Employee expressly waives and relinquishes all rights and benefits under Section 1542 of the California Civil Code, which states:

> "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR."

Employee acknowledges that Employee has read and understands the Employee's rights under Section 1542 of the California Civil Code above, and by signing below, Employee ~~intends to~~voluntarily waives all known and unknown claims existing on or prior to the effective date of this Agreement.

6. Claims Arising After the Effective Date. This Agreement does not apply to rights or claims that may arise after the effective date of this Agreement.

7. No Pending Action. Employer and Employee hereby agree that as of the effective date of this Agreement, no action, suit or proceeding has been or shall be brought or complaint filed or initiated by Employer or Employee or any agent, assign or spouse of either in any court, or with any governmental body. This includes any matter or cause of action based upon any facts that might have occurred prior to the effective date of this Agreement whether known to either party now or discovered by either party hereafter.

8. No Admission of Liability. Employer and Employee agree that this Agreement and the payment by Employer of the consideration described herein is not an admission by Employer, Employer Releasees or Employee of any wrongdoing or liability. All parties specifically deny any liability; wrongful acts; violations of any federal, state, or local law, regulation, order, or other requirement of law; breach of contract (actual or implied); or any other civil wrong. The parties have entered into this Agreement in order to settle all disputes and differences between them, without admitting liability or wrongdoing by any party.

9. Confidentiality. This Agreement shall remain confidential as a personnel record ~~within the meaning of~~to the extent permissible by Government Code Section 6254(c) ~~to the extent permitted by law~~. In the event a Public Records Act request is made to review and/or copy this Agreement, Employer's only obligation shall be to timely notify Employee of that request. Employer shall not be obligated to incur legal expenses to deny such a request.

10. References. If Employee requests an employment reference from Employer, Employer shall only provide the Employee's date(s) of employment and position in response to such requests. All reference requests must be directed to Employer's Human Resources Department.

11. Non-Disparagement. Employer and Employee each warrant and agree that he/she/it will not disseminate, orally or in writing, any comments which are in any way negative

about, or disparaging to the other, or to the other's representatives or Employees, individually or collectively.

12. Employer Property. On Employee's Separation Date, Employee agrees to return all Employer property, including, but not limited to: keys; key cards; equipment and supplies; electronic and physical documents and files; and all confidential, private, and proprietary documents and files. Employee also agrees to continue to comply with CalOptima Policy #: GA 8050: Confidentiality and Nondisclosure, which is incorporated into this Agreement herein by reference, even after the Separation Date.

132. Construction. This Agreement has been negotiated and discussed between the parties and it reflects their mutual agreement regarding the subject matter of this Agreement. Neither party shall be deemed to be the drafter of this Agreement. Therefore no presumption for or against the drafter shall be applicable in interpreting or enforcing this Agreement.

1314. Separability. If any provision of this Agreement, or the application thereof to any person or circumstance, is found to be invalid, the remainder of the provisions of this Agreement, or the application of such provisions to persons or circumstances other than those which it is found to be invalid, as the case may be, shall not be affected.

1415. Advice of Counsel. Employer has advised Employee to consult with a private attorney prior to executing this Agreement. Employee fully understands the right to discuss all aspects of this Agreement with a private attorney and has had reasonable and sufficient time and opportunity to consult with an attorney. Employee has either consulted with an attorney of his or her own choosing or elected to enter into this Agreement without consultation with an attorney despite Employers advice to do so. Employee has had sufficient time to read and consider the terms of this Agreement, fully understands all of the provisions of this Agreement and is freely and voluntarily entering into this Agreement.

1516. Complete Agreement. This is the entire agreement between Employer and Employee with respect to the subject matter herein and this Agreement supersedes all prior and contemporaneous oral and written agreements and discussions.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS THEREOF, Employee acknowledges that Employee has been advised to **CONSULT WITH AN ATTORNEY PRIOR TO SIGNING THIS AGREEMENT AND GENERAL RELEASE**, and Employee understands that by signing this Agreement and General Release, Employee is giving up and waiving important legal rights. Nevertheless, Employee and Employer mutually agree to the terms above, and hereby execute this Agreement on the day and year last shown below.

Date: _____ "EMPLOYER"

_____

By: Michael Schrader
Its: Chief Executive Officer

Date: _____ "EMPLOYEE"

_____

By:_____
(print name)

Back to Agenda

SEPARATION AGREEMENT AND GENERAL RELEASE

By signing this Settlement Agreement and General Release ("Agreement"), I, _____ ("Employee") acknowledge that CalOptima (hereinafter referred to as "Employer") and I have reached a final and binding agreement concerning my separation from employment with Employer. Specifically, I acknowledge that we have agreed on the following terms and that this document contains our entire agreement.

NOW THEREFORE, for good and sufficient consideration, as set forth below, the parties agree as follows:

AGREEMENT

1. Separation Date. Employee's last day of work will be mm,dd,yyyy ("Separation Date").

2. Consideration To Employee. Employee shall be entitled to the following:

A. Employee shall receive his/her regular pay through Separation Date to the extent any is due. Employee will receive a check for all unused Paid Time Off (PTO) and Flex Holiday time, less deductions required by law, accrued by Employee through the Separation Date.

B. If, and only if, Employee signs this Agreement and complies with its terms, Employee shall receive severance pay in [biweekly installments of $$$$$, less deductions required by law and less deductions for medical, dental and vision coverage and/or other benefits where applicable, from the Separation Date through mm,dd,yyyy] OR [a lump sum payment of $$$$$, which reflects XX weeks of severance pay, less deductions required by law and less deductions for medical, dental and vision where applicable] (the Severance Period). [Add the following when employee receives biweekly installments ONLY: As a condition of receiving biweekly installments, Employee shall be required to remain reasonably available during the time period Employee is receiving periodic severance payments to respond to questions from CalOptima and address work related matters.]

C. Employer shall make payments on behalf of Employee for medical, dental and vision through mm,dd,yyyy. All other benefits shall cease on [the Separation Date] OR [at the end of the Severance Period].

D. Employer will not challenge any applications by Employee for unemployment insurance compensation.

E. Employee will receive optional outplacement services through a designated outplacement firm for a period not to exceed thirty (30) days.

3. Acknowledgement. Employee acknowledges that Employee has reviewed the consideration specified above. Employee agrees that the consideration set forth above represents a complete and final settlement of any and all claims Employee has had, now has or may have up

to the effective date of this Agreement, including, without limitation, claims arising out of or in connection with Employee's employment and/or termination by CalOptima. Employee acknowledges Employer does not owe Employee any additional wages, commissions, bonuses, PTO pay, severance pay, overtime pay, or other compensation, benefits or payments of any kind or nature, other than that specifically stated in this Agreement.

4. Specific Release. In exchange for the receipt of the foregoing consideration, Employee expressly releases and discharges Employer, Employer's board members, officers, directors, agents, employees, representatives, attorneys, successors, and assigns, and each of them, and all persons and/or entities acting by, through, under, or in concert with such persons (collectively, the "Employer Releasees") from claims or causes of action Employee has had, now has, or may have up to the effective date of this Agreement, including, without limitation, claims based upon:

A. Title VII of the Civil Rights Act of 1964;

B. The Americans with Disabilities Act (ADA);

C. The Equal Pay Act (EPA);

D. California statutory, regulatory or decisional law, including the State Fair Employment and Housing Act, pertaining to employment discrimination, failure to prevent discrimination, harassment, retaliation, failure to engage in the interactive process or failure to provide reasonable accommodation, wrongful termination or breach of public policy;

E. Any and all State, Federal and local laws as well as common law for claims of breach of implied or express contract, negligent or intentional infliction of emotional distress, defamation, fraud, concealment, false promise, negligent misrepresentation, intentional interference with contractual relations, breach of the covenant of good faith and fair dealing, wrongful termination in violation of public policy, and constructive discharge;

F. California Labor Code provisions pertaining to whistleblower rights and other benefits and protections set forth therein; and

G. Any and all claims arising from the California Labor Code or the Fair Labor Standards Act.

5. General Release. Employee, on behalf of himself/herself and his/her executors, heirs or assigns, hereby releases and discharges Employer Releasees from any and all actual or potential claims, obligations, and causes of action, known or unknown, which Employee has, may have, or may claim to have up to the effective date of this Agreement against Employer Releasees, without limitation, such claims arising out of or in connection with Employee's employment with, and/or separation from the Employer. Employee acknowledges that he or she may have claims that are covered by the terms of this Agreement herein which have not yet been discovered.

Nevertheless, Employee expressly waives and relinquishes all rights and benefits under Section 1542 of the California Civil Code, which states:

> "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR."

Employee acknowledges that Employee has read and understands the Employee's rights under Section 1542 of the California Civil Code above, and by signing below, Employee voluntarily waives all known and unknown claims existing on or prior to the effective date of this Agreement.

6. Claims Arising After the Effective Date. This Agreement does not apply to rights or claims that may arise after the effective date of this Agreement.

7. No Pending Action. Employer and Employee hereby agree that as of the effective date of this Agreement, no action, suit or proceeding has been or shall be brought or complaint filed or initiated by Employer or Employee or any agent, assign or spouse of either in any court, or with any governmental body. This includes any matter or cause of action based upon any facts that might have occurred prior to the effective date of this Agreement whether known to either party now or discovered by either party hereafter.

8. No Admission of Liability. Employer and Employee agree that this Agreement and the payment by Employer of the consideration described herein is not an admission by Employer, Employer Releasees or Employee of any wrongdoing or liability. All parties specifically deny any liability; wrongful acts; violations of any federal, state, or local law, regulation, order, or other requirement of law; breach of contract (actual or implied); or any other civil wrong. The parties have entered into this Agreement in order to settle all disputes and differences between them, without admitting liability or wrongdoing by any party.

9. Confidentiality. This Agreement shall remain confidential as a personnel record to the extent permissible by Government Code Section 6254(c). In the event a Public Records Act request is made to review and/or copy this Agreement, Employer's only obligation shall be to timely notify Employee of that request. Employer shall not be obligated to incur legal expenses to deny such a request.

10. References. If Employee requests an employment reference from Employer, Employer shall only provide the Employee's date(s) of employment and position in response to such requests. All reference requests must be directed to Employer's Human Resources Department.

11. Non-Disparagement. Employer and Employee each warrant and agree that he/she/it will not disseminate, orally or in writing, any comments which are in any way negative

about, or disparaging to the other, or to the other's representatives or Employees, individually or collectively.

12. Employer Property. On Employee's Separation Date, Employee agrees to return all Employer property, including, but not limited to: keys; key cards; equipment and supplies; electronic and physical documents and files; and all confidential, private, and proprietary documents and files. Employee also agrees to continue to comply with CalOptima Policy #: GA 8050: Confidentiality and Nondisclosure, which is incorporated into this Agreement herein by reference, even after the Separation Date.

13. Construction. This Agreement has been negotiated and discussed between the parties and it reflects their mutual agreement regarding the subject matter of this Agreement. Neither party shall be deemed to be the drafter of this Agreement. Therefore no presumption for or against the drafter shall be applicable in interpreting or enforcing this Agreement.

14. Separability. If any provision of this Agreement, or the application thereof to any person or circumstance, is found to be invalid, the remainder of the provisions of this Agreement, or the application of such provisions to persons or circumstances other than those which it is found to be invalid, as the case may be, shall not be affected.

15. Advice of Counsel. Employer has advised Employee to consult with a private attorney prior to executing this Agreement. Employee fully understands the right to discuss all aspects of this Agreement with a private attorney and has had reasonable and sufficient time and opportunity to consult with an attorney. Employee has either consulted with an attorney of his or her own choosing or elected to enter into this Agreement without consultation with an attorney despite Employers advice to do so. Employee has had sufficient time to read and consider the terms of this Agreement, fully understands all of the provisions of this Agreement and is freely and voluntarily entering into this Agreement.

16. Complete Agreement. This is the entire agreement between Employer and Employee with respect to the subject matter herein and this Agreement supersedes all prior and contemporaneous oral and written agreements and discussions.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS THEREOF, Employee acknowledges that Employee has been advised to **CONSULT WITH AN ATTORNEY PRIOR TO SIGNING THIS AGREEMENT AND GENERAL RELEASE**, and Employee understands that by signing this Agreement and General Release, Employee is giving up and waiving important legal rights. Nevertheless, Employee and Employer mutually agree to the terms above, and hereby execute this Agreement on the day and year last shown below.

Date: _____ "EMPLOYER"

_____

By: Michael Schrader
Its: Chief Executive Officer

Date: _____ "EMPLOYEE"

_____

By:_____
(print name)

Back to Agenda

SEPARATION AGREEMENT AND GENERAL RELEASE

By signing this Separation Agreement and General Release ("Agreement"), I, _____ ("Employee") acknowledge that CalOptima (hereinafter referred to as "Employer") and I have reached a final and binding agreement concerning my separation from employment with Employer. Specifically, I acknowledge that we have agreed on the following terms and that this document contains our entire agreement.

NOW THEREFORE, for good and sufficient consideration, as set forth below, the parties agree as follows:

AGREEMENT

1. Separation Date. Employee's last day of work will be mm,dd,yyyy ("Separation Date").

2. Consideration To Employee. Employee shall be entitled to the following:

A. Employee shall receive his/her regular pay through Separation Date to the extent any is due. Employee will receive a check for all unused paid time off (PTO) and Flex Holiday time, less deductions required by law, accrued by Employee through the Separation Date.

B. If, and only if, Employee signs this Agreement and complies with its terms, and after expiration of the seven day revocation period set forth in Paragraph 1~~98~~ of this Agreement, Employee shall receive severance pay in [biweekly installments of $$$$, less deductions required by law and less deductions for medical, dental and vision coverage and/or other benefits where applicable, from the Separation Date through mm,dd,yyyy] OR [a lump sum payment of $$$$$, which reflects XX weeks of severance pay, less deductions required by law and less deductions for medical, dental and vision where applicable] (the Severance Period). [Add the following when employee receives biweekly installments ONLY: As a condition of receiving biweekly installments, Employee shall be required to remain reasonably available during the time period Employee is receiving periodic severance payments to respond to questions from CalOptima and address work related matters.]

C. Employer shall make payments on behalf of Employee for medical, dental and vision coverage through mm,dd,yyyy. All other benefits shall cease on [the Separation Date] OR [at the end of the Severance Period].

D. Employer will not challenge any applications by Employee for unemployment insurance compensation.

E. Employee will receive optional outplacement services through a designated outplacement firm for a period not to exceed thirty (30) days.

3. Acknowledgement. Employee acknowledges that Employee has reviewed the consideration specified above. Employee agrees that the consideration set forth above represents a complete and final settlement of any and all claims Employee has had, now has or may have up to the effective date of this Agreement, including, without limitation, claims arising out of or in

connection with Employee's employment and/or termination by CalOptima. Employee acknowledges Employer does not owe Employee any additional wages, commissions, bonuses, PTO pay, severance pay, overtime pay, or other compensation, benefits or payments of any kind or nature, other than that specifically stated in this Agreement.

4. Specific Release. In exchange for the receipt of the foregoing consideration, Employee expressly releases and discharges Employer, Employer's board members, officers, directors, agents, employees, representatives, attorneys, successors, and assigns, and each of them, and all persons and/or entities acting by, through, under, or in concert with such persons (collectively, the "Employer Releasees") from claims or causes of action Employee has had, now has, or may have up to the effective date of this Agreement, including, without limitation, claims based upon:

A. Title VII of the Civil Rights Act of 1964;

B. The Age Discrimination in Employment Act (ADEA) (as amended by the Older Workers Benefit Protection Act (OWBPA));

C. The Americans with Disabilities Act (ADA);

D. The Equal Pay Act (EPA);

E. California statutory, regulatory, or case law, including the State Fair Employment and Housing Act, pertaining to employment discrimination, failure to prevent discrimination, harassment, retaliation, failure to engage in the interactive process or failure to provide reasonable accommodation, wrongful termination or breach of public policy; ~~and/or~~

F. Any and all State, Federal and local laws as well as common law for claims of breach of implied or express contract, negligent or intentional infliction of emotional distress, defamation, fraud, concealment, false promise, negligent misrepresentation, intentional interference with contractual relations, ~~and~~ breach of the covenant of good faith and fair dealing, wrongful termination in violation of public policy, and constructive discharge; and

G. California Labor Code provisions pertaining to whistleblower rights and other benefits and protections set forth therein; and

H. Any and all claims arising from the California Labor Code or the Fair Labor Standards Act.

5. General Release. Employee, on behalf of himself/herself and his/her executors, heirs or assigns, hereby releases and discharges Employer Releasees from any and all actual or potential claims, obligations, and causes of action, known or unknown, which Employee has, may have, or may claim to have up to the effective date of this Agreement against Employer Releasees, without limitation, such claims arising out of or in connection with Employee's employment with, and/or separation from the Employer. Employee acknowledges that he or she may have claims that are covered by the terms of this Agreement herein which have not yet been discovered.

Nevertheless, Employee hereby expressly waives and relinquishes all rights and benefits under Section 1542 of the California Civil Code which states:

> "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR."

Employee acknowledges that Employee has read and understands the Employee's rights under Section 1542 of the California Civil Code above, and by signing below, Employee ~~intends to~~voluntarily waives all known and unknown claims existing on or prior to the effective date of this Agreement.

6. Claims Arising After the Effective Date. This Agreement does not apply to rights or claims that may arise after the effective date of this Agreement.

7. No Pending Action. Employer and Employee hereby agree that as of the effective date of this Agreement, no action, suit or proceeding has been brought or complaint filed or initiated by Employer or Employee or any agent, assign or spouse of either in any court, or with any governmental body. This includes any matter or cause of action based upon any facts that might have occurred prior to the effective date of this Agreement whether known to either party now or discovered by either party hereafter.

8. No Admission of Liability. Employer and Employee agree that this Agreement and the payment by Employer of the consideration described herein is not an admission by Employer, Employer Releasees or Employee of any wrongdoing or liability. All parties specifically deny any liability; wrongful acts; violations of any federal, state, or local law, regulation, order, or other requirement of law; breach of contract (actual or implied); or any other civil wrong. The parties have entered into this Agreement in order to settle all disputes and differences between them, without admitting liability or wrongdoing by any party.

9. Confidentiality. This Agreement shall remain confidential as a personnel record ~~within the meaning of~~to the extent permissible by Government Code Section 6254(c) ~~to the extent permitted by law~~. In the event a Public Records Act request is made to review and/or copy this Agreement, Employer's only obligation shall be to timely notify Employee of that request. Employer shall not be obligated to incur legal expenses to deny such a request.

10. References. If Employee requests an employment reference from Employer, Employer shall only provide the Employee's date(s) of employment and position in response to such requests. All reference requests must be directed to Employer's Human Resources Department.

11. Non-Disparagement. Employer and Employee each warrant and agree that he/she/it will not disseminate, orally or in writing, any comments which are in any way negative about, or disparaging to the other, or to the other's representatives or Employees, individually or collectively.

12. Employer Property. On Employee's Separation Date, Employee agrees to return all Employer property, including, but not limited to: keys; key cards; equipment and supplies; electronic and physical documents and files; and all confidential, private, and proprietary documents and files. Employee also agrees to continue to comply with CalOptima Policy #: GA 8050: Confidentiality and Nondisclosure, which is incorporated into this Agreement herein by reference, even after the Separation Date.

132. Construction. This Agreement has been negotiated and discussed between the parties and it reflects their mutual agreement regarding the subject matter of this Agreement. Neither party shall be deemed to be the drafter of this Agreement. Therefore, no presumption for or against the drafter shall be applicable in interpreting or enforcing this Agreement.

1314. Separability. If any provision of this Agreement, or the application thereof to any person or circumstance, is found to be invalid, the remainder of the provisions of this Agreement, or the application of such provisions to persons or circumstances other than those which it is found to be invalid, as the case may be, shall not be affected.

1415. Advice of Counsel. Employer has advised Employee to consult with a private attorney prior to executing this Agreement. Employee fully understands the right to discuss all aspects of this Agreement with a private attorney and has had reasonable and sufficient time and opportunity to consult with an attorney. Employee has consulted with an attorney of his or her own choosing, or has elected to enter into this Agreement without consultation with an attorney despite Employer's advice to consult with an attorney. Employee has read and fully understands all of the provisions of this Agreement and is freely and voluntarily entering into this Agreement.

1516. Complete Agreement. This is the entire agreement between Employer and Employee with respect to the subject matter herein and this Agreement supersedes all prior and contemporaneous oral and written agreements and discussions.

1617. Acknowledgment of Days To Consider. Employee has been advised of the right to consider this Agreement for up to twenty-one (21) days if a single termination or up to forty-five (45) days if the termination is of two (2) or more employees prior to its execution and has either: (a) been provided the full period to consider the agreement; or (b) voluntarily waived the full period, electing with full knowledge and consent to execute this Agreement ~~at this time~~as of the date indicated on the signature line of this Agreement.

1718. [USE ONLY For RIF of 2 or more employees] Summary of Considerations. The classification, department, or group of individuals covered by CalOptima's reduction in force (RIF) includes all employees in the [describe impacted location, area, department, line of business, etc., (e.g. CalOPTIMA, Human Resources, PACE, ONECARE, etc.)] whose employment is being terminated in the RIF during the following period (XX/XX/XXXX to XX/XX/XXXX). All employees in [describe impacted location, area, department, line of business, etc., (e.g. CalOPTIMA, PACE, ONECARE, etc.)] whose employment is being terminated are eligible for the RIF.

The following is a listing of the ages and job titles of employees who were and were not selected for layoff [or termination] and offered consideration for signing the waiver. Except for

those employees selected for layoff [or termination], no other employee is eligible or offered consideration in exchange for signing the waiver:

Job Title	Department/Unit	Age	# Selected	# Not Selected

~~18~~19. Revocation. Employee may revoke this Agreement for a period of seven (7) days following its execution. Said revocation must be in writing, must specifically revoke this Agreement, and must be received by ~~Employer~~the Executive Director of Human Resources, at Employer's premises, prior to the end of the seventh day following Employee's execution. Upon expiration of the seven (7) day period, this Agreement becomes effective, enforceable and irrevocable. If Employee has not delivered written revocation of this Agreement to Employer within said seven (7) day period, Employee will receive the consideration described in paragraph 2 above.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS THEREOF, Employee acknowledges that Employee has been advised to **CONSULT WITH AN ATTORNEY PRIOR TO SIGNING THIS AGREEMENT AND GENERAL RELEASE**, and Employee understands that by signing this Agreement and General Release, Employee is giving up and waiving important legal rights. Nevertheless, Employee and Employer mutually agree to the terms above, and hereby execute this Agreement on the day and year last shown below.

Date: _____ "EMPLOYER"

_____

By: Michael Schrader
Its: Chief Executive Officer

Date: _____ "EMPLOYEE"

_____

By:_____
(print name)

SEPARATION AGREEMENT AND GENERAL RELEASE

By signing this Separation Agreement and General Release ("Agreement"), I, _____ ("Employee") acknowledge that CalOptima (hereinafter referred to as "Employer") and I have reached a final and binding agreement concerning my separation from employment with Employer. Specifically, I acknowledge that we have agreed on the following terms and that this document contains our entire agreement.

NOW THEREFORE, for good and sufficient consideration, as set forth below, the parties agree as follows:

AGREEMENT

1. Separation Date. Employee's last day of work will be mm,dd,yyyy ("Separation Date").

2. Consideration To Employee. Employee shall be entitled to the following:

A. Employee shall receive his/her regular pay through Separation Date to the extent any is due. Employee will receive a check for all unused paid time off (PTO) and Flex Holiday time, less deductions required by law, accrued by Employee through the Separation Date.

B. If, and only if, Employee signs this Agreement and complies with its terms, and after expiration of the seven day revocation period set forth in Paragraph 19 of this Agreement, Employee shall receive severance pay in [biweekly installments of $$$$, less deductions required by law and less deductions for medical, dental and vision coverage and/or other benefits where applicable, from the Separation Date through mm,dd,yyyy] OR [a lump sum payment of $$$$$, which reflects XX weeks of severance pay, less deductions required by law and less deductions for medical, dental and vision where applicable] (the Severance Period). [Add the following when employee receives biweekly installments ONLY: As a condition of receiving biweekly installments, Employee shall be required to remain reasonably available during the time period Employee is receiving periodic severance payments to respond to questions from CalOptima and address work related matters.]

C. Employer shall make payments on behalf of Employee for medical, dental and vision coverage through mm,dd,yyyy. All other benefits shall cease on [the Separation Date] OR [at the end of the Severance Period].

D. Employer will not challenge any applications by Employee for unemployment insurance compensation.

E. Employee will receive optional outplacement services through a designated outplacement firm for a period not to exceed thirty (30) days.

3. Acknowledgement. Employee acknowledges that Employee has reviewed the consideration specified above. Employee agrees that the consideration set forth above represents a complete and final settlement of any and all claims Employee has had, now has or may have up to the effective date of this Agreement, including, without limitation, claims arising out of or in

connection with Employee's employment and/or termination by CalOptima. Employee acknowledges Employer does not owe Employee any additional wages, commissions, bonuses, PTO pay, severance pay, overtime pay, or other compensation, benefits or payments of any kind or nature, other than that specifically stated in this Agreement.

4. Specific Release. In exchange for the receipt of the foregoing consideration, Employee expressly releases and discharges Employer, Employer's board members, officers, directors, agents, employees, representatives, attorneys, successors, and assigns, and each of them, and all persons and/or entities acting by, through, under, or in concert with such persons (collectively, the "Employer Releasees") from claims or causes of action Employee has had, now has, or may have up to the effective date of this Agreement, including, without limitation, claims based upon:

A. Title VII of the Civil Rights Act of 1964;

B. The Age Discrimination in Employment Act (ADEA) (as amended by the Older Workers Benefit Protection Act (OWBPA));

C. The Americans with Disabilities Act (ADA);

D. The Equal Pay Act (EPA);

E. California statutory, regulatory, or case law, including the State Fair Employment and Housing Act, pertaining to employment discrimination, failure to prevent discrimination, harassment, retaliation, failure to engage in the interactive process or failure to provide reasonable accommodation, wrongful termination or breach of public policy;

F. Any and all State, Federal and local laws as well as common law for claims of breach of implied or express contract, negligent or intentional infliction of emotional distress, defamation, fraud, concealment, false promise, negligent misrepresentation, intentional interference with contractual relations, breach of the covenant of good faith and fair dealing, wrongful termination in violation of public policy, and constructive discharge; and

G. California Labor Code provisions pertaining to whistleblower rights and other benefits and protections set forth therein; and

H. Any and all claims arising from the California Labor Code or the Fair Labor Standards Act.

5. General Release. Employee, on behalf of himself/herself and his/her executors, heirs or assigns, hereby releases and discharges Employer Releasees from any and all actual or potential claims, obligations, and causes of action, known or unknown, which Employee has, may have, or may claim to have up to the effective date of this Agreement against Employer Releasees, without limitation, such claims arising out of or in connection with Employee's employment with, and/or separation from the Employer. Employee acknowledges that he or she may have claims that are covered by the terms of this Agreement herein which have not yet been discovered.

Nevertheless, Employee hereby expressly waives and relinquishes all rights and benefits under Section 1542 of the California Civil Code which states:

> "A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS OR HER FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM OR HER MUST HAVE MATERIALLY AFFECTED HIS OR HER SETTLEMENT WITH THE DEBTOR."

Employee acknowledges that Employee has read and understands the Employee's rights under Section 1542 of the California Civil Code above, and by signing below, Employee voluntarily waives all known and unknown claims existing on or prior to the effective date of this Agreement.

6. Claims Arising After the Effective Date. This Agreement does not apply to rights or claims that may arise after the effective date of this Agreement.

7. No Pending Action. Employer and Employee hereby agree that as of the effective date of this Agreement, no action, suit or proceeding has been brought or complaint filed or initiated by Employer or Employee or any agent, assign or spouse of either in any court, or with any governmental body. This includes any matter or cause of action based upon any facts that might have occurred prior to the effective date of this Agreement whether known to either party now or discovered by either party hereafter.

8. No Admission of Liability. Employer and Employee agree that this Agreement and the payment by Employer of the consideration described herein is not an admission by Employer, Employer Releasees or Employee of any wrongdoing or liability. All parties specifically deny any liability; wrongful acts; violations of any federal, state, or local law, regulation, order, or other requirement of law; breach of contract (actual or implied); or any other civil wrong. The parties have entered into this Agreement in order to settle all disputes and differences between them, without admitting liability or wrongdoing by any party.

9. Confidentiality. This Agreement shall remain confidential as a personnel record to the extent permissible by Government Code Section 6254(c). In the event a Public Records Act request is made to review and/or copy this Agreement, Employer's only obligation shall be to timely notify Employee of that request. Employer shall not be obligated to incur legal expenses to deny such a request.

10. References. If Employee requests an employment reference from Employer, Employer shall only provide the Employee's date(s) of employment and position in response to such requests. All reference requests must be directed to Employer's Human Resources Department.

11. Non-Disparagement. Employer and Employee each warrant and agree that he/she/it will not disseminate, orally or in writing, any comments which are in any way negative about, or disparaging to the other, or to the other's representatives or Employees, individually or collectively.

12. Employer Property. On Employee's Separation Date, Employee agrees to return all Employer property, including, but not limited to: keys; key cards; equipment and supplies; electronic and physical documents and files; and all confidential, private, and proprietary documents and files. Employee also agrees to continue to comply with CalOptima Policy #: GA 8050: Confidentiality and Nondisclosure, which is incorporated into this Agreement herein by reference, even after the Separation Date.

13. Construction. This Agreement has been negotiated and discussed between the parties and it reflects their mutual agreement regarding the subject matter of this Agreement. Neither party shall be deemed to be the drafter of this Agreement. Therefore, no presumption for or against the drafter shall be applicable in interpreting or enforcing this Agreement.

14. Separability. If any provision of this Agreement, or the application thereof to any person or circumstance, is found to be invalid, the remainder of the provisions of this Agreement, or the application of such provisions to persons or circumstances other than those which it is found to be invalid, as the case may be, shall not be affected.

15. Advice of Counsel. Employer has advised Employee to consult with a private attorney prior to executing this Agreement. Employee fully understands the right to discuss all aspects of this Agreement with a private attorney and has had reasonable and sufficient time and opportunity to consult with an attorney. Employee has consulted with an attorney of his or her own choosing, or has elected to enter into this Agreement without consultation with an attorney despite Employer's advice to consult with an attorney. Employee has read and fully understands all of the provisions of this Agreement and is freely and voluntarily entering into this Agreement.

16. Complete Agreement. This is the entire agreement between Employer and Employee with respect to the subject matter herein and this Agreement supersedes all prior and contemporaneous oral and written agreements and discussions.

17. Acknowledgment of Days To Consider. Employee has been advised of the right to consider this Agreement for up to twenty-one (21) days if a single termination or up to forty-five (45) days if the termination is of two (2) or more employees prior to its execution and has either: (a) been provided the full period to consider the agreement; or (b) voluntarily waived the full period, electing with full knowledge and consent to execute this Agreement as of the date indicated on the signature line of this Agreement.

18. [USE ONLY For RIF of 2 or more employees] Summary of Considerations. The classification, department, or group of individuals covered by CalOptima's reduction in force (RIF) includes all employees in the [describe impacted location, area, department, line of business, etc., (e.g. CalOPTIMA, Human Resources, PACE, ONECARE, etc.)] whose employment is being terminated in the RIF during the following period (XX/XX/XXXX to XX/XX/XXXX). All employees in [describe impacted location, area, department, line of business, etc., (e.g. CalOPTIMA, PACE, ONECARE, etc.)] whose employment is being terminated are eligible for the RIF.

The following is a listing of the ages and job titles of employees who were and were not selected for layoff [or termination] and offered consideration for signing the waiver. Except for those employees selected for layoff [or termination], no other employee is eligible or offered consideration in exchange for signing the waiver:

Job Title	Department/Unit	Age	# Selected	# Not Selected

19. Revocation. Employee may revoke this Agreement for a period of seven (7) days following its execution. Said revocation must be in writing, must specifically revoke this Agreement, and must be received by the Executive Director of Human Resources, at Employer's premises, prior to the end of the seventh day following Employee's execution. Upon expiration of the seven (7) day period, this Agreement becomes effective, enforceable and irrevocable. If Employee has not delivered written revocation of this Agreement to Employer within said seven (7) day period, Employee will receive the consideration described in paragraph 2 above.

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS THEREOF, Employee acknowledges that Employee has been advised to **CONSULT WITH AN ATTORNEY PRIOR TO SIGNING THIS AGREEMENT AND GENERAL RELEASE**, and Employee understands that by signing this Agreement and General Release, Employee is giving up and waiving important legal rights. Nevertheless, Employee and Employer mutually agree to the terms above, and hereby execute this Agreement on the day and year last shown below.

Date: _____ "EMPLOYER"

_____

By: Michael Schrader
Its: Chief Executive Officer

Date: _____ "EMPLOYEE"

_____

By:_____
(print name)

Policy #:	GA.8048
Title:	~~I.~~ **Restrictions on Smoking and Unregulated Nicotine Products ~~Policy~~**
Department:	~~Human Resources~~Facilities
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	02/01/14
Last Review Date:	~~TBD~~12/01/16
Last Revised Date:	~~TBD~~12/01/16

I. PURPOSE

This policy ~~To~~ establishes and defines CalOptima's restrictions on smoking and use of unregulated nicotine products in or on property owned, operated or leased by CalOptima, unless otherwise specified.

