NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, JUNE 7, 2018
2:00 P.M.

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

BOARD OF DIRECTORS

Paul Yost, M.D., Chair	Lee Penrose, Vice Chair
Ria Berger	Ron DiLuigi
Supervisor Andrew Do	Dr. Nikan Khatibi
Alexander Nguyen, M.D.	Richard Sanchez
J. Scott Schoeffel	Supervisor Michelle Steel

Supervisor Lisa Bartlett, 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. June Board Meeting Priorities
   b. Quality Assurance Fee Distribution
   c. State Budget
   d. Whole-Child Model Meetings
   e. Program of All-Inclusive Care for the Elderly (PACE) Tour
   f. Cal MediConnect Study

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 May 3, 2018 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File: January 11, 2018 Meeting of the CalOptima Board of Directors' Member Advisory Committee; Minutes of the February 15, 2018 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Minutes of the February 20, 2018 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee; February 22, 2018 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC); Minutes of the March 8, 2018 Joint Meeting of the Member Advisory Committee, OCC MAC, and Provider Advisory Committee; and April 12, 2018 Meeting of the CalOptima Board of Directors' Provider Advisory Committee

3. Consider Approval of the Methodology for and the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to Participating Health Networks

4. Consider Approval of the Modification of the Previously Approved Pay for Value Payment Methodology for Measurement Year 2017 for CalOptima Community Network Providers by Incorporating an Improvement Factor

5. Consider Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year (FY) 2018-19

6. Consider Adopting Resolution Authorizing and Directing the Chairman of the Board of Directors to Execute Contract MS-18-19-41 with the California Department of Aging for the Multipurpose Senior Services Program (MSSP) for Fiscal Year 2018-19

7. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Expansion of Behavioral Health Treatment Services

8. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreements with the California Department of Health Care Services (DHCS) Related to Rate Changes

9. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Whole Child Model Program

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

11. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the In-Home Supportive Services Benefit

12. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to Agreement 16-93274 with the California Department of Health Care Services (DHCS) in Order to Continue Operation of the OneCare and OneCare Connect Programs

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

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

15. Consider Appointments to the CalOptima Board of Directors' Provider Advisory Committee (PAC); Consider Appointment of PAC Chair and Vice Chair

REPORTS

16. Consider Approval of the CalOptima Fiscal Year 2018-19 Operating Budget

17. Consider Approval of the CalOptima Fiscal Year 2018-19 Capital Budget

18. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Except Those Associated With the University of California, Irvine, Children's Hospital of Orange County or St. Joseph Healthcare and its Affiliates

19. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated With the University of California, Irvine

20. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated With St. Joseph Healthcare and its Affiliates

21. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated With the Children's Hospital of Orange County

22. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service (FFS) Primary Care Physician (PCP) Contracts, Except Those Associated With the University of California – Irvine or St. Joseph Healthcare and its Affiliates

23. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service Primary Care Physician Contracts Associated With St. Joseph Healthcare and its Affiliates

24. Consider Authorizing Extensions and Amendments of the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service Primary Care Physician Contracts Associated With the University of California, Irvine

25. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts that Expire During Fiscal Year 2018-19

26. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service Hospital Contracts

27. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service Specialist Physician Contracts Except Those Associated With the University of California, Irvine, Children's Hospital of Orange County or St. Joseph Healthcare and its Affiliates

28. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated With the University of California, Irvine

29. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service Specialist Physician Contracts Associated With St. Joseph Healthcare and its Affiliates

30. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service Specialist Physician Contracts Associated With Children's Hospital of Orange County

31. Consider Authorizing Extension and Amendment of the CalOptima Medi-Cal Full-Risk Health Network Contract With Kaiser Permanente

32. Consider Authorizing Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contract With Heritage Provider Network, Inc., Monarch Family Healthcare and Prospect Medical Group

33. Consider Authorizing Amendments to the CalOptima Medi-Cal Shared Risk (SRG) Health Network Physician Contracts for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Network

34. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Physician Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

35. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Physician Contracts for CHOC Physicians Network and Children's Hospital of Orange County

36. Consider Authorizing an Amendment to Extend the Coordination and Provision of Public Health Care Services Contract with the Orange County Health Care Agency

37. Consider Adoption of Resolution Approving Updated Human Resources Policies

38. Consider Actions Related to the Provision of Medi-Cal Perinatal Support Services, Including Withdrawing Request for Proposal (RFP), and Revising Payment Methodology and Contracting Strategy with Providers and Vendors

39. Consider Authorizing Revision and Expansion of the Program of All Inclusive Care Primary Care (PACE) Provider (PCP) Incentive Program and Related Changes to PCP Contracts

40. Consider Authorizing Selection and Contracting for State Legislative Advocacy Services

41. Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment

42. Consider Approving Grant Allocation(s) of Intergovernmental Transfer (IGT) 6 and 7 Funds

43. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Event

44. Consider Authorization of Expenditures Related to Board Membership in the National Association of Corporate Directors

45. Consider Actions Related to CalOptima's Whole-Child Model Program

46. Consider Modifications to CalOptima Policy and Procedures Related to the Delivery of Child Health and Disability Prevention Services for Medi-Cal Members Effective July 1, 2018

47. Consider Actions for the Implementation of Proposition 56 Provider Payment

48. Consider Authorizing a Contract Extension with the Healthcare Effectiveness Data and Information Set (HEDIS) Reporting Vendor, Inovalon, for Software Licensing, Maintenance, and Related Services

49. Consider Adoption of Resolution Approving Revisions to CalOptima Policy GA. 5002: Purchasing

50. Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Connect Bid for Calendar Year 2019 and Execute Contract with the Centers for Medicare & Medicaid Services and the California Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare Connect Health Network Contracts and Take Other Actions as Necessary to Implement *(to follow Closed Session)*

51. Consider Chief Executive Officer and Chief Counsel Performance Reviews and Compensation *(to follow Closed Session)*

52. Election of Officers of the Board of Directors for Fiscal Year 2018-19

ADVISORY COMMITTEE UPDATES

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

54. Member Advisory Committee Update

55. Provider Advisory Committee Update

INFORMATION ITEMS

56. April 2018 Financial Summary

57. Compliance Report

58. Federal and State Legislative Advocates Report

59. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

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

CS 2 Pursuant to Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer)

CS 3 Pursuant to Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS
Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose)
Unrepresented Employee: (Chief Executive Officer)

CS 4 Pursuant to Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Counsel)

CS 5 Pursuant to Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS
Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose)
Unrepresented Employee: (Chief Counsel)

ADJOURNMENT

MEMORANDUM

DATE:	June 7, 2018
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

June Board Meeting Focuses on Strategic Priorities, Sets Stage for New Fiscal Year
CalOptima's June Board meeting reflects the agency's commitment to the 2017–2019 Strategic Plan and new fiscal year preparation. With the strategic priorities of innovation and value in mind, CalOptima is seeking Board approval to integrate two programs into Medi-Cal: behavioral health treatment for children without autism, starting July 1, 2018, and California Children's Services, starting January 1, 2019. Carving in programs simplifies the health care experience for vulnerable members. Partnerships are a key focus in the Strategic Plan as well, and to that end, CalOptima is enhancing support for providers who deliver quality care. Primary care providers, psychiatrists, hospitals, and long-term and hospice care facilities will receive rate increases for certain services as part of the FY 2018–19 $3.5 billion operating budget. Further, engagement with our community stakeholders is essential in fulfilling CalOptima's mission, and proposed actions at the meeting uphold this priority, as we will appoint candidates for all three of our existing advisory committees and our new Whole-Child Model Family Advisory Committee. I look forward to working with the Board and our community to ensure CalOptima's success in the new year and beyond.

Hospitals Receive $130.7 Million in Quality Assurance Fee (QAF) Distribution
Earlier this month, CalOptima distributed $130.7 million in QAF dollars to 23 Orange County hospitals, representing dates of service from July–December 2016. For hospitals that serve Medi-Cal and uninsured patients, the supplemental funding is provided by the state, and the Hospital Association of Southern California supplies CalOptima with a distribution list of dollar amounts by hospital.

State Budget Includes a Surplus That May Impact Medi-Cal Spending
On May 11, Gov. Brown released the May Revision to his January budget proposal. He indicated that state revenue grew faster than expected and that the Department of Finance is predicting a surplus of approximately $8 billion. At the same time, he advocated for fiscal restraint, recommending that much of the surplus be designated for the state's Rainy Day Fund. Proposed Medi-Cal spending remains essentially flat compared with the January budget proposal and reflects additional costs incurred by the state for current year Medi-Cal spending. However, the Legislature, perhaps in anticipation of the larger surplus, indicated its desire to spend a portion of it on existing state programs and services, including Medi-Cal. The Assembly Budget Subcommittee on Health and Human Services proposed an additional $1 billion in health care

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spending for FY 2018–19, including more than $300 million for Medi-Cal. The Legislature and governor will negotiate a final spending plan soon, as California's final budget must be adopted by June 15.

CalOptima Invites Community to Whole-Child Model (WCM) Meetings
Continuing our widely recognized WCM engagement strategy, CalOptima is inviting leaders from community-based organizations (CBOs) to participate in focus groups on June 14, 10 a.m.–noon, and June 15, 2–4 p.m., at CalOptima's offices. The goal is to collaborate with CBOs and consider their feedback during WCM implementation in January 2019. For more information, contact BusinessIntegration@CalOptima.org.

Rep. Correa Tours CalOptima Program of All-Inclusive Care for the Elderly (PACE)
The PACE center welcomed U.S. Rep. Lou Correa for a one-hour visit and tour on May 25. Rep. Correa spent most of his time cordially interacting with participants, including speaking to those in the center's English-learners class and wishing all a Happy Memorial Day. He also received an update about the PACE expansion initiatives of alternative care settings, service area expansion to South Orange County and community-based physicians. Rep. Correa expressed support for CalOptima PACE and was happy to hear about the current growth of the center.

Cal MediConnect Results in Improved Care Transitions, Report Says
In May, the University of California released a SCAN Foundation-funded report about coordinated care for dual eligibles through Cal MediConnect (CMC), known as OneCare Connect in Orange County. Findings show that CMC encourages provider collaboration, which improves transitions across care settings.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

May 3, 2018

A Regular Meeting of the CalOptima Board of Directors was held on May 3, 2018, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:00 p.m. Director Berger led the Pledge of Allegiance.

ROLL CALL

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

Members Absent: Richard Sanchez (non-voting); Supervisor Michelle Steel

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

PRESENTATIONS

Chair Yost presented the Association for Community Affiliated Plans (ACAP) Leadership in Advocacy Award – Honorable Mention to Dr. Bharath Chakravarthy, an emergency physician, an Associate Professor of Clinical Emergency Medicine and Public Health at the University of California, Irvine, and co-leader of SafeRX OC. ACAP grants the award to individuals who exceed the norm in advocating for Medi-Cal and other safety net health programs.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader provided an overview of the meeting agenda and reported that CalOptima received its Medi-Cal rates for the new fiscal year from the state on Monday, April 30, 2018. Mr. Schrader noted that staff does not anticipate proposing rate reductions to providers as part of the Fiscal Year (FY) 2018-19 budget.

PUBLIC COMMENTS

There were no requests for public comment.

CONSENT CALENDAR

2. Minutes

a. Approve Minutes of the April 5, 2018 Regular Meeting of the CalOptima Board of Directors
b. Receive and File Minutes of the February 8, 2018 Meeting of the CalOptima Board of Directors' Provider Advisory Committee

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

REPORTS

3. Consider Adoption of Resolution Approving Updated CalOptima Employee Handbook and Proposed Market Adjustments

Director Berger directed staff to look into the possibility of conducting periodic salary surveys and including implementing funds in the budget so that staff would not need to return to the Board to request authority to implement these salary adjustments on a case-by-case basis.

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors adopted Resolution No. 18-0503, Approving Updated CalOptima Employee Handbook, and approved proposed market adjustments for two positions. (Motion carried 8-0-0; Supervisor Steel absent)***

4. Consider Authorizing Allocations/Reallocations of Spending Rate Year 2011–12 Intergovernmental Transfer (IGT 2) Funds

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized extension of the timeline for previously-approved spending of Rate Year 2011-12 Intergovernmental Transfer (IGT 2) funds for OneCare Connect Personal Care Coordinators (PCCs) until the funds have been exhausted, and authorized using the remaining approximate $2.3 million in IGT 2 funds for PCCs for CalOptima members assigned to health networks and or CalOptima Care Network in all CalOptima lines of business. (Motion carried 8-0-0; Supervisor Steel absent)***

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

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors: 1) Authorized up to $2,500 and staff participation in the Orange County Iranian American Chamber of Commerce and Alzheimer's Orange County's OC Iranian Health Expo on Saturday, June 2, 2018 at Alzheimer's Orange County in Irvine; 2) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3) Authorized the Chief Executive Officer to execute agreements as necessary for the events and expenditures. (Motion carried 8-0-0; Supervisor Steel absent)***

6. Consider Authorizing Memorandum of Understanding with the Regional Center of Orange County for the Coordination of Behavioral Health Treatment Services

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into a Memorandum of Understanding with the Regional Center of***

Orange County to coordinate Behavioral Health Treatment services and information exchange activities. (Motion carried 8-0-0; Supervisor Steel absent)

7. Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2019 and Execute Contract with the Centers for Medicare & Medicaid Services; Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement
This item was considered after closed session. It was noted that Director Schoeffel will not participate in the discussion or vote on this item due to potential conflicts of interest.

ADVISORY COMMITTEE UPDATES

8. Provider Advisory Committee (PAC) Update
PAC Chair Teri Miranti provided a brief update on the May 10, 2018 PAC meeting agenda items. The Nominations Subcommittee will present the slate of candidates for open positions on the PAC, and the Committee will consider candidates for Chair and Vice Chair for the upcoming fiscal year. Recommendations will be presented to the Board of Directors for consideration at the June Board meeting.

9. OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) Update
This item was accepted as presented.

10. Member Advisory Committee (MAC) Update
This item was accepted as presented.

INFORMATION ITEMS

11. Introduction to the FY 2018-19 CalOptima Budget: Part 2
Greg Hamblin, Chief Financial Officer, presented an overview of enrollment for all lines of business, public plan comparison in the areas of medical loss ratio, administrative loss ratio, and NCQA rankings, as well as the revenue and medical expense trends. The rate development process was also reviewed with the Board. Mr. Hamblin reported that CalOptima received overall favorable Medi-Cal rates from the state on April 30, 2018. An in-depth review of the proposed FY 2018-19 operating and capital budgets will be provided at the May 17, 2018 Board of Directors' Finance and Audit Committee meeting and presented to the Board of Directors for consideration at the June 7, 2018 meeting.

The following Information Items were accepted as presented:
12. March 2018 Financial Summary
13. Compliance Report
14. Federal and State Legislative Advocates Report
15. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Supervisor Do provided a report on behalf of the IGT 6&7 Ad Hoc Committee. The ad hoc, including Directors Nguyen and Schoeffel, was formed to make recommendations on the IGT 6&7 expenditure plan and how best to invest approximately $22 million available for community grants in three Board-approved priority areas: opioid overuse, children's mental health, homeless health care access, and staff

driven internal projects. Supervisor Do reported that the ad hoc recently met to explore the possibilities of utilizing the IGT 6&7 funding to address homeless health care access and opioid overuse as part of the County's effort to address the medical needs of homeless Medi-Cal beneficiaries. The ad hoc will develop a recommended expenditure plan for Board consideration at a future meeting.

Chair Yost reported that CalOptima's contract with its state lobbyist, Edelstein Gilbert Robson & Smith is expiring in June, and a Request for Proposal (RFP) process was conducted and announced the formation of an ad hoc committee to interview RFP finalists. Chair Yost appointed Directors DiLuigi and Khatibi to serve on this ad hoc.

Chair Yost noted that the election of the Board Chair and Vice Chair for Fiscal Year 2018-19 will occur at the June 7, 2018 Board meeting. To facilitate the process, a Nominations Ad Hoc Committee was formed to make information available on the duties, responsibilities, and the number of extra hours the Chair and Vice Chair position typically requires above and beyond serving as a member of the Board. Chair Yost appointed Vice Chair Penrose and Director Berger to serve on this ad hoc. Board members were asked to contact the ad hoc with interest in being considered or to nominate a fellow Board member for the Chair or Vice Chair position. The Nominations Ad Hoc will present nominations, along with any nominations from the floor, for consideration at the June 7, 2018 Board meeting.

Chair Yost reported that an ad hoc committee composed of the Chair and Vice Chair will meet regarding the performance evaluations for the Chief Executive Officer and Chief Counsel. Consistent with the process used in prior years, the ad hoc will request input from the Board in order to prepare the draft reviews, which will be shared with the full Board ahead of the June 7, 2018 meeting, at which time the Board will complete the reviews.

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 3:20 p.m. pursuant to Government Code Section 54956.87, subdivision (b), Health Plan Trade Secrets – OneCare.

The Board reconvened to open session at 3:57 p.m. with no reportable actions taken.

7. Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Bid for Calendar Year 2019 and Execute Contract with the Centers for Medicare & Medicaid Services (CMS); Authorize the CEO to Amend/Execute OneCare Health Network Contracts and Take Other Actions as Necessary to Implement

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors authorized the CEO to submit the Calendar Year 2019 OneCare bid by June 4, 2018, make minor benefit changes to the final bid, as necessary, to address CMS feedback following the release of the National Average Bid, and sign the OneCare contract with CMS; and authorized the CEO to amend OneCare Health Network contracts and take other actions as necessary to implement. (Motion carried 7-0-0; Supervisor Steel and Director Schoeffel absent)***

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ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 3:58 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: June 7, 2018

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MINUTES

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

January 11, 2018

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on January 11, 2018 at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair called the meeting to order at 2:38 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Sally Molnar, Chair; Suzanne Butler; Connie Gonzalez; Donna Grubaugh; Patty Mouton; Jaime Muñoz; Christina Sepulveda; Sr. Mary Therese Sweeney; Mallory Vega; Lisa Workman
Members Absent:	Sandy Finestone, Ilia Rolon, Velma Shivers, Christine Tolbert
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Phil Tsunoda, Executive Director, Public Affairs; Candice Gomez, Executive Director, Program Implementation; Sesha Mudunuri, Executive Director, Operations; Michelle Laughlin, Executive Director, Network Operations; Emily Fonda, M.D., Medical Director; Belinda Abeyta, Director, Customer Service (Medi-Cal); Le Nguyen, Associate Director, Customer Service; Becki Melli, Customer Service; Eva Garcia, Customer Service

MINUTES

Approve the Minutes of the November 9, 2017, Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

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

PUBLIC COMMENT
There were no requests for public comment.