~~**DEFINITIONS**~~

~~Term~~	~~Definition~~

II. POLICY

A. As a public agency providing access to quality health care services, CalOptima endeavors to maintain a safe and healthful environment for its employees, M~~m~~embers, and visitors of CalOptima ~~Property~~Properties. Therefore, smoking, inclusive of electronic smoking devices, and the use of unregulated nicotine products are strictly prohibited inside and outside of CalOptima Property, except in designated outside smoking areas at least twenty-five (25) feet away from the building. This policy is effective from Monday through Sunday, twenty-four (24) hours per day.

B. CalOptima Property as used herein includes any propert~~y~~ies~~-~~ owned, operated, or leased by CalOptima, including the administration building at 505 City Parkway West, in the City of Orange, State of California, and the PACE building at 13300 Garden Grove Boulevard, in the City of Garden Grove, State of California, and including Cal~~-~~Optima ~~–~~owned, or leased, vehicles.

C. All CalOptima Employees shall adhere to this Policy. Employees as referred to in this Policy include, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, interns/volunteers, CalOptima Board members, advisory and Standing Committee members and authorized contractors and consultants. Failure to follow this policy may result in progressive disciplinary action or termination.

D. Smoking shall be defined as the carrying or holding of any lighted pipe, cigar, or cigarettes of any kind, including electronic smoking devices (e.g. e-cigarettes and/or vaporizers), any lighted

smoking equipment, or the lighting, inhaling, or exhaling of smoke from a pipe, cigar, or cigarette of any kind, including e-cigarettes and vaporizers.

E. Unregulated nicotine product means any product containing or delivering nicotine intended or expected for human consumption, or any part of such a product, that has not been approved or otherwise certified for sale by the United States Food and Drug Administration as a tobacco use cessation product or for other medical purposes.

F. Smoking and use of unregulated nicotine only within the designated smoking area located at least twenty-five (25) feet away from CalOptima Property shall be strictly enforced by all CalOptima Employees.

G. CalOptima's p~~P~~roperty ~~Facilities M~~manager shall be responsible for posting appropriate signage in key areas in and around CalOptima P~~p~~roperty, in addition, but not limited to, entrances, exits~~, 1st floor assembly rooms, stairwells, restrooms, lobby~~, and parking lot.

1. Adjacent public thoroughfares, sidewalks, and parking lots not owned by CalOptima are subject to local jurisdiction such as regulations governing smoking proximate to building entrances, exits, ventilation intakes, and open windows.

2. The ~~Manager of~~ Facilities Manager ~~Manager~~ shall request that the ~~building manage~~P~~p~~roperty M~~m~~anager accommodate the terms of this policy as it might apply to common areas shared by non-CalOptima entities.

H. CalOptima e~~E~~mployees who smoke, use an electronic smoking device, or use unregulated nicotine products in, or on, CalOptima Property outside of the designated smoking area(s) are in violation of this policy and shall be subject to corrective measures, including discipline in accordance with CalOptima Policies GA.8022: Progressive Discipline~~ and GA.8021: Employee Conduct, or termination.~~

III. PROCEDURE

Responsible Party	Action
Employee	1. Adhere to the requirements in this Policy.
Manager	1. Interpret and enforce this Policy in their area of responsibility. 2. If a CalOptima e~~E~~mployee disregards and/or violates this policy, the manager will address the employee immediately.
Human Resources	~~1.~~ Provide CalOptima e~~E~~mployees with the Restrictions on Smoking and Unregulated Nicotine Products Policy. 1.
Property Manager	2. The Propertry Manager will enforce CalOptima's Restrictions on Smoking and Unregulated Nicotine Product Policy as directed by the CalOptima Facilities Manager.
Facilities Manager	3. ~~Assure~~ Ensure the Property Manager adheres to the provisions of this policy

IV. ATTACHMENTS

Not Applicable

~~V. DEFINITIONS~~

~~Not Applicable~~

~~VI.~~V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8000: Glossary of Terms
~~C. CalOptima Policy GA.8021: Employee Conduct~~
~~D.~~ CalOptima Policy GA.8022: Progressive Discipline
~~E.~~C. ~~CalOptima Employee Handbook~~
~~F.~~D. California Labor Code, ~~Section~~ §6404.5

VI. REGULATORY AGENCY APPROVALS ~~OR~~

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	02/01/2014	GA.8048	Restrictions on Smoking and Unregulated Nicotine Products	Administrative
~~Revision Date 1~~Revised	12/01/2016	GA.8048	Restrictions on Smoking and Unregulated Nicotine Products	Administrative

~~Not Applicable~~

IX. GLOSSARY

Term	Definition
CalOptima Employees	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, interns/volunteers, CalOptima Board members, advisory and Standing Committee members and authorized contractors and consultants.
CalOptima Property	Any property owned, operated or leased by CalOptima, including the administration building at 505 City Parkway West, in the City of Orange, State of California, and the PACE building at 13300 Garden Grove Boulevard, in the City of Garden Grove, State of California, and including Cal-Optima owned or leased vehicles.
Facilities Manager	For purposes of this policy ensures upkeep, maintenance, CalOptima Employee safety, building rules and regulations are adhered to in conjunction with the Property Manager.
Member	A beneficiary who is enrolled in a CalOptima Program.
~~Smoking~~	~~For purposes of this policy, shall be defined as the carrying or holding of any lighted pipe, cigar, or cigarettes of any kind, including electronic smoking devices (e.g. e-cigarettes and/or vaporizers), any lighted smoking equipment, or the lighting, inhaling, or exhaling of smoke from a pipe, cigar, or cigarette of any kind, including e-cigarettes and vaporizers.~~
Property Manager	For ~~the~~ purposes of this policy, the Property Manager is defined as an outside fee--based property management company, with experience at managing high rise office buildings
Smoking	For purposes of this policy, shall be defined as the carrying or holding of any lighted pipe, cigar, or cigarettes of any kind, including electronic smoking devices (e.g. e-cigarettes and/or vaporizers), any lighted smoking equipment, or the lighting, inhaling, or exhaling of smoke from a pipe, cigar, or cigarette of any kind, including e-cigarettes and vaporizers.
~~Facilities Manager~~	~~For the purposes of this policy assureensures upkeep, maintenance, CalOptima eEmployee safety, building rules and regulations are adhered to in conjuctionconjunction with the Property Manager.~~

~~IX. KEYWORDS~~

~~Perimeter~~
~~Second hand~~
~~Smoke-Free~~
~~Property~~
~~Smoking~~
~~Tobacco Use~~

Policy #:	GA.8048		
Title:	~~Smoke-Free Work Environment Policy~~Restrictions on Smoking and Unregulated Nicotine Products	~~Effective~~ Revised Date:	~~2/1/14~~12/01/16

Policy #:	GA.8048
Title:	**Restrictions on Smoking and Unregulated Nicotine Products**
Department:	Facilities
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	02/01/14
Last Review Date:	12/01/16
Last Revised Date:	12/01/16

I. PURPOSE

This policy establishes and defines CalOptima's restrictions on smoking and use of unregulated nicotine products in or on property owned, operated or leased by CalOptima, unless otherwise specified.

II. POLICY

A. As a public agency providing access to quality health care services, CalOptima endeavors to maintain a safe and healthful environment for its employees, Members, and visitors of CalOptima Properties. Therefore, smoking, inclusive of electronic smoking devices, and the use of unregulated nicotine products are strictly prohibited inside and outside of CalOptima Property, except in designated outside smoking areas at least twenty-five (25) feet away from the building. This policy is effective from Monday through Sunday, twenty-four (24) hours per day.

B. CalOptima Property as used herein includes any properties owned, operated, or leased by CalOptima, including the administration building at 505 City Parkway West, in the City of Orange, State of California, and the PACE building at 13300 Garden Grove Boulevard, in the City of Garden Grove, State of California, and including CalOptima-owned, or leased, vehicles.

C. All CalOptima Employees shall adhere to this Policy. Employees as referred to in this Policy include, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, interns/volunteers, CalOptima Board members, advisory and Standing Committee members and authorized contractors and consultants. Failure to follow this policy may result in progressive disciplinary action or termination.

D. Smoking shall be defined as the carrying or holding of any lighted pipe, cigar, or cigarettes of any kind, including electronic smoking devices (e.g. e-cigarettes and/or vaporizers), any lighted smoking equipment, or the lighting, inhaling, or exhaling of smoke from a pipe, cigar, or cigarette of any kind, including e-cigarettes and vaporizers.

E. Unregulated nicotine product means any product containing or delivering nicotine intended or expected for human consumption, or any part of such a product, that has not been approved or otherwise certified for sale by the United States Food and Drug Administration as a tobacco use cessation product or for other medical purposes.

F. Smoking and use of unregulated nicotine only within the designated smoking area located at least twenty-five (25) feet away from CalOptima Property shall be strictly enforced by all CalOptima Employees.

G. CalOptima's property manager shall be responsible for posting appropriate signage in key areas in and around CalOptima Property, in addition, but not limited to, entrances, exits, and parking lot.

1. Adjacent public thoroughfares, sidewalks, and parking lots not owned by CalOptima are subject to local jurisdiction such as regulations governing smoking proximate to building entrances, exits, ventilation intakes, and open windows.

2. The Facilities Manager shall request that the Property Manager accommodate the terms of this policy as it might apply to common areas shared by non-CalOptima entities.

H. CalOptima employees who smoke, use an electronic smoking device, or use unregulated nicotine products in, or on, CalOptima Property outside of the designated smoking area(s) are in violation of this policy and shall be subject to corrective measures, including discipline in accordance with CalOptima Policies GA.8022: Progressive Discipline.

III. PROCEDURE

Responsible Party	Action
Employee	1. Adhere to the requirements in this Policy.
Manager	1. Interpret and enforce this Policy in their area of responsibility. 2. If a CalOptima Employee disregards and/or violates this policy, the manager will address the employee immediately.
Human Resources	1. Provide CalOptima Employees with the Restrictions on Smoking and Unregulated Nicotine Products Policy.
Property Manager	2. The Propertry Manager will enforce CalOptima's Restrictions on Smoking and Unregulated Nicotine Product Policy as directed by the CalOptima Facilities Manager.
Facilities Manager	3. Ensure the Property Manager adheres to the provisions of this policy

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8000: Glossary of Terms
C. CalOptima Policy GA.8022: Progressive Discipline
D. California Labor Code, §6404.5

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/2014	GA.8048	Restrictions on Smoking and Unregulated Nicotine Products	Administrative
Revised	12/01/2016	GA.8048	Restrictions on Smoking and Unregulated Nicotine Products	Administrative

IX. GLOSSARY

Term	Definition
CalOptima Employees	For purposes of this policy, include, but are not limited to, all full-time and part-time regular CalOptima employees, all temporary employees, interns/volunteers, CalOptima Board members, advisory and Standing Committee members and authorized contractors and consultants.
CalOptima Property	Any property owned, operated or leased by CalOptima, including the administration building at 505 City Parkway West, in the City of Orange, State of California, and the PACE building at 13300 Garden Grove Boulevard, in the City of Garden Grove, State of California, and including Cal-Optima owned or leased vehicles.
Facilities Manager	For purposes of this policy ensures upkeep, maintenance, CalOptima Employee safety, building rules and regulations are adhered to in conjunction with the Property Manager.
Member	A beneficiary who is enrolled in a CalOptima Program.
Property Manager	For purposes of this policy, the Property Manager is defined as an outside fee-based property management company, with experience at managing high rise office buildings
Smoking	For purposes of this policy, shall be defined as the carrying or holding of any lighted pipe, cigar, or cigarettes of any kind, including electronic smoking devices (e.g. e-cigarettes and/or vaporizers), any lighted smoking equipment, or the lighting, inhaling, or exhaling of smoke from a pipe, cigar, or cigarette of any kind, including e-cigarettes and vaporizers.

Policy #:	GA.8050
Title:	**Confidentiality**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	02/01/14
Last Review Date:	~~N/A~~TBD
Last Revised Date:	12/01/16
	~~N/A~~12/01/16~~TBD~~

I. PURPOSE

This policy ~~To~~ outlines CalOptima's guidelines for protecting proprietary, private, and confidential information.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~Medical Record:~~	~~Any single or complete record kept or required to be kept that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.~~
~~Protected Health Information (PHI):~~	~~Individually identifiable health information as defined in Section 160.103 of Title 45, Code of Federal Regulations.~~

~~A. Medical Record: Any single or complete record kept or required to be kept that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.~~

~~B. Protected Health Information (PHI): Individually identifiable health information as defined in Section 160.103 of Title 45, Code of Federal Regulations.~~

~~III.~~II. POLICY

A. CalOptima Board members, e~~E~~xecutive s~~S~~taff, employees, contractors, interns, volunteers, and temporary employees (referred to herein collectively as "Employees") shall not disclose, divulge, or make accessible proprietary, private and/or confidential information belonging to, or obtained through the Employee's affiliation with CalOptima to any person, including relatives, friends, and business and professional associates, other than to persons who have a legitimate business need for such information and to whom CalOptima has authorized disclosure. This obligation includes making sure electronic proprietary, private and confidential information is secure, taking precautions to secure files, and following all federal, state and local laws and regulations.

B. Proprietary information includes all information obtained by Employees during the course of their work with or at CalOptima, including, but not limited to, intellectual property, computer software,

and provider identification numbers. Private information includes, but is not limited to, any information related to a person's health, employment application, residence address, testing scores, personnel reviews, social security number, etc. Confidential i~~I~~nformation is any information that is not known generally to the public, including, but not limited to, Protected Health Information (PHI), personnel files, provider rates, the Department of Health Care Services (DHCS) reimbursement rates, and any other information that may exist in contracts, administrative files, personnel records, computer records, computer programs, and financial data.

C. Inappropriate use, unauthorized copy and transfer, attempted destruction, the destruction or disclosure of confidential, private or proprietary information obtained through the Employee's affiliation with CalOptima will subject an E~~e~~mployee to discipline, up to and including termination, and possible legal recourse.

~~IV.~~III. PROCEDURE

A. CalOptima Employees shall:

1. Use proprietary, private, and/or confidential information solely for the purpose of performing services as a trustee or e~~e~~mployee of CalOptima;

2. Exercise good judgment and care at all times to avoid unauthorized or improper disclosures of proprietary, private, and/or confidential information; and

3. Adhere to all CalOptima compliance and Health Insurance Portability and Accountability Act (HIPAA) policies, in accordance with CalOptima Policies IS.1101: EPHI Physical Controls, IS.1201: EPHI Technical Safeguards - Access Controls, IS.1202: EPHI Technical Safeguards - Data Controls, GA.5005.a: Use of Technology Resources, and IS.1301: Security of Workforce Access to EPHI.

B. Conversations in public places, such as restaurants, elevators, restrooms, hallways, lobbies, and while traveling via public transportation, should be limited to matters that do not pertain to information of a sensitive, proprietary, private, and/ or confidential nature. In addition, Employees must be sensitive to the risk of inadvertent disclosure and should refrain from leaving proprietary, private and/or confidential information on desks, workspaces, personal computers, cars, or otherwise in plain view of unauthorized persons, and Employees shall refrain from the use of speaker phones to discuss confidential information if the conversation could be heard by unauthorized persons.

C. CalOptima employees may receive more specific requirements regarding the confidentiality of the information. In brief summary, Employees and individuals affiliated with CalOptima are subject to various confidentiality provisions such as:

1. Public Assistance Recipients: The identity of an individual receiving public services/assistance is protected by federal law. Medi-Cal is a form of public assistance and providing information regarding an individual's eligibility is limited only to purposes of service delivery. Only those designated individuals responsible for verifying eligibility to p~~P~~roviders should be providing such information and only to authorized recipients.

2. Medical Records: Medical condition and treatment records are confidential between the treating healthcare Provider and Member. Such information is protected under California and federal law. When authorized, such records may be subject to review by qualified professionals involved in CalOptima's responsibilities related to such functions as claims, utilization review, quality assurance, grievance appeals, etc. Any knowledge obtained in this regard must be kept confidential and may not be disclosed to unauthorized persons.

3. Special Health Conditions: Information related to the identity of individuals receiving treatment with certain health conditions carry further confidentiality protection, e.g., AIDS, substance abuse, mental illness, or venereal disease.

4. Special Categories: Other conditions or circumstances are covered by special confidentiality provisions, e.g., minors, victims of abuse, etc.

5. Rates: The rates paid to CalOptima by the Department of Health Care Services (DHCS) and the rates CalOptima pays to its contractors/p~~P~~roviders are confidential under state and federal law.

D. HIPAA requires CalOptima, its Employees, and its agents to comply with the following standards to protect the privacy of an individual's PHI. PHI is any individually identifiable health information, including demographic information. CalOptima is committed to ensuring the privacy and security of Member information, and Employees shall comply with applicable laws and CalOptima policies and procedures to protect and maintain the confidentiality of PHI as outlined below:

1. General Use: PHI pertaining to Members may only be used to perform functions, activities or services for the purpose of treatment, payment, or health care operations, unless otherwise authorized by the Member or required by law. In addition, use or disclosure of PHI should be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

2. Unacceptable Use: PHI shall not be used for personal benefit or for the benefit of any other person or entity. Divulging the Medi-Cal status or other PHI of a Member to unauthorized recipients is prohibited.

3. Privacy and Security Safeguards: CalOptima is required to have in place administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI. These safeguards may include, but is not limited to, physically securing PHI in paper form and encrypting PHI in electronic form.

E. At the end of a Board member's term in office or upon the termination of an Employee's relationship with CalOptima, he or she shall immediately return all documents, papers, electronic files, and other materials, regardless of medium, which may contain or be derived from confidential, private or proprietary information in his or her possession.

F. Any individual covered by this policy who violates its provisions shall be subject to discipline and/or separation from service or affiliation with CalOptima as well as possible civil and/or criminal liability. The restrictions of this policy also pertain to any disclosure or use of confidential, private, or proprietary information after leaving affiliation with CalOptima.

G. CalOptima shall provide new hires with this policy.

1. All Employees are required to sign an acknowledgment agreeing to comply with this policy.

2. Failure to sign such acknowledgment may result in disciplinary action, up to and including possible termination.

~~V.~~IV. ATTACHMENTS

A. CalOptima Code of Conduct
~~B. Confidentiality Memorandum~~

~~VI.~~V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Employee Handbook
C. CalOptima Policy GA.8000: Glossary of Terms
~~A.~~D. CalOptima Policy GA.5005.a: Use of Technology Resources
~~B.~~E. CalOptima Policy IS.1101: EPHI Physical Controls
~~C.~~F. CalOptima Policy IS.1201: EPHI Technical Safeguards - Access Controls
~~D.~~G. CalOptima Policy IS.1202: EPHI Technical Safeguards - Data Controls
~~E.~~H. CalOptima Policy IS.1301: Security of Workforce Access to EPHI
~~F.A. CalOptima Employee Handbook~~
~~G.A. CalOptima Code of Conduct~~

VI. REGULATORY AGENCY APPROVALS ~~OR~~

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	02/01/2014	GA.8050	Confidentiality	Administrative
~~Revision Date 1~~Revised	12/01/2016	GA.8050	Confidentiality	Administrative

~~Not Applicable~~

IX. GLOSSARY

Term	Definition
Medical Record	Any single or complete record kept or required to be kept that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	An enrollee-beneficiary of a CalOptima program.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

~~IX. KEYWORDS~~

~~Confidentiality~~
~~HIPAA~~
~~PHI~~

Policy #:	GA.8050
Title:	**Confidentiality**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	02/01/14
Last Review Date:	12/01/16
Last Revised Date:	12/01/16

I. PURPOSE

This policy outlines CalOptima's guidelines for protecting proprietary, private, and confidential information.

II. POLICY

A. CalOptima Board members, executive staff, employees, contractors, interns, volunteers, and temporary employees (referred to herein collectively as "Employees") shall not disclose, divulge, or make accessible proprietary, private and/or confidential information belonging to, or obtained through the Employee's affiliation with CalOptima to any person, including relatives, friends, and business and professional associates, other than to persons who have a legitimate business need for such information and to whom CalOptima has authorized disclosure. This obligation includes making sure electronic proprietary, private and confidential information is secure, taking precautions to secure files, and following all federal, state and local laws and regulations.

B. Proprietary information includes all information obtained by Employees during the course of their work with or at CalOptima, including, but not limited to, intellectual property, computer software, and provider identification numbers. Private information includes, but is not limited to, any information related to a person's health, employment application, residence address, testing scores, personnel reviews, social security number, etc. Confidential information is any information that is not known generally to the public, including, but not limited to, Protected Health Information (PHI), personnel files, provider rates, the Department of Health Care Services (DHCS) reimbursement rates, and any other information that may exist in contracts, administrative files, personnel records, computer records, computer programs, and financial data.

C. Inappropriate use, unauthorized copy and transfer, attempted destruction, the destruction or disclosure of confidential, private or proprietary information obtained through the Employee's affiliation with CalOptima will subject an Employee to discipline, up to and including termination, and possible legal recourse.

III. PROCEDURE

A. CalOptima Employees shall:

1. Use proprietary, private, and/or confidential information solely for the purpose of performing services as a trustee or employee of CalOptima;

2. Exercise good judgment and care at all times to avoid unauthorized or improper disclosures of proprietary, private, and/or confidential information; and

3. Adhere to all CalOptima compliance and Health Insurance Portability and Accountability Act (HIPAA) policies, in accordance with CalOptima Policies IS.1101: EPHI Physical Controls, IS.1201: EPHI Technical Safeguards - Access Controls, IS.1202: EPHI Technical Safeguards - Data Controls, GA.5005.a: Use of Technology Resources, and IS.1301: Security of Workforce Access to EPHI.

B. Conversations in public places, such as restaurants, elevators, restrooms, hallways, lobbies, and while traveling via public transportation, should be limited to matters that do not pertain to information of a sensitive, proprietary, private, and/ or confidential nature. In addition, Employees must be sensitive to the risk of inadvertent disclosure and should refrain from leaving proprietary, private and/or confidential information on desks, workspaces, personal computers, cars, or otherwise in plain view of unauthorized persons, and Employees shall refrain from the use of speaker phones to discuss confidential information if the conversation could be heard by unauthorized persons.

C. CalOptima employees may receive more specific requirements regarding the confidentiality of the information. In brief summary, Employees and individuals affiliated with CalOptima are subject to various confidentiality provisions such as:

1. Public Assistance Recipients: The identity of an individual receiving public services/assistance is protected by federal law. Medi-Cal is a form of public assistance and providing information regarding an individual's eligibility is limited only to purposes of service delivery. Only those designated individuals responsible for verifying eligibility to providers should be providing such information and only to authorized recipients.

2. Medical Records: Medical condition and treatment records are confidential between the treating healthcare Provider and Member. Such information is protected under California and federal law. When authorized, such records may be subject to review by qualified professionals involved in CalOptima's responsibilities related to such functions as claims, utilization review, quality assurance, grievance appeals, etc. Any knowledge obtained in this regard must be kept confidential and may not be disclosed to unauthorized persons.

3. Special Health Conditions: Information related to the identity of individuals receiving treatment with certain health conditions carry further confidentiality protection, e.g., AIDS, substance abuse, mental illness, or venereal disease.

4. Special Categories: Other conditions or circumstances are covered by special confidentiality provisions, e.g., minors, victims of abuse, etc.

5. Rates: The rates paid to CalOptima by the Department of Health Care Services (DHCS) and the rates CalOptima pays to its contractors/providers are confidential under state and federal law.

D. HIPAA requires CalOptima, its Employees, and its agents to comply with the following standards to protect the privacy of an individual's PHI. PHI is any individually identifiable health information, including demographic information. CalOptima is committed to ensuring the privacy and security of Member information, and Employees shall comply with applicable laws and CalOptima policies and procedures to protect and maintain the confidentiality of PHI as outlined below:

1. General Use: PHI pertaining to Members may only be used to perform functions, activities or services for the purpose of treatment, payment, or health care operations, unless otherwise authorized by the Member or required by law. In addition, use or disclosure of PHI should be limited to the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

2. Unacceptable Use: PHI shall not be used for personal benefit or for the benefit of any other person or entity. Divulging the Medi-Cal status or other PHI of a Member to unauthorized recipients is prohibited.

3. Privacy and Security Safeguards: CalOptima is required to have in place administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of PHI. These safeguards may include, but is not limited to, physically securing PHI in paper form and encrypting PHI in electronic form.

E. At the end of a Board member's term in office or upon the termination of an Employee's relationship with CalOptima, he or she shall immediately return all documents, papers, electronic files, and other materials, regardless of medium, which may contain or be derived from confidential, private or proprietary information in his or her possession.

F. Any individual covered by this policy who violates its provisions shall be subject to discipline and/or separation from service or affiliation with CalOptima as well as possible civil and/or criminal liability. The restrictions of this policy also pertain to any disclosure or use of confidential, private, or proprietary information after leaving affiliation with CalOptima.

G. CalOptima shall provide new hires with this policy.

1. All Employees are required to sign an acknowledgment agreeing to comply with this policy.

2. Failure to sign such acknowledgment may result in disciplinary action, up to and including possible termination.

IV. ATTACHMENTS

A. CalOptima Code of Conduct

V. REFERENCES

A. CalOptima Code of Conduct
B. CalOptima Employee Handbook
C. CalOptima Policy GA.8000: Glossary of Terms
D. CalOptima Policy GA.5005.a: Use of Technology Resources
E. CalOptima Policy IS.1101: EPHI Physical Controls
F. CalOptima Policy IS.1201: EPHI Technical Safeguards - Access Controls
G. CalOptima Policy IS.1202: EPHI Technical Safeguards - Data Controls
H. CalOptima Policy IS.1301: Security of Workforce Access to EPHI

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/2014	GA.8050	Confidentiality	Administrative
Revised	12/01/2016	GA.8050	Confidentiality	Administrative

IX. GLOSSARY

Term	Definition
Medical Record	Any single or complete record kept or required to be kept that documents all the medical services received by the Member, including, but not limited to, inpatient, outpatient, and emergency care, referral requests, authorizations, or other documentation as indicated by CalOptima policy.
Member	An enrollee-beneficiary of a CalOptima program.
Protected Health Information (PHI)	Has the meaning in 45 Code of Federal Regulations Section 160.103, including the following: individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by Cal Optima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.

Code of Conduct

Principle	Standard
Mission, Vision, and Values CalOptima is committed to its Mission, Vision and Values	**Mission** To provide members with access to quality health care services delivered in a cost-effective and compassionate manner. **Vision** To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all CalOptima members**.** **Values = CalOptima CARES** **C**ollaboration; **A**ccountability; **R**espect; **E**xcellence; **S**tewardship
Compliance with the Law CalOptima is committed to conducting all activities and operations in compliance with applicable laws.	**Transparent, Legal and Ethical Business Conduct** CalOptima is committed to conducting its business with integrity, honesty and fairness and in compliance with all laws and regulations that apply to its operations. CalOptima depends on its Board Members, Employees and those who do business with it to help fulfill this commitment. **Obeying the Law** Board members, Employees and Contractors (including First Tier and Downstream Entities included in the term "FDRs") shall not lie, steal, cheat or violate any law in connection with their employment and/or engagement with CalOptima. **Fraud, Waste & Abuse (FWA)** CalOptima shall refrain from conduct, which would violate the fraud, waste and abuse laws. CalOptima is committed to the detection, prevention, and reporting of fraud, waste and abuse. CalOptima is also responsible for ensuring that Board members, Employees and FDRs receive appropriate FWA training as described in regulatory guidance. CalOptima's Compliance Plan, Fraud, Waste and Abuse Plan and policies describe examples of potential fraud, waste and abuse and discuss Employee and Contractor FWA obligations and potential sanctions arising from relevant federal and state FWA laws. CalOptima expects and requires that its Board members, Employees, and Contractors do not participate in any conduct that may violate the FWA laws including, federal and state anti-kickback laws, false claims acts, and civil monetary penalty laws. **Political Activities** CalOptima's political participation is limited by law. CalOptima funds, property, and resources are not to be used to contribute to political campaigns, political parties, and/or organizations. Board members, Employees and Contractors may participate in the political process on their own time and at their own expense but shall not give the impression that they are speaking on behalf of or representing CalOptima in these activities. **Anti-Trust** All Board members, Employees, and Contractors must comply with applicable antitrust, unfair competition and similar laws, which regulate competition. Such persons shall seek advice from legal counsel if they encounter any business decisions involving a risk of violation of antitrust laws. The types of activities that potentially implicate antitrust laws include, without limitation, agreements to fix prices, bid rigging and related activities; boycotts, certain exclusive dealings and price discrimination agreements; unfair trade practices; sales or purchases conditioned on reciprocal purchases or sales; and discussion of factors determinative of prices at trade association meetings.

Code of Conduct

Principle	Standard
Member Rights CalOptima is committed to meeting the health care needs of its members by providing access to quality health care services.	**Member Choice, Access to Health Care Services, Continuity of Care** Employees and Contractors shall comply with CalOptima policies and procedures and applicable law governing member choice, access to health care services and continuity of Member care. Employees and Contractors shall comply with all requirements for coordination of medical and support services for persons with special needs. **Cultural and Linguistic Services** CalOptima and Contractors shall provide culturally, linguistically and sensory appropriate services to CalOptima members to ensure effective communication regarding diagnosis, medical history and treatment, and health education. **Disabled Member Access** CalOptima's Facilities shall adhere to the requirements of Title III of the Americans with Disabilities Act of 1990 by providing access for disabled Members. **Emergency Treatment** Employees and Contractors shall comply with all applicable guidelines, policies and procedures and law governing CalOptima member access and payment of emergency services including, without limitation, the Emergency Medical Treatment and Active Labor Act ("EMTALA") and state patient "anti-dumping" laws, prior authorization limitations, and payment standards. **Grievance and Appeals Processes** CalOptima, its Physician Groups, its Health Networks and Third Party Administrators (TPA) shall ensure that CalOptima members are informed of their grievance and appeal rights including, the State Hearing process, through member handbooks and other communications in accordance with CalOptima policies and procedures and applicable laws. Employees and Contractors shall address, investigate, and resolve CalOptima member complaints and grievances in a prompt and nondiscriminatory manner in accordance with CalOptima Policies and applicable law.
Business Ethics In furtherance of CalOptima's commitment to the highest standards of business ethics, Employees and Contractors shall accurately and honestly represent CalOptima and shall not engage in any activity or scheme intended to defraud anyone of money, property, or honest services.	**Candor & Honesty** CalOptima requires candor and honesty from individuals in the performance of their responsibilities and in communications including, communications with CalOptima's Board of Directors, supervisory employees attorneys, and auditors. No Board member, Employee, or Contractor shall make false or misleading statements to any members and/or persons or entities doing business with CalOptima or about products or services of CalOptima. **Financial and Data Reporting** All financial reports, accounting records, research reports, expense accounts, data submissions, attestations, timesheets and other documents must accurately and clearly represent the relevant facts and the true nature of a transaction. CalOptima maintains a system of internal controls to ensure that all transactions are executed in accordance with management's authorization and recorded in a proper manner to maintain accountability of the agency's assets. Improper or fraudulent accounting documentation or financial reporting or false or misleading encounter, claims, cost or other required regulatory data submissions is contrary to the policy of CalOptima and may be in violation of applicable law and regulatory obligations. **Regulatory Agencies and Accrediting Bodies** CalOptima will deal with all regulatory agencies and accrediting bodies in a direct, open and honest manner. Employees and Contractors shall not take action with regulatory agencies and accrediting bodies that is false or misleading.

Code of Conduct

Principle	Standard
Public Integrity CalOptima and its Board members and Employees shall comply with laws and regulations governing public agencies.	**Public Records** CalOptima shall provide access to CalOptima Public Records to any person, corporation, partnership, firm or association requesting to inspect and copy them in accordance with the California Public Records Act, California Government Code Sections 6250 et seq. and CalOptima Policies. **Public Funds** CalOptima, its Board members, and Employees shall not make gifts of public funds or assets or lend credit to private persons without adequate consideration unless such actions clearly serve a public purpose within the authority of the agency and are otherwise approved by legal counsel. CalOptima, its Board members, and Employees shall comply with applicable law and CalOptima Policies governing the investment of public funds and expenditure limitations. **Public Meetings** CalOptima, and its Board members, and Employees shall comply with requirements relating to the notice and operation of public meetings in accordance with the Ralph M. Brown Act, California Government Code Sections 54950 et seq.
Confidentiality Board members, Employees, and Contractors shall maintain the confidentiality of all confidential information in accordance with applicable law and shall not disclose such confidential information except as specifically authorized by CalOptima policies, procedures, and applicable law.	**No Personal Benefit** Board members, Employees and Contractors shall not use confidential or proprietary CalOptima information for their own personal benefit or for the benefit of any other person or entity, while employed at or engaged by CalOptima, or at any time thereafter. **Duty to Safeguard Member Confidential Information** CalOptima recognizes the importance of its members' right to confidentiality and implements policies and procedures to ensure its members' confidentiality rights and the protection of medical and other confidential information. Board members, Employees and Contractors shall safeguard CalOptima member identity, eligibility, social security, medical information and other confidential information in accordance with applicable laws including the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH Act) and implementing regulations, the California Security Breach Notification Law, the California Confidentiality of Medical Information Act, other applicable federal and state privacy laws and CalOptima policies and procedures. **Personnel Files** Personal information contained in Employee personnel files shall be maintained in a manner designed to ensure confidentiality in accordance with applicable law. **Proprietary Information** Subject to its obligations under the Public Records Act, CalOptima shall safeguard confidential proprietary information including, without limitation, Contractor information and proprietary computer software, in accordance with and, to the extent required by, contract or law. CalOptima shall also safeguard provider identification numbers including, without limitation, Medi-Cal license, Medicare numbers, social security numbers, and other identifying numbers.