Chair Molnar reordered the agenda to hear item VI.B. Behavioral Health In-House Transition Update.

Behavioral Health In-House Transition Update
Dr. Sharps, Medical Director, Behavioral Health, reported that effective January 1, 2018, CalOptima assumed responsibility for administering Medi-Cal behavioral health benefits . CalOptima's efforts to contract with numerous providers offering mental health and Applied Behavior Analysis (ABA) services ensured that most members were able to continue seeing their

existing providers. Fewer than 300 members requested continuity of care arrangements. Under a continuity of care arrangement, a member may continue to see the same provider for up to a year if the provider agrees to accept the standard rate through a member-specific Letter of Agreement.

Dr. Sharps reported that CalOptima has hired nearly all the necessary clinical and customer service staff needed to administer the Medi-Cal behavioral health benefits. CalOptima's Customer Service staff began operation of the behavioral health line on January 2, 2018. Customer Service will adjust the staff work schedule as needed to meet member and provider call demands.

Chair Molnar reordered the agenda to hear item VI.C Assisted Living Waiver Overview.

Assisted Living Waiver Overview

Debbie Kegel, Manager, Business Integration, presented an overview of the Assisted Living Waiver (ALW) Program. The ALW is part of a waiver program through the Department of Health Care Services (DHCS), and is designed to assist Medi-Cal beneficiaries to remain in their community as an alternative to residing in a licensed health care facility. The program provides specified benefits to eligible seniors and people with disabilities who are 21 years old and over and have full scope Medi- Cal with no share of cost. Currently, there are about 3,700 openings with an additional 2,000 openings proposed for FY 2018-19. The program seeks to transition eligible individuals from a nursing facility to a community home-like setting, such as public housing, Residential Care for the Elderly (RCFE), or an Adult Residential Facility (ARF). CalOptima will keep MAC members apprised of the proposed openings.

CHIEF EXECUTIVE OFFICER AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, reported that CalOptima has begun the process of transitioning the California Children's Services (CCS) program from a Medi-Cal carve-out administered by the Orange County Health Care Agency to the fully integrated Whole Child Model (WCM), which will be administered by CalOptima effective January 1, 2019. This transition will affect more than 13,000 Orange County children, all of whom have significant medical conditions. Approximately, 90% of CCS children are CalOptima members who are already assigned to a health network and primary care physician for their non-CCS health care. CalOptima proposes using its existing delivery system to provide the CCS services. CalOptima is launching an eleven-member WCM Family Advisory Committee (WCM FAC) to assist CalOptima in bringing on this program. The committee will consist of seven to nine family members of a CCS recipient and two to four community advocates. CalOptima urged the MAC to refer prospective candidates.

Mr. Schrader reported that effective January 1, 2018, the State restored benefits to the Denti-Cal program for adults ages 21 and over. This restoration of benefits is due to the Proposition 56 tobacco tax approval by voters in 2016.

Chief Medical Officer Update

Richard Bock, M.D., Deputy Chief Medical Officer, reported that in addition to the WCM FAC, there will also be a clinical advisory committee to advise the WCM program.

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Dr. Bock reported that effective January 1, 2018, palliative care services were implemented as a new Medi-Cal benefit for Medi-Cal Managed Care plans to administer. Palliative care is defined as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. In addition, palliative care addresses physical, intellectual, emotional, social and spiritual needs and facilitates patient autonomy, access to information and choice.

Dr. Bock reported that at the February 1, 2018 Board of Directors meeting, CalOptima staff will request Board approval to contract with five alternative care setting sites for the Program of All-Inclusive Care for the Elderly (PACE) program. CalOptima issued a request for proposal (RFP) in the fall and upon evaluation of the proposals, is recommending contracting with five Community-Based Adult Service (CBAS) centers to expand the PACE program.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, reported that CalOptima issued letters to 2,000 members in November 2017, as part of the Qualified Medicare Beneficiary (QMB) program outreach. If members are determined eligible for QMB, the State will cover the member's Medicare Part A premium.

Network Operations Update

Michelle Laughlin, Executive Director, Network Operations, reported that the provider network for Medi-Cal behavioral health was successfully implemented. Ms. Laughlin reported that this year's primary focus is to ensure that CalOptima has a full network of CCS providers contracted for the new WCM program.

Federal and State Legislative Update

Phil Tsunoda, Executive Director, Public Affairs, reported that H.R. 1, officially referred to as the Tax Cuts and Jobs Act, was signed into law by President Trump on December 22, 2017, and amends portions of the Internal Revenue Code that address corporate and individual tax rates and deductions. While most of the income tax-related provisions were effective January 1, 2018, the elimination of the penalty associated with the Affordable Care Act's individual mandate is effective December 31, 2018.

Mr. Tsunoda reported that H.R. 1370, a continuing resolution (CR) signed into law by the President on December 22, 2017, funds the federal government at current levels through January 19, 2018. The CR also allocates $2.85 billion to the Children's Health Insurance Program (CHIP), which will fund the program for the first half of the federal fiscal year, until March 31, 2018. CalOptima has over 112,000 children who access care through CHIP and whose family income is between 101 and 266 percent of the federal poverty level. Policy issues still unresolved include long-term financing of CHIP and the status of the Deferred Action for Childhood Arrivals (DACA) recipients.

Mr. Tsunoda reported that Governor Brown released his proposed FY 2018–19 State Budget, which starts on July 1, 2018. CalOptima staff is in the process of developing a comprehensive analysis of the proposed $190 billion spending plan, including an additional $6.2 billion surplus for which the governor has proposed establishing a reserve account.

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INFORMATION ITEMS

MAC Member Updates

Chair Molnar announced that Carlos Robles resigned his MAC seat as the Recipients of CalWORKs representative. Recruitment to complete the remainder of his term will coincide with the annual recruitment for all renewing MAC seats starting in March 2018. Chair Molnar asked for volunteers to serve on the Nominations Ad Hoc Subcommittee to review the prospective candidates' applications. Members Suzanne Butler and Mallory Vega volunteered for the Nominations Ad Hoc. The expiring seats are for individuals representing, or that represent the interests of: Children, Consumer, Foster Children, Long-Term Services and Supports, Medically Indigent Persons, Persons with Mental Illness, and Persons with Special Needs. Chair Molnar also asked for volunteers to serve on the MAC Goals and Objectives Ad Hoc Subcommittee. Chair Molnar and Patty Mouton will serve on that ad hoc.

Chair Molnar reminded the MAC a Joint meeting of the MAC, OneCare Connect Member Advisory Committee, and Provider Advisory Committee will be held on March 8, 2018 at 8 a.m. Proposed topics include presentations on Orange County's mental health coalition, the opioid epidemic, Healthcare Effectiveness Data and Information Set (HEDIS), and a discussion on member access to providers.

Chair Molnar urged MAC members to refer potential candidates to CalOptima for the WCM FAC. Members Jaime Munoz, Connie Gonzalez and Christine Tolbert will serve on the WCM FAC Nominations Ad Hoc Subcommittee to review applications.

Human Arc Overview

Belinda Abeyta, Medi-Cal Customer Service Director, presented an overview of Human Arc, a CalOptima contracted vendor that identifies members through their predictive modeling software to determine who may potentially qualify for the Supplemental Security Income (SSI) program. SSI is a federal program that helps those who are either aged (e.g., 65 or over), blind, or disabled and have little or no income. Human Arc outreaches to members via an introduction letter that offers aid to the member through the application process. There is no cost to CalOptima members for this service.

ADJOURNMENT

Hearing no further business, Chair Molnar adjourned the meeting at 4:00 p.m.

/s/ Eva Garcia
Eva Garcia
Program Assistant

Approved: May 10, 2018

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 15, 2018

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

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

Members Absent: All members present

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

MANAGEMENT REPORTS

1. Chief Financial Officer (CFO) Report

CFO Greg Hamblin presented an overview of the Department of Health Care Services (DHCS) Medical Loss Ratio (MLR) calculation for Medi-Cal Adult Expansion Members (MCE) for the 18-month period of January 1, 2014 through June 30, 2015, and the 12-month period of July 1, 2015 through June 30, 2016. DHCS has provided the final data request templates and instructions designed to collect the data needed to perform the MCE-MLR calculations. The estimated timeline was reviewed, including: MLR data due to DHCS on March 9, 2018; DHCS review of data files is estimated between March 10 and April 30, 2018; and receipt of the DHCS determination letter is anticipated in April 2018. Payments due to DHCS are anticipated to occur in the July-August 2018 timeframe. It was noted that CalOptima's health network MLR audit is currently in process. Field work is expected to be completed by the end of February 2018, and final audit reports are anticipated to be completed by the end of March 2018.

PUBLIC COMMENT
Ana Sanchez, M.D. – Oral re: Agenda Item 4, Consider Recommending Board of Directors' Receive and File the 2017 Compliance Program Effectiveness Audit Report.

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INVESTMENT ADVISORY COMMITTEE UPDATE

2. Treasurer's Report

Mr. Hamblin presented an overview of the Treasurer's Report for the period October 1, 2017 through December 31, 2017. 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.

CONSENT CALENDAR

3. Approve the Minutes of the November 16, 2017 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the October 30, 2017 Special 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

4. Consider Recommending Board of Directors Receive and File the 2017 Compliance Program Effectiveness Audit Report

Silver Ho, Executive Director, Compliance, presented the action to recommend that the Board of Directors receive and file the 2017 Compliance Program Effectiveness (CPE) Audit Report. The Centers for Medicare & Medicaid Services (CMS) requires that all Medicare Advantage (Part C) and Prescription Drug (Part D) plan sponsors conduct an independent audit to assess the effectiveness of its Compliance Program on at least an annual basis and share the results with its Board of Directors. Compliance Strategies, Inc., conducted the CPE audit for the period October 1, 2016 through September 30, 2017. Virgilio Florentino, Principal, Compliance Strategies, provided an overview of the audit components, assessment and audit results, and determined that CalOptima demonstrated it had an effective Compliance Program to review and address issues of non-compliance and potential fraud and abuse.

Action: ***On motion of Director DiLuigi, seconded and carried, the Committee recommended the Board of Directors' receive and file the 2017 Compliance Program Effectiveness Audit Report as presented. (Motion carried 3-0-0)***

5. Consider Recommending the Board of Directors Authorize Proposed Budget Allocation Changes in the CalOptima Fiscal Year 2017-2018 Operating Budget

Chief Operating Officer Ladan Khamseh presented the action to recommend that the Board of Directors authorize reallocation of budgeted, but unused, funds in the amount of $150,000 from Claims Administration Purchased Services – Claims Imaging and Indexing services to fund the annual fees through June 30, 2018 of the Claims Administration Purchased Services – Electronic Data Interchange (EDI) Clearinghouse Services, and $70,000 from Claims Administration Purchased Services – Trizetto Group for Robot Process for Rate Adjustments to fund the annual fees through June 30, 2018 of the Claims Administration Purchased Services – EDI Clearinghouse Services. It was noted that a shortfall of nearly $220,000 is projected for Claims Administration Purchased Services – Electronic Data

Interchange (EDI) Clearinghouse Services by June 30, 2018 due to under estimation of the expenses related to the two EDI clearinghouses. The proposed budget allocations are anticipated to correspond to the expected transactional volume for these services during the current fiscal year.

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

Action: ***On motion of Director Schoeffel, seconded and carried, the Committee recommended that the Board of Directors authorize reallocation of budgeted, but unused, funds in the amount of $150,000 from Claims Administration Purchased Services – Claims Imaging and Indexing services to fund the annual fees through June 30, 2018 of the Claims Administration Purchased Services – Electronic Data Interchange (EDI) Clearinghouse Services, and $70,000 from Claims Administration Purchased Services – Trizetto Group for Robot Process for Rate Adjustments to fund the annual fees through June 30, 2018 of the Claims Administration Purchased Services – EDI Clearinghouse Services. (Motion carried 3-0-0)***

INFORMATION ITEMS

6. December 2017 Financial Summary

Mr. Hamblin provided an overview of the balance sheet, Board-Designated Reserves and tangible net equity (TNE) requirement as of December 31, 2017.

7. Child Health and Disability Prevention Program (CHDP) Update

Candice Gomez, Executive Director, Program Implementation, presented an update on the recent changes to CHDP, a preventive program for children and youth up to 21 years of age that includes periodic health assessments, care coordination, immunizations, and access to diagnostic and treatment services. Since 1998, CalOptima has covered CHDP services on a fee for service basis for all members up to age 21. The recent DHCS transition of CHDP fee for service claims to national standards, as well as the impact of phasing out the PM 160 form, was reviewed with the Committee. Staff is awaiting final reporting guidance from DHCS.

The following Information Items were accepted as presented:

8. CalOptima Information Systems Security Update
9. Cost Containment Improvements/Initiatives
10. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Reinsurance Report
    c. Health Network Financial Report
    d. Purchasing Report

COMMITTEE MEMBER COMMENTS

Committee members congratulated staff on the successful Compliance Program Effectiveness Audit.

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ADJOURNMENT

Hearing no further business, Chair Penrose adjourned the meeting at 2:54 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: May 17, 2018

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

February 20, 2018

CALL TO ORDER
Chair Paul Yost called the meeting to order at 3:03 p.m. Director Berger led the pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Ria Berger, Alexander Nguyen M.D.

Members Absent: Dr. Nikan Khatibi

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

PUBLIC COMMENTS
There were no requests for public comment.

CONSENT CALENDAR

1. Approve the Minutes of the November 15, 2017 Regular Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Director Nguyen, seconded and carried, the Committee approved the Minutes of the November 15, 2017 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Director Khatibi absent)***

REPORTS

2. Consider Recommending Board of Directors' Ratification of CalOptima's Pharmacy Management Residency Program and Approval of Related Policy
Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to recommend that the Board of Directors ratify CalOptima's Pharmacy Management Residency Program and approve Policy GG.1426, Residency Program, Pharmacy Management.

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Nicki Ghazanfarpour, PharmD, Pharmacy Clinical Programs Manager, provided an overview of the CalOptima Pharmacy Management Program that began in 2010 and is included in CalOptima's 2017 Utilization Management Program. The Pharmacy Resident position is 12-months in duration that consists of structured rotations through different areas in Pharmacy Management, and residents are required to complete a longitudinal drug utilization review (DUR) project that contributes to the Centers for Medicare & Medicaid Services (CMS) and Department of Managed Health Care (DHCS) DUR requirements. It was noted that Pharmacy Residents have consistently engaged in quality improvement and assessment activities, assisted in staff development, and have supported innovative approaches to care that have positively impacted CalOptima members.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended that the Board of Directors ratify CalOptima's Pharmacy Management Residency Program and approve Policy GG.1426, Residency Program, Pharmacy Management. (Motion carried 3-0-0; Director Khatibi absent)***

3. Receive and File the CalOptima 2017 Quality Improvement Program Evaluation

Dr. Bock presented a review of the 2017 Quality Improvement (QI) Program evaluation accomplishments during 2017, including: recognition by the National Committee for Quality Assurance (NCQA) for top quality care for Medi-Cal members and maintaining "Commendable" NCQA accreditation status; revised Health Network Pay for Value (P4V) program that demonstrated improved performance in adult and children P4V measures; implementation of eight targeted quality initiatives with member and/or provider incentives to improve HEDIS scores; transitioned the administration of Medi-Cal behavioral health services in-house; and redesigned and expanded the childhood obesity program, Shape Your Life, and the perinatal program, Bright Steps. QI opportunities for 2018 include continued maintenance of NCQA accreditation and top Medicaid health plan rating, implementing a P4V program for CalOptima Care Network (CCN) providers, implementing provider and office staff coaching program, and implementation of the newly redesigned Shape Your Life and Bright Steps programs.

Action: ***On motion of Director Berger, seconded and carried, the Committee received and filed the CalOptima 2017 Quality Improvement Program Evaluation as presented. (Motion carried 3-0-0; Director Khatibi absent)***

4. Consider Recommending Board of Directors' Approval of the CalOptima 2018 Quality Improvement (QI) Program and 2018 QI Work Plan

Dr. Bock presented the action to recommend Board of Directors' approval of the recommended revisions to the 2018 QI Program and 2018 QI Work Plan.

Esther Okajima, Quality Improvement Director, presented an overview of the proposed revisions to the 2018 QI Program Description and Work Plan. As proposed, the recommended revisions ensure that the QI Program reflects health network and strategic organizational changes, and that all regulatory requirements and NCQA accreditation standards are met in a consistent manner across all lines of business.

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Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima 2018 Quality Improvement (QI) Program and 2018 QI Work Plan. (Motion carried 3-0-0; Director Khatibi absent)***

5. Consider Recommending Board of Directors' Approval of the 2018 CalOptima Utilization Management Program

Steve Chang, Long-Term Support Services Director, presented the action to recommend Board of Directors' approval of the 2018 Utilization Management (UM) Program. Mr. Chang provided an overview of the proposed revisions, including: aligning the program descriptions and committee references with the QI Program; updates to reflect the transition of mild to moderate mental health benefit administration for the Medi-Cal program from Magellan to CalOptima; incorporation of new health network risk structure models; and modified the description of Managed Long-Term Services and Supports to reflect In Home Support Services reverting to the County of Orange administrative responsibility.

Action: ***On motion of Director Berger, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima 2018 Utilization Management Program. (Motion carried 3-0-0; Director Khatibi absent)***

6. Receive and File the 2017 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assurance Performance Improvement Plan Annual Evaluation

Miles Masatsugu, M.D., Medical Director, presented the recommended action to receive and file the 2017 CalOptima PACE Quality Assurance Performance Improvement Plan Annual Evaluation. A review of the 2017 accomplishments was provided to the Committee, including: membership growth to 236 participants; completion of successful DHCS level of care audits; 100% of participants received influenza and pneumococcal immunizations and completed a Physician's Order for Life-Sustaining Treatment; and significant improvement in patient satisfaction. Opportunities for improvement in 2018 are in the areas of utilization, membership growth, participant satisfaction, and additional quality of care HEDIS elements.