Code of Conduct

Principle	Standard
Business Relationships Business transactions with vendors, Contractors, and other third parties shall be conducted at arm's length in fact and in appearance, transacted free from improper inducements and in accordance with applicable law and ethical standards.	**Business Inducements** Board members, Employees, and Contractors shall not seek to gain advantage through improper use of payments, business courtesies, or other inducements. The offering, giving, soliciting, or receiving any form of bribe or other improper payment is prohibited. Board members, Employees, Contractors and providers shall not use their positions to personally profit or assist others in profiting in any way at the expense of Federal and/or State health care programs, CalOptima or CalOptima members. **Gifts to CalOptima** Board members and Employees are specifically prohibited from soliciting and accepting personal gratuities, gifts, favors, services, entertainment or any other things of value from any person or entity that furnishes items or services used, or that may be used, in CalOptima and its programs unless specifically permitted under CalOptima Policies. Employees may not accept cash or cash equivalents. Perishable or consumable gifts given to a department or group are not subject to any specific limitation and business meetings at which a meal is served is not considered a prohibited business courtesy. **Provision of Gifts by CalOptima** Employees may provide gifts, entertainment or meals of nominal value to CalOptima's current and prospective business partners and other persons when such activities have a legitimate business purpose, are reasonable, and are otherwise consistent with applicable law and CalOptima Policies on this subject. In addition to complying with statutory and regulatory requirements, it is critical to even avoid the appearance of impropriety when giving gifts to persons and entities that do business or are seeking to do business with CalOptima. **Third-Party Sponsored Events** CalOptima's joint participation in Contractor, vendor or other third-party sponsored events, educational programs and workshops is subject to compliance with applicable law including gift of public fund requirements and fraud and abuse prohibitions, and must be approved in accordance with CalOptima Policies on this subject. In no event, shall CalOptima participate in any joint Contractor, vendor, or third party sponsored event where the intent of the other participant is to improperly influence, or gain unfair advantage from, CalOptima or its operations. Employees' attendance at Contractor, vendor or other third-party sponsored events, educational programs and workshops is generally permitted where there is a legitimate business purpose but is subject to prior approval in accordance with CalOptima Policies. **Provision of Gifts to Government Agencies** Board members, Employees and Contractors shall not offer or provide any money, gifts or other things of value to any government entity or its representatives, except campaign contributions to elected officials in accordance with applicable campaign contribution laws. **Broad Application of Standards** CalOptima intends that these standards be construed broadly to avoid even the appearance of improper activity.

Code of Conduct

Principle	Standard
Conflicts of Interests Board members and Employees owe a duty of undivided and unqualified loyalty to CalOptima.	**Conflict of Interest Code** Designated Employees, including Board members, shall comply with the requirements of the CalOptima Conflict of Interest Code and applicable laws. Board members and Employees are expected to conduct their activities to avoid impropriety and/or the appearance of impropriety, which might arise from the influence of those activities on business decisions of CalOptima, or from disclosure of CalOptima's business operations. **Outside Services and Interests** Without the prior written approval of the Chief Executive Officer (or in the case of the Chief Executive Officer, the Chair of the CalOptima Board of Directors), no employee shall (1) perform work or render services for any Contractor, association of Contractors or other organizations with which CalOptima does business or which seek to do business with CalOptima, (2) be a director, officer, or consultant of any Contractor or association of Contractors; or (3) permit his or her name to be used in any fashion that would tend to indicate a business connection with any Contractor or association of Contractors.
Discrimination CalOptima acknowledges that fair and equitable treatment of employees, members, providers, and other persons is fundamental to fulfilling its mission and goals.	**No Discrimination** CalOptima is committed to compliance with applicable anti-discrimination laws including Title VI of the Civil Rights Act of 1964. Board members, Employees and Contractors shall not unlawfully discriminate on the basis of race, color, religion, national origin, age, gender, sexual orientation, physical or mental disability or any other classification protected by law. CalOptima is committed to providing a work environment free from discrimination and harassment based on any classification noted above. **Reassignment** CalOptima, Physician Groups, and Health Networks shall not reassign members in a discriminatory manner, including based on the enrollee's health status.
Participation Status CalOptima requires that Employees, Contractors, Providers and Suppliers meet Government requirements for participation in CalOptima's programs.	**Federal and State Health Care Program Participation Status** Board members, Employees, and Contractors shall not be currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal or State health care program, including the Medi-Cal program and Medicare programs. **CalOptima Screening** CalOptima will monitor the participation status of Employees, individuals and entities doing business with CalOptima by conducting regular exclusion screening reviews in accordance with CalOptima Policies. **Disclosure of Participation Status** Board members, Employees and Contractors shall disclose to CalOptima whether they are currently suspended, terminated, debarred, or otherwise ineligible to participate in any Federal and/or State Health Care program. Employees and individuals and entities that do business with CalOptima shall disclose to CalOptima any pending investigation, disciplinary action or other matter that could potentially result in their exclusion from participation in any Federal or State health care program.
	Delegated Third Party Administrator Review CalOptima requires that its Health Networks, Physician Groups, and third party administrators review participating providers and suppliers for licensure and participation status as part of the delegated credentialing and recredentialing processes when such obligations have been delegated to them. **Licensure** CalOptima requires that all Employees, Contractors, Health Networks, participating providers and suppliers who are required to be licensed, credentialed, certified and/or registered in order to furnish items or services to CalOptima and its members have valid and current licensure, credentials, certification and/or registration as applicable.

Code of Conduct

Principle	Standard
Government Inquiries/Legal Disputes Employees shall notify CalOptima upon receipt of Government inquiries and shall not destroy or alter documents in response to a government request for documents or information.	**Notification of Government Inquiry** Employees shall notify the Executive Director, Department of Compliance and/or their Supervisor immediately upon the receipt (at work or at home) of an inquiry, subpoena or other agency or government requests for information regarding CalOptima. **No Destruction of Documents** Employees shall not destroy or alter CalOptima information or documents in anticipation of, or in response to, a request for documents by any governmental agency or from a court of competent jurisdiction. **Preservation of Documents Including Electronically Stored Information** Board members and employees shall comply with all obligations to preserve documents, data, and records including, electronically stored information, in accordance with CalOptima Policies and shall comply with instructions on preservation of information and prohibitions on destruction of information issued by Legal Counsel.
Compliance Program Reporting Board members, Employees, and Contractors have a duty to comply with CalOptima's Compliance Program and such duty shall be a condition of their respective appointment, employment, or engagement.	**Reporting Requirements** All Board members, Employees and Contractors are expected and required to promptly report suspected violations of any statute, regulation or guideline applicable to Federal and/or State health care programs or of CalOptima's own Policies in accordance with CalOptima's reporting Policies and its Compliance Plan. Such reports may be made to a Supervisor, the Executive Director, Office of Compliance. Reports can also be made to CalOptima's hotline number below. Persons making reports to the hotline can do so on an anonymous basis **Compliance and Ethics Hotline: 877-837-4417** **Disciplinary Action** Failure to comply with the Compliance Program, including the Code of Conduct, Policies and/or applicable statutes, regulations and guidelines may lead to disciplinary action. Discipline for failure to abide by the Code of Conduct may, in CalOptima's discretion, range from oral correction to termination in accordance with CalOptima's Policies. In addition, failure to comply may result in the imposition of civil, criminal or administrative fines on the individual or entity and CalOptima or exclusion from participation in Federal and/or State health care programs. **Training and Education** CalOptima provides training and education to Board members, Employees, and FDRs. Timely completion of compliance and HIPAA training is mandatory for all CalOptima Employees. **No-Retaliation Policy** CalOptima prohibits retaliation against any individual who reports discrimination or harassment or compliance concerns or participates in an investigation of such reports. Employees involved in any retaliatory acts may be subject to discipline, up to and including termination of employment. **Referrals of FWA to Government Agencies** CalOptima is obligated to coordinate compliance activities with federal and state regulators. Employees shall comply with CalOptima policies related to FWA referral requirements to federal and state regulators, delegated program integrity contractors and law enforcement agencies. **Certification** All Board members, Employees and Contractors are required to certify, in writing, that they have received, read, understand and will abide by the Code of Conduct and applicable Policies.

Policy #:	GA.8051
Title:	**Hiring of Relatives**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	02/01/14
Last Revised Date:	~~TBD~~12/01/16
Last Review Date:	~~TBD~~12/01/16

I. PURPOSE

~~The purpose of t~~This policy ~~is to~~ outlines CalOptima's guidelines for hiring of relatives.

~~DEFINITIONS~~

~~Term~~	~~Definition~~

II. POLICY

A. CalOptima shall not discriminate in its employment and personnel actions with respect to its employees and applicants on the basis of marital or family status. Notwithstanding this policy, CalOptima retains the right to refuse to appoint a person to a position in the same department or division, wherein his or her relationship to another employee has the potential for creating serious conflicts or an adverse impact on supervision, safety, security, or employee morale.

III. PROCEDURE

A. CalOptima shall consider the hiring of relatives, or non-relatives of the same residence (housemate), only if (1) the applicant will not be working directly for or directly supervising an existing employee, or (2) a determination can be made by the department head, with concurrence by the Human Resources Director, that a potential for adverse impact on supervision, safety, security or employee morale does not exist. Supervising means having authority in the interest of CalOptima to hire, transfer, suspend, layoff, recall, promote, discharge, assign, reward, or discipline other employees, or responsibility to direct them.

~~A.~~B. If the relationship is established after the employee's employment with CalOptima, i.e. two (2) existing employees marry, or become housemates, and a determination has been made that the potential for adverse impact does exist, the department head in conjunction with the Human Resources Director, shall make reasonable efforts to minimize problems of supervision, or safety, security, or morale, through reassignment of duties, relocation, or transfer to another position for which he or she is qualified, if such position is available. If CalOptima is unable to make an acceptable accommodation, then the employee and his or her relative and/or housemate shall be

given an opportunity to decide which person shall be transferred, if possible, or terminated from employment. If the employees do not make a decision within thirty (30) business days, CalOptima shall automatically reassign one (1) of the employees, if possible, or terminate one (1) of the employees from employment. The decision as to which employee will leave will be at the discretion of CalOptima with consideration of CalOptima's business needs.

~~B.~~C. This policy applies to individuals who are related by birth, marriage, domestic partner status, or legal guardianship including, but not limited to, the following relationships: spouse, child, step-children, parent, step-parent, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt, uncle, niece, nephew, parent-in-law, daughter-in-law, son-in-law, brother-in-law, and sister-in-law (collectively, "relatives"). In implementing this policy, an applicant may be asked to state whether he or she has a relative, or housemate, presently employed by CalOptima, but such information may not be used as a basis for an employment decision except as stated herein.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Employee Handbook
~~B.~~ CalOptima Policy GA.8000: Glossary of Terms
~~C.~~B. ~~CalOptima Employee Handbook~~
~~D.~~C. Government Code ~~section~~, §-12920 *et seq*.

VI. REGULATORY AGENCY APPROVALS ~~OR~~

None to Date

~~VI.~~VII. BOARD ACTIONS

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

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

Version	Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	02/01/2014	GA.8051	Hiring of Relatives	Administrative
~~Revision Date 1~~Revised~~/ Reviewed~~	12/01/2016	GA.8051	Hiring of Relatives	Administrative

~~Not Applicable~~

IX. GLOSSARY

Not Applicable

~~VIII. KEYWORDS~~

~~Hiring~~
~~Relatives~~

Policy #:	GA.8051
Title:	**Hiring of Relatives**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	02/01/14
Last Revised Date:	12/01/16
Last Review Date:	12/01/16

I. PURPOSE

This policy outlines CalOptima's guidelines for hiring of relatives.

II. POLICY

A. CalOptima shall not discriminate in its employment and personnel actions with respect to its employees and applicants on the basis of marital or family status. Notwithstanding this policy, CalOptima retains the right to refuse to appoint a person to a position in the same department or division, wherein his or her relationship to another employee has the potential for creating serious conflicts or an adverse impact on supervision, safety, security, or employee morale.

III. PROCEDURE

A. CalOptima shall consider the hiring of relatives, or non-relatives of the same residence (housemate), only if (1) the applicant will not be working directly for or directly supervising an existing employee, or (2) a determination can be made by the department head, with concurrence by the Human Resources Director, that a potential for adverse impact on supervision, safety, security or employee morale does not exist. Supervising means having authority in the interest of CalOptima to hire, transfer, suspend, layoff, recall, promote, discharge, assign, reward, or discipline other employees, or responsibility to direct them.

B. If the relationship is established after the employee's employment with CalOptima, i.e. two (2) existing employees marry, or become housemates, and a determination has been made that the potential for adverse impact does exist, the department head in conjunction with the Human Resources Director, shall make reasonable efforts to minimize problems of supervision, or safety, security, or morale, through reassignment of duties, relocation, or transfer to another position for which he or she is qualified, if such position is available. If CalOptima is unable to make an acceptable accommodation, then the employee and his or her relative and/or housemate shall be given an opportunity to decide which person shall be transferred, if possible, or terminated from employment. If the employees do not make a decision within thirty (30) business days, CalOptima shall automatically reassign one (1) of the employees, if possible, or terminate one (1) of the employees from employment. The decision as to which employee will leave will be at the discretion of CalOptima with consideration of CalOptima's business needs.

C. This policy applies to individuals who are related by birth, marriage, domestic partner status, or legal guardianship including, but not limited to, the following relationships: spouse, child, step-children, parent, step-parent, grandparent, grandchild, brother, sister, half-brother, half-sister, aunt, uncle, niece, nephew, parent-in-law, daughter-in-law, son-in-law, brother-in-law, and sister-in-law

(collectively, "relatives"). In implementing this policy, an applicant may be asked to state whether he or she has a relative, or housemate, presently employed by CalOptima, but such information may not be used as a basis for an employment decision except as stated herein.

IV. ATTACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8000: Glossary of Terms
C. Government Code, §12920 *et seq*.

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/2014	GA.8051	Hiring of Relatives	Administrative
Revised	12/01/2016	GA.8051	Hiring of Relatives	Administrative

IX. GLOSSARY

Not Applicable

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	05/01/14
Last Review Date:	~~11/03~~12/01/16
Last Revised Date:	~~11/03~~12/01/16

~~*Board Approved Policy*~~

I. PURPOSE

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

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

II. POLICY

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

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

2. Identification of position titles for every employee position;

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

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

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

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

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

and

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

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

III. PROCEDURE

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

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

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

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

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of ~~11/03~~12/01/16)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

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

1

IX. GLOSSARY

Not Applicable

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	12/01/16
Last Revised Date:	12/01/16

I. PURPOSE

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

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

II. POLICY

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

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

2. Identification of position titles for every employee position;

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

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

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

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

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

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

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

III. PROCEDURE

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

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

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

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

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of 12/01/16)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8057	Compensation Program and	Administrative

Version	Date	Policy Number	Policy Title	Line(s) of Business
			Salary Schedule	
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative

1

IX. GLOSSARY

Not Applicable

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Summary of Changes to Salary Schedule

For December 2016 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Community Relations Specialist Sr	N/A	K	This is a new position that will coordinate and oversee CalOptima's daily operation at the County Community Service Center (CCSC) by promoting/outreaching of programs and services available at the CCSC to increase member awareness.	N/A	December 2016
Manager Pharmacy Operations	N	N/A	Remove title from salary schedule. Position no longer exists at CalOptima.	N/A	December 2016
Supervisor Pharmacist	P	N/A	Remove title from salary schedule. Position no longer exists at CalOptima.	N/A	December 2016

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Te Taken October 3, 2006
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. E. Approve Discretionary Supplemental PARS Retirement Plan Contribution

Contact
Kim Cunningham, Executive Officer, Human Resources and Facilities (714) 246-8400

Recommended Actions
A. Approve additional discretionary contributions to the PARS Retirement Plan as permissible under the law after taking into account the contributions made to the PARS Plan under the generally applicable retirement contribution arrangements for executive employees; and,
B. Continue these supplemental contributions from year to year.

Background
CalOptima provides retirement benefits to its employees using the California Public Employees' Retirement System (PERS). CalOptima also provides certain supplemental retirement benefits through the Public Agency Retirement System (PARS) Plan.

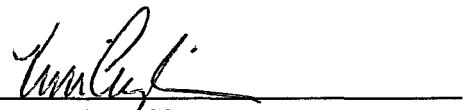
Discussion
The PERS formula is a life annuity payable at age 60 equal to 2% of the employee's final average base pay multiplied by his or her years of service with CalOptima. However, IRS rules prevent the Plan from recognizing compensation above a specified limit in calculating the benefit. Employees earning more than the limit do not accrue a full PERS pension benefit on their total base compensation and are at a relative disadvantage to employees whose compensation falls within this limit. To mitigate the shortfall in PERS contributions, it is recommended that additional discretionary contributions be made to the PARS Plan to allow employees to accrue retirement benefits up to amounts equal to their full PERS pension benefit on their total base compensation. The Board reserves the right to discontinue these supplemental contributions at any time.

Fiscal Impact
The recommended action will result in an additional $25,702 in pension contribution expenditures for 2006. Because the IRS limit on PARS Plan contributions is indexed for inflation, this amount may increase in future years.

Back to Agenda

Concurrence
Foley & Lardner LLP

Attachment
Board direction to the Human Resources Executive



Authorized Signature

10-3-01

Date

SDCA_293226.2

Back to Agenda

BOARD DIRECTION TO HUMAN RESOURCES EXECUTIVE

Starting with the 2006 Plan Year, Human Resources Executive, Kim Cunningham, or her successor, is hereby directed to make additional annual contributions to the PARS Retirement Plan for CEO Richard Chambers equal to the maximum contribution allowed by Internal Revenue Code Section 415 and any other applicable provisions of the law, reduced by the contributions that are already made by Cal Optima into the PARS plan on Mr. Chambers behalf under the generally applicable retirement contribution arrangements for executive employees. These contributions are to continue from year to year until discontinued by action of the Board. These supplemental contributions are discretionary and the Board has the power to discontinue these supplemental contributions at any time.

Date: 10/3/06

Juliette A. Poulson

Juliette A. Poulson, R.N., M.N.
Chair
Cal Optima Board of Directors

Back to Agenda

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

October 3, 2006

A Regular Meeting of the CalOptima Board of Directors was held on October 3, 2006, at CalOptima, 1120 W. La Veta Avenue, Suite 200, Orange, California.

CALL TO ORDER
Chair Julie Poulson called the meeting to order at 3:00 p.m.

ROLL CALL

Members Present: Julie Poulson, R.N. M.N., Chair; Michael Stephens, Vice Chair; Jacqueline Cherewick, John Gaffney, Mary Paul, Supervisor Thomas Wilson (at 3:05 p.m.), Paul Yost, M.D. (at 3:04 p.m.)

Members Absent: Jean Forbath

Others Present: Richard Chambers, Chief Executive Officer; Greg Buchert, M.D., Interim Chief Operating Officer; Keith Quinlivan, Chief Financial Officer; Kenneth Bell, M.D., Chief Medical Officer; Trudi Carter, M.D., Medi-Cal and Healthy Families Program Executive Director; Kurt Hubler, OneCare Executive Director; George Root, Esq., and Samuel Hoffman, Esq., Foley & Lardner LLP; Suzanne Turf, Clerk of the Board

MINUTES

Approve the Minutes of the August 30, 2006 Special Meeting of the CalOptima Board of Directors; Receive and File Minutes of the July 13, 2006 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee, and the July 6, 2006 Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

Action: ***On motion of Vice Chair Stephens, seconded and carried, the minutes of the August 30, 2006 Special Meeting of the Board of Directors were approved as presented, and the minutes of the Member and Provider Advisory Committees were received and filed. (Motion carried 5-0; Directors Forbath, Wilson and Yost, absent)***

PUBLIC COMMENT
Public comment was received, and the transcript is attached to these minutes (Attachment A).

Back to Agenda

CONSENT CALENDAR

Approve Appointment to the Board of Directors' Provider Advisory Committee

Action: ***On motion of Director Gaffney, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried 5-0; Directors Forbath, Wilson and Yost, absent)***

REPORTS

Approve Modifications to Auto Assignment Policy

Director Cherewick abstained from participating in the discussion citing her interests in the Community Care Health Centers.

Dr. Greg Buchert, Interim Chief Operating Officer, presented the following recommended actions: revise criteria for participation by safety net providers, community clinics (including enhanced allocation for Federally Qualified Health Centers (FQHC) and FQHC Look-Alikes) and safety net hospitals; and, incorporate criteria by which health networks receive auto assignment allocation using the health networks' performance on quality, member satisfaction, administrative, and access capacity indicators.

The current auto assignment policy was established in the Fall of 1995 and the formula is driven by geographic access, safety net hospital participation, and community clinic participation. The proposed revisions would update the auto assignment policy to reflect safety net definitions in CalOptima's current contract with the Department of Health Services, reflect significant changes in the county's safety net during the past eleven years, and recognize the process as a proxy for member choice. The proposed policy is based on assigning members to health networks that have demonstrated superior performance, considering geographic access, member satisfaction, quality, and physician access while protecting the safety net providers. While refining the process, staff also obtained input from the Member and Provider Advisory Committees, the health networks, and the Coalition of Orange County Community Clinics.

Dr. Buchert reviewed the following proposed changes to the Auto Assignment Policy. Safety net providers will be defined as "community health centers, Federally Qualified Health Centers, qualified look-a-like clinics… and Disproportionate Share Hospitals, public and university hospitals, and… children's hospitals." Revised criteria for community clinics to be eligible for auto assignments includes the ability to function as a PCP, affiliation with a CalOptima contracted network, and recognized by DHS as a licensed community clinic or a FQHC/FQHC Look-Alike. Points would be assigned directly to health networks based upon safety net hospital affiliation and performance measures, including Quality, Member Satisfaction, Administrative Excellence, and Access Capacity. A health network's receipt of auto assigned members from a community clinic shall not affect the health network's receipt of any other auto assigned members. New entrants shall receive some assignments during the first period of participation, and their portion shall be determined by community clinic participation, safety net hospital

Back to Agenda

participation and point distribution as determined by performance criteria. Pediatric clinics meeting the above-listed criteria would be eligible to receive auto assigned members aged 16 years or younger. FQHC/FQHC Look-Alike clinics will receive twice as many members as other clinics. The starting maximal percentage of auto-assignments going to community clinics will be 20 percent, but if additional clinics become FQHC/FQHC Look-Alikes, an additional one percent will be attributed to the clinic percentage for each additional FQHC/FQHC Look-Alike.

Twenty percent of auto assignments will be allocated to the health networks based upon the health network's affiliation with Safety Net Hospitals. If the health network's primary hospital is a Safety Net Hospital, the health network shall receive double the percentage a health network that has a contract with a Safety Net Hospital and lists them in the Provider Directory distributed to members. The remaining 60 percent of auto assignment will be assigned to health networks based upon their performance on the identified indicators measuring member satisfaction, quality, and physician access.

The implementation of the proposed revisions will be phased in throughout 2007 with final conversion in January 2008.

Action: ***On motion of Director Gaffney, seconded and carried, the Board of Directors approved the revised criteria for participation by safety net providers, community clinics and safety net hospitals; and, approved incorporating criteria by which health networks receive Auto Assignment allocation using the health networks' performance on Quality, Member Satisfaction, Administrative, and Access Capacity indicators (Motion carried 6-0; Director Cherewick abstained; Director Forbath, absent)***

Chair Poulson reordered the agenda to present recognition to former Board Director Gloria Reyes.

On behalf of the Orange County Board of Supervisors, Supervisor Thomas Wilson presented a proclamation recognizing Gloria Reyes and her service on the Board of Directors and to Orange County's Medi-Cal beneficiaries. Chair Poulson also presented recognition to Ms. Reyes on behalf of the Board of Directors.

Authorize CalOptima to Implement a Healthy Kids Program Including the Execution of Required Agreements with Children's Health Initiative of Orange County Designated Legal Entity to Accept Premiums Contingent on Government Authority and Funding for the Program

Dr. Greg Buchert presented the following recommended actions: authorize the CalOptima CEO to implement the Healthy Kids Program for a minimum 1,000 children after twelve (12) months including non-subsidized start-up costs up to $50,000 and based on the attached operational budget upon receipt of state legislative, county and regulatory authority and funding for the budget; and, authorize the CalOptima CEO to enter into an agreement, with the assistance of

legal counsel, with the Children's Health Initiative of Orange County-designated legal entity to accept premium for the administration of a Healthy Kids Program.

The proposed Healthy Kids Program would provide health care coverage to uninsured children in Orange County age 0 to 18, at or below 300 percent of the federal poverty level, and not eligible for Medi-Cal or Healthy Families. The proposed start date is January 1, 2007 subject to availability of funding. If funding is delayed, the start date would similarly be delayed. The CHIOC is attempting to raise funds for premiums from foundations and other sources. Currently $154,000 has been committed for premium support and over $4 million in potential annual premium support has been identified starting 2007, pending definitive commitments by funders. CalOptima would postpone implementation of a Healthy Kids Program until sufficient funds are available to provide premium support for at least 1,000 children for one year.

Dr. Buchert provided an overview of the program features. The benefits would be the same as those under the Healthy Families Program including medical, dental and vision services. The proposed provider network would be the existing Healthy Families network. The funds paid to medical groups and hospitals are identical to those paid for children in the Healthy Families Program. Eligibility would be determined by the CHIOC, and that organization would provide lists of eligible funded members to CalOptima. Specific funds for each child would include a $10 member monthly premium and a capitation payment paid by the CHIOC.

The fundraising efforts required to subsidize the premiums under Healthy Kids would be the full responsibility of the Initiative. A commitment of twelve months of premium is required up front for each child enrolled in the Healthy Kids Program.

The Healthy Kids Program is anticipated to incur non-subsidized start up costs not to exceed $50,000. The operational budget is based on two additional full-time employees, which are fully subsidized through the premiums received from the Initiative when the minimal enrollment level is attained. If fewer than 1,000 children are enrolled by the end of the first year, the cost of salary, benefits and other administrative expenses shall not exceed $130,000. The program will operate at a break even budget with 1,000 children; however, if additional children are enrolled, the intention is that excess funds will be used to support the Healthy Kids Program.

Public Comment was received and the transcript is attached to these minutes (Attachment B).

Chair Poulson commented in support of the recommended action stating that the Health Care Agency has been working with CalOptima and others regarding health insurance for as many children as possible and the proposed program is a good start. Vice Chair Stephens also commented in support stating that while there may be risks, it is important to step forward and take the initiative with this program.

Back to Agenda

Action: ***On motion of Director Yost, seconded and carried, the Board of Directors authorized the CEO to implement the Healthy Kids Program including the execution of required agreements with the Children's Health Initiative of Orange County designated legal entity to accept premiums contingent on government authority and funding for the program. (Motion carried 7-0; Director Forbath, absent)***

Authorize CalOptima to Enter Into New Provider Contracts for OneCare and Approve Changes to Current OneCare Provider Agreements

Kurt Hubler, OneCare Executive Director, presented the following recommended actions: authorize the CalOptima CEO to enter into OneCare contracts with physician groups and hospitals that are not network prime contractors under the Medi-Cal program, as well as with Universal Care, Inc., a HMO, on behalf of its medical group; and, approve changes to the OneCare Provider Agreements.

The OneCare program has been operational for one year and serves approximately 8,000 dual eligibles. Currently, there are 912 participating primary care physicians, and 1,448 specialists. Those numbers represent two-thirds and one-third respectively of the physicians practicing in Orange County. The providers participate through at least one of the five medical groups in the OneCare network. All of the current five medical groups are also contracted to deliver healthcare services to the CalOptima Medi-Cal program. It was reported that the majority of the OneCare disenrollments are due to a member's physician or preferred hospital not participating in OneCare. Pharmacy data from 2005 indicates that many of the dual eligibles obtain their healthcare services from physicians and hospitals that do not participate in the CalOptima Medi-Cal program.

In addition to requesting authorization for CalOptima to enter into a OneCare contract with Universal Care, Inc., a HMO, on behalf of its medical group, the following recommended actions were presented: staff to contract with medical groups and hospitals that do not contract to participate in the CalOptima program if they otherwise meet CalOptima criteria; and, staff to modify existing OneCare provider contract templates (hospital and physician) to be used in the next contracting cycle based on OneCare experience to date and to align them with industry standards for this line of business. The following provisions would be modified as follows: medical groups would not be required to post a financial security deposit but would be required to comply with Medicare's financial solvency regulations and Knox Keene SB 260 requirements; the medical loss ratio policy, approved by the Board for Medi-Cal and Healthy Families, would not be separately required in the OneCare contract; allow each party to be responsible for Coordination of Benefits for the services they are contractually obligated to provide; revise sanctions provisions to include maximum financial sanctions; and, allow for mutual without cause termination with at least 120 days advance notice.

Back to Agenda

Action: ***On motion of Director Gaffney, seconded and carried, the Board of Directors authorized the CEO to enter into OneCare contracts with physician groups that are not network prime contractors under the Medi-Cal program, as well as with Universal Care, Inc., a HMO, on behalf of its medical group; and approved changes to the OneCare Provider Agreements as presented. (Motion carried 6-1; Director Forbath, absent)***

Authorize CalOptima to Make Certain Long Term Care Supplemental Pass-Through Payments to Nursing Facilities and Intermediate Care Facilities – Developmentally Disabled

Richard Chambers presented the recommended action to authorize CalOptima to make certain supplemental pass-through payments to Long-Term Care (LTC) nursing facilities and Intermediate Care Facilities – Developmentally Disabled (ICF-DD).

As part of its contract with the Department of Health Services (DHS), CalOptima manages the LTC benefit for members in nursing facilities and ICF-DD facilities. The Legislature has enacted a number of LTC rate enhancement programs over the past years that provide additional funds to the facilities to improve the quality of care to residents. Supplemental payment programs include Quality Assurance Fees (QAFs), Cost of Living Adjustments (COLAs), and facility-specific per diem rates. Mr. Chambers reported that the complexity of implementing these pass-through rate supplements has been challenging for DHS in fee-for-service Medi-Cal and equally challenging for the California Medical Assistance Commission (CMAC) and CalOptima in negotiating capitation rate increases to incorporate these pass-through payments into managed care capitation rates. The LTC provider community in Orange County has also had to endure delays in receiving supplemental payments due to the length of time it takes CMAC and CalOptima to agree on the accuracy of revised capitation payments.

Mr. Chambers stated that CalOptima has concerns about its rates for the current fiscal year relating to obligations for these supplemental payments to LTC facilities and is actively pursuing relief from the State to meet these obligations. Board approval was requested to distribute one-half of supplemental payments for the period October 1, 2005 (or August 1, 2005, as applicable) through June 30, 2006 with the expectation that CalOptima will resolve additional funding issues for these obligations with the State. The amount of this partial payment to LTC facilities is approximately $14 million. CalOptima reserved this amount in the FY 2005-06 Budget as a potential liability.

Vice Chair Stephens expressed his concerns regarding obtaining a predictable payment schedule from the State, and commented in support of the recommended action as there is a need to assist these facilities that operate on a very thin margin. Chair Poulson also commented in support and suggested that the Board communicate its concerns to the State regarding these vulnerable members.

Back to Agenda

Action: ***On motion of Director Yost, seconded and carried, the Board of Directors authorized CalOptima to make certain supplemental pass-through payments to LTC nursing facilities and ICF-DDs as presented. (Motion carried 7-0; Director Forbath, absent)***

INFORMATION ITEMS

August 2006 Financial Statements

Keith Quinlivan presented an overview of the financial statements for the month ending August 31, 2006. Medi-Cal enrollment was reported at 293,150 members; OneCare enrollment was reported at 8,032 members, and Healthy Families Program enrollment was 28,880. Total operating revenue was $74.5 million and revenues less than expenses for all lines of business were reported at $1.1 million.

Medi-Cal revenues for the month of August were reported at $63.7 million, medical expenses totaled $64.4 million, and administrative costs were $2.2 million. Revenues less than expenses totaled $1.3 million for the Medi-Cal program.

For the month of August, OneCare revenues were reported at $8.3 million, medical expenses were $7.7 million, and administrative expenses were reported at $496,605. Revenues in excess of expenses for OneCare totaled $89,326 for the month.

Reinsurance Update

Keith Quinlivan reported that the Board of Directors approved a $5 million reinsurance budget for 2007 to supplement capitated PHC payments on August 30, 2006. CalOptima staff modeled recent reinsurance activity and worked with Milliman USA to develop a $5 million Reinsurance Program for 2007. CalOptima staff released the 2007 Reinsurance Program to the networks on September 12, 2006 to assist with financial modeling. The attachment point will be for aid code groupings in the Medi-Cal line of business. .The hospital attachment point will be $90,000 per annum. The professional attachment point will be $12,500 per annum.

In response to stakeholder feedback, CalOptima will price hospital days at a significantly higher rate with an average of $1,300 per diem to reflect enhanced hospital rates. CalOptima will continue to pay networks for 90% of fees that exceed the attachment point.

Public Comment was received and the transcript is attached to these minutes (Attachment C).

Transplant Program Update

Dr. Kenneth Bell, Chief Medical Officer, presented an update on CalOptima's Transplant Program. On October 4, 2005, the Board approved that CalOptima would be financially responsible for transplant services effective January 1, 2006. With the collapse of the UCI Liver Transplant Program, CalOptima also initiated management of liver transplant candidates effective November 1, 2005. Currently there are 255 transplant candidates in the program.

Back to Agenda

Transplant centers that have a relationship with CalOptima include Cedars-Sinai Medical Center, USC University, Loma Linda University, St. Joseph's Hospital, UC San Diego, Scripps-Green Hospital, Western Medical Center – Santa Ana, UCI Medical Center, UCLA, and City of Hope.

The Transplant Committee meets monthly to review individual patient information as well as UNOS reports, and evaluates the transplant centers focusing on DHS/CMS certification status, wait time, number of transplants performed at each center, the survival rate after one-year post treatment, and mortality rate while on the wait list. In addition, the Transplant Committee reviews updates on UNOS policies, technology and medications that enhance medical outcomes and prevents further disease process, and articles on transplant centers and alternative medicine.

Director Yost thanked Dr. Bell and staff for their efforts on the transplant program that greatly benefits the patients.

CEO AND MANAGEMENT REPORTS

Richard Chambers provided an update on the 2007 Health Network Contracts that are due on October 13. To date CalOptima has received three signed contracts, which represent approximately 25 percent of our members. Staff continues to work with networks on questions or concerns regarding the contract. A contingency planning workgroup has been formed to address any contingencies that may arise.

Mr. Chambers reported that the Governor signed AB 2918 (Wolk) and SB 458 (Speier) on September 30, 2006. Both bills give CalOptima the authority to be the health plan provider for Healthy Kids in Orange County.

Kurt Hubler, OneCare Executive Director, presented an update on OneCare enrollment, which is currently at 7,688 members. OneCare inquiries by source are tracked on a monthly basis including direct mail response cards and telephone inquiries, member and physician referrals, newspaper, marketing event, pharmacy or radio advertisements. OneCare outreach includes physician offices, senior and community centers, and approximately fifteen marketing events are held each month. Information regarding voluntary and involuntary disenrollments is received from CMS and the reasons for disenrollment include physician does not participate in OneCare, the co-pay for generic drugs and prior authorization of drugs. Going forward, staff will continue to seek additional providers to the program, work closely with medical group operations, and continued member outreach.

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 5:15 p.m. pursuant to Government Code § 54956.9(b) Conference with Legal Counsel – Anticipated Litigation [one case], and Government Code §54957 – Public Employee Performance Evaluation [Chief Executive Officer].

The Board reconvened to open session at 6:35 p.m. and after discussion and a presentation by Samuel Hoffman of Foley & Lardner LLP, took the following action.

Back to Agenda

Consider Amendment to Supplemental PARS Retirement Plan

Action: ***On motion of Director Gaffney, seconded and carried, the Board of Directors approved additional discretionary contributions to the PARS Retirement Plan for CEO Richard Chambers equal to the maximum contribution allowed by Internal Revenue Code Section 415 and any other applicable provisions of the law, reduced by the contributions that are already made by CalOptima into the PARS plan on Mr. Chambers behalf under the generally applicable retirement contribution arrangements for executive employees. These contributions are to continue from year to year until discontinued by action of the Board. These supplemental contributions are discretionary and the Board has the power to discontinue these supplemental contributions at any time. (Motion carried 5-0; Directors Cherewick, Forbath and Wilson, absent)***

ADJOURNMENT
Hearing no further business, Chair Poulson adjourned the meeting at 6:40 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: November 7, 2006

Back to Agenda

TRANSCRIPT OF PUBLIC COMMENT

Linda Smith, CalOptima Member Advisory Committee

Good afternoon. You'll notice that I have no written comments in front of me today because I'm not speaking about an issue before the Board. I'm speaking about issues that are very dear to my heart.

I have a real concern that there is no user of services sitting on the CalOptima Board. There is a new Board seat that just came up, and I'm a little confused about the process. Because I thought that that person might be joining the Board in October, I've contacted Julie's office twice and it appears that it is not going to go before the Consent Calendar to the Board of Supervisors until possibly December. I don't understand why, because I've also been advised that the candidate has been picked weeks ago. So I hope that you all did the right thing and really are going to put a consumer, somebody who uses CalOptima's services in that seat. I've really been concerned because our voice has been outnumbered. We have so many physician groups and so many hospital groups and so many network people that speak and give their opinion on CalOptima and it can be very, very political. But who is more important than the people that you are supposed to serve? We don't have a voice as a user of services on your committee.

You guys make the very best decisions you can, but you get to go home and leave those decisions there. We live every day, every single day with the decisions you make and there is no one at this table who has input as to how those decisions are made, who actually utilizes those services. So I don't understand your governance. I don't know if it would be a change in bylaws. I don't know what your process is, but I would ask that you would consider doing what I think is the ethical right thing and put a user of services on the Board.

Secondly, I'm very concerned because I think the issues are becoming so complicated and so much more complex and that the members don't have enough of a voice. I would encourage you to go to our MAC meetings. You know sometimes I get feedback that members really don't understand; we're not educated. We wouldn't take that approach if we really knew what was going on. But you know we spend hours studying the issues. If you went to some of our MAC meetings on the issues you would be shocked at the degree and the depth of the discussion that takes place. But I have never seen any of you at a MAC meeting regarding an issue that has come before CalOptima. I've never received a phone call from one of you asking what do I as a member feel about any of the issues before you. I don't know that you regularly contact any of the MAC members, but if you don't, I would encourage you because I am very, very concerned that our voice, the little voice, the two people that come up every meeting versus the ten or twelve that come up from the professional community get heard, that we not get lost and what's being done and the decisions being made.

Thank you.

TRANSCRIPT OF PUBLIC COMMENT

Kelly Peter, CalOptima Member Advisory Committee

Hi, I'll be brief. Orange County has the second largest number of uninsured children in the state. At least 40,000 children in Orange County are without basic medical, dental and vision insurance. Without health insurance, children may be missing out on critical preventive services as well as treatment for acute chronic conditions such as ear infections and asthma. Lack of health insurance for our children puts an added burden on families, schools, health care systems and in the community in general. By providing a Healthy Kids Program through CalOptima families in need would have one reliable source of health care for themselves and their children. While Kaiser has a comprehensive program for uninsured children, it has limited space available. California Kids serves more than 5,000 children in Orange County but is not comprehensive and it provides for a very fragmented source of health care.

Increasing enrollment in Healthy Kids equates to increasing enrollment in Medi-Cal and Healthy Families. As the largest insurer of children in Orange County, CalOptima is a perfect fit administering the Healthy Kids Program.

On a very personal note, I am the eyes of this community. I sit every day with these families and it is very hard for me to tell your two kids will be insured on Healthy Families or Medi-Cal, and unfortunately this other one will be without insurance. So, I do ask you to take into consideration this project because it will benefit our community.

Thank you.

TRANSCRIPT OF PUBLIC COMMENT

Julie Puentes Hospital Association of Southern California

Good afternoon. Here I am again. So as not to repeat what I've already told you a couple of times, let me just say that reinsurance continues to be of great concern to the hospitals. Bottom line, the hospitals are being asked to pick up $5-10 million of the projected actual costs. The projected costs of reinsurance, $15 million; the budget you approved is fine, pretty straight forward. This is serious enough for the hospitals in and of itself, but what we have now is a situation where on top of that there are other impending changes and issues that the hospitals have identified that will impact their considerations with regard to the 2007 PHC or network contracts.

One of those issues has to do with how services to the ABD population are going to be provided. We had anticipated that recommendations from the staff on that item might be on today's agenda; they are not. How those services are to be provided to that population, whether they will be a distribution across the networks or whether the services will be provided in some other way has serious implications for the risk that the hospitals and physicians for that matter that the networks are being asked to consider undertaking. Obviously, we have talked about before a predictable business climate, stability, knowing that the contracts that you sign are going to be what continues throughout the contract period, that there won't be changes in reimbursement rates and so forth. You can see that we don't have that kind of predictable stable business climate as the October 13 date approaches very rapidly for the hospitals to make those decisions.

Those two issues, reinsurance and the ABD population issues coupled with some others are issues that I have brought to the staff's attention that I'm going to be putting in writing in a letter that will reach the agency by tomorrow. My hope is that we can work with the staff to secure as many answers as possible for the hospitals so that they can make the decisions they need to make by the October 13 deadline, or that there would be some consideration of an extension of that deadline so that when decisions are made and approved by your Board, not just recommended and not just told to us but approved by your Board, so that there is that certainty then the hospitals will know what they are dealing with and they can make their decisions and move forward.

That's the plan. I'm sure that staff will share the correspondence with you. I know I only have a short period of time so I will stop there unless you have any questions.

Vice Chair Stephens

Just to clarify for me, when you are refer to ABD you're talking specifically about the UCI population of 3,000 plus.

Ms. Puentes

Right, about 3,300.

Mr. Stephens And the uncertainties of where they are going and how do I work that into my projections as I look at the contracts.

Ms. Puentes Basically, yes. I wish I could persuade you to revisit that decision obviously.

AMENDMENT III

TO EXECUTIVE EMPLOYMENT AGREEMENT

THE EXECUTIVE EMPLOYMENT AGREEMENT ("Agreement") between the Orange County Health Authority, dba Orange Prevention and Treatment Integrated Medical Assistance, dba CalOptima ("Employer" or "CalOptima") and Michael Schrader ("Employee") is modified by this third amendment ("Amendment III"), effective December 1, 2016, with respect to the following facts.

RECITALS

WHEREAS, CalOptima entered into an Executive Employment Agreement with Employee on or about December 6, 2012; and

WHEREAS, the Agreement was amended on or about December 24, 2012, to revise the effective date; and

WHEREAS, the Agreement was amended a second time on or about February 17, 2015, to reflect action by the Board of Directors on February 5, 2015, to eliminate the reference to incentive compensation, adjust the base salary, and provide for automatic salary increases for the next three (3) years; and

WHEREAS, consistent with Board of Directors action on December 1, 2016, CalOptima and Employee now wish to further modify the Agreement.

NOW, THEREFORE, the parties agree to the following modifications to the Agreement.

AGREEMENT

Effective December 1, 2016, the Agreement shall be modified as follows:

1. Section 3.d.i. shall be deleted in its entirety and replaced with the following language:

> 3.d.i. To the extent permitted under applicable law, (a) Employer will pay for Employee's portion of contributions to his CalPERS ("PERS") retirement plan; and (b) Employer will make supplemental Public Agency Retirement System ("PARS") retirement contributions equal to the maximum contribution allowed by Internal Revenue Code Section 415 and any other applicable provisions of the law, reduced by the contributions that are already made by CalOptima into the PARS plan under the generally applicable retirement contribution arrangements made for employees. These PARS retirement contributions are to continue from year to year until discontinued by the Board. These supplemental PARS retirement contributions are discretionary

Back to Agenda

and the Board has the power to discontinue these supplemental contributions at any time.

2. This Amendment III is by this reference made part of said Agreement. Except as otherwise provided in this Amendment III, all of the terms, conditions, and provisions of the Agreement and prior amendments, shall continue in full force in effect.

ORANGE COUNTY HEALTH AUTHORITY

Employer:

_____
Mark Refowitz, Chairman
Board of Directors

Date:_____

Employee:

_____
Michael Schrader

Date:_____

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

19. Consider Approval of Expenditures and Contract Related to Financial Analysis and Regulatory Requirements Assessment of Converting OneCare from a Dual Eligible Special Needs Plan (D-SNP) to a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP)

Contact

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

Recommended Actions

1. Authorize amendment of Scope of Work of current contract with Milliman, Inc. to add financial analysis and regulatory requirements assessment related to converting OneCare from a Dual Eligible Special Needs Plan (D-SNP) to a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) with the assistance of Legal Counsel; and
2. Appropriate expenditures of unbudgeted funds of up to $30,000 from existing reserves for this purpose.

Background

Since 2005, CalOptima has operated OneCare, a Medicare Advantage Dual-Eligible Special Needs Plan. OneCare is a Medicare program, regulated by the federal Centers for Medicare & Medicaid Services (CMS). Each year, health plans like CalOptima that intend to operate a Medicare program must submit a bid, which is typically handled with the assistance of a bid actuary firm. CalOptima currently contracts with Milliman, Inc. to assist with the annual CMS bid process for both OneCare and the Program of All-Inclusive Care for the Elderly (PACE). Milliman supports CalOptima throughout the bid process, including monitoring CMS regulations, and understanding all aspects of the bidding process, to ensure the successful submission of the bids.

CMS oversees regulatory requirements and contracts with several types of Medicare Advantage plans, including Medicare Special Needs Plans (SNPs). Medicare SNPs limit membership to people with specific diseases or characteristics, and tailor their benefits, provider choices, and covered prescription drugs to best meet the specific needs of the groups they serve. OneCare is a D-SNP, which is designed for dual eligibles, or, individuals with both Medicare and Medicaid coverage. Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) is another type of Medicare SNP. FIDE SNPs were created by Congress in section 3205 of the Affordable Care Act (ACA), and were designed to promote the full integration and coordination of Medicare and Medicaid benefits for dual eligible beneficiaries by a single managed care organization.

Discussion

In January 2016, due to federal and state regulations, CalOptima transitioned most OneCare members to OneCare Connect. There are currently approximately 1,236 members who remain in OneCare. These individuals are not eligible to join OneCare Connect due to their health care conditions. FIDE SNPs were created to provide increased coordination of care for dual eligibles, specifically, high-risk individuals who are in need of long-term care benefits and services. One of the advantages of a FIDE SNP over a D-SNP is that due to the nature of the population that FIDE SNPs are intended to provide

Back to Agenda

services to, CMS applies a "frailty" adjustment – or, increased reimbursements – to the payment it provides to these plans. Frailty scores are calculated using the limitation on activities of daily living (ADL) reported by a plan's enrollees, based on the Medicare Health Outcomes Survey (HOS) from the year previous to the payment year. Each year during the annual bid process, CMS requests that health plans inform them if they would like to be reviewed as a FIDE SNP. If the CalOptima Board decides to have OneCare reviewed as a FIDE SNP for Calendar Year 2018, CalOptima would need to submit an attestation to CMS by February 2017. In July 2017, CMS would confirm if it is still the plan's intent to be reviewed as a FIDE-SNP and then in September 2017, CMS would issue approvals if all goes as planned.

Due to the high-acuity level of members who remain in OneCare and the likelihood that there might be increased reimbursements from CMS due to the potential application of the frailty adjustment, staff is recommending that CalOptima consider conducting an analysis to determine the benefit of converting OneCare from a D-SNP to a FIDE SNP. Staff is recommending Board approval to include in Milliman's Scope of Work a financial analysis of converting OneCare from a D-SNP to a FIDE SNP. Also as part of the analysis, Milliman would assess the regulatory requirements of a FIDE SNP compared to a D-SNP, to ensure that staff has appropriate resources to be in compliance.

Fiscal Impact
The recommended action to authorize a contract amendment to perform a financial analysis and regulatory requirements assessment of converting OneCare from a D-SNP to a FIDE SNP is an unbudgeted item. A proposed allocation of up to $30,000 from existing reserves will fund this action.

Rationale for Recommendation
Staff recommends Board consideration of this action due to the potential of receiving increased reimbursements from CMS for the OneCare program.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
20. Consider Authorization of Expenditures to Fund Membership Dues for Medicaid Health Plans of America (MHPA)

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

Recommended Action
Authorize expenditures of up to $50,000 from existing reserves to fund membership dues for Medicaid Health Plans of America (MHPA) through June 30, 2017.

Background
CalOptima is an active member of health care industry associations that help provide regulatory and legislative advocacy, share best practices, and increase the organization's ability to influence federal and state policy. Currently, CalOptima is a member of two primary statewide associations: California Association of Health Plans (CAHP), and Local Health Plans of California (LHPC). CAHP is considered the most influential voice of the health care industry in Sacramento and its membership includes 49 health plans, both commercial and public. LHPC represents all 16 public Medi-Cal managed care plans in California, and provides great value to help shape policy in the best interest of public plans. In most cases, the Department of Health Care Services (DHCS) works through CAHP and LHPC to solicit feedback regarding regulatory guidance. Often, key legislators will also work through CAHP and LHPC when they are drafting bills that impact the Medicaid program. At the federal level, CalOptima is a member of the Association for Community Affiliated Plans (ACAP), which includes 57 local, not-for-profit, community-affiliated Safety Net Health Plans. ACAP provides support to CalOptima staff with regard to federal regulatory guidance, relationship-building with key Medicare leadership at the Centers for Medicare & Medicaid Services (CMS), and roundtable calls with member plans to share best practices. Recent ACAP-led efforts have resulted in improved federal regulations for CalOptima's Medicare programs, including increases in funding levels.

Discussion
In the aftermath of the expansion of Medicaid as part of the federal Affordable Care Act (ACA), there has been an increased national focus on the impact of the program, its impacts on the national's overall health, and its overall fiscal sustainability in light of competing federal budget priorities.

MHPA's membership includes 165 commercial and non-profit plans that serve 28 million Medicaid enrollees in 39 states. MHPA has a strong presence in Washington, D.C. with leaders in Congress on both sides of the aisle, and its primary goal is to provide advocacy and research that supports policy solutions to enhance the delivery of quality care for Medicaid enrollees through improved access and cost-effective services. MHPA members include large commercial health plans such as Aetna, Anthem, and United Healthcare, and public plans such as Southern California-based L.A. Care Health Plan and Inland Empire Health Plan (IEHP).

Back to Agenda

Fiscal Impact
The recommended action to authorize expenditures for MHPA membership dues through June 30, 2017, is an unbudgeted item. As proposed, an allocation of up to $50,000 from existing reserves will fund this action.

Rationale for Recommendation
The increased national focus on the Medicaid program has already resulted in major regulatory changes to the program, including the recent CMS final rule that makes major changes to Medicaid Managed Care regulations aimed at enhancing the beneficiary experience of care, strengthening beneficiary protections, as well as overall payment and delivery system reform. Additionally, there are many congressional proposals which may also have major impacts to the Medicaid program, including entitlement reform, and potential efforts that may significantly change how program dollars are distributed to states.

In today's dynamic health care landscape, Medicaid is likely to continue to grow in visibility and increasingly become the subject of policy discussions. By aligning with MHPA, CalOptima will have the opportunity to engage in, and more importantly, help influence federal policy that impacts our Medicaid program, which consists of over 97% of our membership.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

11/22/2016 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
21. Consider Authorization of Extension of Contract for Federal Advocacy Services

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

Recommended Action
Authorize extension of contract, with the assistance of legal counsel, with federal advocate James McConnell for up to six months, through no later than July 7, 2017.

Background
James McConnell provides CalOptima with federal advocacy services, under a contract set to expire on January 7, 2017. As part of CalOptima's routine procurement process, staff initiated a Request for Proposal (RFP) process for federal advocacy services on September 8, 2016. In addition, on October 6, 2016, the Board Chair established a Board Ad Hoc review committee to provide guidance and make recommendations on the selection process for a federal advocacy services firm.

Discussion
Staff released the federal advocacy services RFP on September 8, 2016 with proposals due from interested firms by October 10, 2016. CalOptima received six proposals, and an RFP evaluation committee consisting of both staff and external subject matter experts reviewed and scored them. The top four candidates were asked to participate in interviews conducted by the Board Ad Hoc. However, scheduling conflicts prevent the Board Ad Hoc from meeting with the candidates until December 2016.

Following the recommendation of the Board Ad Hoc, staff expects to bring the federal advocacy services agenda item to the February 2, 2017, meeting for Board consideration. In order to ensure that CalOptima has uninterrupted representation in Washington, D.C., staff recommends Board consideration to authorize an extension of the current contract with Mr. McConnell for up to six additional months, through no later than July 7, 2017. If the Board takes action to select a new While the full additional six months may not be needed, staff also requests Board authorization for staff to use discretion with regard to the length of the contract extension with Mr. McConnell.

Fiscal Impact
The CalOptima Fiscal Year (FY) 2016-17 Operating Budget approved by the Board on June 2, 2016, included professional fees for federal advocacy services. Assuming continuance of the terms of the current contract and no overlap between the current and future contract, the recommended action to extend the contract for federal advocacy services firm for six months is a budgeted item with no additional fiscal impact.

Back to Agenda

Rationale for Recommendation
Staff recommends extension of the current contract with Mr. McConnell for up to six additional months, through July 7, 2017, to allow time to select a federal advocacy services firm, based on the RFP process.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *11/22/2016*
Authorized Signature **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
22. Consider Authorization of Expenditures in Support of CalOptima's Participation in 2017 Lunar New Year Festivals

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

Recommended Actions
1. Authorize expenditures for CalOptima's participation in the following 2017 Lunar New Year Tet Festivals scheduled in Orange County:
   a. Up to $3,500 and staff participation in the ~~Vietnamese Community of Southern California's (VNCSC)~~ County of Orange's Tet Festival 2017 Year of the Rooster ~~on Friday-Sunday,~~ during the weekend of January 27-29, 2017 in Fountain Valley; and
   b. Up to $3,500 and staff participation in the Union of Vietnamese Student Associations Southern California's (UVSA) 36th Annual Tet Festival Year of the Rooster on Friday-Sunday, January 27-29, 2017 in Costa Mesa.
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.

Rev. 12/1/2016

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 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 expenditures for participation in the two Lunar New Year Tet Festivals scheduled in Orange County (Fountain Valley and Costa Mesa). The events will provide CalOptima with opportunities to conduct outreach and education about our programs and services to Vietnamese-speaking members, who comprise approximately twelve percent of our total membership.

Back to Agenda

a. A $3,500 financial commitment for VNCSC's Tet Festival 2017 Year of the Rooster includes: Two (2) 10x10 exhibitor booths; logo on promotional posters (1,000) and flyers (5,000); one (1) CalOptima banner at the main event entrance; two (2) VIP parking permits; logo on the OC Tet Festival website for one (1) year; on stage, TV and radio announcements; and short video display on stage at the festival. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services. The Fountain Valley festival will take place locally near the largest Vietnamese community in Orange County as well as draw from communities throughout the county. Last year's event drew in over 20,000 attendees.

b. A $3,500 financial commitment for UVSA's 36th Annual Tet Festival Year of the Rooster in Costa Mesa includes: One (1) 10x10 exhibitor booth in prime location; one (1) CalOptima banner at front gate; CalOptima's logo on promotional posters and fliers; UVSA's Tet Festival website for one (1) year; twenty-five (25) admission tickets; two (2) VIP admission badges; and two (2) VIP parking permits. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services. The Costa Mesa festival attracts over 60,000 attendees from outside of the county in addition to local communities.

CalOptima staff has reviewed each request and both meet the considerations for participation including the following:

1. 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;
2. Participation promotes health and wellness among the populations CalOptima serves;
3. The number of people the activity/event will reach;
4. The marketing benefits accrued to CalOptima;
5. The strength of the partnership or level of involvement with the requesting entity;
6. Past participation;
7. Staff availability; and
8. Available budget.

CalOptima's involvement in community events has been coordinated by the Community Relations department. The Community Relations department will take the lead to coordinate staff schedules, resources, and appropriate materials for each event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended actions of up to $7,000 to participate in two 2017 Lunar New Year Tet Festivals in Orange County is included as part of the Community Events budget under the CalOptima Fiscal Year 2016-17 Operating Budget approved by the CalOptima Board of Directors on June 2, 2016.

Back to Agenda

Rationale for Recommendation
Staff recommends approval of the recommended actions in order to support community activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, and promote health and wellness. Participation in these events will also provide an opportunity to conduct outreach and education about CalOptima's programs and services to Vietnamese-speaking members.

Concurrence
Gary Crockett, Chief Counsel

Attachment
UVSA Informational Packet

/s/ Michael Schrader — *11/22/2016*
Authorized Signature — **Date**

Back to Agenda

DEAR PROSPECTIVE SPONSOR,

The Union of Vietnamese Student Associations Southern California (UVSA) is proud to submit this proposal for your review. We wish to provide your organization with unique and advantageous marketing opportunities to promote your brand and business to the Vietnamese community.

The 36th Annual UVSA Tết Festival will take place between January 27- January 29, 2017 at OC Fair & Event Center—adjacent to Costa Mesa, Newport Beach, Santa Ana and Irvine. The event attracts over 60,000 attendees, encompassing a multi-ethnic populace with strong Asian American presence.

UVSA Tết Festival is recognized as the most distinguished Vietnamese Lunar New Year celebration in the nation for many reasons:

- **We are the largest Tết Festival in the world with 35 years of success**
- **UVSA is one of the four pillars upholding the Vietnamese community in cooperation with the Vietnamese American Federation of Southern California, the Coalition of Vietnamese Armed Forces, and the Association of Vietnamese Language & Culture Schools of Southern California**
- **We are the strongest Vietnamese youth organization in the country and we represent students and young leaders in the Santa Barbara, Los Angeles, Riverside, San Bernardino, and San Diego counties**
- **Our involvement in the Vietnamese community is built on cultural awareness, education, social and civic engagement**
- **We join together 300+ youth volunteers and provide them with opportunities for community service and leadership development with real life application at Tết Festival**
- **UVSA is a 501(c)3 grant-giving organization and has awarded over $1,000,000 in festival proceeds to deserving non-profit organizations across Southern California**

We cordially invite your team to join the festivities this year, in making UVSA Tết Festival 2017 the most spectacular yet! We are confident that you will acquire benefits that only UVSA can offer, like brand publicity, lead generation, customer contact, community impact and prestigious affiliation.
We look forward to building a prolific partnership with you to welcome a prosperous and successful Year of the Rooster. Thank you for your consideration to support UVSA Tet Festival 2017!

Sincerely,

Thao-Chi (TC) Pham
Sponsorship Director
thaochi.pham@uvsa.org

Back to Agenda

SPONSORSHIP PACKAGES

Your company's sponsorship directly impacts the success of Tết Festival, UVSA's ability to provide funding to nearly one hunded non-profit organizations across Southern California, and UVSA's ability to provide leadership and community programming to the youth. We offer the following packages, which include standard benefits or the option to tailor your participation to meet company needs. We hope that you take this opportunity to sponsor Tết Festival as a means to promote brand loyalty from a very accomplished community. All monetary sponsorships to the Tết Festival are tax-deductible. Please contact our Sponsorship Director for more information.

THAO-CHI (TC) PHAM
Tet Festival Sponsorship Director
Direct: 949.237.2887
Email: thaochi.pham@uvsa.org

Wells Fargo (Title Sponsor) presents a scholarship award to the Miss Vietnam of Southern California winner.

UVSA interviews Saving Call (Gold Sponsor) about their experience at the festival.

BRONZE SPONSOR: $3,500

- 10′ x 10′ booth in prime location at Tết Festival
- One (1) 2.5′ x 8′ banner display: Front Gate
- Booth listing in Festival program booklet
- Sponsor logo on promotional posters & flyers
- Sponsor logo on UVSA Tết Festival website for one (1) year
- Twenty-five (25) Tết Festival admission tickets
- Two (2) VIP admission badges
- Two (2) VIP parking permits

SILVER SPONSOR: $6,000

- 20′ x 10′ booth in prime location at Tết Festival
- Two (2) 2.5′ x 8′ banner displays: Front Gate, Food Court
- Quarter page color ad in Festival program booklet
- Booth listing in Festival program booklet
- Sponsor logo on all promotional posters & flyers
- Sponsor logo on UVSA Tết Festival website for one (1) year
- Fourty (40) Tết Festival admission tickets
- Four (4) VIP admission badges
- Four (4) VIP parking permits

GOLD SPONSOR: $12,000

- 20′ x 20′ booth in prime location at Tết Festival
- Three (3) 2.5' x 8' banner displays: Front Gate, Food Court, Main Stage
- Half page color ad in Festival program booklet
- Three (3) Main Stage graphic ad impressions
- Five (5) mentions on Main Stage
- Fifteen (15) radio impressions
- Booth listing in Festival program booklet
- Sponsor logo on promotional posters and flyers
- Sponsor logo on Tet Festival website for one (1) year
- Sixty (60) Tết Festival admission tickets
- Six (6) VIP admission badges
- Six (6) VIP parking permits

ADDITIONAL BENEFITS

- 2.5′ x 8′ color Banner Printing -- $150
- Banner display near Tết Festival Front Gate -- $500
- Banner display near Tết Festival Food Court -- $750
- Flyer distribution at Tết Festival Info Booth (15,000):
    - o Before 12/30/16 -- $500
    - o After 12/30/16 -- $750
- Logo link on Tết Festival website for one (1) year -- $500
- Logo on Tết Festival staff and volunteer t-shirts -- $500
- Social Media impression on Tết Festival page -- $500 *(1x)*
- Social Media promo video production -- $1000 *(1 min)*
- Tết Festival Main Stage Ad impression:
    - o Graphic -- $500 *(3x)*
    - o 30 seconds video -- $750 *(3x)*
    - o Prime Time video -- $1000 *(3x)*
- 8.5" x 5.5″ Tết Festival Program Booklet Ad *(60,000)*:
    - o Quarter page color -- $1000
    - o Half page color -- $2,000
    - o Full page color -- $3,000
- Presenting Sponsor *(please ask for full list of benefits)*:
    - o Pho Eating Contest -- $1500
    - o Children's Pageant -- $3,000
    - o Talent Show -- $3,000
    - o Youth Night -- $3,000
    - o Grand Concert -- $5,000
- Additional 10′ x 10′ booth in prime location -- $3,000
- Prize Donations -- VARY

MEDIA TRADE

- 2.5′ X 8′ Tanner display near Front Gate or Food Court
- Logo link on Tết Festival website for one (1) year
- Logo on all promotional posters and flyers
- Twenty-five (25) Tết Festival admission tickets
- Four (4) VIP admission badges
- Two (2) VIP parking permits
- Additional 10′ x 10′ booth in prime location *(by agreement)*

DIAMOND SPONSOR: $22,000

- 30′ x 20′ booth in prime location at Tết Festival
- Four (4) 2.5' x 8' banner displays: Front Gate, Food Court, Main Stage, Exit
- Full page color ad in Festival program booklet
- Half page color ad in Pageant program
- Three (3) Main Stage video ad impressions *(30 sec)*
- Three (3) Main Stage graphic ad impressions
- Ten (10) mentions on Main Stage
- Thirty (30) radio impressions
- Fifteen (15) newspaper and magazine impressions
- Five (5) television impressions
- One (1) social media impression
- Booth listing in Festival program booklet
- Medium sponsor logo on promotional posters and flyers
- Medium sponsor logo on Tet Festival website for one (1) year
- One hundred (100) Tết Festival admission tickets
- Eight (8) VIP admission badges
- Eight (8) VIP parking permits

TITLE SPONSOR: $35,000

- 40′ x 20′ booth in prime location at Tết Festival
- Six (6) 2.5' x 8' banner displays: Front Gate, Food Court, Main Stage, Exit
- Full page Back Cover color ad in Festival program booklet
- Logo on Tết Festival billboard in Little Saigon
- Logo on the back of all Tết Festival admission tickets
- Logo on UVSA Tết Festival staff and volunteer t-shirts
- Title Sponsor speech at the Opening Ceremony *(5 mins)*
- Title Sponsor speech at Pageant Night *(5 mins)*
- Present winning check to Miss Vietnam Southern California
- Full page Editorial in Pageant program
- Six (6) Main Stage video ad impressions *(30 sec)*
- Six (6) Main Stage graphic ad impressions
- Fifteen (15) mentions on Main Stage
- Sixty (60) radio impressions
- Thirty (30) newspaper and magazine impressions
- Ten (10) television impressions
- Two (2) social media impressions
- Booth listing in Tết Festival program booklet
- Large sponsor logo on promotional posters and flyers
- Large sponsor logo on Tết Festival website for one (1) year
- One hundred and fifty (150) Tết Festival admission tickets
- Twelve (12) VIP admission badges
- Twelve (12) VIP parking permits

Back to Agenda

CalOptima Board of Directors

Supplemental to
December 1, 2016 Board of Directors Meeting Agenda

REPORTS

S22A Consider Amendment of Kaiser Foundation Health Plan, Inc. (Kaiser) Medi-Cal Full-Risk Health Network Contract to Extend Agreement

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
S22A Consider Amendment of Kaiser Foundation Health Plan, Inc. (Kaiser) Medi-Cal Full-Risk Health Network Contract to Extend Agreement

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an amendment to extend the Kaiser Foundation Health Plan, Inc. (Kaiser) Medi-Cal Full-Risk Health Network Contract through June 30, 2017 on the same terms and conditions.

Background
At its May 5, 2016 meeting, the CalOptima Board of Directors authorized the extension of CalOptima's contracts with Full-Risk health network Kaiser Foundation Health Plan, Inc (Kaiser) from July 1, 2016 to December 31, 2016.

At the May 5, 2016 meeting, staff had recommended extension of all health network contracts through June 30, 2017. Due to lower than anticipated utilization (and corresponding rate reductions from the state), staff also had recommended reducing the capitation rates paid to health networks for the Medi-Cal Expansion (MCE) members by 15% for the FY2016-17 fiscal year. However, based in part on stakeholder input, the Board approved the rate reduction, but only for a six-month period – effective July 1, 2016 through December 31, 2016 – for the health networks. The Board Chair established a Board ad hoc committee to evaluate the financial impact of the rate reduction for the MCE members to CalOptima and the health networks and make recommendations for the second half of the 2016-17 fiscal year.

Discussion
Following appointment by the Board Chair, the members of the ad hoc met to review member utilization levels and discuss and evaluate the financial impact of the reduction in rates on CalOptima and the health networks, with the final recommendation to: 1) maintain the current capitation rates for the full-risk health network for the remainder of the fiscal year; and 2) extend the current health network contract term through June 30, 2017. Consistent with the Board's actions in October 2016 (extending shared risk group and other full-risk network contracts) and November 2016 (extending the physician-hospital consortium contracts), and also consistent with the CalOptima-Kaiser-Department of Health Care Services three-way (and related) agreement(s)), staff recommends that the Board similarly authorize extension of the Kaiser full-risk health network contract through June 2017 under the current terms and conditions.