Action: ***On motion of Director Berger, seconded and carried, the Committee received and filed the 2017 CalOptima PACE Quality Assurance Performance Improvement Plan Annual Evaluation as presented. (Motion carried 3-0-0; Director Khatibi absent)***

7. Consider Recommending Board of Directors' Approval of the 2018 CalOptima Program of All-Inclusive Care for the Elderly (PACE) Quality Assessment and Performance Improvement Plan

Dr. Masatsugu presented the action to recommend Board of Directors' approval of the 2018 CalOptima PACE Quality Assessment and Performance Improvement (QAPI) Plan. The 2018 QAPI plan is based on the opportunities for quality improvement noted in the 2017 QAPI Plan Evaluation. Work plan elements for 2018 include: preventative care, quality of care, infection control, access and availability, utilization management, delegation oversight, and patient satisfaction/member experience. New work plan elements focus on comprehensive diabetes care, potentially harmful drug-disease interactions in the elderly, and transitions of care.

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Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of the 2018 CalOptima PACE Quality Assurance Performance Improvement Plan. (Motion carried 3-0-0; Director Khatibi absent)***

8. Consider Recommending Board of Directors' Ratification of Increased Payment to Primary Care Physicians for the Depression Screening Incentive Program Funded by Intergovernmental Transfer (IGT) 1

Donald Sharps, M.D., Medical Director, presented the action to recommend that the Board of Directors' ratify a $20 increase per depression screening to $50 for all screens completed by physicians for eligible members retroactively to May 1, 2017, and authorize incentive payments of $50 per depression screening for members prospectively through May 2019, or until available funding has been exhausted, whichever comes first.

Dr. Sharps reported that on December 1, 2016, the Board of Directors authorized the reallocation of $1,000,000 from 2010-11 IGT 1 funds to support a physician incentive program aimed at increasing the rate of depression screenings conducted during annual wellness visits for members ages 12 to 18. At that time, $30 per screening was approved as the incentive payment amount to be made directly to primary care physicians. In January 2018, the discrepancy between the Board approved $30 per screening amount and the actual $50 per incentive payment per screen gained broader visibility within the organization.

Based on the screenings completed to date, the rate change resulted in an increase in payment of $38,960, or 66% through December 2017. The annual increase in payment is projected to be $66,000. It was noted that with an annual utilization rate of approximately 20%, the $50 incentive payment per screen will use approximately 33% of the $1,000,000 allotted to the program within a two-year period. As proposed, Board ratification of the higher incentive payments and authorizing payments at the higher level going forward, will enable CalOptima to build on the momentum created during the first eight months of the program. Staff will continue to monitor the volume of screenings and depression diagnosis, and will keep the Board updated on the program, and return with further recommendations. Additionally, staff will implement internal validation and control measures to ensure that system and process implementations are consistent with Board-approved actions.

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

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended that the Board of Directors ratify a $20 increase per depression screening to $50 for all screens completed by physicians for eligible members retroactively to May 1, 2017, and authorize incentive payments of $50 per depression screening for members prospectively through May 2019, or until available funding has been exhausted, whichever comes first. (Motion carried 3-0-0; Director Khatibi absent)***

9. Consider Recommending Board of Directors' Approval of Policy GG.1656, Conflict of Interest

Dr. Bock presented the action to recommend Board of Directors' approval of CalOptima Policy GG.1656, with the following revised title: Quality Improvement and Utilization Management Conflicts of Interest. This new policy was developed in response to a Department of Health Care Services and the

Centers for Medicare & Medicaid Services contract requirement to ensure rules of confidentiality in quality improvement discussions, as well as avoidance of conflict of interest on the part of committee members. As proposed, the new policy will ensure that the Quality Improvement Committee and its subcommittees who oversee quality and utilization activities fully disclose any actual or perceived conflicts of interest.

Action: ***On motion of Chair Yost, seconded and carried, the Committee recommended Board of Directors' approval of CalOptima Policy GG.1656: Quality Improvement and Utilization Management Conflicts of Interest. (Motion carried 3-0-0; Director Khatibi absent)***

INFORMATION ITEMS

The following Information Items were accepted as presented:

10. PACE Member Advisory Committee Update
11. Quarterly Reports to the Quality Assurance Committee
    a. Quality Improvement Report - Fourth Quarter 2017 Update
    b. Member Trend Report – Third Quarter 2017 Update

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 4:22 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: May 16, 2018

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MINUTES

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

February 22, 2018

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on February 22, 2018 at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Gio Corzo called the meeting to order at 3:04 p.m. and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Gio Corzo, Chair; Patty Mouton, Vice Chair; Ted Chigaros, Christine Chow, Josefina Diaz, Sandy Finestone, Sara Lee, Richard Santana, Kristin Trom, Jyothi Atluri (non-voting)
Members Absent:	John Dupies, Adam Crits (non-voting); Amber Nowak (non-voting); Erin Ulibarri (non-voting)
Others Present:	Richard Helmer, M.D., Chief Medical Officer; Candice Gomez, Executive Director, Program Implementation; Sesha Mudunuri, Executive Director, Operations; Albert Cardenas, Director, Customer Service (Medicare); Becki Melli, Customer Service; Eva Garcia, Program Assistant

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MINUTES

Approve the Minutes of the December 14, 2017 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

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

PUBLIC COMMENT
There were no requests for public comment.

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Medical Officer (CMO) Update
Richard Helmer, M.D., Chief Medical Officer, reported that CalOptima is working with the Orange County Health Care Agency (HCA) to address the health needs of CalOptima members

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who are homeless and residing at the Santa Ana Riverbed. CalOptima personal care coordinators will work with HCA staff to identify mental and physical health care needs.

Palliative care services were implemented as a new Medi-Cal benefit for Medi-Cal Managed Care plans, effective January 1, 2018. Palliative care is patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering.

Beginning January 1, 2018, CalOptima assumed responsibility for administering Medi-Cal behavioral health benefits. Dr. Helmer reported that the behavioral health transition has gone smoothly and has improved access to services. Most members were able to continue seeing their existing providers due to CalOptima's efforts to contract with a majority of members' existing providers.

It was also reported that at the February 1, 2018 meeting, the Board of Directors authorized CalOptima to contract with alternative care settings to support the expansion and growth of the Program of All-Inclusive Care for the Elderly (PACE).

INFORMATION ITEMS

OCC MAC Member Updates

OCC MAC Member Presentation on SeniorServ

Chair Corzo presented on SeniorServ's Home Care Services. Celebrating its 50th anniversary, SeniorServ's mission is to nourish the wellness, purpose, and dignity of seniors and their families in the community. SeniorServ offers many services, including Meals on Wheels, Senior Center lunch programs, Adult Day Care /Adult Day Health Care/ Community-Based Adult Services, and Care Management services. By providing healthy meals for seniors, these programs have reduced isolation/loneliness, contributed to an increase in wellness, and improved quality of life. SeniorServ meets the needs of Orange County's seniors through its 600+ volunteers.

OCC MAC Member Presentation on Ombudsman Update

Member Sara Lee, Legal Aid Society of Orange County (LASOC), reported that the Ombudsman Service Program (OSP) at LASOC continues to assist members with OneCare Connect (OCC) enrollment issues, potential OCC disenrollment, and to help bridge services for members who have been terminated from OCC. Other services include assistance to dual eligible members with Share of Cost issues, and education of members on their OCC benefits, the role of the Personal Care Coordinator and care coordination. Ms. Lee reported that members need clarification on dental benefits and supplemental dental benefits since Denti-Cal was restored.

ADJOURNMENT

Chair Corzo announced that the next OCC MAC Meeting is Thursday, April 26, 2018.

Hearing no further business, the meeting adjourned at 4:18 p.m.

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/s/ Eva Garcia
Eva Garcia
Program Assistant

Approved: April 26, 2018

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MINUTES

SPECIAL JOINT MEETING OF THE CALOPTIMA BOARD OF DIRECTORS' MEMBER ADVISORY COMMITTEE, ONECARE CONNECT CAL MEDICONNECT PLAN (MEDICARE-MEDICAID PLAN) MEMBER ADVISORY COMMITTEE AND PROVIDER ADVISORY COMMITTEE

March 8, 2018

A Special Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC) and Provider Advisory Committee (PAC) was held on Thursday, March 8, 2018, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Sally Molnar, MAC Chair, called the meeting to order at 8:04 a.m., and PAC Chair Teri Miranti led the Pledge of Allegiance.

ESTABLISH QUORUM

Member Advisory Committee

Members Present: Sally Molnar, Chair; Patty Mouton, Vice Chair; Suzanne Butler, Sandy Finestone, Connie Gonzalez, Donna Grubaugh, Jaime Muñoz, Ilia Rolon, Christina Sepulveda, Velma Shivers, Sr. Mary Therese Sweeney, Christine Tolbert, Mallory Vega, Lisa Workman

Members Absent: All members present

OneCare Connect Member Advisory Committee

Members Present: Gio Corzo, Chair; Patty Mouton, Vice Chair; Sandy Finestone, Sara Lee, Richard Santana, Amber Nowak (non-voting)

Members Absent: Ted Chigaros, Christine Chow, Josefina Diaz, John Dupies, Kristin Trom; Jyothi Atluri (non-voting); Adam Crits (non-voting); Erin Ulibarri (non-voting)

Provider Advisory Committee

Members Present: Teri Miranti, Chair; Suzanne Richards, Vice Chair; Anjan Batra, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Steve Flood; Jena Jensen; Pamela Kahn, R.N.; Craig Myers; John Nishimoto, O.D; George Orras, Ph.D., FAAP; Mary Pham, Pharm.D., CHC; Pamela Pimentel, R.N.; Jacob Sweidan, M.D.

Members Absent: Mary Hale

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Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Dr. Richard Bock, Deputy Chief Medical Officer; Tracy Hitzeman, Executive Director, Clinical Operations; Michelle Laughlin, Executive Director, Provider Network Operations; Sesha Mudunuri, Executive Director, Operations; Kelly Rex-Kimmet, Interim Executive Director, Quality Analytics; Becki Melli, Program Specialist; and Cheryl Simmons, Project Manager

OCC MAC Chair Gio Corzo noted that the OCC MAC did not reach quorum.

PUBLIC COMMENTS

No requests for public comment were received.

Chief Executive Officer Report

Michael Schrader, Chief Executive Officer, reported that the County of Orange relocated 700 homeless individuals from the Santa Ana riverbed to motels. CalOptima personal care coordinators and Orange County Health Care Agency (HCA) staff will visit the motels to assess the health care needs of CalOptima members. Coordinated efforts are underway for a long-term solution. Mr. Schrader reported that the transition from California Children's Services' (CCS) to the Whole-Child Model (WCM) is on target. CalOptima's scheduled transition to the WCM is January 1, 2019. Mr. Schrader also reported that CalOptima's behavioral health transition has gone smoothly and has improved members' access to behavioral health services.

INFORMATION ITEMS

Orange County's Opioid Epidemic

Sandra Fair, Administrative Manager, Orange County Health Care Agency, presented an update on Orange County's opioid usage, including prescriptions, opioid-related emergency department (ED) visits and morbidity/mortality statistics. The HCA, along with community stakeholders, are focusing on prevention, harm reduction, treatment and recovery. Stakeholder and community planning sessions will begin in October 2018 and be held through January 2019. Upon completion of the community stakeholder meetings, a final report will be issued.

Orange County Coalition for Behavioral Health Presentation

Marshall Moncrief, Regional Executive Director, Institute for Mental Health and Wellness, Providence St. Joseph Health, Southern California Region, presented an overview of the Orange County Coalition for Behavioral Health. Mr. Moncrief reported that numerous public and private health care entities have convened to develop a coordinated system of care to improve mental and behavioral health care outcomes in Orange County. Three workgroups have been formed: 1) System of Care; 2) Infrastructure; and 3) Funding. Mr. Moncrief invited the Committee members to participate in these workgroups.

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Healthcare Effectiveness Data and Information Set (HEDIS) Performance

Kelly Rex-Kimmet, Interim Executive Director, Quality Analytics, provided an update on CalOptima's efforts to improve targeted underperforming HEDIS measures. CalOptima has implemented several member and provider quality initiatives. Although the findings are preliminary, the incentives appear to have improved some of the HEDIS scores.

Member Access to Providers

Several Committee members raised concerns regarding the difficulty members face in accessing providers and shared anecdotal accounts from members and providers regarding the difficulty in finding specialists who are culturally sensitive and can address rare or complex conditions. In addition, it was noted that members sometimes experience difficulty understanding the authorization and referral process.

ADJOURNMENT

There being no further business before the Committees, the meeting adjourned at 10:34 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: April 12, 2018

/s/ Becki Melli
Becki Melli
Staff to the MAC and OCC MAC

Approved: May 10, 2018

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MINUTES

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

April 12, 2018

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, April 12, 2018, 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 8:06 a.m., and Member Caliendo led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Teri Miranti, Chair; Anjan Batra, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Steve Flood; Jena Jensen; Pamela Kahn, R.N.; Craig G. Myers; John Nishimoto, O.D; Mary Pham, Pharm.D., CHC; Pamela Pimentel, R.N.; Jacob Sweidan, M.D.
Members Absent:	George Orras, Ph.D., FAAP; Suzanne Richards, MBA, FACHE, Vice Chair;
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Gary Crockett, Chief Counsel; Michelle Laughlin, Executive Director, Network Operations; Nancy Huang, Controller; Cheryl Simmons, Staff to the PAC

Chair Miranti announced that Mary Hale, Orange County Health Care Agency (OCHCA) Representative, has retired from the OCHCA.

MINUTES

Approve the Minutes of the February 8, 2018 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the minutes of the February 8, 2018 meeting. (Motion carried 12-0-0; Vice Chair Richards and Member Orras absent)***

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Approve the Minutes of the March 8, 2018 Joint Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC), OneCare Connect MAC and Provider Advisory Committees

Action: ***On motion of Member Pimentel, seconded and carried, the Committee approved the minutes of the March 8, 2018 Joint Meeting. (Motion carried 12-0-0; Vice Chair Richards and Member Orras absent)***

PUBLIC COMMENTS

No requests for public comment were received.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, referred PAC members to the CEO report included in the meeting materials.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, provided updates to several ongoing items. She noted that Behavioral Health Treatment Services were transferring from the Regional Center of Orange County (RCOC) effective July 1, 2018. Ms. Khamseh also discussed the timeline associated with the Whole Child Model (WCM), and the transition of the Child Health and Disability Prevention Program (CHDP) claim forms and the delegation of payment to the health networks. She noted that the Department of Healthcare Services changed the start date of the Health Homes Program from January 1, 2019 to July 1, 2019. Ms. Khamseh updated the PAC on anticipated additional Proposition 56 (Tobacco tax) funds and also mentioned that Medicare has begun to issue the new Medicare identification cards, which removes the member's social security number and replaces it with a new identification number.

Chief Financial Officer Update

Nancy Huang, Controller, presented the February 2018 financial report, and summarized CalOptima's financial performance and current reserve levels. Ms. Huang also provided a 2018-19 budget briefing and noted that the final budget would be presented to the Board at the June 7, 2018 meeting for their approval.

Network Operations Update

Michelle Laughlin, Executive Director, Network Operations, introduced Jennifer Bamberg as the new Director of Provider Relations. Ms. Laughlin shared the new Medicaid enrollment flier that has been developed and will be sent to all providers who are not registered in the State's Medi-Cal program. The flier informs providers about the new rule imposed by the Centers for Medicare & Medicaid Services (CMS) that all provider applications must be completed and submitted by the December 31, 2018 deadline to CMS. Ms. Laughlin also discussed the CCS transition to CalOptima. It was noted that discussions continue with the State concerning rates. It is anticipated that additional information will be provided at the May 10, 2018 PAC meeting.

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INFORMATION ITEMS

Strategic Plan Update
Michael Schrader, Chief Executive Officer, presented an update on CalOptima's 2017-2019 Strategic Plan. There was much discussion centered on the Intergovernmental Transfer (IGT) funds and the programs attributed to the various IGTs, in particular, IGTs 5, 6 and 7. Mr. Schrader reported that a Request for Information (RFI) would be sent out with the next week or two to identify the best use of IGT 5 funds for mental health purposes.

Joint MAC/OCC MAC and PAC Meeting Debrief
This agenda item was moved to the May PAC meeting.

PAC Goals and Objectives
Chair Miranti asked the committee to review the Goals and Objectives for the second quarter and let Staff know if they had any suggested changes.

PAC Member Updates
Chair Miranti noted that the PAC Nominations Ad Hoc Committee would be meeting on April 18, 2018 to review the candidates for the open PAC seats.

ADJOURNMENT
There being no further business before the Committee, Chair Miranti adjourned the meeting at 9:59 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: May 10, 2018

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

3. Consider Approval of the Methodology for and the Disbursement of Years 2-5 OneCare Connect Quality Withhold Payment to Participating Health Networks

Contact

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

Recommended Action

Approve the methodology for and the disbursement strategy of One Care Connect (OCC) demonstration years (DY) 2-5 (calendar years 2016 – 19), Quality Withhold payment to contracted Health Networks, including CalOptima's Community Network (CCN).

Background

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

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

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

To better align quality with cost of care, the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A/B capitation. Medi-Cal monies are not withheld from health networks. The amounts of the withhold are 1% for Year One (calendar year 2015), 2% for Year Two (calendar year 2016), and 3% for Years Three, Four, and Five (calendar years 2017-2019). All or a part of the withhold may be earned back based on a percentage of quality withhold measures that achieved benchmarks established by DHCS and CMS. Measures and benchmarks are based on final guidance received by CalOptima Regulatory Affairs from CMS and DHCS.

On August 6, 2015, the CalOptima Board of Directors approved the methodology and disbursement of the DY 1 (MY2015) quality withhold that was received from DHCS and CMS in October 2017 and

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distributed to the health networks. Additional Board action is required for the methodology and distribution of earned quality withhold dollars for DY2-5.

Discussion

CalOptima began to participate in the Cal MediConnect program on July 1, 2015. Because CalOptima's participation in Cal MediConnect began midyear, the measurement period for DY 1 was considered July 1, 2015 to December 31, 2015. Subsequent years (years 2-5) began in 2016 and reflect services rendered from January 1 to December 31 of each year.

The quality withhold reduces capitation for both Medi-Cal and Medicare payments to CalOptima by two percent (2%) in Year Two and by three percent (3%) in Years Three, Four, and Five. These withheld funds can be earned back by CalOptima by "passing" a percentage of defined quality withhold measures. Measures are "passed" by managed care plans by achieving the established benchmark set by CMS for each quality withhold measure. The measures are prescribed by DHCS and CMS based on industry standard quality metrics such as HEDIS/Star measures and are communicated to plans via the Medicare-Medicaid Capitated Financial Alignment Model Quality Withhold Technical Notes. Managed care plans earn their withhold back according to the following guidance:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

While the health networks do not have full accountability for every measure, there are measures that CalOptima has direct responsibility for and others that have shared responsibility between the delegated health networks and CalOptima.