Back to Agenda

Fiscal Impact
Kaiser's reimbursement rates are established by the three-way agreement for Medi-Cal (Classic and Expansion) and are directly tied to our rates from DHCS. The fiscal impact related to the extension of the Kaiser agreement is included in the CalOptima Fiscal Year 2016-17 Operating Budget.

Consistent with its actions regarding the other CalOptima health networks, staff recommends extending the CalOptima Medi-Cal health network contract with Kaiser through June 30, 2017 under the same terms and conditions. No budget revisions are required for this proposed extension.

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

Concurrence
Gary Crockett, Chief Counsel

Attachment
Board Action dated May 5, 2016, Ratify Contract Extension Amendment and Authorize Amendment of the CalOptima Medi-Cal Health Network Contract for Kaiser Foundation Health Plan, Inc.

/s/ Michael Schrader — *11/28/2016*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 5, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
12. Ratify Contract Extension Amendment and Authorize Amendment of the CalOptima Medi-Cal Health Network Contract for Kaiser Foundation Health Plan, Inc.

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

Recommended Actions
1. Ratify the Contract amendment extending the Kaiser Foundation Health Plan, Inc. Medi-Cal Health Network contract through June 30, 2016; and

2. Authorize the Chief Executive Officer (CEO) to enter into a Contract Amendment, with the assistance of Legal Counsel, for the Kaiser Foundation Health Plan, Inc. Medi-Cal Health Network Contract which extends the Contract through ~~June 30, 2017~~ December 31, 2016.

Rev. 5/5/16

Background
CalOptima's current Kaiser Foundation Health Plan, Inc. Medi-Cal Health Network Contract (Contract) was amended July 1, 2015 to extend the contract through June 30, 2016 and included, at CalOptima's option, two additional one year extensions.

Based on two separate CalOptima Board actions, taken on June 4, 2015 and September 3, 2015, revised rates for the Medi-Cal Expansion members referencing that the Health Network contracts were in place and effective through June 30, 2016. However, the staff recommendation omitted the specific request for the extension of the health network contracts themselves. The contract amendments contain provisions allowing CalOptima to exercise the option to extend the contracts under the same terms and conditions for two one year periods.

Discussion
CalOptima staff is requesting authority to enter into an Amendment of the Health Network Contract that would extend the term and incorporate other changes if and as approved by your Board in another Board item.

Extension of Contract Term: CalOptima staff is requesting Board ratification of the Medi-Cal Kaiser Foundation Health Plan, Inc. Health Network Contract amendment that extended the Contract through June 30, 2016.

CalOptima staff is also requesting authority to amend the Kaiser Foundation Health Plan, Inc. Medi-Cal Health Network Contract to further extend the Contract through June 30, 2017.

Back to Agenda

Fiscal Impact
The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs of the recommended actions. Management plans to include expenses associated with the extended contracts in the proposed CalOptima FY 2016-17 Operating Budget.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory and CalOptima policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *04/28/2016*
Authorized Signature — **Date**

Back to Agenda

Board of Directors Meeting
December 1, 2016

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

OneCare Connect Member Advisory Committee (OCC MAC) members commended Members Patty Mouton and Gio Corzo for their Board appointments to the Chair and Vice Chair positions, respectively.

At the October 27, 2016 meeting, OCC MAC members received an overview on statistics and trends for Community-Based Adult Services (CBAS), including utilization, referral sources and quality oversight. Committee members noted the increased number of CBAS centers that received a perfect score of 100% in the annual CBAS satisfaction survey. OCC MAC members also received a presentation on the hospice benefit for OneCare Connect members. After considerable discussion on the benefit, availability and eligibility for hospice care, the committee members requested a follow up presentation at a future meeting. OCC MAC members Christine Chow and Erin Ulibarri presented an overview on the Orange County aging report and strategic plan. The OC aging report provided an overview of the health and wellbeing of the older adult population. The strategic plan outlined how Orange County can prepare for the growing numbers of seniors and the issues they face.

Also at the October 27, 2016 meeting, OCC MAC members received the following updates from CalOptima's executive staff: Chief Medical Officer update; State and Federal Legislative update; and OneCare Connect update.

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

Back to Agenda

Board of Directors Meeting
December 1, 2016

Member Advisory Committee Update

At the November 10, 2016 Member Advisory Committee (MAC) meeting, MAC members considered the recommendation from the MAC Nominations Ad Hoc to appoint Carlos Robles as the representative to fill the vacant Recipients of CalWORK's seat, Mallory Vega as the MAC Chair and Patty Mouton as the MAC Vice Chair. MAC forwarded the recommended candidates to the Board of Directors for consideration.

MAC members received several informational presentations. MAC Member Christine Tolbert presented an overview on the State Council on Developmental Disabilities (SCDD), formerly Area Boards. SCDD is a federally funded state agency that advocates for individuals with developmental disabilities and their families. Cheryl Meronk, Director, Strategic Development, provided two updates to the MAC, including the Intergovernmental Transfer (IGT) expenditure update and the CalOptima Strategic Plan. Both of these items are being considered at the December Board of Directors meeting. Rena Smith, Director, Program of All-Inclusive Care for the Elderly (PACE), presented an overview on the PACE Center, including eligibility requirements, services provided and PACE in the continuum of care.

Also at the November 10, 2016 meeting, MAC members received the following updates from CalOptima's executive staff: Chief Medical Officer update; Chief Operating Officer update; and State and Federal Legislative update.

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

Back to Agenda

Board of Directors Meeting
December 1, 2016

Provider Advisory Committee (PAC) Update

November 10, 2016 PAC Meeting

Thirteen (13) PAC members were in attendance for the November PAC meeting.

PAC received an update on the behavioral health transition to Magellan Healthcare which takes effect on January 1, 2017. Dr. Donald Sharps, Medical Director, Behavioral Health, along with Magellan representative Harry Best, provided the PAC with an update on the current status and answered questions regarding provider credentialing status, provider overlap, continuity of care and case management services available for CalOptima members.

PAC members received a CEO update from Michael Schrader on the Affordable Care Act (ACA) rate payment bump to the Medicare rate for those PCPs who missed the initial Attestation date. The State agreed to make payments to providers who attested between December 31, 2014 and June 15, 2015. CalOptima will make additional payments to the providers who were impacted by this decision.

PAC members discussed the uncertainty regarding potential changes to the ACA and Medi-Cal with the new incoming Trump Administration and how this may require a re-assessment of the plan within the next several months. The PAC recommended that staff come back in six months to discuss impact to CalOptima.

Dr. Richard Helmer, Chief Medical Officer, provided updates on the PACE Program and the Long-Term Care program.

PAC received an update on the status of the IGT 1-3 projects and recommended expenditure plan for available dollars from IGTs 1 through 5, as well as an update on the CalOptima draft Strategic Plan that incorporated feedback from the PAC ad hoc committee.

PAC members received informative presentations from the Quality Initiatives department on Medi-Cal focused measures and a California plan performance comparison. PAC looks forward to continue working with CalOptima to help raise the benchmark levels to help maintain CalOptima's number one ranking.

PAC also received CFO and COO reports, as well as a State and Federal Legislative update covering results from the local elections and propositions.

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

Back to Agenda

A Public Agency

CalOptima

Better. Together.

Financial Summary

October 2016

Board of Directors Meeting

December 1, 2016

Chet Uma

Chief Financial Officer

Back to Agenda

FY 2016-17: Consolidated Enrollment

- October 2016 MTD:

  - Overall enrollment was 800,170 member months
    - Actual lower than budget by 1,989 or 0.2%
      - Medi-Cal: favorable variance of 2,657 members
        - Medi-Cal Expansion (MCE) growth higher than budget
        - SPD enrollment higher than budget due to less than anticipated dual eligible members transferring to OneCare Connect
        - Offset by lower than budget TANF enrollment
      - OneCare Connect: unfavorable variance of 4,651 members
    - 0.5% increase from prior month
      - OneCare Connect: increase of 28 from September
      - Medi-Cal: increase of 4,343 from September

Back to Agenda

FY 2016-17: Consolidated Enrollment

- October 2016 YTD:

  - Overall enrollment was 3,193,669 member months
    - Actual lower than budget by 7,814 or 0.2%
      - Medi-Cal: favorable variance of 8,690 members
        - Medi-Cal Expansion (MCE) growth higher than budget
        - SPD enrollment higher than budget due to less than anticipated dual eligible members transferring to OneCare Connect
        - Offset by lower than budget TANF enrollment
      - OneCare Connect: unfavorable variance of 16,342 members or 18.5%
      - OneCare: unfavorable variance of 187 members or 3.8%
      - PACE: favorable variance of 25 members or 3.6%
    - 2.2% or 16,987 increase in enrollment from prior year

Back to Agenda

FY 2016-17: Consolidated Revenues

- October 2016 MTD:
  - Actual higher than budget by $5.3 million or 1.9%
    - Medi-Cal: favorable to budget by $16.4 million
      - Favorable price variance of $15.6 million
        - $8.0 million due to Hep C retro adjustment
        - Remainder due to IHSS variance
      - Favorable volume variance of $0.8 million
    - OneCare Connect: unfavorable variance of $11.4 million
      - Unfavorable price variance of $1.8 million due to cohort experience
      - Unfavorable volume variance of $9.6 million due to lower enrollment
    - OneCare: unfavorable to budget by $0.5 million due to prior year revenue adjustment

- October 2016 YTD:
  - Actual lower than budget by $3.1 million or 0.3%
    - Medi-Cal: favorable to budget by $38.0 million
    - OneCare Connect: unfavorable variance of $40.9 million

Back to Agenda

FY 2016-17: Consolidated Medical Expenses

- October 2016 MTD:
  - ➢ Actual higher than budget by $6.8 million or 2.5%
    - ▪ Medi-Cal: unfavorable variance of $17.4 million
      - MLTSS unfavorable variance $14.1 million
        - ➢ IHSS related unfavorable variance approximately $8.3 million
        - ➢ LTC unfavorable variance $5.4 million
          - $3.4 million due to less than anticipated members enrolling in OneCare Connect
          - $2.0 million variance from mandated rate accrual
      - Professional Claims unfavorable $3.1 million due to higher IBNR expense in COD and crossover categories
    - ▪ OneCare Connect: favorable variance of $10.3 million (in-line with lower enrollment)
      - Favorable volume variance of $9.0 million
      - Favorable price variance of $1.3 million

Back to Agenda

FY 2016-17: Consolidated Medical Expenses (Cont.)

- October 2016 YTD:
  - Actual higher than budget by $9.1 million or 0.8%
    - Medi-Cal: unfavorable variance of $48.8 million
      - Unfavorable price variance of $46.3 million
        - IHSS estimated expense $20.8 million higher than budget
        - Long Term Care expense $15.8 million higher than budget
        - Facilities expense $9.7 million higher than budget
      - Unfavorable volume variance of $2.5 million
    - OneCare Connect: favorable variance of $38.5 million
      - Favorable volume variance of $31.6 million
      - Favorable price variance of $6.9 million

- Medical Loss Ratio (MLR):
  - October 2016 MTD: Actual: 96.7% Budget: 96.1%
  - October 2016 YTD: Actual: 96.7% Budget: 95.6%

Back to Agenda

FY 2016-17: Consolidated Administrative Expenses

- October 2016 MTD:
  - Actual lower than budget by $2.6 million or 22.4%
    - Salaries and Benefits: favorable variance of $2.0 million driven by lower than budgeted FTE of 98
    - Other categories: favorable variance of $0.5 million
- October 2016 YTD:
  - Actual lower than budget by $10.1 million or 21.7%
    - Salaries and Benefits: favorable variance of $7.3 million driven by lower than budgeted FTE of 384
    - Other categories: favorable variance of $2.9 million
- Administrative Loss Ratio (ALR):
  - October 2016 MTD: Actual: 3.1% Budget: 4.1%
  - October 2016 YTD: Actual: 3.2% Budget: 4.1%

Back to Agenda

FY 2016-17: Change in Net Assets

- October 2016 MTD:
  - $1.5 million surplus
  - $1.9 million favorable to budget
    - Higher than budgeted revenue of $5.3 million
    - Higher medical expenses of $6.8 million
    - Lower administrative expenses of $2.6 million
    - Higher investment income of $0.8 million

- October 2016 YTD:
  - $4.1 million surplus
  - $0.8 million favorable to budget
    - Lower than budgeted revenue of $3.1 million
    - Higher medical expenses of $9.1 million
    - Lower administrative expenses of $10.1 million
    - Higher investment income of $2.6 million

Back to Agenda

Enrollment Summary: October 2016

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
58,682	55,236	3,446	6.2%	Aged	230,914	219,991	10,923	5.0%
613	677	(64)	(9.5%)	BCCTP	2,505	2,703	(198)	(7.3%)
48,616	47,448	1,168	2.5%	Disabled	193,725	189,971	3,754	2.0%
335,636	340,196	(4,560)	(1.3%)	TANF Child	1,340,205	1,356,196	(15,991)	(1.2%)
103,015	109,584	(6,569)	(6.0%)	TANF Adult	412,897	438,823	(25,926)	(5.9%)
3,227	2,693	534	19.8%	LTC	13,046	10,724	2,322	21.7%
231,629	222,928	8,701	3.9%	MCE	922,689	888,884	33,805	3.8%
781,418	**778,761**	**2,657**	**0.3%**	**Medi-Cal**	**3,115,981**	**3,107,291**	**8,690**	**0.3%**
17,352	**22,004**	**(4,651)**	**(21.1%)**	**OneCare Connect**	**72,226**	**88,568**	**(16,342)**	**(18.5%)**
180	**180**	**-**	**0.0%**	**PACE**	**715**	**690**	**25**	**3.6%**
1,220	**1,215**	**5**	**0.4%**	**OneCare**	**4,747**	**4,934**	**(187)**	**(3.8%)**
800,170	**802,159**	**(1,989)**	**(0.2%)**	**CalOptima Total**	**3,193,669**	**3,201,483**	**(7,814)**	**(0.2%)**

Back to Agenda

CalOptima A Public Agency Better. Together.

Financial Highlights: October 2016

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
800,170	802,159	(1,989)	(0.2%)	Member Months	3,193,669	3,201,483	(7,814)	(0.2%)
287,354,235	282,028,360	5,325,875	1.9%	Revenues	1,123,074,547	1,126,179,985	(3,105,439)	(0.3%)
277,873,182	271,029,416	(6,843,766)	(2.5%)	Medical Expenses	1,085,872,456	1,076,803,238	(9,069,218)	(0.8%)
8,901,812	11,464,522	2,562,710	22.4%	Administrative Expenses	36,493,244	46,618,122	10,124,878	21.7%
579,242	**(465,578)**	**1,044,819**	**(224.4%)**	**Operating Margin**	**708,846**	**2,758,625**	**(2,049,779)**	**(74.3%)**
966,954	143,250	823,704	575.0%	Non Operating Income (Loss)	3,401,743	573,000	2,828,743	493.7%
1,546,196	**(322,328)**	**1,868,523**	**579.7%**	**Change in Net Assets**	**4,110,590**	**3,331,626**	**778,964**	**23.4%**
96.7%	96.1%	(0.6%)		Medical Loss Ratio	96.7%	95.6%	(1.1%)	
3.1%	4.1%	1.0%		Administrative Loss Ratio	3.2%	4.1%	0.9%	
0.2%	(0.2%)	0.4%		Operating Margin Ratio	0.1%	0.2%	(0.2%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

Consolidated Performance Actual vs. Budget: October 2016 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(0.3)	(0.6)	0.3	Medi-Cal	(1.5)	1.7	(3.2)
(0.3)	0.0	(0.3)	OneCare	(0.4)	0.1	(0.5)
0.5	0.4	0.1	OCC	1.9	2.0	0.0
0.6	(0.2)	0.9	PACE	0.7	(1.0)	1.7
0.6	**(0.5)**	**1.0**	**Operating**	**0.7**	**2.8**	**(2.1)**
1.0	0.1	0.8	Inv./Rental Inc, MCO tax	3.4	0.6	2.9
1.0	**0.1**	**0.8**	**Non-Operating**	**3.4**	**0.6**	**2.9**
1.5	**(0.3)**	**1.9**	**TOTAL**	**4.1**	**3.3**	**0.8**

Consolidated Revenue & Expense: October 2016 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	552,648	228,770	$ 781,418	1,220	17,352	180	800,170
REVENUES							
Capitation Revenue	146,821,675	103,728,418	$ 250,550,093	$ 912,888	$ 33,964,294	$ 1,926,960	$ 287,354,235
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	146,821,675	103,728,418	250,550,093	912,888	33,964,294	1,926,960	287,354,235
MEDICAL EXPENSES							
Provider Capitation	38,576,425	35,916,879	74,493,305	321,063	7,594,469	-	82,408,837
Facilities	26,591,365	31,699,067	58,290,432	313,110	9,448,792	340,757	68,393,090
Ancillary				45,850	698,874	-	744,723
Skilled Nursing				33,274	7,303,176	-	7,336,450
Professional Claims	12,589,008	7,858,631	20,447,638	-	-	219,121	20,666,760
Prescription Drugs	19,592,874	15,536,252	35,129,126	435,603	6,190,562	81,293	41,836,583
Quality Incentives					-		-
Long-term Care Facility Payments	45,328,466	6,134,677	51,463,143	-	-	13,948	51,477,091
Contingencies	-	-	-	-	-	-	-
Medical Management	2,819,801	-	2,819,801	(51,954)	995,920	448,013	4,211,780
Reinsurance & Other	(316,438)	912,437	595,999	4,806	104,442	92,620	797,867
Total Medical Expenses	145,181,502	98,057,943	243,239,445	1,101,752	32,336,234	1,195,752	277,873,182
Medical Loss Ratio	**98.9%**	**94.5%**	**97.1%**	**120.7%**	**95.2%**	**62.1%**	**96.7%**
GROSS MARGIN	**1,640,173**	**5,670,475**	**7,310,649**	**(188,863)**	**1,628,060**	**731,208**	**9,481,053**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			4,835,911	17,871	729,821	85,448	5,669,050
Professional Fees			66,806	9,954	49,800	3,938	130,498
Purchased Services			577,013	19,377	102,515	1,133	700,038
Printing and Postage			103,314	10,899	48,881	1,193	164,287
Depreciation and Amortization			510,580			2,014	512,595
Other Expenses			1,258,077	120	35,772	5,418	1,299,387
Indirect Cost Allocation, Occupancy Expense			238,773	12,495	172,584	2,105	425,957
Total Administrative Expenses			7,590,474	70,716	1,139,371	101,250	8,901,812
Admin Loss Ratio			**3.0%**	**7.7%**	**3.4%**	**5.3%**	**3.1%**
INCOME (LOSS) FROM OPERATIONS			(279,826)	(259,580)	488,689	629,958	579,242
INVESTMENT INCOME			-	-	-	-	988,412
NET RENTAL INCOME			-	-	-	-	2,190
OTHER INCOME			69	-	-	-	69
CHANGE IN NET ASSETS			**$ (303,474)**	**$ (259,580)**	**$ 488,689**	**$ 629,958**	**$ 1,546,196**
BUDGETED CHANGE IN ASSETS			(639,940)	14,045	401,571	(241,253)	(322,328)
VARIANCE TO BUDGET - FAV (UNFAV)			336,467	(273,625)	87,117	871,212	1,868,523

Back to Agenda

CalOptima A Public Agency Better. Together.

Consolidated Revenue & Expense: October 2016 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	2,424,921	691,060	$ 3,115,981	4,747	72,226	715	3,193,669
REVENUES							
Capitation Revenue	657,847,467	313,684,901	$ 971,532,368	$ 4,699,462	$ 141,678,585	$ 5,164,131	$ 1,123,074,547
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	657,847,467	313,684,901	971,532,368	4,699,462	141,678,585	5,164,131	1,123,074,547
MEDICAL EXPENSES							
Provider Capitation	176,049,310	120,093,879	296,143,189	1,484,383	30,039,618	-	327,667,190
Facilities	137,759,710	97,882,871	235,642,581	1,191,464	39,073,619	1,008,969	276,916,634
Ancillary				179,828	2,961,858	-	3,141,687
Skilled Nursing				154,483	25,318,073	-	25,472,556
Professional Claims	49,610,085	23,468,015	73,078,101	-	-	764,620	73,842,720
Prescription Drugs	89,625,503	50,153,940	139,779,442	1,686,768	30,871,165	354,310	172,691,686
Quality Incentives					-		-
Long-term Care Facility Payments	167,360,585	18,483,483	185,844,068	-	-	41,958	185,886,026
Contingencies	-	-	-	-	-	-	-
Medical Management	11,596,450	-	11,596,450	17,578	3,936,606	1,542,807	17,093,442
Reinsurance & Other	(443,973)	2,833,536	2,389,563	17,186	398,044	355,723	3,160,516
Total Medical Expenses	631,557,670	312,915,725	944,473,395	4,731,690	132,598,983	4,068,388	1,085,872,456
Medical Loss Ratio	**96.0%**	**99.8%**	**97.2%**	**100.7%**	**93.6%**	**78.8%**	**96.7%**
GROSS MARGIN	**26,289,797**	**769,177**	**27,058,974**	**(32,229)**	**9,079,602**	**1,095,743**	**37,202,091**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			20,687,414	110,928	2,960,361	353,759	24,112,462
Professional Fees			579,541	57,181	324,341	12,753	973,816
Purchased Services			2,546,443	84,754	522,912	10,414	3,164,523
Printing and Postage			720,660	15,742	213,359	1,725	951,486
Depreciation and Amortization			1,483,246			8,057	1,491,303
Other Expenses			4,120,099	1,692	135,606	21,999	4,279,396
Indirect Cost Allocation, Occupancy Expense			(1,575,294)	100,975	2,985,056	9,521	1,520,258
Total Administrative Expenses			28,562,110	371,273	7,141,635	418,227	36,493,244
Admin Loss Ratio			**2.9%**	**7.9%**	**5.0%**	**8.1%**	**3.2%**
INCOME (LOSS) FROM OPERATIONS			(1,503,136)	(403,501)	1,937,967	677,517	708,846
INVESTMENT INCOME			-	-	-	-	3,421,329
NET RENTAL INCOME			-	-	-	-	14,859
OTHER INCOME			528	-	-	-	528
CHANGE IN NET ASSETS			**$ (1,537,581)**	**$ (403,501)**	**$ 1,937,967**	**$ 677,517**	**$ 4,110,590**
BUDGETED CHANGE IN ASSETS			1,676,137	120,541	1,957,870	(995,923)	3,331,626
VARIANCE TO BUDGET - FAV (UNFAV)			(3,213,718)	(524,042)	(19,903)	1,673,439	778,964

Back to Agenda

CalOptima A Public Agency Better. Together.

Balance Sheet: As of October 2016

ASSETS		
Current Assets		
Operating Cash		$270,855,000
Catastrophic Reserves		11,631,134
Investments		1,530,023,287
Capitation receivable		315,840,792
Receivables - Other		16,260,007
Prepaid Expenses		10,508,224
Total Current Assets		**2,155,118,444**
Capital Assets	Furniture and equipment	28,851,790
	Leasehold improvements	13,672,881
	505 City Parkway West	46,707,144
		89,231,814
	Less: accumulated depreciation	(34,156,427)
	Capital assets, net	**55,075,387**
Other Assets	Restricted deposit & Other	284,715
	Board-designated assets	
	Cash and cash equivalents	7,193,708
	Long term investments	468,806,679
	Total Board-designated Assets	476,000,387
	Total Other Assets	**476,285,102**
	Deferred outflows of Resources - Pension Contributions	3,787,544
	Deferred outflows of Resources - Difference in Experience	1,215,473
TOTAL ASSETS & OUTFLOWS		**2,691,481,950**

LIABILITIES & FUND BALANCES	
Current Liabilities	
Accounts payable	$19,267,245
Medical claims liability	601,542,015
Accrued payroll liabilities	11,069,277
Deferred revenue	859,374,315
Deferred lease obligations	267,070
Capitation and withholds	496,295,584
Total Current Liabilities	**1,987,815,506**
Other employment benefits liability	28,397,235
Net Pension Liabilities	9,336,900
Long Term Liabilities	100,000
TOTAL LIABILITIES	**2,025,649,641**
Deferred inflows of Resources - Excess Earnings	502,900
Deferred inflows of Resources - changes in Assumptions	1,651,640
Tangible net equity (TNE)	92,537,605
Funds in excess of TNE	571,140,163
Net Assets	**663,677,768**
TOTAL LIABILITIES, INFLOWS & FUND BALANCES	**2,691,481,950**

Back to Agenda

Board Designated Reserve and TNE Analysis
As of October 2016

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	135,453,317				
	Tier 1 - Logan Circle	125,485,817				
	Tier 1 - Wells Capital	125,393,598				
Board-designated Reserve						
		386,332,733	282,762,752	443,549,577	103,569,981	(57,216,844)
TNE Requirement	Tier 2 - Logan Circle	89,667,654	92,406,506	92,406,506	(2,738,852)	(2,738,852)
	Consolidated:	**476,000,387**	**375,169,258**	**535,956,083**	**100,831,129**	**(59,955,696)**
	Current reserve level	*1.78*	*1.40*	*2.00*		

Back to Agenda

CalOptima A Public Agency Better. Together.

UNAUDITED FINANCIAL STATEMENTS

October 2016

Back to Agenda

Table of Contents

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the Four Months Ended October 31, 2016

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
800,170	802,159	(1,989)	(0.2%)	Member Months	3,193,669	3,201,483	(7,814)	(0.2%)
287,354,235	282,028,360	5,325,875	1.9%	Revenues	1,123,074,547	1,126,179,985	(3,105,439)	(0.3%)
277,873,182	271,029,416	(6,843,766)	(2.5%)	Medical Expenses	1,085,872,456	1,076,803,238	(9,069,218)	(0.8%)
8,901,812	11,464,522	2,562,710	22.4%	Administrative Expenses	36,493,244	46,618,122	10,124,878	21.7%
579,242	**(465,578)**	**1,044,819**	**(224.4%)**	**Operating Margin**	**708,846**	**2,758,625**	**(2,049,779)**	**(74.3%)**
966,954	143,250	823,704	575.0%	Non Operating Income (Loss)	3,401,743	573,000	2,828,743	493.7%
1,546,196	**(322,328)**	**1,868,523**	**(579.7%)**	**Change in Net Assets**	**4,110,590**	**3,331,626**	**778,964**	**23.4%**
96.7%	96.1%	(0.6%)		Medical Loss Ratio	96.7%	95.6%	(1.1%)	
3.1%	4.1%	1.0%		Administrative Loss Ratio	3.2%	4.1%	0.9%	
0.2%	(0.2%)	0.4%		Operating Margin Ratio	0.1%	0.2%	(0.2%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

CalOptima
Financial Dashboard
For the Four Months Ended October 31, 2016

MONTH

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	781,418	778,761	2,657	0.3%
OneCare	1,220	1,215	5	0.4%
OneCare Connect	17,352	22,003	(4,651)	(21.1%)
PACE	180	180	-	0.0%
Total	800,170	802,159	(1,989)	(0.2%)

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (303)	$ (640)	$ 336	52.6%
OneCare	(260)	14	(274)	(1948.2%)
OneCare Connect	489	402	87	21.7%
PACE	630	(241)	871	361.1%
505 Bldg.	2	(65)	67	103.4%
Investment Income & Other	988	208	780	374.5%
Total	$ 1,546	$ (322)	$ 1,869	579.7%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.1%	96.4%	(0.6)
OneCare	120.7%	92.0%	(28.7)
OneCare Connect	95.2%	94.1%	(1.1)

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 7,590	$ 8,963	$ 1,373	15.3%
OneCare	71	97	26	27.2%
OneCare Connect	1,139	2,283	1,144	50.1%
PACE	101	121	20	16.2%
Total	$ 8,902	$ 11,465	$ 2,563	22.4%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	826	886	60
OneCare	3	3	0
OneCare Connect	217	239	21
PACE	40	57	17
Total	1,086	1,184	98

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	946	879	67
OneCare	408	405	3
OneCare Connect	80	92	(12)
PACE	5	3	1
Total	1,438	1,379	59

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	3,115,981	3,107,291	8,690	0.3%
OneCare	4,747	4,934	(187)	(3.8%)
OneCare Connect	72,226	88,568	(16,342)	(18.5%)
PACE	715	690	25	3.6%
Total	3,193,669	3,201,483	(7,814)	(0.2%)

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (1,538)	$ 1,676	$ (3,214)	(191.7%)
OneCare	(404)	121	(524)	(434.7%)
OneCare Connect	1,938	1,958	(20)	(1.0%)
PACE	678	(996)	1,673	168.0%
505 Bldg.	15	(260)	275	105.7%
Investment Income & Other	3,422	833	2,589	310.6%
Total	$ 4,111	$ 3,332	$ 779	23.4%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.2%	95.9%	(1.3)
OneCare	100.7%	91.1%	(9.6)
OneCare Connect	93.6%	93.7%	0.1

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 28,562	$ 36,215	$ 7,652	21.1%
OneCare	371	383	12	3.2%
OneCare Connect	7,142	9,558	2,417	25.3%
PACE	418	462	44	9.5%
Total	$ 36,493	$ 46,618	$10,125	21.7%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	3,285	3,544	258
OneCare	14	12	(2)
OneCare Connect	899	954	55
PACE	153	226	73
Total	4,352	4,736	384

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	948	877	72
OneCare	339	411	(72)
OneCare Connect	80	93	(12)
PACE	5	3	2
Total	1,372	1,384	(11)

Back to Agenda

CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended October 31, 2016

	Month					
	Actual		Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	800,170		802,159		(1,989)	
Revenues						
Medi-Cal	$ 250,550,093	$ 320.64	$ 234,143,010	$ 300.66	$ 16,407,083	$ 19.97
OneCare	912,888	748.27	1,390,124	1,144.13	(477,236)	(395.87)
OneCare Connect	33,964,294	1,957.37	45,358,435	2,061.47	(11,394,141)	(104.10)
PACE	1,926,960	10,705.33	1,136,791	6,315.50	790,170	4,389.83
Total Operating Revenue	287,354,235	359.12	282,028,360	351.59	5,325,875	7.53
Medical Expenses						
Medi-Cal	243,239,445	311.28	225,819,716	289.97	(17,419,729)	(21.31)
OneCare	1,101,752	903.08	1,278,913	1,052.60	177,162	149.53
OneCare Connect	32,336,234	1,863.55	42,673,506	1,939.44	10,337,272	75.90
PACE	1,195,752	6,643.07	1,257,281	6,984.89	61,528	341.82
Total Medical Expenses	277,873,182	347.27	271,029,416	337.87	(6,843,766)	(9.39)
Gross Margin	9,481,053	11.85	10,998,944	13.71	(1,517,891)	(1.86)
Administrative Expenses						
Salaries and benefits	5,669,050	7.08	7,709,189	9.61	2,040,138	2.53
Professional fees	130,498	0.16	439,633	0.55	309,135	0.38
Purchased services	700,038	0.87	947,175	1.18	247,136	0.31
Printing and Postage	164,287	0.21	464,271	0.58	299,984	0.37
Depreciation and amortization	512,595	0.64	385,117	0.48	(127,477)	(0.16)
Other	1,299,387	1.62	1,091,832	1.36	(207,555)	(0.26)
Indirect Cost Allocation, Occupancy Expense	425,957	0.53	427,305	0.53	1,348	0.00
Total Administrative Expenses	8,901,812	11.12	11,464,522	14.29	2,562,710	3.17
Income (Loss) From Operations	579,242	0.72	(465,578)	(0.58)	1,044,819	1.30
Investment income						
Interest income	1,530,608	1.91	208,333	0.26	1,322,275	1.65
Realized gain/(loss) on investments	34,111	0.04	-	-	34,111	0.04
Unrealized gain/(loss) on investments	(576,307)	(0.72)	-	-	(576,307)	(0.72)
Total Investment Income	988,412	1.24	208,333	0.26	780,079	0.98
Net Rental Income	2,190	0.00	(65,083)	(0.08)	67,273	0.08
Other Income	69	0.00	-	-	69	0.00
Change In Net Assets	**1,546,196**	**1.93**	**(322,328)**	**(0.40)**	**1,868,523**	**2.33**
Medical Loss Ratio	**96.7%**		**96.1%**		**(0.6%)**	
Administrative Loss Ratio	**3.1%**		**4.1%**		**1.0%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

Back to Agenda

CalOptima - Consolidated - Year to Date
Statement of Revenue and Expenses
For the Four Months Ended October 31, 2016

	Year to Date					
	Actual		Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	3,193,669		3,201,483		(7,814)	
Revenues						
Medi-Cal	$ 971,532,368	$ 311.79	$ 933,571,329	$ 300.45	$ 37,961,040	$ 11.34
OneCare	4,699,462	989.99	5,666,331	1,148.43	(966,869)	(158.44)
OneCare Connect	141,678,585	1,961.60	182,580,292	2,061.47	(40,901,707)	(99.87)
PACE	5,164,131	7,222.56	4,362,034	6,321.79	802,097	900.77
Total Operating Revenue	1,123,074,547	351.66	1,126,179,985	351.77	(3,105,439)	(0.11)
Medical Expenses						
Medi-Cal	944,473,395	303.11	895,680,642	288.25	(48,792,753)	(14.86)
OneCare	4,731,690	996.77	5,162,432	1,046.30	430,742	49.52
OneCare Connect	132,598,983	1,835.89	171,064,187	1,931.44	38,465,204	95.55
PACE	4,068,388	5,690.05	4,895,976	7,095.62	827,589	1,405.57
Total Medical Expenses	1,085,872,456	340.01	1,076,803,238	336.35	(9,069,218)	(3.66)
Gross Margin	37,202,091	11.65	49,376,748	15.42	(12,174,657)	(3.77)
Administrative Expenses						
Salaries and benefits	24,112,462	7.55	31,368,370	9.80	7,255,908	2.25
Professional fees	973,816	0.30	1,523,462	0.48	549,646	0.17
Purchased services	3,164,523	0.99	3,655,775	1.14	491,252	0.15
Printing and Postage	951,486	0.30	1,838,030	0.57	886,544	0.28
Depreciation and amortization	1,491,303	0.47	1,540,469	0.48	49,166	0.01
Other	4,279,396	1.34	4,977,948	1.55	698,552	0.21
Indirect cost allocation, Occupancy Expense	1,520,258	0.48	1,714,068	0.54	193,810	0.06
Total Administrative Expenses	36,493,244	11.43	46,618,122	14.56	10,124,878	3.13
Income (Loss) From Operations	708,846	0.22	2,758,625	0.86	(2,049,779)	(0.64)
Investment income						
Interest income	4,829,737	1.51	833,334	0.26	3,996,404	1.25
Realized gain/(loss) on investments	274,910	0.09	-	-	274,910	0.09
Unrealized gain/(loss) on investments	(1,683,318)	(0.53)	-	-	(1,683,318)	(0.53)
Total Investment Income	3,421,329	1.07	833,334	0.26	2,587,996	0.81
Net Rental Income	14,859	0.00	(260,333)	(0.08)	275,192	0.09
Other Income	528	0.00	-	-	528	0.00
Change In Net Assets	**4,110,590**	**1.29**	**3,331,626**	**1.04**	**778,964**	**0.25**
Medical Loss Ratio	**96.7%**		**95.6%**		**(1.1%)**	
Administrative Loss Ratio	**3.2%**		**4.1%**		**0.9%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

Back to Agenda

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended October 31, 2016

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	552,648	228,770	$ 781,418	1,220	17,352	180	800,170
REVENUES							
Capitation Revenue	146,821,675	103,728,418	$ 250,550,093	$ 912,888	$ 33,964,294	$ 1,926,960	$ 287,354,235
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	146,821,675	103,728,418	250,550,093	912,888	33,964,294	1,926,960	287,354,235
MEDICAL EXPENSES							
Provider Capitation	38,576,425	35,916,879	74,493,305	321,063	7,246,369	-	82,060,737
Facilities	26,591,365	31,699,067	58,290,432	313,110	9,448,792	340,757	68,393,090
Ancillary				45,850	698,874	-	744,723
Skilled Nursing				33,274	7,303,176	-	7,336,450
Professional Claims	12,589,008	7,858,631	20,447,638	-	-	219,121	20,666,760
Prescription Drugs	19,592,874	15,536,252	35,129,126	435,603	6,190,562	81,293	41,836,583
Quality Incentives					348,100		348,100
Long-term Care Facility Payments	45,328,466	6,134,677	51,463,143	-	-	13,948	51,477,091
Contingencies	-	-	-	-	-	-	-
Medical Management	2,819,801	-	2,819,801	(51,954)	995,920	448,013	4,211,780
Reinsurance & Other	(316,438)	912,437	595,999	4,806	104,442	92,620	797,867
Total Medical Expenses	145,181,502	98,057,943	243,239,445	1,101,752	32,336,234	1,195,752	277,873,182
Medical Loss Ratio	**98.9%**	**94.5%**	**97.1%**	**120.7%**	**95.2%**	**62.1%**	**96.7%**
GROSS MARGIN	**1,640,173**	**5,670,475**	**7,310,649**	**(188,863)**	**1,628,060**	**731,208**	**9,481,053**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			4,835,911	17,871	729,821	85,448	5,669,050
Professional Fees			66,806	9,954	49,800	3,938	130,498
Purchased Services			577,013	19,377	102,515	1,133	700,038
Printing and Postage			103,314	10,899	48,881	1,193	164,287
Depreciation and Amortization			510,580			2,014	512,595
Other Expenses			1,258,077	120	35,772	5,418	1,299,387
Indirect Cost Allocation, Occupancy Expense			238,773	12,495	172,584	2,105	425,957
Total Administrative Expenses			7,590,474	70,716	1,139,371	101,250	8,901,812
Admin Loss Ratio			**3.0%**	**7.7%**	**3.4%**	**5.3%**	**3.1%**
INCOME (LOSS) FROM OPERATIONS			(279,826)	(259,580)	488,689	629,958	579,242
INVESTMENT INCOME			-	-	-	-	988,412
NET RENTAL INCOME			-	-	-	-	2,190
OTHER INCOME			69	-	-	-	69
CHANGE IN NET ASSETS			**$ (303,474)**	**$ (259,580)**	**$ 488,689**	**$ 629,958**	**$ 1,546,196**
BUDGETED CHANGE IN ASSETS			(639,940)	14,045	401,571	(241,253)	(322,328)
VARIANCE TO BUDGET - FAV (UNFAV)			336,467	(273,625)	87,117	871,212	1,868,523

Back to Agenda

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Four Months Ended October 31, 2016

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	2,424,921	691,060	$ 3,115,981	4,747	72,226	715	3,193,669
REVENUES							
Capitation Revenue	657,847,467	313,684,901	$ 971,532,368	$ 4,699,462	$ 141,678,585	$ 5,164,131	$ 1,123,074,547
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	657,847,467	313,684,901	971,532,368	4,699,462	141,678,585	5,164,131	1,123,074,547
MEDICAL EXPENSES							
Provider Capitation	176,049,310	120,093,879	296,143,189	1,484,383	28,592,778	-	326,220,350
Facilities	137,759,710	97,882,871	235,642,581	1,191,464	39,073,619	1,008,969	276,916,634
Ancillary				179,828	2,961,858	-	3,141,687
Skilled Nursing				154,483	25,318,073	-	25,472,556
Professional Claims	49,610,085	23,468,015	73,078,101	-	-	764,620	73,842,720
Prescription Drugs	89,625,503	50,153,940	139,779,442	1,686,768	30,871,165	354,310	172,691,686
Quality Incentives					1,446,840		1,446,840
Long-term Care Facility Payments	167,360,585	18,483,483	185,844,068	-	-	41,958	185,886,026
Contingencies	-	-	-	-	-	-	-
Medical Management	11,596,450	-	11,596,450	17,578	3,936,606	1,542,807	17,093,442
Reinsurance & Other	(443,973)	2,833,536	2,389,563	17,186	398,044	355,723	3,160,516
Total Medical Expenses	631,557,670	312,915,725	944,473,395	4,731,690	132,598,983	4,068,388	1,085,872,456
Medical Loss Ratio	**96.0%**	**99.8%**	**97.2%**	**100.7%**	**93.6%**	**78.8%**	**96.7%**
GROSS MARGIN	**26,289,797**	**769,177**	**27,058,974**	**(32,229)**	**9,079,602**	**1,095,743**	**37,202,091**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			20,687,414	110,928	2,960,361	353,759	24,112,462
Professional Fees			579,541	57,181	324,341	12,753	973,816
Purchased Services			2,546,443	84,754	522,912	10,414	3,164,523
Printing and Postage			720,660	15,742	213,359	1,725	951,486
Depreciation and Amortization			1,483,246			8,057	1,491,303
Other Expenses			4,120,099	1,692	135,606	21,999	4,279,396
Indirect Cost Allocation, Occupancy Expense			(1,575,294)	100,975	2,985,056	9,521	1,520,258
Total Administrative Expenses			28,562,110	371,273	7,141,635	418,227	36,493,244
Admin Loss Ratio			**2.9%**	**7.9%**	**5.0%**	**8.1%**	**3.2%**
INCOME (LOSS) FROM OPERATIONS			(1,503,136)	(403,501)	1,937,967	677,517	708,846
INVESTMENT INCOME			-	-	-	-	3,421,329
NET RENTAL INCOME			-	-	-	-	14,859
OTHER INCOME			528	-	-	-	528
CHANGE IN NET ASSETS			**$ (1,537,581)**	**$ (403,501)**	**$ 1,937,967**	**$ 677,517**	**$ 4,110,590**
BUDGETED CHANGE IN ASSETS			1,676,137	120,541	1,957,870	(995,923)	3,331,626
VARIANCE TO BUDGET - FAV (UNFAV)			(3,213,718)	(524,042)	(19,903)	1,673,439	778,964

Back to Agenda

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $1.5 million, $1.9 million favorable to budget
- Operating surplus is $0.6 million with a surplus in non-operating of $1.0 million

YEARLY RESULTS:

- Change in Net Assets is $4.1 million, $0.8 million favorable to budget
- Operating surplus is $0.7 million with a surplus in non-operating of $3.4 million

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(0.3)	(0.6)	0.3	Medi-Cal	(1.5)	1.7	(3.2)
(0.3)	0.0	(0.3)	OneCare	(0.4)	0.1	(0.5)
0.5	0.4	0.1	OCC	1.9	2.0	0.0
0.6	(0.2)	0.9	PACE	0.7	(1.0)	1.7
0.6	**(0.5)**	**1.0**	**Operating**	**0.7**	**2.8**	**(2.1)**
1.0	0.1	0.8	Inv./Rental Inc, MCO tax	3.4	0.6	2.9
1.0	**0.1**	**0.8**	**Non-Operating**	**3.4**	**0.6**	**2.9**
1.5	**(0.3)**	**1.9**	**TOTAL**	**4.1**	**3.3**	**0.8**

Back to Agenda

CalOptima

Enrollment Summary

For the Four Months Ended October 31, 2016

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
58,682	55,236	3,446	6.2%	Aged	230,914	219,991	10,923	5.0%
613	677	(64)	(9.5%)	BCCTP	2,505	2,703	(198)	(7.3%)
48,616	47,448	1,168	2.5%	Disabled	193,725	189,971	3,754	2.0%
335,636	340,196	(4,560)	(1.3%)	TANF Child	1,340,205	1,356,196	(15,991)	(1.2%)
103,015	109,584	(6,569)	(6.0%)	TANF Adult	412,897	438,823	(25,926)	(5.9%)
3,227	2,693	534	19.8%	LTC	13,046	10,724	2,322	21.7%
231,629	222,928	8,701	3.9%	MCE	922,689	888,884	33,805	3.8%
781,418	**778,761**	**2,657**	**0.3%**	**Medi-Cal**	**3,115,981**	**3,107,291**	**8,690**	**0.3%**
17,352	**22,004**	**(4,651)**	**(21.1%)**	**OneCare Connect**	**72,226**	**88,568**	**(16,342)**	**(18.5%)**
180	**180**	**-**	**0.0%**	**PACE**	**715**	**690**	**25**	**3.6%**
1,220	**1,215**	**5**	**0.4%**	**OneCare**	**4,747**	**4,934**	**(187)**	**(3.8%)**
800,170	**802,159**	**(1,989)**	**(0.2%)**	**CalOptima Total**	**3,193,669**	**3,201,483**	**(7,814)**	**(0.2%)**
				Enrollment (By Network)				
49,038	47,775	1,263	2.6%	HMO	192,297	188,824	3,473	1.8%
231,705	234,635	(2,930)	(1.2%)	PHC	926,066	936,347	(10,281)	(1.1%)
341,954	340,509	1,445	0.4%	Shared Risk Group	1,370,981	1,364,681	6,300	0.5%
158,721	155,843	2,878	1.8%	Fee for Service	626,637	617,445	9,192	1.5%
781,418	**778,761**	**2,657**	**0.3%**	**Medi-Cal**	**3,115,981**	**3,107,291**	**8,689**	**0.3%**
17,352	**22,004**	**(4,651)**	**(21.1%)**	**OneCare Connect**	**72,226**	**88,568**	**(16,342)**	**(18.5%)**
180	**180**	**0**	**0.0%**	**PACE**	**715**	**690**	**25**	**3.6%**
1,220	**1,215**	**5**	**0.4%**	**OneCare**	**4,747**	**4,934**	**(187)**	**(3.8%)**
800,170	**802,159**	**(1,989)**	**(0.2%)**	**CalOptima Total**	**3,193,669**	**3,201,483**	**(7,814)**	**(0.2%)**

Back to Agenda

CalOptima
Enrollment Trend by Network Type
Fiscal Year 2017

Network Type	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	MMs
HMO													
Aged	351	350	355	368	-	-	-	-	-	-	-	-	1,424
BCCTP	1	1	1	(8)	-	-	-	-	-	-	-	-	(5)
Disabled	1,799	1,797	1,813	1,866	-	-	-	-	-	-	-	-	7,275
TANF Child	24,211	24,455	24,733	24,928	-	-	-	-	-	-	-	-	98,327
TANF Adult	7,929	7,872	7,914	7,850	-	-	-	-	-	-	-	-	31,565
LTC	-	-	-	-	-	-	-	-	-	-	-	-	-
MCE	12,989	13,224	13,464	14,034	-	-	-	-	-	-	-	-	53,711
	47,280	47,699	48,280	49,038	-	-	-	-	-	-	-	-	192,297
PHC													
Aged	1,495	1,464	1,488	1,458	-	-	-	-	-	-	-	-	5,905
BCCTP	-	-	-	1	-	-	-	-	-	-	-	-	1
Disabled	7,903	7,872	7,862	7,865	-	-	-	-	-	-	-	-	31,502
TANF Child	169,358	168,529	169,733	169,714	-	-	-	-	-	-	-	-	677,334
TANF Adult	15,260	14,945	14,649	14,593	-	-	-	-	-	-	-	-	59,447
LTC	-	-	-	4	-	-	-	-	-	-	-	-	4
MCE	38,002	38,200	37,601	38,070	-	-	-	-	-	-	-	-	151,873
	232,018	231,010	231,333	231,705	-	-	-	-	-	-	-	-	926,066
Shared Risk Group													
Aged	7,658	7,627	7,635	7,726	-	-	-	-	-	-	-	-	30,646
BCCTP	-	-	-	8	-	-	-	-	-	-	-	-	8
Disabled	14,428	14,307	14,189	14,253	-	-	-	-	-	-	-	-	57,177
TANF Child	118,748	118,149	118,421	117,922	-	-	-	-	-	-	-	-	473,240
TANF Adult	63,849	62,814	62,579	62,266	-	-	-	-	-	-	-	-	251,508
LTC	-	-	-	3	-	-	-	-	-	-	-	-	3
MCE	140,640	140,811	137,172	139,776	-	-	-	-	-	-	-	-	558,399
	345,323	343,708	339,996	341,954	-	-	-	-	-	-	-	-	1,370,981
Fee for Service (Dual)													
Aged	43,684	45,173	45,173	45,522	-	-	-	-	-	-	-	-	179,552
BCCTP	27	26	24	23	-	-	-	-	-	-	-	-	100
Disabled	19,790	20,086	20,071	20,264	-	-	-	-	-	-	-	-	80,211
TANF Child	3	2	2	3	-	-	-	-	-	-	-	-	10
TANF Adult	1,179	1,162	1,184	1,197	-	-	-	-	-	-	-	-	4,722
LTC	2,868	2,910	2,941	2,906	-	-	-	-	-	-	-	-	11,625
MCE	2,960	2,975	2,721	2,750	-	-	-	-	-	-	-	-	11,406
	70,511	72,334	72,116	72,665	-	-	-	-	-	-	-	-	287,626
Fee for Service (Non-Dual)													
Aged	3,746	2,850	3,183	3,608	-	-	-	-	-	-	-	-	13,387
BCCTP	606	608	598	589	-	-	-	-	-	-	-	-	2,401
Disabled	4,533	4,269	4,390	4,368	-	-	-	-	-	-	-	-	17,560
TANF Child	22,710	23,011	22,504	23,069	-	-	-	-	-	-	-	-	91,294
TANF Adult	15,792	16,253	16,501	17,109	-	-	-	-	-	-	-	-	65,655
LTC	368	370	362	314	-	-	-	-	-	-	-	-	1,414
MCE	35,946	36,543	37,812	36,999	-	-	-	-	-	-	-	-	147,300
	83,701	83,904	85,350	86,056	-	-	-	-	-	-	-	-	339,011
MEDI-CAL TOTAL													
Aged	56,934	57,464	57,834	58,682	-	-	-	-	-	-	-	-	230,914
BCCTP	634	635	623	613	-	-	-	-	-	-	-	-	2,505
Disabled	48,453	48,331	48,325	48,616	-	-	-	-	-	-	-	-	193,725
TANF Child	335,030	334,146	335,393	335,636	-	-	-	-	-	-	-	-	1,340,205
TANF Adult	104,009	103,046	102,827	103,015	-	-	-	-	-	-	-	-	412,897
LTC	3,236	3,280	3,303	3,227	-	-	-	-	-	-	-	-	13,046
MCE	230,537	231,753	228,770	231,629	-	-	-	-	-	-	-	-	922,689
	778,833	778,655	777,075	781,418	-	-	-	-	-	-	-	-	3,115,981
PACE	177	179	179	180	-	-	-	-	-	-	-	-	715
OneCare	1,171	1,164	1,192	1,220	-	-	-	-	-	-	-	-	4,747
OneCare Connect	18,902	18,245	17,727	17,352	-	-	-	-	-	-	-	-	72,226
TOTAL	799,083	798,243	796,173	800,170	-	-	-	-	-	-	-	-	3,193,669

Back to Agenda

ENROLLMENT:

Overall MTD enrollment was 800,170

- Unfavorable to budget by 1,989
- Decreased 3,997 or 0.5% from prior month
- Increased 16,987 or 2.2% from prior year (October 2015)

Medi-Cal enrollment was 781,418

- Favorable to budget by 2,657 primarily driven by:
    - 0 Medi-Cal Expansion favorable by 8,701 and SPD by 4,550
    - 0 Offset by TANF unfavorable by 11,129

- Increased 4,343 from prior month

OneCare enrollment was 1,220

- Favorable to budget by 5
- Increased 28 from prior month

OneCare Connect enrollment was 17,352

- Unfavorable to budget by 4,651
- Decreased 375 from prior month

PACE enrollment at 180

- In line with budget
- Increased 1 from prior month

CalOptima - MediCal Total
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
781,418	778,761	2,657	0.3%	Member Months	3,115,981	3,107,291	8,690	0.3%
				Revenues				
250,550,093	234,143,010	16,407,083	7.0%	Capitation revenue	971,532,368	933,571,329	37,961,040	4.1%
250,550,093	234,143,010	16,407,083	7.0%	Total Operating Revenues	971,532,368	933,571,329	37,961,040	4.1%
				Medical Expenses				
74,493,305	75,005,966	512,662	0.7%	Provider capitation	296,143,189	299,678,555	3,535,367	1.2%
58,290,432	56,934,189	(1,356,243)	(2.4%)	Facilities	235,642,581	225,354,470	(10,288,111)	(4.6%)
20,447,638	17,301,360	(3,146,278)	(18.2%)	Professional Claims	73,078,101	67,207,012	(5,871,089)	(8.7%)
35,129,126	34,766,998	(362,129)	(1.0%)	Prescription drugs	139,779,442	137,162,214	(2,617,228)	(1.9%)
51,463,143	37,399,161	(14,063,982)	(37.6%)	MLTSS	185,844,068	148,395,438	(37,448,630)	(25.2%)
2,819,801	4,365,375	1,545,574	35.4%	Medical Management	11,596,450	17,696,286	6,099,835	34.5%
595,999	46,667	(549,332)	(1,177.1%)	Reinsurance & other	2,389,563	186,667	(2,202,896)	(1,180.1%)
243,239,445	225,819,716	(17,419,729)	(7.7%)	Total Medical Expenses	944,473,395	895,680,642	(48,792,753)	(5.4%)
7,310,649	8,323,294	(1,012,646)	(12.2%)	Gross Margin	27,058,974	37,890,687	(10,831,713)	(28.6%)
				Administrative Expenses				
4,835,911	6,656,734	1,820,823	27.4%	Salaries, wages & employee benefits	20,687,414	27,121,912	6,434,498	23.7%
66,806	328,112	261,306	79.6%	Professional fees	579,541	1,181,984	602,443	51.0%
577,013	745,673	168,660	22.6%	Purchased services	2,546,443	2,864,984	318,541	11.1%
103,314	312,948	209,634	67.0%	Printing and postage	720,660	1,248,205	527,545	42.3%
510,580	383,061	(127,519)	(33.3%)	Depreciation & amortization	1,483,246	1,532,244	48,998	3.2%
1,258,077	1,077,408	(180,669)	(16.8%)	Other operating expenses	4,120,099	4,423,181	303,082	6.9%
238,773	(540,702)	(779,475)	(144.2%)	Indirect cost allocation	(1,575,294)	(2,157,960)	(582,666)	(27.0%)
7,590,474	8,963,235	1,372,760	15.3%	Total Administrative Expenses	28,562,110	36,214,550	7,652,440	21.1%
				Operating Tax				
10,227,488	8,830,945	(1,396,543)	(15.8%)	Tax Revenue	41,126,965	35,243,581	(5,883,383)	(16.7%)
10,225,313	0	(10,225,313)	0.0%	Premium tax expense	40,901,252	0	(40,901,252)	0.0%
2,175	8,830,945	8,828,770	100.0%	Sales tax expense	225,713	35,243,581	35,017,869	99.4%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
0	287,500	(287,500)	(100.0%)	Grant Revenue	207,500	1,150,000	(942,500)	(82.0%)
(118)	250,000	250,118	100.0%	Grant expense - Service Partner	176,375	1,000,000	823,625	82.4%
23,835	37,500	13,665	36.4%	Grant expense - Administrative	66,098	150,000	83,902	55.9%
(23,717)	0	(23,717)	0.0%	Total Net Grant Income	(34,973)	0	(34,973)	0.0%
69	0	69	0.0%	Other income	528	0	528	0.0%
(303,474)	(639,940)	336,467	52.6%	Change in Net Assets	(1,537,581)	1,676,137	(3,213,718)	(191.7%)
97.1%	96.4%	-0.6%	-0.7%	Medical Loss Ratio	97.2%	95.9%	-1.3%	-1.3%
3.0%	3.8%	0.8%	20.9%	Admin Loss Ratio	2.9%	3.9%	0.9%	24.2%

Back to Agenda

MEDI-CAL INCOME STATEMENT – OCTOBER MONTH:

REVENUES of $250.6 million are favorable to budget by $16.4 million, driven by:

- Price related variance of: $15.6 million due to IHSS variance
- Volume related favorable variance of: $0.8 million

MEDICAL EXPENSES: Overall $243.2 million, unfavorable to budget by $17.4 million due to:

- **Long term care claim payments (MLTSS)** are unfavorable to budget $14.1 million due to:
    - Price related unfavorable variance of: $13.9 million related to actuarial experience and County IHSS expense reporting
    - Volume related unfavorable variance of: $0.1 million

- **Professional claims** are unfavorable to budget $3.1 million due to:
    - Price related unfavorable variance of: $3.1 million related to claims actuarial experience

ADMINISTRATION EXPENSES are $7.6 million, favorable to budget $1.4 million, driven by:

- Salary & Benefits: $1.8 million favorable to budget
- Non-Salary: $0.4 million unfavorable to budget across most categories

CHANGE IN NET ASSETS is $(0.3) million for the month, favorable to budget by $0.3 million

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
17,352	22,003	(4,651)	(21.1%)	Member Months	72,226	88,568	(16,342)	(18.5%)
				Revenues				
33,964,294	45,358,435	(11,394,141)	(25.1%)	Capitation revenue	141,678,585	182,580,292	(40,901,707)	(22.4%)
33,964,294	45,358,435	(11,394,141)	(25.1%)	Total Operating Revenue	141,678,585	182,580,292	(40,901,707)	(22.4%)
				Medical Expenses				
7,594,469	9,987,751	2,393,282	24.0%	Provider capitation	30,039,618	40,203,472	10,163,854	25.3%
9,448,792	11,530,849	2,082,057	18.1%	Facilities	39,073,619	46,237,440	7,163,821	15.5%
698,874	688,465	(10,408)	(1.5%)	Ancillary	2,961,858	2,771,262	(190,596)	(6.9%)
7,303,176	10,393,095	3,089,919	29.7%	Long Term Care	25,318,073	41,835,093	16,517,020	39.5%
6,190,562	8,199,763	2,009,201	24.5%	Prescription drugs	30,871,165	32,576,166	1,705,001	5.2%
995,920	1,239,925	244,005	19.7%	Medical management	3,936,606	4,890,108	953,502	19.5%
104,442	633,658	529,216	83.5%	Other medical expenses	398,044	2,550,648	2,152,604	84.4%
32,336,234	42,673,506	10,337,272	24.2%	Total Medical Expenses	132,598,983	171,064,187	38,465,204	22.5%
1,628,060	2,684,929	(1,056,869)	(39.4%)	Gross Margin	9,079,602	11,516,105	(2,436,502)	(21.2%)
				Administrative Expenses				
729,821	939,382	209,561	22.3%	Salaries, wages & employee benefits	2,960,361	3,789,787	829,426	21.9%
49,800	86,521	36,721	42.4%	Professional fees	324,341	266,478	(57,863)	(21.7%)
102,515	181,140	78,626	43.4%	Purchased services	522,912	709,097	186,185	26.3%
48,881	135,914	87,033	64.0%	Printing and postage	213,359	534,199	320,840	60.1%
35,772	2,910	(32,862)	(1,129.3%)	Other operating expenses	135,606	508,711	373,105	73.3%
172,584	937,491	764,907	81.6%	Indirect cost allocation, Occupancy Expense	2,985,056	3,749,963	764,906	20.4%
1,139,371	2,283,358	1,143,987	50.1%	Total Administrative Expenses	7,141,635	9,558,234	2,416,599	25.3%
				Operating Tax				
(1,869)	0	(1,869)	0.0%	Tax Revenue	(2,916)	0	(2,916)	0.0%
(1,869)	0	1,869	0.0%	Sales tax expense	(2,916)	0	2,916	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
488,689	401,571	87,117	21.7%	Change in Net Assets	1,937,967	1,957,870	(19,903)	(1.0%)
95.2%	94.1%	-1.1%	-1.2%	Medical Loss Ratio	93.6%	93.7%	0.1%	0.1%
3.4%	5.0%	1.7%	33.4%	Admin Loss Ratio	5.0%	5.2%	0.2%	3.7%

ONECARE CONNECT INCOME STATEMENT – OCTOBER MONTH:

REVENUES of $34.0 million are unfavorable to budget by $11.4 million driven by:

- Price related unfavorable variance of: $1.8 million due to cohort experience
- Volume related unfavorable variance of: $9.6 million due to the lower enrollment

MEDICAL EXPENSES are favorable to budget $10.3 million due to:

- Corresponding to revenue

ADMINISTRATIVE EXPENSES are favorable to budget by $1.1 million

CHANGE IN NET ASSETS is $0.5 million, favorable to budget by $0.1 million

CalOptima - OneCare
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,220	1,215	5	0.4%	Member Months	4,747	4,934	(187)	(3.8%)
				Revenues				
912,888	1,390,124	(477,236)	(34.3%)	Capitation revenue	4,699,462	5,666,331	(966,869)	(17.1%)
912,888	1,390,124	(477,236)	(34.3%)	Total Operating Revenue	4,699,462	5,666,331	(966,869)	(17.1%)
				Medical Expenses				
321,063	377,003	55,940	14.8%	Provider capitation	1,484,383	1,539,105	54,722	3.6%
313,110	310,769	(2,341)	(0.8%)	Inpatient	1,191,464	1,263,724	72,260	5.7%
45,850	48,553	2,703	5.6%	Ancillary	179,828	195,746	15,918	8.1%
33,274	23,110	(10,164)	(44.0%)	Skilled nursing facilities	154,483	93,096	(61,387)	(65.9%)
435,603	464,261	28,658	6.2%	Prescription drugs	1,686,768	1,885,367	198,599	10.5%
(51,954)	13,960	65,914	472.2%	Medical management	17,578	57,460	39,882	69.4%
4,806	41,257	36,451	88.4%	Other medical expenses	17,186	127,934	110,748	86.6%
1,101,752	1,278,913	177,162	13.9%	Total Medical Expenses	4,731,690	5,162,432	430,742	8.3%
(188,863)	111,211	(300,074)	(269.8%)	Gross Margin	(32,229)	503,899	(536,128)	(106.4%)
				Administrative Expenses				
17,871	21,167	3,296	15.6%	Salaries, wages & employee benefits	110,928	85,569	(25,359)	(29.6%)
9,954	13,333	3,380	25.3%	Professional fees	57,181	53,333	(3,848)	(7.2%)
19,377	19,373	(5)	(0.0%)	Purchased services	84,754	77,598	(7,156)	(9.2%)
10,899	13,710	2,811	20.5%	Printing and postage	15,742	48,529	32,787	67.6%
120	89	(31)	(35.5%)	Other operating expenses	1,692	354	(1,337)	(377.4%)
12,495	29,494	16,999	57.6%	Indirect cost allocation, Occupancy Expense	100,975	117,974	16,999	14.4%
70,716	97,166	26,449	27.2%	Total Administrative Expenses	371,273	383,358	12,085	3.2%
(259,580)	14,045	(273,625)	(1,948.2%)	Change in Net Assets	(403,501)	120,541	(524,042)	(434.7%)
120.7%	92.0%	-28.7%	-31.2%	Medical Loss Ratio	100.7%	91.1%	-9.6%	-10.5%
7.7%	7.0%	-0.8%	-10.8%	Admin Loss Ratio	7.9%	6.8%	-1.1%	-16.8%

Back to Agenda

CalOptima - PACE
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
180	180	0	0.0%	Member Months	715	690	25	3.6%
				Revenues				
1,542,819	805,448	737,371	91.5%	Medi-Cal capitation revenue	3,930,265	3,086,609	843,656	27.3%
384,141	331,342	52,799	15.9%	MediCare capitation revenue	1,233,866	1,275,425	(41,559)	(3.3%)
1,926,960	1,136,791	790,170	69.5%	Total Operating Revenues	5,164,131	4,362,034	802,097	18.4%
				Medical Expenses				
345,849	394,442	48,593	12.3%	Clinical salaries & benefits	1,128,091	1,589,932	461,840	29.0%
0	0	0	0.0%	Pace Center Support salaries & benefits	0	0	0	0.0%
				Provider capitation				
340,757	234,335	(106,422)	(45.4%)	Claims payments to hospitals	1,008,969	890,935	(118,034)	(13.2%)
219,121	248,095	28,974	11.7%	Professional Claims	764,620	939,555	174,935	18.6%
81,293	133,907	52,614	39.3%	Prescription drugs	354,310	509,111	154,801	30.4%
13,948	24,000	10,052	41.9%	Long-term care facility payments	41,958	91,247	49,289	54.0%
57,444	74,500	17,056	22.9%	Patient Transportation	228,274	283,245	54,971	19.4%
48,342	49,349	1,007	2.0%	Depreciation & amortization	193,368	197,396	4,029	2.0%
37,655	37,214	(441)	(1.2%)	Occupancy expenses	150,620	148,856	(1,764)	(1.2%)
16,092	13,833	(2,259)	(16.3%)	Utilities & Facilities Expense	69,990	55,332	(14,658)	(26.5%)
75	273	198	72.5%	Purchased Services	739	1,038	299	28.8%
12,875	24,547	11,672	47.6%	Indirect Allocation	77,908	98,188	20,280	20.7%
22,302	22,785	483	2.1%	Other Expenses	49,541	91,140	41,599	45.6%
1,195,752	1,257,281	61,528	4.9%	Total Medical Expenses	4,068,388	4,895,976	827,589	16.9%
731,208	(120,490)	851,698	706.9%	Gross Margin	1,095,743	(533,943)	1,629,686	305.2%
				Administrative Expenses				
85,448	91,905	6,457	7.0%	Salaries, wages & employee benefits	353,759	371,103	17,344	4.7%
3,938	11,667	7,728	66.2%	Professional fees	12,753	21,667	8,914	41.1%
1,133	988	(145)	(14.6%)	Purchased services	10,414	4,096	(6,318)	(154.2%)
1,193	1,699	506	29.8%	Printing and postage	1,725	7,097	5,372	75.7%
2,014	2,056	42	2.0%	Depreciation & amortization	8,057	8,225	168	2.0%
5,418	11,426	6,008	52.6%	Other operating expenses	21,999	45,702	23,704	51.9%
2,105	1,023	(1,083)	(105.9%)	Indirect cost allocation, Occupancy Expense	9,521	4,091	(5,430)	(132.7%)
101,250	120,764	19,514	16.2%	Total Administrative Expenses	418,227	461,980	43,753	9.5%
629,958	(241,253)	871,212	361.1%	Change in Net Assets	677,517	(995,923)	1,673,439	168.0%
62.1%	110.6%	48.5%	43.9%	Medical Loss Ratio	78.8%	112.2%	33.5%	29.8%
5.3%	10.6%	5.4%	50.5%	Admin Loss Ratio	8.1%	10.6%	2.5%	23.5%

Back to Agenda

CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
24,056	21,285	2,772	13.0%	Rental income	96,226	85,140	11,086	13.0%
24,056	21,285	2,772	13.0%	Total Operating Revenue	96,226	85,140	11,086	13.0%
				Administrative Expenses				
1,525	2,085	560	26.8%	Professional fees	5,520	8,340	2,820	33.8%
27,683	22,405	(5,279)	(23.6%)	Purchase services	123,046	89,619	(33,427)	(37.3%)
199,033	210,141	11,108	5.3%	Depreciation & amortization	668,249	840,563	172,314	20.5%
16,000	14,300	(1,700)	(11.9%)	Insurance expense	64,002	57,201	(6,801)	(11.9%)
138,506	189,537	51,031	26.9%	Repair and maintenance	396,414	758,149	361,735	47.7%
15,449	0	(15,449)	0.0%	Other Operating Expense	224,498	0	(224,498)	0.0%
(376,331)	(352,100)	24,231	6.9%	Indirect allocation, Occupancy Expense	(1,400,363)	(1,408,399)	(8,037)	(0.6%)
21,866	86,368	64,502	74.7%	Total Administrative Expenses	81,367	345,473	264,106	76.4%
2,190	(65,083)	67,273	103.4%	Change in Net Assets	14,859	(260,333)	275,192	105.7%