CalOptima proposes the following methodology to distribute earned funds back to contracted health networks:

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Health Network Scoring

- Quality Points is the sum of all points earned for each measure.

Health Network Measure Performance Points

- Uses NCQA National Medicaid HEDIS Percentiles as benchmark for NCQA HEDIS measures
- Uses CMS Star Cut Points as Benchmark for CMS Star Measure(s)
- Minimum denominator of 1% of Total Denominator

Quality Points	Star / Percentile
1	3 Stars / 50th Percentile
2	4 Stars / 75th Percentile
3	5 Stars / 90th Percentile

Health Plan Measure Points

- Benchmark is set by Cal MediConnect.
- Points based on CalOptima's rate for measure
  - 1 point if CalOptima passes measure
  - 0 point if CalOptima does not pass measure

Distribution of Earned Withhold Funds to the Health Networks

CalOptima's contracts with the health networks provides that "CalOptima will allocate to Physician Group an amount of revenue withhold attributed to Physician Group's performance on the withhold measures. Final distribution methodology to Physician Group is subject to CalOptima Board of Directors approval."

- The methodology that staff is proposing for DY2-5 provides that Medicare withhold funds which are earned back by CalOptima will be distributed to the Health Networks, including the CalOptima Community Network (CCN), based on performance and percent of premium (POP). The distribution to a health network will not exceed the amount of funds originally withheld from its capitation. If CMS does not return withheld funds based on performance results, then no Quality Withhold money will be paid out to any network, regardless of their performance on the quality measures.
- Eligibility to receive any withhold monies earned by CalOptima will be dependent on the health network's good standing with CalOptima and their active contractual status with CalOptima during any part of the measurement period, as well as at the time of distribution.

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- Distribution of earned back withhold funds attributable to CalOptima Community Network (CCN) membership will be similar to other health network distribution of withheld dollars. Staff will return at a later date to propose a distribution strategy specifically to CCN providers.
- Withhold money will be distributed to health networks, including CalOptima Community Network (CCN), after CalOptima receives the withhold money from CMS.
- Health Networks will receive their withhold money within 90 days of CalOptima receiving the withhold money from CMS.
- CalOptima contracts with health networks under various arrangements and the allocation for each health network will depend on the withheld amounts received from CMS and the health network performance on the quality measures benchmarked by CMS.
- Health Network payment will depend on the arrangement with CalOptima. Based on current capitation contract arrangement with health networks for CMS revenue, Health Maintenance Organizations (HMOs) will receive their contractually agreed percentage of the withheld amounts for professional services and for hospital services.
- For Physician Hospital Consortiums (PHCs) however, the Physician side of the PHCs will receive their contractually agreed percentage of the withheld amounts for professional services but CalOptima will pay the contractually agreed percentage for hospital services directly to the hospitals.
- Shared Risk Groups (SRGs) will also receive their contractually agreed percentage of the withheld amounts for professional services but the hospital allocation will be contributed to the SRG pool.

Fiscal Impact

The recommended action is budget neutral to CalOptima. The amount of Medicare quality withhold funds earned back by CalOptima, if any, will be sufficient to fund distributions to health networks and CCN with no additional fiscal impact to the operating budget.

Rationale for Recommendation

These recommendations reflect alignment between health network and CalOptima activities to provide quality healthcare to dual eligible members based on DHCS and CMS directed measures. Greater success in demonstrating quality healthcare will also result in earning back a greater amount of the withhold amount.

Concurrence

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

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Attachment
Board Action dated August 6, 2015, Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks

/s/ Michael Schrader *5/30/2018*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
VIII. F. Approve the Methodology for and the Disbursement of the Year One, OneCare Connect Quality Withhold Payment to Participating Health Networks

Contact
Richard Bock, MD, Deputy Chief Medical Officer, (714) 246-8400

Recommended Action
Approve the methodology for and the disbursement of the Year One, OneCare Connect Quality Withhold payment to participating Health Networks.

Background
July 2012 marked the passage of the Coordinated Care Initiative in California. The Coordinated Care Initiative (CCI) aims to integrate the delivery of medical, behavioral, and long term care services while providing a road map to integrate Medicare and Medi-Cal for people in both programs, called "dual eligible" members.

Central to the CCI model is care coordination. And a critical piece to the model is the care coordination provided for by the member's primary care provider (PCP) and health network. The CCI is expected to produce greater value by improving health outcomes and containing costs; primarily by shifting clinically appropriate service delivery into the home and community and away from expensive institutional settings.

In order to better align quality with cost of care, the Department of Health Care Services (DHCS) and Centers for Medicare & Medicaid Services (CMS) have constructed a quality withhold process, which applies to Medi-Cal and Medicare Part A/B capitation. The amounts of the withhold are 1% for Year One, 2% for Year Two, and 3% for Year Three. All or a part of the withhold may be earned back based on a methodology developed by DHCS and CMS.

Discussion
CalOptima began to participate in the CCI program on July 1, 2015. Given the delayed start date of the program, the first year of the withhold process will be shortened to reflect services rendered from July 1, 2015 to December 30, 2015.

There are ten quality withhold measures in CCI for Year one. Five of these measures are California-specific and were just released by CMS on July 8, 2015.

- Encounter data
- Getting appointments and care quickly
- Customer service
- Behavioral Health provider participates in care plan development (shared accountability measure, payout shared with county)

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- Documentation of care goals
- Case Management contact with member
- OneCare Connect Member Advisory Council implementation
- Memorandum of understanding with County Mental Health
- Timely completion of Health Risk Assessments
- Physical access work plan

Capitation for both Medi-Cal and Medicare payments to CalOptima will be reduced by one percent (1%) in Year One. These withheld funds can be earned back by CalOptima in the following manner:

- Plan will pass or fail each measure based on benchmarks
- All withhold measures will be weighted equally
- If a measure cannot be calculated due to timing constraints (of the shortened Year one) or enrollment requirements, it will be removed from the total number of withhold measures on which the plan will be evaluated.
- Payout will be based on:

Percent of Measures Passed	Percent of Withhold MMP Receives
0-19%	0%
20-39%	25%
40-59%	50%
60-79%	75%
80-100%	100%

Distribution of Earned Withhold Funds to the Health Networks:
CalOptima's contracts with the networks provides that "CalOptima will allocate to Physician Group, and amout of revenue withhold attributed to Physician Group's performance on the withhold measures. Final distribution methodology to Physician Group is subject to CalOptima Board of Directors approval." While the health networks do not have full accountability for every measure, there are measures that CalOptima has direct responsibility for and others that have shared responsibility between the delegated health networks and CalOptima. In addition, since the two Behavioral Health measures are governed by language in the three-way contract regarding shared responsibility with County Mental Health, disbursement for them will be described in a future staff recommendation to the Board after further guidance from the State is released. Similarly, distribution of earned back withhold funds attributable to Community Network membership will be described in a future staff recommendation. As 1% of capitation is withheld from CalOptima, the downstream percent of premium (POP) Medicare capitation payments to Health Networks will be similarly reduced. Taking into consideration the truncated duration of Year One and continuing regulatory refinement of the program, the methodology that staff is proposing for Year One provides that Medicare withhold funds which are earned back by CalOptima will be shared with the Health Networks using the identical POP formula.

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- For example, if CalOptima's revenue is $1,000 per member per month (PMPM), the quality withhold is 1%, and a networks's POP is 35%, the network's capitation will be 35% x $990, which is $346.50 PMPM.

- Assuming CalOptima recoups the full withhold of $10, the network will receive 35%, or $3.50 PMPM.

- Future distribution formulae for Years 2 and 3 may take into account the Health Networks' per cent responsibility for, and the relative performance on, the expanded measure set, but this simpler approach is more appropriate for Year One.

- If CalOptima does not recoup any withhold money, then no Quality Withhold money will be paid out to any network regardless of their performance on the quality measures.

Eligibility to receive any withhold monies earned by CalOptima will be dependent on the health network's good standing with CalOptima and their active contractual status with CalOptima during any part of the measurement period as well as at the time of distribution.

Fiscal Impact
The recommended action is projected to be budget neutral to CalOptima. Distributions to health networks will not exceed the amount of withheld funds that are earned back.

Rationale for Recommendation
These recommendations reflect alignment between health network and CalOptima activities to provide quality healthcare to dual eligible members based on DHCS and CMS directed measures. Greater success in demonstrating quality healthcare will also result in earning back a greater amount of the withhold amount.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

07/31/2015 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

4. Consider Approval of the Modification of the Previously Approved Pay for Value (P4V) Payment Methodology for Measurement Year 2017 (MY2017) for CalOptima Community Network (CCN) Providers by Incorporating an Improvement Factor

Contact

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

Recommended Action

Approve the addition of an improvement factor to the MY2017 payment methodology for CCN primary care providers for Medi-Cal, subject to regulatory approval, as applicable.

Background

CCN Provider distribution was approved by the Board of Directors on November 02, 2017. This COBAR describes the proposed improvement factor which will be included with the distribution of payments to the CCN providers for earned CCN MY2017 P4V distribution.