Back to Agenda

OTHER STATEMENTS – OCTOBER MONTH:

ONECARE INCOME STATEMENT

REVENUES of $0.9 million are unfavorable to budget by $0.5 million due to direct subsidy restatement

CHANGE IN NET ASSETS is ($0.3) million, $0.3 million unfavorable to budget

PACE INCOME STATEMENT

- **Change in Net Assets** for the month is $630.0 thousand, which is operating favorable to budget by $871.2 thousand

505 CITY PARKWAY BUILDING INCOME STATEMENT

- **Change in Net Assets** for the month is $2.2 thousand which is favorable to budget $67.3 thousand

CalOptima
BALANCE SHEET
October 31, 2016

ASSETS			LIABILITIES & FUND BALANCES	
Current Assets			Current Liabilities	
	Operating Cash	$270,855,000	Accounts payable	$19,267,245
	Catastrophic Reserves	11,631,134	Medical claims liability	601,542,015
	Investments	1,530,023,287	Accrued payroll liabilities	11,069,277
	Capitation receivable	315,840,792	Deferred revenue	859,374,315
	Receivables - Other	16,260,007	Deferred lease obligations	267,070
	Prepaid Expenses	10,508,224	Capitation and withholds	496,295,584
	Total Current Assets	**2,155,118,444**	**Total Current Liabilities**	**1,987,815,506**
Capital Assets	Furniture and equipment	28,851,790		
	Leasehold improvements	13,672,881		
	505 City Parkway West	46,707,144	Other employment benefits liability	28,397,235
		89,231,814		
	Less: accumulated depreciation	(34,156,427)	Net Pension Liabilities	9,336,900
	Capital assets, net	**55,075,387**	Long Term Liabilities	100,000
			TOTAL LIABILITIES	**2,025,649,641**
Other Assets	Restricted deposit & Other	284,715		
			Deferred inflows of Resources - Excess Earnings	502,900
	Board-designated assets		Deferred inflows of Resources - changes in Assumptions	1,651,640
	Cash and cash equivalents	7,193,708		
	Long term investments	468,806,679	Tangible net equity (TNE)	92,537,605
	Total Board-designated Assets	476,000,387	Funds in excess of TNE	571,140,163
	Total Other Assets	**476,285,102**		
			Net Assets	**663,677,768**
	Deferred outflows of Resources - Pension Contributions	3,787,544		
	Deferred outflows of Resources - Difference in Experience	1,215,473		
TOTAL ASSETS & OUTFLOWS		**2,691,481,950**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,691,481,950**

Back to Agenda

CalOptima
Board Designated Reserve and TNE Analysis
as of October 31, 2016

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	135,453,317				
	Tier 1 - Logan Circle	125,485,817				
	Tier 1 - Wells Capital	125,393,598				
Board-designated Reserve		386,332,733	282,762,752	443,549,577	103,569,981	(57,216,844)
TNE Requirement	Tier 2 - Logan Circle	89,667,654	92,406,506	92,406,506	(2,738,852)	(2,738,852)
	Consolidated:	**476,000,387**	**375,169,258**	**535,956,083**	**100,831,129**	**(59,955,696)**
	Current reserve level	1.78	1.40	2.00		

Back to Agenda

CalOptima
Statement of Cash Flows
October 31, 2016

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	1,546,196	4,110,590
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	512,595	1,491,303
Changes in assets and liabilities:		
Prepaid expenses and other	926,197	(3,723,977)
Catastrophic reserves		
Capitation receivable	(52,120,700)	181,721,669
Medical claims liability	(4,828,792)	2,847,157
Deferred revenue	52,067,395	268,671,674
Payable to providers	46,914,896	94,469,282
Accounts payable	(20,208,007)	(13,982,008)
Other accrued liabilities	813,166	3,408,569
Net cash provided by/(used in) operating activities	25,622,945	539,014,259
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	(16,696,839)	(510,758,655)
Purchase of property and equipment	(458,325)	(1,571,126)
Change in Board designated reserves	62,304	(149,736)
Net cash provided by/(used in) investing activities	(17,092,859)	(512,479,518)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	8,530,086	26,534,741
CASH AND CASH EQUIVALENTS, beginning of period	$273,956,048	255,951,393
CASH AND CASH EQUIVALENTS, end of period	**$ 282,486,135**	**$ 282,486,135**

Back to Agenda

BALANCE SHEET:

ASSETS Increased $76.3 million from September

- **Cash and Cash Equivalents** increased by $8.5 million from September based upon timing of state checks received, month-end cut-off and cash funding requirements
- **Net Capitation Receivables** increased $53.8 million based upon payment receipt timing and receivables

LIABILITIES increased $74.8 million from September

- **Deferred Revenue** increased by $52.1 million from September due to:
    - DHS overpayments
- **Total Capitation Payable** increased $46.9 million based upon timing of pool estimates, recalculations and payouts
- **Accrued Expenses** decreased **$**20.9 million due to tax payments

NET ASSETS are $663.7 million

CalOptima Foundation
Statement of Revenues and Expenses
For the Four Months Ended October 31, 2016
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	2,264	(2,264)	(100.0%)	Income - Grant	27,164	9,058	18,107	199.9%
(10,962)	0	(10,962)	(100.0%)	In Kind Revenue - HITEC Grant	61,997	0	61,997	100.0%
(10,962)	2,264	(13,226)	(584.1%)	Total Operating Revenue	89,161	9,058	80,104	884.4%
				Operating Expenditures				
(8,577)	6,184	14,761	238.7%	Personnel	27,195	24,737	(2,458)	(9.9%)
(4,468)	2,985	7,453	249.7%	Taxes and Benefits	26,240	11,939	(14,301)	(119.8%)
0	0	0	0.0%	Travel	(3)	0	3	100.0%
0	0	0	0.0%	Supplies	7,009	10,000	2,991	29.9%
0	0	0	0.0%	Contractual	20,388	17,174	(3,214)	(18.7%)
2,083	232,065	229,982	99.1%	Other	8,332	928,261	919,929	99.1%
(10,962)	241,234	252,196	104.5%	Total Operating Expenditures	89,161	992,111	902,950	91.0%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
0	(238,970)	(238,970)	100.0%	Program Income	0	(983,053)	(983,053)	100.0%

Back to Agenda

CalOptima Foundation
Balance Sheet
October 31, 2016

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,894,727	Accounts payable-Current	0
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	(118)
Total Current Assets	**2,894,727**	Grants-Foundation	0
		Total Current Liabilities	**(118)**
		Total Liabilities	**(118)**
		Net Assets	**2,894,845**
TOTAL ASSETS	**2,894,727**	**TOTAL LIABILITIES & NET ASSETS**	**2,894,727**

Back to Agenda

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 $0 for October, 2016
    - HITEC Grant revenue totaled $27.2 thousand YTD, which leaves $0.0 remaining in HITEC Grant funding
    - CalOptima in-kind contribution totaled $62.0 thousand YTD
- Revenue budget variances attributed to:
    - Grant funding originally allocated July-September 2016 for original extension, later ONC extended it through September 2016
    - CalOptima in-kind revenue was not included in FY17 budget

Expenses

- $89.2 thousand for grant related activities incurred YTD FY17
- Expense categories include staff services, travel and miscellaneous supplies
    - $903 thousand favorable variance YTD
    - FY17 budget was based on remaining fund balance in Foundation total assets
    - Actual expenses were much lower than anticipated for CalOptima support activities

BALANCE SHEET:

Assets

- Cash of $2.9 million remains from the FY14 $3.0 million transfer from CalOptima for grants and programs in support of providers and community

Budget Allocation Changes
Reporting changes for October 2016

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	OneCare Connect	Office of Compliance - Professional Fees (Consultant for Annual CPE Audit & CMS Mock Audit)	Office of Compliance - Professional Fees - Consultant for DMHC Mock Audit	$69,000	Re-purpose $53,631 from Professional Fees (Consultant for Annual CPE Audit) and $15,369 from Professional Fees (Consultant for CMS Mock Audit) to pay for consultant for DMHC Mock Audit	2017
July	COREC	REC - Other	REC - Comp Supply/Minor Equip	$10,000	Re-allocate funds to cover costs for computer equipment upgrade which is approved ONC grant managers	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$63,810	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for FY17 Ceridian Software Maintenance	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$15,010	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for FY17 Talentova Learning Management System	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$23,900	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for Silk Road	2017
July	Medi-Cal	Claims Administration - Purchased Services - Integration of Claim Editing Software	Claims Administration - Purchased Services - LTC Rate Adjustments	$98,000	Re-purpose funds from within Purchased Services (Integration of Claim Editing Software) to pay for LTC Adjustments (TriZetto Robot Process)	2017
July	Medi-Cal	Human Resources - Advertising, Travel, Comp Supply/Minor Equip, Subscriptions, Courier/Delivery	Human Resources - Professional Fees (Salary & Compensation Research), Public Activities, Office Supplies, Food Service Supplies, Professional Dues, Training & Seminars, Cert./Cont. Education	$84,491	Re-allocate HR FY17 Budget based on HR dept's past spending trends to better meet department's need	2017
July	Medi-Cal	IS-Infrastructure - Telephone - General Telecommunication and Network Connectivity	IS-Infrastructure - Purchased Services - Disaster Recovery Services	$35,575	Re-allocate funds from Telephone (General Telecommunication and Network Connectivity) to Purchased Services to pay for Disaster Recovery Services	2017
August	Medi-Cal	Other Pay	Quality Analytics - Purchased Services	$67,000	Re-allocate funds to Quality Analytics Purchased Services for additional funds that is needed for CG-CAHPS survey	2017
August	Medi-Cal	Other Pay	Community Relations - Professional Fees & Printing	$43,640	Re-allocate funds to Community Relations Professional Fees and Printing budgets for contracts with Tony Lam and Communications Lab and printing costs of Community Option Fair	2017
August	Medi-Cal	IS-Application Management - Purchased Services - Healthcare Productivity Automation	IS-Application Management - Purchased Services - Direct Hire Fees	$10,957	Re-purpose funds from Purchased Services (Healthcare Productivity Automation) to pay for Direct Hire fees	2017
August	Medi-Cal	Other Pay	IS-Application Development - Comp Supplies/Minor Equipments	$20,400	Re-allocate funds to cover costs of DocuSign, Box, and Primal Script 2016	2017
August	Medi-Cal	Claims Administration - Purchased Services	Claims Administration - Office Supplies, Training & Seminars, Printing	$15,000	Re-allocate funds from Purchased Services (Integration of Claim Editing Software & Inventory Management Forecasting) to Office Supplies, Training & Seminars, and Printing to better meet department's needs	2017
September	Medi-Cal	Health Education & Disease Management - Professional Fees	Health Education & Disease Management - Other Operating Expenses	$30,000	Re-allocate funds from Professional Fees (Childhood Obesity Program Design & Evaluation) to Member & Provider Incentives to support incentives for the Group Needs Assessment (GNA) and other Health Education / Disease Management activities.	2017
October	Capital	Facilities - Relocate Trash Enclosure	Facilities - 505 Sound Recording System	$50,555	Re-allocate from Relocate Trash Enclosure project for additional funds that are needed for the 505 Sound Recording System project.	2017
October	Medi-Cal	IS-Infrastructure - Professional Fees - Enterprise Identity Access Management	IS-Infrastructure - Software Maintenance - Security Solution Annual Maintenance	$21,041	Re-allocate from Professional Services for an Enterprise Identity Access Management to HW/SW Maintenance for Information Security Data Loss Prevention Solution Annual Maintenance.	2017
October	Medi-Cal	Facilities - Computer Supply/Minor Equipment - Office Furniture & Equipment	Facilities - Computer Supply/Minor Equipment - Other Articles of Minor Equipment	$27,000	Repurpose funds in Comp supply/minor equipment for re-upholstering chairs in the member service lobby and other minor equipment expenses to better meet the Department's need.	2017

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Back to Agenda

Board of Directors' Meeting
December 1, 2016

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and external audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare Connect

- OneCare Connect CMS Mock Audit: In preparation for a full-scope CMS program audit of its OneCare Connect program, CalOptima has engaged a consultant to conduct a mock audit on its OneCare Connect program using the 2016 CMS audit protocols. Mock audit activities began in June 2016 and will continue through January 2017. Remediation of mock audit findings, including improvements made to policies and procedures, is currently ongoing.

- OneCare Connect DMHC Audit: The Department of Managed Health Care (DMHC) will audit the provision of Medicaid-based services for OneCare Connect from February 6-10, 2017. The DMHC will conduct this audit on behalf of the Department of Health Care Services (DHCS) as part of an inter-agency agreement. To prepare, CalOptima engaged a consultant and conducted a mock audit on its OneCare Connect program using the DMHC Cal MediConnect Technical Assistance Guide (TAG) tools.

2. PACE

- 2016 Annual PACE Audit: On September 29, 2016, CMS issued the final audit report to CalOptima PACE, which identified three (3) findings in the following areas --- Infection Control, Internal Quality Assessment and Performance Improvement Program Activities, and Transportation Services. Corrective action plans (CAPs) were submitted to CMS and DHCS on October 27, 2016. CalOptima is pending acceptance of the CAPs and closure of the audit.

- 2016 PACE Level of Care (LOC) Audit: On October 26, 2016, CalOptima PACE completed its level of care (LOC) audit and received a written pass from the DHCS auditor. The purpose of the audit is to ensure the information submitted on the initial LOC documents is consistent with the assessments documented by the Interdisciplinary Care Team.

Back to Agenda

3. Medi-Cal

- 2015 Medi-Cal Audit: The DHCS conducted an onsite audit of CalOptima's Medi-Cal program from February 8 – 19, 2016. On July 13, 2016, DHCS issued the final audit report, which identified findings in the following three (3) areas --- case management and care coordination, member's rights, and administrative and organizational capacity. CalOptima submitted its corrective action plans (CAPs) to the DHCS by the August 15, 2016 deadline. DHCS accepted CalOptima's CAPs and closed the audit on November 8, 2016.

- 2017 Medi-Cal Audit: The DHCS has engaged CalOptima in an audit of its Medi-Cal program. The DHCS Medi-Cal audit will consist 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. DHCS will be onsite at CalOptima from February 6-17, 2017.

- DMHC 1115 Waiver Seniors and Persons with Disabilities (SPD) Audit: The DMHC will conduct an audit of Medi-Cal SPDs from February 6-10, 2017. DMHC will conduct this audit on behalf of the DHCS as part of an inter-agency agreement. CalOptima was last subject to this tri-annual audit in 2014.

4. Other

- 2016 DMHC Routine Examination: The DMHC began an onsite routine examination of CalOptima's financial and administrative affairs on August 15, 2016. The onsite portion of the audit concluded the week ending September 16, 2016. The audit primarily focused on CalOptima's Healthy Families Program in place during the review period, and on CalOptima's organization-wide finances and administration. The DMHC will provide CalOptima with a draft/preliminary audit report within sixty (60) days of the last day of the audit, and will give CalOptima a chance to review and comment on the report prior to its finalization.

B. Regulatory Compliance Notices

1. OneCare

- On October 27, 2016, CMS issued a Notice of Non-Compliance to CalOptima for failure to download enrollment applications via the Medicare Online Enrollment Center (OEC) console on a daily basis for contract year 2017. The Office of Compliance issued a request for a corrective action plan (CAP) to the impacted business area, and will monitor the CAP to ensure full remediation.

2. OneCare/OneCare Connect

- On October 28, 2016, CMS issued a Notice of Non-Compliance to CalOptima for failure to safeguard data and timely notify CMS of an information breach. The Office of Compliance is in the process of issuing a request for a corrective action plan (CAP) to the impacted business area, and will monitor the CAP to ensure full remediation.

C. Updates on Internal and Health Network Audits

1. Internal Audits: Medi-Cal

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for 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
June 2016	10%	NA	NA	0%	60%	90%	77%	14%
July 2016	100%	67%	89%	0%	70%	90%	93%	25%
August 2016	0%	N/A	N/A	0%	80%	87%	96%	0%

- The lower scores for timeliness of urgent PA requests were due to failure to meet decision timeframes (72 hours).

- The lower scores for timeliness of routine PA requests were due to the following reasons:
  - Failure to meet provider initial notification timeframe (24 hours)

- The lower scores for timeliness of denials were due to the following reasons:
  - Failure to meet decision timeframe (5 business days)
  - Failure to meet provider initial notification timeframe (24 hours)
  - Failure to meet provider written notification timeframe (2 business days)

- The lower scores for timeliness of extended PA requests were due to the following reasons:
  - Failure to meet provider initial notification timeframe (24 hours)
  - Failure to meet member written notification timeframe (2 business days)
  - Failure to meet provider delay notification timeframe (2 business days)
  - Failure to meet provider written notification timeframe (2 business days)

- The lower scores for clinical decision making (CDM) of denials were due to failure to cite the criteria utilized to make the decision.

- The lower letter scores for denials were due to the following reasons:

  - Failure to use lay language for services description
  - Failure to describe reason the request did not meet criteria in lay language
  - Failure to provide alternative direction

- Medi-Cal Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2016	70%	97%	87%	100%
July 2016	100%	100%	97%	70%
August 2016	100%	100%	97%	70%

  - The compliance rate for paid claims timeliness and accuracy has remained at 100% from July 2016 to August 2016.

  - The compliance rate for denied claims timeliness has remained at 97% from July 2016 to August 2016.

  - The compliance rate for denied claims accuracy has remained at 70% from July 2016 to August 2016 due to incorrect coding of denial claim.

- Medi-Cal Claims: Provider Dispute Resolution (PDR)

Month	Letter Accuracy	Determination Timeliness	Acknowledgement Timeliness
June 2016	100%	83%	100%
July 2016	100%	50%	100%
August 2016	100%	50%	100%

  - The compliance rate for letter accuracy has remained at 100% for the past three (3) months.

  - The compliance rate for determination timeliness has remained at 50% from July 2016 to August 2016 due to PDR was incorrectly processed.

  - The compliance rate for acknowledgement timeliness has remained at 100% from June 2016 to August 2016.

- Medi-Cal Customer Service: Review for appropriate classification, routing and privacy handling for Medi-Cal Call Center and Member Liaison Call Center

Month	Medi-Cal Call Center	Member Liaison Call Center
June 2016	98%	100%
July 2016	99%	98%
August 2016	100%	97%

- The compliance rate for the Medi-Cal Call Center has remained at or above 98% from June 2016 to August 2016.

- The compliance rate for the Member Liaison Call Center has remained at or above 97% from June 2016 to August 2016.

2. Internal Audits: OneCare

- OneCare Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
April 2016	0%
May 2016	0%
June 2016	0%
July 2016	0%
August 2016	0%

- No claims were rejected in error due to formulary restrictions from April to August 2016.

- OneCare Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
June 2016	100%
July 2016	100%
August 2016	100%

- The compliance rate for coverage determination timeliness remains consistent at 100% from June 2016 to August 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
June 2016	1	0	100%
July 2016	0	0	NA
August 2016	2	0	100%

- The compliance rate for protected classes of drugs remains consistent at 100% for June 2016 and August 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
June 2016	19	0	100%
July 2016	8	0	100%
August 2016	17	0	100%

- The compliance rate for unprotected classes of drugs remains consistent at 100% from June 2016 to August 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
June 2016	50%
July 2016	100%
August 2016	NA

- The DMR compliance rate has increased from 50% to 100% from June 2016 to July 2016.

- OneCare Utilization Management

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
June 2016	Nothing to Report	Nothing to Report	Nothing to Report	100%	50%	Nothing to Report	Nothing to Report	Nothing to Report
July 2016	Nothing to Report	Nothing to Report	Nothing to Report	75%	33%	Nothing to Report	Nothing to Report	Nothing to Report
August 2016	Nothing to Report	Nothing to Report	Nothing to Report	100%	33%	50%	50%	88%

- The compliance rate for SOD timeliness has increased from 75% to 100% from July 2016 to August 2016.

- The lower letter scores for SODs were due to the following reasons:
  - Failure to use approved CMS letter template
  - Failure to use lay language

- The lower timeliness score for denials was due to failure to meet provider written notification timeframe (2 business days).

- The lower score for clinical decision making for denials was due to the following reasons:
  - Failure to cite specific criteria used for decision making
  - Failure to obtain adequate clinical information

- The lower letter score for denials was due to failure to use approved CMS letter template.

- OneCare Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2016	100%	100%	100%	100%
July 2016	100%	100%	100%	100%
August 2016	100%	100%	100%	100%

- The compliance rate for paid and denied claims timeliness has remained consistent at 100% from June 2016 to August 2016.

- The compliance rate for paid and denied claims accuracy has remained consistent at 100% from June 2016 to August 2016.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check Lag
June 2016	60%	100%	90%	NA
July 2016	100%	100%	100%	NA
August 2016	100%	100%	100%	NA

  - The compliance rate for determination accuracy has remained consistent at 100% from June 2016 to August 2016.
  - The compliance rate for letter accuracy has remained at 100% from June 2016 to August 2016.
  - The compliance rate for acknowledgement timeliness has remained consistent at 100% from July 2016 to August 2016.

- OneCare Customer Service: Review for appropriate classification, routing and privacy handling for OneCare Call Center.

Month	OneCare Call Center
June 2016	99%
July 2016	99%
August 2016	99%

  - The compliance rate for the OneCare Call Center has been at 99% from June 2016 to August 2016.

3. Internal Audits: OneCare Connect

- OneCare Connect Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
April 2016	0%
May 2016	0%
June 2016	0%
July 2016	0%
August 2016	0%

  - No claims were rejected in error due to formulary restrictions from April to August 2016.

- OneCare Connect Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
June 2016	100%
July 2016	99.49%
August 2016	100%

  - Coverage determination timeliness remained consistent at or above 99% from June 2016 to August 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
June 2016	22	0	100%
July 2016	28	0	100%
August 2016	36	0	100%

  - The compliance rate for coverage determinations for protected drug cases remains consistent at 100% from June 2016 to August 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
June 2016	98	1	99%
July 2016	122	2	98%
August 2016	84	1	98%

  - The compliance rate for coverage determinations for unprotected classes of drugs has been at or above 98% from June 2016 to August 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
June 2016	5	0	100%
July 2016	3	0	100%
August 2016	6	0	100%

  - The compliance rate for DMRs is consistent at 100% from June 2016 to August 2016.

- OneCare Connect Utilization Management: Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Review for Urgents	Timeliness For Routine	Letter Review for Routine	Timeliness for Denials	Clinical Decision Making (CDM) for Denials	Letter Review for Denials	Timeliness for Deferrals	Clinical Decision Making (CDM) for Deferrals	Letter Review for Deferrals
June 2016	0%	NA	70%	40%	70%	50%	92%	100%	Nothing to Report	Nothing to Report	Nothing to Report
July 2016	100%	67%	89%	20%	60%	100%	100%	88%	Nothing to Report	Nothing to Report	Nothing to Report
August 2016	Nothing to Report	Nothing to Report	Nothing to Report	0%	100%	60%	60%	85%	Nothing to Report	Nothing to Report	Nothing to Report

  - The lower scores for timeliness of routine PA requests were due to the following reasons:
    - Failure to meet provider initial notification timeframe (24 hours)
    - Failure to provide written provider notification (2 business days)
    - Failure to meet the decision timeframe (5 business days)

  - The compliance rate for letter review of routine PA requests has increased from 60% to 100% from July 2016 to August 2016.

  - The lower score for clinical decision making for denied PA requests were due to the failure to meet provider initial notification timeframe (24 hours).

  - The lower scores for letter review of denied PA requests were due to the following reasons
    - Failure to use approved letter template
    - Failure to provide alternative direction
    - Failure to describe why request did not meet criteria in lay language
    - Failure to use lay language for services description

- OneCare Connect Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2016	67%	93%	100%	100%
July 2016	7%	73%	100%	85%
August 2016	70%	73%	100%	85%

  - The lower scores for paid claims timeliness for the months of June through August 2016 were due to a failure to meet non-contracted paid clean claim timeframe (30 calendar days).

  - The lower scores for paid claims accuracy during the months of July and August 2016 were due to the following reasons:
    - Incorrect development of claim
    - Incorrect interest amount applied

  - The compliance rate for denied claims timeliness has remained at 100% from June 2016 through August 2016.

  - The lower scores for denied claims accuracy during the months of July and August 2016 were due to the following reasons:
    - Incorrect development of claim
    - Incorrectly processed as a denied claim

- OneCare Connect Claims: Provider Dispute Resolution (PDR) Claims

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check Lag
June 2016	94%	100%	100%	50%
July 2016	100%	100%	100%	100%
August 2016	100%	100%	100%	NA

  - The compliance rate for determination accuracy has remained at 100% from July 2016 to August 2016.

  - The compliance rate for both letter accuracy and acknowledgement timeliness has remained at 100% from June 2016 to August 2016.

- OneCare Connect Customer Service: Review for appropriate classification, routing and privacy handling for OneCare Connect Call Center.

Month	OneCare Call Center
June 2016	100%
July 2016	100%
August 2016	99%

  - The compliance rate for the OneCare Connect Call Center has been at or above at 99% from June 2016 to August 2016.

4. Internal Audits: PACE

- PACE Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2016	100%	100%	100%	92%
July 2016	77%	100%	100%	100%
August 2016	77%	100%	100%	100%

  - The compliance rate for paid claims timeliness has decreased from 100% to 77% due to the following reasons:
    - Incorrect development of claim
    - Claim not paid within timeframe (30 calendar days)

  - The compliance rate for paid claims accuracy and denied claims timeliness has remained consistent at 100% from June 2016 to August 2016.

  - The compliance rate for denied claims accuracy has remained consistent at 100% from July 2016 to August 2016.

- PACE Claims: Provider Dispute Resolution (PDR)

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check LAG
June 2016	100%	100%	100%	NA
July 2016	100%	100%	100%	NA
August 2016	100%	100%	100%	NA

- The compliance rate for determination accuracy, letter accuracy, and acknowledgement timeliness has remained consistent at 100% from June 2016 to August 2016.

5. Health Network 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	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
June 2016	86%	83%	100%	89%	80%	91%	94%	92%	95%	99%	50%	87%	78%
July 2016	85%	100%	98%	93%	70%	91%	94%	94%	98%	97%	50%	67%	45%
August 2016	87%	79%	86%	87%	72%	92%	89%	71%	94%	98%	100%	100%	93%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days)
  - Failure to meet timeframe for member notification (Routine – 2 business days)
  - Failure to meet timeframe for provider initial notification (24 hours)
  - Failure to provide proof of successful initial written notification to requesting provider (24 hours)

- 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 of adequate clinical information obtained to make the decision to deny
  - No indication that the medical reviewer was involved in the denial determination

- The lower letter scores were due to the following reasons:
  - Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document
  - Failure to provide letter with description of services in lay language
  - Failure to provide letter in member's primary language
  - Failure to include name and contact information for health care professional responsible for decision to deny
  - Failure to notify member of delayed decision and anticipated decision date
  - Failure to notify provider of delayed decision and anticipated decision date
  - Failure to provide information on how to file a grievance

- Failure to outline reason for not meeting the criteria in lay language
- Failure to provide referral back to Primary Care Physician (PCP) on denial letter
- Failure to provide peer-to-peer discussion of the decision with medical reviewer

- Medi-Cal Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
June 2016	100%	89%
July 2016	97%	96%
August 2016	98%	97%

➢ The compliance rate for misclassified paid claims and denied claims increased from July 2016 to August 2016.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2016	93%	81%	86%	91%
July 2016	93%	92%	92%	87%
August 2016	97%	86%	98%	92%

➢ The compliance rate for paid claims timeliness, denied claims timeliness and denied claims accuracy increased from July 2016 to August 2016.

➢ The compliance rate for paid claims accuracy decreased to 86% from July 2016 to August 2016 due to non-contracted claims being paid untimely when they were received after the 180 day timeframe.

- Medi-Cal Claims: Misclassified Hospital Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
June 2016	100%	57%
July 2016	100%	77%
August 2016	100%	100%

- The compliance rates for misclassified paid and denied claims were at 100% for August 2016.

- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2016	100%	100%	93%	100%
July 2016	100%	97%	100%	100%
August 2016	100%	100%	100%	100%

- The compliance rate for paid claims timeliness, paid claims accuracy, denied claims timeliness and denied claims accuracy were at 100% for August 2016.

6. Health Network Audits: OneCare

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
June 2016	100%	Nothing to Report	98%	98%	94%	100%	89%	97%
July 2016	83%	Nothing to Report	95%	97%	93%	100%	100%	100%
August 2016	69%	Nothing to Report	88%	80%	87%	100%	83%	89%

- OneCare Utilization Management (UM): Prior Authorization (PA) Requests

  - The lower letter scores were due to the following reasons:
    - Failure to use approved CMS letter template
    - Failure to provide letter with description of services in lay language
    - Failure to meet timeframe for decision (Standard – 14 calendar days)
    - Failure to offer to discuss decision with a reviewer
    - Failure to provide CalOptima logo on letter template

  - The lower scores for timeliness were due to the following reasons:
    - Failure to meet timeframe for member oral notification (Expedited – 72 hours)

- OneCare Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
June 2016	99%	97%
July 2016	98%	100%
August 2016	99%	100%

  - The compliance rate for misclassified paid claims increased to 99% from July 2016 to August 2016.
  - The compliance rate for misclassified denied claims remained at 100% from July to August 2016.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2016	91%	92%	100%	95%
July 2016	100%	100%	100%	95%
August 2016	100%	46%	100%	92%

  - The compliance rate for paid claims accuracy decreased to 46% for August 2016 due to inappropriate application of 2% sequestration rate.
  - The compliance rate for denied claims accuracy decreased to 92% for August 2016 due to inappropriate application of 2% sequestration rate.
  - The compliance rate for paid claims timeliness and denied claims timeliness remained at 100% from July to August 2016.

7. Health Network Audits: OneCare Connect

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
June 2016	76%	99%	74%	71%	75%	58%	98%	84%	50%	90%	77%	Nothing to Report	Nothing to Report	Nothing to Report
July 2016	75%	100%	72%	79%	72%	51%	81%	80%	60%	89%	75%	Nothing to Report	Nothing to Report	Nothing to Report
August 2016	59%	50%	65%	76%	72%	59%	87%	73%	93%	100%	94%	Nothing to Report	Nothing to Report	Nothing to Report

- OneCare Connect Utilization Management (UM): Prior Authorization (PA) Requests

  - The lower scores for timeliness were due to the following reasons:
    - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days)
    - Failure to meet timeframe for member notification (2 business days)
    - Failure to meet timeframe for provider initial notification (24 hours)
    - Failure to provide proof of successful initial written notification to requesting provider (24 hours)

  - The lower scores for clinical decision making were due to the following reasons:
    - Failure to cite the criteria utilized to make the decision
    - No indication of adequate clinical information obtained to make the decision to deny

  - The lower letter scores were due to the following reasons:
    - Failure to provide letter in member's primary language
    - Failure to outline reason for not meeting the criteria in lay language in denial letter
    - Failure to provide letter with description of services in lay language
    - 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
June 2016	99%	100%
July 2016	99%	98%
August 2016	99%	98%

- The compliance rate for misclassified paid claims remained stable at 99% from June to August 2016.

- The compliance rate for misclassified denied claims remained stable at 98% from July to August 2016.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
June 2016	94%	96%	100%	94%
July 2016	96%	96%	91%	89%
August 2016	92%	40%	100%	84%

- The compliance rate for paid claims timeliness decreased to 92% from July to August 2016 due to incorrect interest rate being paid.

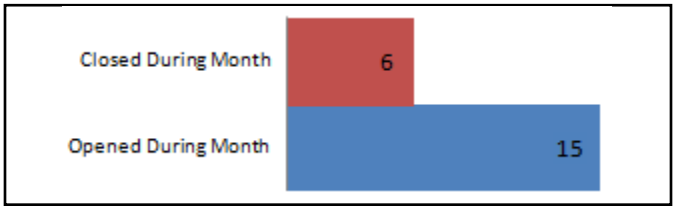
- The compliance rate for paid claims accuracy decreased to 40% from July to August 2016 due to inappropriate application of 2% sequestration rate.

- The compliance rate for denied claims timeliness increased to 100% from July to August 2016.

- The compliance rate for denied claims accuracy decreased to 84% from July to August 2016 due to incorrect interest rate being paid.

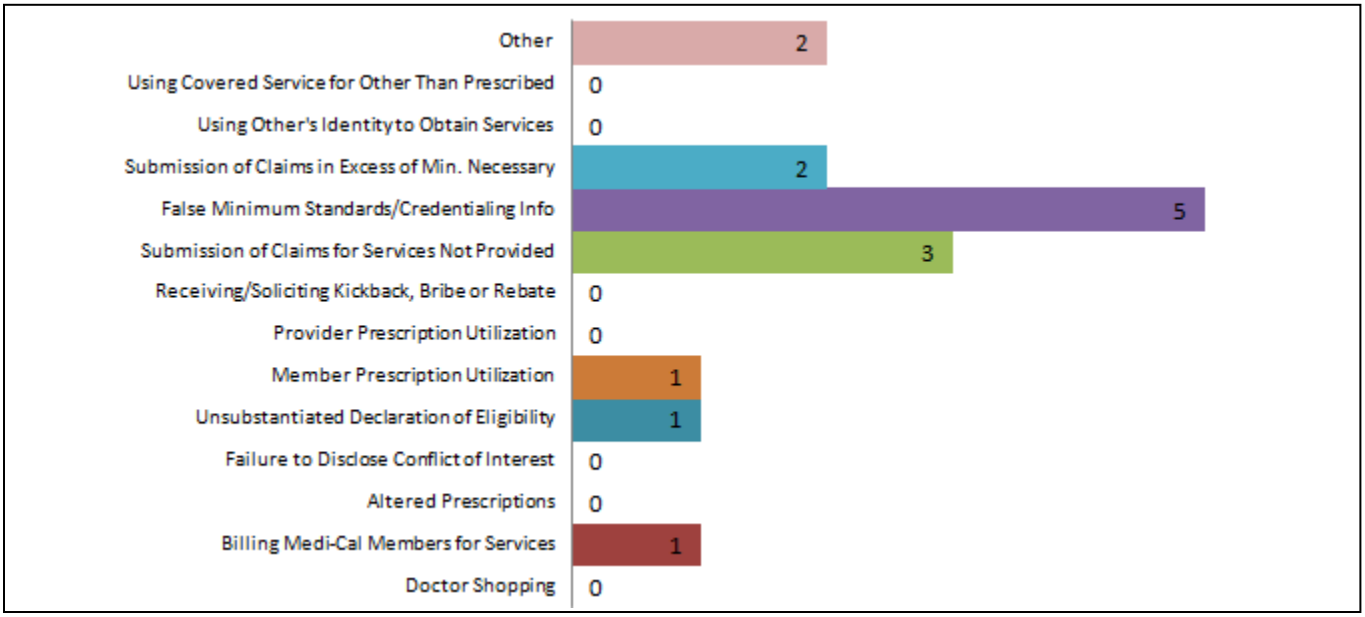
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations (October 2016)

Case Status
Case status at the end of October 2016

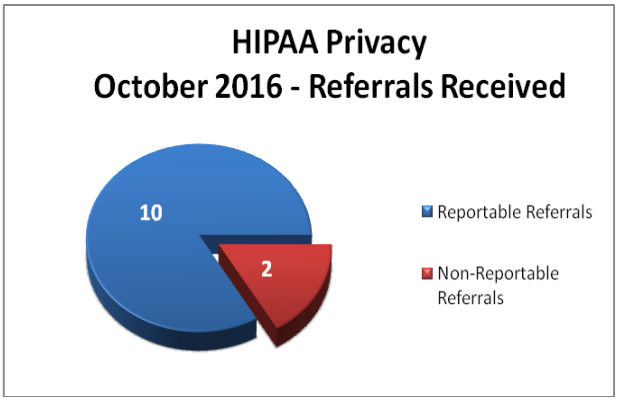


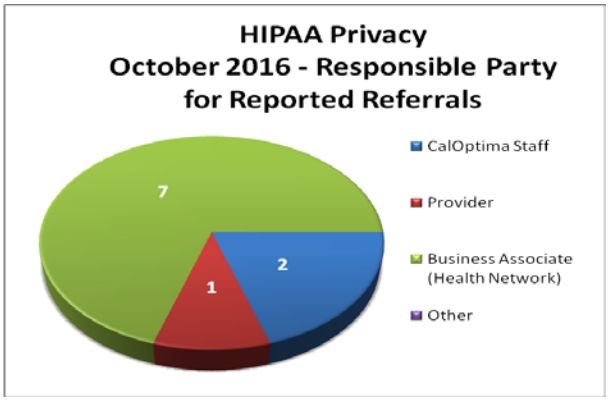
Note: Cases that are referred to DHCS or the MEDIC are not "closed" until CalOptima receives notification of case closure from the applicable government agency.

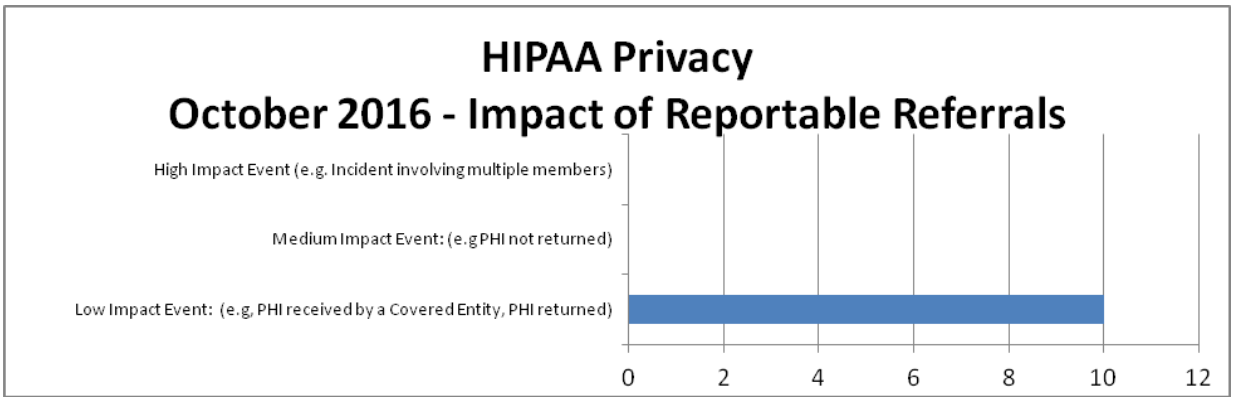
Types of FWA Cases: (Received in October 2016)



E. Privacy Update (October 2016)







PRIVACY STATISTICS

• Total Number of Referrals Reported to DHCS (State)	10
• Total Number of Referrals Reported to Office of Civil Rights (OCR)	0
Total Number of Referrals Reported	**10**

2017-18 Legislative Priorities

Board of Directors Meeting

December 1, 2016

Phil Tsunoda

Executive Director, Public Policy and Public Affairs

Back to Agenda

2017-18 Orange County Legislative Delegation

Federal

- U.S. Senate
  - **Kamala Harris (D) *Replacing Barbara Boxer***
  - Dianne Feinstein (D)
- U.S. House of Representatives
  - CD 38 – Linda Sanchez (D)
  - CD 39 – Ed Royce (R)
  - CD 45 – Mimi Walters (R)
  - **CD 46 – Lou Correa (D) *Replacing Loretta Sanchez***
  - CD 47 – Alan Lowenthal (D)
  - CD 48 – Dana Rohrabacher (R)
  - CD 49 – Darrell Issa (R)/Doug Applegate (D)

Back to Agenda

2017-18 Orange County Legislative Delegation

State

- State Senate
  - **SD 29 – Ling Ling Chang (R)/Josh Newman (D) *Replacing Bob Huff****
  - SD 32 – Tony Mendoza (D)
  - SD 34 – Janet Nguyen (R)
  - SD 36 – Pat Bates (R)
  - SD 37 – John Moorlach (R)

**As of this printing, the election results for this contest have yet to be finalized*

Back to Agenda

2017-18 Orange County Legislative Delegation

State

- State Assembly
  - **AD 55 – Phillip Chen (R) *Replacing Ling Ling Chang***
  - **AD 65 – Sharon Quirk-Silva (D) *Replacing Young Kim***
  - **AD 68 – Steven Choi (R) *Replacing Don Wagner***
  - AD 69 – Tom Daly (D)
  - AD 72 – Travis Allen (R)
  - AD 73 – William Brough (R)
  - AD 74 – Matthew Harper (R)

Back to Agenda

2017-18 Orange County Legislative Delegation

County

- Board of Supervisors
  - First District – **Andrew Do/Michele Martinez***
  - Second District – Michelle Steel
  - Third District – Todd Spitzer
  - Fourth District – Shawn Nelson
  - Fifth District – Lisa Bartlett

**As of this printing, the election results for this contest have yet to be finalized*

Back to Agenda

2017-18 Legislative Priorities

- Purpose
  - Highlight federal and state legislative issues relevant to CalOptima
  - Provide framework for CalOptima's legislative advocacy efforts
- Goals
  - Preserve and protect CalOptima's interests and the County Organized Health System (COHS) model
  - Engage in legislative and regulatory policy issues in order to represent and advocate for CalOptima's priorities
  - Maintain an active and influential presence in Sacramento and Washington, D.C.

Back to Agenda

2017-18 Federal Health Care Issues

Back to Agenda

2017 Federal Health Care Issues

- The Affordable Care Act (ACA)
  - Modification of Medicaid eligibility
  - Reduced federal funding for Medicaid expansion
- Entitlement Program Reform
  - Medicaid state-based block grant system
  - Medicare voucher program
- FY 17-18 Federal Budget
  - Determination of Medicare/Medicaid funding levels
  - 2% Medicare provider payment reduction (sequestration)

Back to Agenda

2017 Federal Health Care Issues

- Program of All-Inclusive Care for the Elderly (PACE)
  - Expanded role for community based physicians
  - Improved rate setting methodology
  - Expanded role for non-physician providers
- Opioid Abuse
  - Explore potential grants, health education initiatives and local prevention opportunities
  - Legislative and regulatory policy aimed at control and opioid abuse prevention
- Re-authorization of Children's Health Insurance Program (CHIP)
  - Currently funded through FY-17
  - Re-authorize CHIP to ensure member coverage is not disrupted

Back to Agenda

2017 Federal Health Care Issues

- Medicare/Medicaid Plans (MMPs)
  - Continuation of federal demonstration project
- Dual Eligible Special Needs Plans (D-SNPs)
  - Permanent re-authorization
  - Conversion of D-SNPs to Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNPs)
- Medicare Payment Reform
  - Medicare moving towards quality and outcome-based provider reimbursements
- Medicaid “Churn” Members
  - Members who frequently transition to and from Medicaid
  - Federal Bridge Plan

Back to Agenda

2017-18 State Health Care Issues

Back to Agenda

2017 State Health Care Issues

- Medi-Cal Reimbursement Rates
  - Improvement in reimbursement rates
  - Rate-setting methodology reform efforts
- Hospital Quality Assurance Fee (QAF)
  - Implementation of QAF with passage of Prop 52
- Program of All-Inclusive Care for the Elderly (PACE)
  - Geographic rate disparity
  - Actuarial soundness
  - PACE expansion through alternative care setting (ACS) model
- Behavioral and Mental Health
  - Integration of services for high-risk members

Back to Agenda

2017 State Health Care Issues

- Transportation Benefits
  - Accurately calculated reimbursement rates for plans
- Knox-Keene Licensure
  - COHS health plans requirement to obtain a Knox-Keene license
- Dental Managed Care
  - Carve-in of dental benefit into managed care
- Coordinated Care Initiative (CCI)
  - Medi-Medi developmentally disabled members (regional centers) – CCI eligibility
  - Passive enrollment for individuals who age into Medicare

Back to Agenda

Timeline

- California State Legislature
  - **December 5, 2016:** State Legislature's 2017-18 regular session convenes
- Congress
  - **November 14, 2016:** 114th Congress "lame duck" session convenes
  - **December 16, 2016:** 114th Congress adjourns
  - **January 3, 2017:** 115th Congress slated to convene
- Administration
  - **January 20, 2017:** Inauguration of President-Elect Trump and Vice President-Elect Pence

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting
December 1, 2016

James McConnell / Edelstein Gilbert Robson & Smith

Back to Agenda

JAMES F. MCCONNELL
ATTORNEY-AT-LAW
1130 CONNECTICUT AVENUE, N.W.
SUITE 300
WASHINGTON, D.C. 20036
Mobile: 917-434-3603
E-mail: jmcconnell@tfgnet.com

CalOptima
Washington Report
November 18, 2016

Donald J. Trump was elected President of the United States on November 8, 2016. The House of Representatives and the Senate remained under Republican majority control. Therefore, the Affordable Care Act (ACA) will be repealed and replaced in the 115th Congress.

The timing of the repeal and the form of replacement have yet to be determined. In the wake of his election, the President-elect said he intended no break in coverage between the ACA and its replacement. He endorsed such ACA provisions as portability, coverage for pre-existing conditions, and the right of persons to remain covered by their parents' health insurance to age 26.

There have been many operational glitches in the ACA since its enactment in 2010. The ACA is the only major law enacted in the modern era that has never been amended after enactment to make legislative fixes and remedy anomalies not noticed or understood until after the law went into operation.

Perhaps the most problematic feature of the ACA has been the individual mandate which was provides the financial underpinnings for subsidies to those ineligible for Medicaid but for whom private health insurance is unaffordable. A restructuring of the individual health insurance market, including the exchanges in some fashion, to allow for more product flexibility so insurance products can be tailored to younger and healthier populations is one oft-stated Republican goal.

Even if the new Administration and Republican Congress does not keep insurance subsidies, they may opt for tax credits to help people purchase coverage. Meanwhile, there will likely have to be some type of required continuous coverage to replace the individual mandate.

President-elect Trump said, in the week after the election, that it was his intention that no one lose health insurance coverage during the transition process from Obamacare to whatever replaces it. That would suggest that the new Administration will not take immediate administrative action after assuming office to dismantle the ACA without a legislative successor in place.

Back to Agenda

While the Republican majority in Congress has talked about repeal and replacement since taking control of Congress after the 2010 elections, they have not proposed an agreed upon piece of legislation to accomplish that. Therefore, it seems likely that the ACA will remain operational until a successor plan is developed, introduced, debated, and enacted. That could easily take all of 2017 or longer to accomplish.

(If replacement legislation is proposed as part of the annual budget reconciliation process later in 2017, it would not be subject to filibuster in the Senate. Therefore, a replacement bill could be adopted by majority vote in both the House and Senate, thus eliminating the need to secure 60 votes in the Senate to shut off a filibuster.)

Associated with a replacement of the ACA is the future of funding for Medicaid (Medi-Cal in California.) For years, congressional Republicans have advocated Medicaid block grant payments to the states as a way of reining in cost increases in the entitlement program to the Federal Government. This could form a major part of replacement legislation.

If state block grants start at the current level of Medicaid spending in each state and are adjusted annually for inflation and population changes, California—and Orange County—will be permanently disadvantaged. California spends approximately half the amount of what New York spends each year on each Medicaid enrollee. Therefore, under the block grant proposal New York would begin receiving twice as much as California for each Medicaid enrollee under the new system and California will never catch up.

CalOptima has made this point for years to the Orange County congressional delegation and they are cognizant of it and recognize the implications for California and Orange County. It will be incumbent on CalOptima to continue to make these facts and the information available to the delegation and California's Senators in the new year as the debate begins on ACA replacement.

The 115th Congress convenes on January 3. Inauguration Day is January 20, 2017.

CALOPTIMA
CALIFORNIA ELECTION RECAP
by Don Gilbert, Mike Robson, Trent Smith, and Jason Ikerd
November 17, 2016

The election of Donald Trump as President of the United States has rightly dominated the news cycle. His election as President and his promise to reduce taxes, reduce regulation, and deport immigrants puts his agenda and the agenda of the Democrats in the State Legislature at odds and will make for an interesting year in California politics.

While several down-ticket legislative races are still too close to call, the following is a snapshot of the big stories coming out of the November election and a preview of some of the issues that will likely surface in the coming legislative year.

California -- The Outlier
The major theme of the November election is that California voters defied national trends by overwhelmingly voting for people and issues that are typically identified as Democrat. Hillary Clinton carried California by nearly a two to one margin and voters approved ballot measures to raise taxes, legalize marijuana, promote bilingual education, and to ban the use of plastic grocery bags.

The Trump Effect on Down-ticket Races
It does not appear that Donald Trump's unpopularity in California had too much effect on down-ticket legislative races. Early on there was speculation that five or six legislative seats would change parties as Democrats tried to tie all Republican candidates to Trump. A couple of races are still too close to call, but so far the Assembly Democrats have only picked up three seats from the Republicans and two of the three seats were Democrat seats lost in the previous midterm election. So while every competitive congressional and legislative campaign in the state attempted to tie the Republican candidate to Donald Trump, it does not appear that this strategy worked as well as some would have thought early on.

Party Registration
A more relevant factor in the outcome of legislative and congressional races, is the relative decline in party registration of the Republican Party. Twenty years ago, 36 percent of the electorate was Republican. Today, Republicans only make up 26 percent of the electorate. It is worth noting that the percentage share of the electorate is down for both major parties in that time span, but the Republicans have seen a far greater decline with current party registration numbers nearly equal to those who register as No Party Preference. Millennials now make-up the greatest share of eligible voters and they are not registering or voting Republican. This is troubling for the Republican Party as it makes winning legislative elections very difficult if new voters are not among the base of party voters.

1127 11TH Street SUITE 1030 Sacramento, CA 95814 (916) 443-6400 FAX (916) 443-6445
www.edelsteingilbert.com

Supermajority
With the pickup of three seats, the Democrats have regained a two-thirds supermajority in the Assembly. There is still one Senate race to be decided by late arriving ballots which could result in the Senate Democrats picking up a two-thirds supermajority. Much is made of the fact that with a supermajority, the Democrats can, by party-line vote, raise taxes and place Constitutional amendments on the ballot. However, it is highly unlikely that such controversial items could garner party-line votes. The more practical impact is the fact that majority vote bills are simply easier to pass with a larger majority party.

Moderate Democrats
The Democrats' strong majorities will be tempered a bit by those who self-identify as "moderate" Democrats. These are Democrats who, depending on the issue, align with business interests on matters involving taxes, fees, regulations, and government bureaucracy.

The November election featured several races pitting two Democrats against each other. The following self-identified moderates prevailed:

Bill Dodd:	**State Senate representing Napa, Sonoma, Yolo, and Solano Counties**
Tim Grayson:	**State Assembly representing Contra Costa County**
Anna Caballero:	**State Assembly representing Monterey, Santa Clara, San Benito, and Santa Cruz**
Raul Bocanegra:	**State Assembly representing San Fernando Valley**

At the same time**, Assemblywoman Cheryl Brown**, a moderate Democrat from San Bernardino was defeated in her re-election effort.

How the moderate Democrats and the more traditional liberal Democrats work together in the upcoming legislative session will be an ongoing matter to monitor.

CalOptima Legislative Delegation
Orange County was ground zero for the balance of power in the State Legislature. Two races, one in the Senate and one in the Assembly, were "top target" races for each political party. In the Assembly, former Democratic Assemblywoman Sharon Quirk-Silva recaptured her seat from Republican Young Kim. Like two years ago when Kim won the seat by beating Quirk-Silva, this election was very close. Quirk-Silva's win helps the Democrats achieve a two-thirds majority in the Assembly.

In another very close race, Republican Ling Ling Chang holds a narrow lead over Democrat Josh Newman. Chang's lead is less than 4,000 votes and there are still many ballots to be counted. This seat is currently held by Republican Bob Huff. If Newman were to win the seat, it would give Democrats a two-thirds majority in the Senate.

In another Orange County Assembly race, Republican Steven Choi won the seat currently held by Don Wagner. The rest of the Orange County delegation remains the same.

Back to Agenda

Ballot Propositions

Proposition 55 -- Tax Extension to Fund Education and Healthcare -- Approved by Voters

In 2012, with California government in deep deficit, the California Legislature could not cut enough services to bring the budget into balance. At that time, Governor Brown with significant support from the teachers union, public employees and business successfully passed Proposition 30 to temporarily raise income tax on couples making over $500,000 per year and to temporarily increase the statewide sales tax. This measure passed and yielded significant new revenues which has since helped the Legislature pass a balanced budget in a timely manner, without cutting services.

Proposition 55 continues the increased income tax until 2030, while allowing the sales tax increase to expire. The state will continue to see between $4 billion to $9 billion in revenues, of which half would go to K-14 education. If Proposition 55 did not pass, the California Legislature would have found it difficult to find replacement revenues and/or make the necessary budget cuts to balance future state budgets.

Proposition 64 -- Legalize Recreational Use of Marijuana -- Approved by Voters

Marijuana for medical use is already allowed in California. Proposition 64 allows non-medical use, sale, and cultivation in California. It is estimated that this measure will generate more than $1 billion in annual state and local tax revenue over time. Initial state tax revenue would come from a new state tax on marijuana growing and production plus a new excise tax at the retail level. There will also be additional revenues from applying the existing sales tax at the retail level and state and local governments would be allowed to impose other taxes as well.

The initiative specifically does not preclude employers from having anti-marijuana workplace policies and nothing prohibits drug testing of employees and prospective employees in accordance with federal law. These issues will likely be debated by the Legislature in 2017.

Proposition 61 State Drug Purchasing -- Rejected by Voters

This proposition would have prohibited state agencies from paying more on any prescription drug than what is paid by the United States Department of Veteran Affairs. Proponents argued that this measure would have saved the state money through lower drug costs. Opponents argued that it could actually lead to higher drug costs. The independent Legislative Analyst argued that savings were purely speculative.

Proposition 56 Tobacco Tax -- Approved by Voters

This ballot measure raised the state excise tax on tobacco products $2.00 from 87 cents per pack of cigarettes to $2.87. It is estimated that the higher tax will generate over $1 billion in new revenues to the state that is earmarked primarily to support the Medi-Cal program and to make up for tobacco tax revenues that have been lost due to the reduction in smoking.

Proposition 52 -- Hospital Fee -- Approved by Voters

This measure makes permanent the existing Hospital Quality Assurance Fee which was due to expire in 2018. Fee revenue is used to support public and private hospital's care for Medi-Cal services to children and offsets state General Fund dollars that would otherwise be needed to pay

Back to Agenda

for these services. This new revenue also helps draw down an equal amount of federal revenue thereby doubling the support for hospitals.

2017 Legislative Forecast
It is too early to predict legislative priorities in 2017. However, the following is a guide:
In the week following the Presidential election, Assembly Speaker Anthony Rendon and Senate President Pro Tem Kevin De Leon issued a statement that the Legislature will seek to defend ongoing state programs that rely on federal funding in the event that a Trump Administration might seek to reduce those funds.

Additionally, the Legislature will convene for one day on December 5 to be sworn in for the 2017-18 Legislative Session. At that time, legislators will be able to begin submitting legislation for consideration in the coming year.

Finally, the Governor will release his proposed State Budget in early January which typically sets the stage for legislative debate on spending priorities in the coming year.

Back to Agenda

Board of Directors Meeting
December 1, 2016

CalOptima Community Outreach Summary — November 2016

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in any of CalOptima's programs.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

Requests for sponsorship are considered based on several factors including: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in a number of community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues. CalOptima strives to address issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima's Community Alliances Forum

On Wednesday, December 14, the Community Relations Department and community partners will host the Community Alliances Forum at the Delhi Center in Santa Ana from 9 – 11am. The presentation will feature the Orange County Community Indicators, a comprehensive report that measures the health and well being of Orange County's people, community, and economy. Representatives from the Orange County United Way, the Orange County Department of Education and Hope Through Housing Foundation will provide a comprehensive overview of three critical pivot points: affordable housing, the opportunity gap for Latino students, and children's health and well being. Presenters will discuss the complexities of these three pivot points, how they impact the wellbeing of our county and share innovative strategies for effective change.

There will be a Q & A portion following the presentation, which will provide an opportunity for our community partners to ask additional questions, share their experience in these areas and contribute in the discussion regarding solutions towards creating progressive and lasting changes in these critical areas.

The Community Alliances Forum was established to strengthen, develop and sustain positive relationships with community-based organizations, health care providers, policy makers, and other individuals/organizations that care about community health.

For additional information about the Community Alliances Forum, contact Tiffany Kaaiakamanu, Manager of Community Relations at 1-657-235-6872 or via e-mail at tkaaiakamanu@caloptima.org.

Back to Agenda

Summary of Public Activities
CalOptima participated in 49 community events and coalition and committee meetings:

Date	Events/Meetings	Audience Reached
11/01	• Susan G. Komen Orange County — Unidos Contra el Cancer del Seno Coalition Round Table	Health and Human Service Providers
11/02	• Senior Salute Week Health Fair hosted by La Habra Collaborative and Institute for Healthcare Advancement	Members/Potential Members
	• Veterans Summit	Health and Human Service Providers
11/03	• Homeless Provider Forum	Health and Human Service Providers
	• Senior Abuse Awareness hosted by the Office of Supervisor Todd Spitzer and Orange County Social Service Agency	Members/Potential Members
	• Transportation Awareness Day 2016 hosted by Golden Rain Foundation of Laguna Woods Village (*Sponsorship Fee: $100 included 1 table for outreach, recognition on printed materials for event and agency's name in program)*	Members/Potential Members
11/04	• Covered Orange County — General Meeting	Health and Human Service Providers
	• Resource Fair and Flu Shot Clinics hosted by City of Tustin Senior Center (*Registration Fee: $50 included 2 tables and 4 chairs for outreach*)	Members/Potential Members
11/05	• Seventh Annual Alzheimer's Latino Conference hosted by Alzheimer's Orange County (*Sponsorship Fee: $500 included 1 table and 2 chairs for outreach, recognition at event during opening ceremony, agency's logo placed at the conference and program agenda, agency's information in goody bag and certificate of recognition)*	Members/Potential Members
	• Fall Health Festival hosted by Walnut Elementary School	Members/Potential Members
11/06	• Health Fair hosted by Vietnamese Community Health at UC Los Angeles	Members/Potential Members
11/07	• Orange County Health Care Agency Mental Health Services — Steering Committee Meeting	Health and Human Service Providers
	• State Council on Developmental Disabilities Orange County — Regional Advisory Committee Meeting	Health and Human Service Providers
11/08	• Susan G. Komen Orange County — Unidos Contra el Cancer del Seno Coalition Round Table	Health and Human Service Providers
	• Buena Clinton Neighborhood Coalition Meeting	Health and Human Service Providers
	• Meet and Greet with Orange County Department	Health and Human Service Providers

Back to Agenda

	of Education	
	• Meet and Greet with Casa de La Familia	Health and Human Service Providers
11/09	• Buena Park Collaborative Meeting	Health and Human Service Providers
	• Anaheim Homeless Collaborative	Health and Human Service Providers
	• Mission Hospital Community Health Needs Assessment Informational Session — Phone Survey Preliminary Findings	Health and Human Service Providers
11/10	• Orange County Health Improvement Partnership Meeting	Health and Human Service Providers
	• Orange County Women's Health Project Meeting	Health and Human Service Providers
	• Community Collaboration Conference hosted by Fullerton Collaborative and Cal State Fullerton Gianneschi Center for Nonprofit Research (*Registration Fee: $110 included 2 reserved registration for staff to attend conference*)	Health and Human Service Providers
	• Community Health Fair hosted by Wellness Center West	Members/Potential Members
11/11	• Caregiver Wellness Training Program hosted by Orange County In-Home Supportive Services Public Authority	Members/Potential Members
11/14	• Fullerton Collaborative Meeting	Health and Human Service Providers
	• Orange County Veterans and Military Families Collaborative	Health and Human Service Providers
11/15	• North Orange County Senior Collaborative Meeting	Health and Human Service Providers
	• Placentia Community Collaborative Meeting	Health and Human Service Providers
	• Coordinated Entry's Healthcare and Housing Integration Workgroup	Health and Human Service Providers
	• Orange County Communications Workgroup Meeting	Health and Human Service Providers
11/16	• Covered Orange County — Steering Committee Meeting	Health and Human Service Providers
	• Minnie Street Family Resource Center Professional Roundtable Meeting	Health and Human Service Providers
	• Orange County Promotoras	Health and Human Service Providers
	• Annual Meeting and Allied Conference hosted by California Association of Area Agencies on Aging (*Registration Fee: $500 included 1 table and 2 chairs for outreach and 1 reserved registration for staff to attend 2-day conference*)	Health and Human Service Providers
	• 2016 Fall Conference and Annual Meeting hosted by California Association for Adult Day Services (*Registration Fee: $710 included 1 table and 2 chairs for outreach and 2 reserved registrations for staff to*	Health and Human Service Providers

Back to Agenda

attend 2-day conference)

11/17	• Orange County Children's Partnership Committee Meeting	Health and Human Service Providers
	• Orange County Women's Health Project Advisory Board Meeting	Health and Human Service Providers
11/18	• Senior Citizen Advisory Council Meeting	Health and Human Service Providers
11/19	• My Health, My Family, My Community Health Fair hosted by Cal State Fullerton Center for Healthy Neighborhoods	Members/Potential Members
11/22	• Orange County Senior Roundtable Meeting	Health and Human Service Providers
	• Santa Ana Building Healthy Communities	Health and Human Service Providers
11/23	• California Association of Area Agencies on Aging Advisory Board Meeting	Health and Human Service Providers
11/28	• Stanton Collaborative Meeting	Health and Human Service Providers
11/30	• Orange County Human Trafficking Task Force — General Meeting	Health and Human Service Providers

CalOptima organized or convened the following four community stakeholder events, meetings and presentations:

Date	Event/Meeting	Audience Reached
11/04	• County Community Service Center Education Seminar — Topic: Surviving the Holidays with Healthy Lifestyle Skills (*English*)	Member/Potential Member Providers
11/08	• OneCare Connect Education Presentation hosted in collaboration with Institute for Healthcare Advancement	Member/Potential Member Providers
11/10	• County Community Service Center Education Seminar — Topic: What is Memory Loss? (*Spanish)*	Member/Potential Member Providers
11/18	• County Community Service Center Education Seminar — Topic: Medicare 101: Understanding Your Benefits and Options (*Vietnamese*)	Member/Potential Member Providers

CalOptima endorsed the following seven events during this reporting period (e.g., letters of support, program/public activity event with support, or use of name/logo):

Back to Agenda

1. Letter of Support for the Friends of Family Health Center's application to the U.S. Department of Health and Human Services, Health Resources and Services Administration (17-054) — Services Area Competition.

2. Letter of Support for the Vietnamese Community of Orange County, Inc., Southland Health Center's application to the U.S. Department of Health and Human Services, Health Resources and Services Administration (17-054) — Services Area Competition.

3. 7th Annual Alzheimer's Latino Conference hosted by Alzheimer's Orange County.
(Listed in Public Activities)

4. Transportation Awareness Day 2016 hosted by Golden Rain Foundation of Laguna Woods Village.
(Listed in Public Activities)

Back to Agenda

CalOptima Board of Directors
Community Activities

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
December 2016			
Thursday, 12/1 9-11am	++Homeless Provider Forum	**Steering Committee Meeting: Open to Collaborative Members**	1855 Orange Olive Rd. Orange
Friday, 12/2 9-10:30am	++Covered Orange County General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	1575. E. 17th St. Santa Ana
Monday, 12/5 1-4pm	++OCHCA Mental Health Services Act Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	505 E. Central Ave. Santa Ana
Friday, 12/6 9:30-11am	++Collaborative to Assist Motel Families	**Steering Committee Meeting: Open to Collaborative Members**	250 E. Center St. Anaheim
Wednesday, 12/7 9-10:30am	++OC Aging Services Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	2515 McCabe Way Irvine
Wednesday, 12/7 10am-12pm	++Anaheim Human Services Network	**Steering Committee Meeting: Open to Collaborative Members**	250 E. Center St. Anaheim
Thursday, 12/8 11:30am-12:30pm	++FOCUS Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	11402 Magnolia St. Garden Grove

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Monday, 12/12 2:30-3:30pm	++Fullerton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	353 West Commonwealth Ave. Fullerton
Tuesday, 12/13 11:30am-12:30pm	++Buena Clinton Neighborhood Coalition	**Steering Committee Meeting: Open to Collaborative Members**	12661 Sunswept Ave. Garden Grove
Wednesday, 12/14 12-1:30pm	++Anaheim Homeless Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	500 W. Broadway Anaheim
Thursday, 12/15 8:30-10am	++Orange County Children's Partnership Committee	**Steering Committee Meeting: Open to Collaborative Members**	10 Civic Center Plaza Santa Ana
Thursday, 12/15 1-2:30pm	++Surf City Senior Providers Network and Lunch	**Steering Committee Meeting: Open to Collaborative Members**	18041 Goldenwest St. Huntington Beach
Tuesday, 12/20 10-11:30am	++Placentia Community Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	849 Bradford Ave. Placentia
Tuesday, 12/20 2-3:30pm	++Coordinated Entry's Healthcare and Housing Integration Workgroup	**Steering Committee Meeting: Open to Collaborative Members**	1505 E. 17th St. Santa Ana
Wednesday, 12/21 8:30-10:30am	++La Habra Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	1211 Fahringer Way La Habra
Wednesday, 12/21 9:15-10:45am	++Covered Orange County Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	18012 Mitchell S. Irvine
Wednesday, 12/21 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	1300 McFadden Ave. Santa Ana

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Tuesday, 12/27 7:30-9am	++OC Senior Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	170 S. Olive Orange
Tuesday, 12/27 3:30-4:30pm	++Santa Ana Building Healthy Communities	**Steering Committee Meeting: Open to Collaborative Members**	1902 W. Chestnut Ave. Santa Ana
Wednesday, 12/28 10:30-11:30am	++OC Human Trafficking Task Force General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	1221 E. Dyer Rd. Santa Ana
Events Pending			
Saturday, 12/3 Sunday, 12/4 8am-2pm	+City of Anaheim, GBS Linens, Anekant Community Center and Lestonnac Free Clinic Anaheim Health Fair	**Health/Resource Fair Open to the Public**	800 W. Katella Ave. Anaheim
Friday, 1/27 7am-6pm	+Orange County Breastfeeding Coalition	**Presentation: Open to CBO's, Health Advocates, Service Providers** **Health/Resource Fair: Open to Public** ***Registration recommended***	12021 Harbor Blvd. Garden Grove
Friday-Sunday, 1/27-1/29 9am-5pm	+Union of Vietnamese Student Associations of Southern California Tet Festival	**Health/Resource Fair Open to the Public**	88 Fair Dr. Costa Mesa