Discussion

There are no changes to the previously approved P4V measures for MY 2016-2017 nor any changes to eligibility for payment. This amendment seeks to align the health network and CCN P4V programs by including an improvement factor for the CCN P4V program in recognition of the fact that the CCN P4V program has attained an adequate program history to measure and incentivize improvement in performance from the prior year.

To recognize performance and support sustained improvement in the overall P4V measures, staff recommends that the improvement factor for CCN providers be based on the following principles:

- The Medi-Cal CCN Clinical measures improvement payment calculations will include the percent change from the previous year. A relative point system is applied based on the percent change achieved.
- Clinical funds will be distributed 25% for improvement and 75% for performance.
- A detailed description of the improvement factor methodology is included in Attachment 2.

Distribution of Incentive Dollars

Performance allocations are distributed upon final calculation and validation of each measurement rate. To qualify for payment for each of the clinical measures, the provider must meet the minimum denominator and distribution, as noted.

To qualify for payments, a physician or clinic must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

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Fiscal Impact

The recommended action to add an improvement factor to the MY2017 payment methodology for Medi-Cal CCN providers is budget neutral. The P4V program funding for the Medi-Cal line of business is budgeted up to a maximum of $2.00 per member per month. The distribution of incentive dollars for the MY2017 P4V program for Medi-Cal will be made in Fiscal Year (FY) 2018-19. Management will include expenses related to the program in the upcoming proposed FY 2018-19 operating budget.

Rationale for Recommendation

This alignment will leverage improvement efforts and efficiencies that the CalOptima Community Health Network implements in conjunction with the other Health Networks. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

Concurrence

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

Attachment

Board Action dated November 02, 2017, Approve Measurement Year 2016 Payment Methodology and Distribution Strategy for the Pay for Value (P4V) Program for CalOptima Community Network (CCN) Providers for Medi-Cal and OneCare Connect (OCC)

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

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

3. Consider Approval of the Proposed Pay for Value (P4V) Payment Methodology for CalOptima Community Network (CCN) Providers for Medi-Cal and OneCare Connect, and Distribution of Payments to Providers

Contact

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

Recommended Actions

1. Approve Measurement Years 2016 and 2017 payment methodology for the Pay for Value (P4V) Program for CalOptima Community Network (CCN) Providers for Medi-Cal and OneCare Connect (OCC), subject to regulatory approval, as applicable (Attachment 1); and
2. Authorize distribution of P4V payments based on this methodology in an amount not to exceed $2.00 per member per month (pmpm) for CCN Medi-Cal and $20.00 pmpm for CCN OneCare Connect membership.

Background

CalOptima Community Network (CCN) was established in March 2015 as a health network as a component of CalOptima Direct (COD). Since then, CCN has been held accountable to the same standards as other delegated health networks and is routinely assessed by CalOptima's Audit and Oversight Department for regulatory, operational, and accreditation compliance. CCN now has over 3,500 contracted Specialists, 600 primary care providers (PCPs), and serves over 70,000 members. CalOptima did not establish a Pay for Value program or incentive payments for CCN in 2015, as time was needed to have at least a full year of meaningful data before performance measures could be calculated and comparisons made.

CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care. CCN, as a Health Network, will potentially pay incentive dollars to 97% of its contracted and eligible PCPs through the 2016 P4V Program. The 2017 P4V program is still in process, so it it currently unknown what portion of contracted PCPs will be eligible for P4V incentive payments under the 2017 P4V plan. CCN intends to distribute earned P4V dollars directly to contracted Primary Care Providers (PCPs) in an effort to gain attention, involvement and investment in quality initiatives.

The purpose of CalOptima's P4V program for our Health Networks, which includes CalOptima Community Network as previously approved by the Board on April 7, 2016 (Attachment 2) and amended on October 6, 2016 for Fiscal Year (FY) 2016 (Attachment 3) and approved by the Board on March 2, 2017 for FY 2017 (Attachment 4), is three-fold:

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1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks and physicians on their quality improvement efforts.

Based on these previous staff recommendations, the Board approved the inclusion of CCN in the overarching P4V program and payment as a Health Network. This staff report provides the clarifying details on the scoring, payment methodology, and distribution of payments directly to the CCN PCPs. No elements of this plan changes CalOptima's overarching P4V Health Network program, as previously approved by the Board of Directors.

Discussion

In order to recognize individual provider performance, and gain involvement in improving quality measures, staff recommends that the scoring methodology for CCN providers be based on the following principles:

- The Medi-Cal CCN P4V program includes the same clinical performance measures as all other HN's included in CalOptima's MY 2016 and 2017 Pay for Value program – measured at the individual provider level;
- The Medi-Cal CCN P4V program includes the same measures of member satisfaction as all other HN's which assesses the parent's satisfaction with their child's care and adult members' satisfaction with their care, measured at the CCN (i.e., Health Network) level, as surveys were not conducted at the individual provider level;
- For the clinical measures, the program rewards performance by clinical measure – there will not be a measure for improvement, as 2016 is considered the baseline year for CCN; for 2017, the program will include a reward for improvement;
- Due to smaller denominators at the physician specific level for CCN, a minimum denominator size of 5 eligible members for each performance measure will be required to be eligible for incentive payment (Medi-Cal only);
- The Medi-Cal CCN Clinical measures payment calculations will include performance score by measure plus a factor for member months (recognizing the volume of members attributed to a particular provider);
- The Medi-Cal CCN CAHPS member satisfaction survey was only completed at the Health Network level, therefore, this component of the CCN P4V payment will be based on the provider's membership percentage of Medi-Cal CCN Health Network CAHPS funds and based on the overall CAHPS performance for CCN;
- An individual provider's distribution must be a minimum of $100 for payment to be made.
- The proposed methodology will be utilized for Measurement Years 2016 and 2017 P4V Medi-Cal and OCC programs

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Based on this distribution methodology, over 97% of CCN's contracted and eligible PCPs will earn P4V dollars based on their performance during MY 2016.

Distribution of Incentive Dollars

Performance allocations are distributed based upon final calculation and validation of each measurement rate. To qualify for payment for each of the clinical measures, the provider must meet the minimum denominator and distribution, as noted.

The Medi-Cal CCN provider payments for clinical measures will be based on the provider's measurement rate for each clinical performance measure and member months. As CalOptima did not obtain individual provider satisfaction data, staff recommends that CAHPS payments will be distributed based on the provider's percent of total CCN Medi-Cal membership.

Staff also recommends that the OneCare Connect CCN provider payments will be based on the provider's percent of total CCN OCC membership.

In order to qualify for payments, a physician or clinic must be contracted with CalOptima during the entire measurement period, and the period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

Fiscal Impact

The recommended action to approve the Measurement Year 2016 payment methodology and distribution strategy for the P4V Program for CCN Provisions for the Medi-Cal and OCC program is a budgeted item and included in the CalOptima FY 2017-18 Operating Budget approved by the Board on June 1, 2017 up to a maximum of $2.00 pmpm for CCN Medi-Cal and $20.00pmpm for CCN OneCare Connect membership. Since the distribution of incentive dollars for the MY 2017 P4V Programs for Medi-Cal and OneCare Connect will be made in FY 2018-19, Management plans to include expenses related to the MY 2017 P4V programs in the upcoming proposed FY 2018-19 operating budget.

Rationale for Recommendation

This alignment will leverage improvement efforts and efficiencies that the CalOptima Community Health Network implements in conjunction with the other Health Networks. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

Concurrence

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

Attachments

1. PowerPoint Presentation dated September 20, 2017 - Pay for Value Program: CCN Provider Payment Methodology
2. Board Action dated October 6, 2016, Consider Approval of Amendment to the Measurement Year 2016 Pay for Value Program Payment Methodology for Medi-Cal
    a. Attachment - Board Action dated April 7, 2016, Approve Measurement Year CY2016 Pay for Value Programs for Medi-Cal and OneCare Connect

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3. Board Action dated March 2, 2017, Consider Approval of the Fiscal Year 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect

/s/ Michael Schrader *10/23/2017*
Authorized Signature **Date**

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Pay for Value Program CCN Provider Payment Methodology

Board of Directors' Quality Assurance Committee Meeting

September 20, 2017

Richard Bock, M.D., M.B.A.

Deputy Chief Medical Officer

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Medi-Cal Health Network Payment Methodology

Population Included

Total Number of Adult Member Months (MM) and Total Number of Child MM

SPD Members Weighted 4x Non-SPD Members

Payment Calculation

- **Allocated Funds =** Total MM for all health networks x the allocated PMPM.
- Allocated PMPM for 2016 is **$2.00**

Clinical Funds = 60% of Allocated Funds ($1.20 PMPM)

- **Clinical Funds =** Performance Funds ($0.60 PMPM) + Improvement Funds ($0.60)
- **Performance Payments =** Performance Funds
- **Improvement Payments =** Improvement Funds **x** CalOptima overall improvement pct.

CAHPS Funds = 40% of Allocated Funds ($0.80 PMPM)

- **CAHPS Funds =** Performance Funds ($0.40 PMPM) + Improvement Funds ($0.40)
- **Performance Payments =** Performance Funds
- **Improvement Payments =** Improvement Funds **x** CalOptima overall improvement pct.

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Medi-Cal Health Network Payments
Clinical Adult (No overall CalOptima Improvement)

Health Network	Member Months	Perform Score	Perform Payment	Improv Score	Improv Payment	Clinical Payment	PMPM
CCN	547,289	2	$220,178	NA	$0	$220,178	$0.40
HN 1	7,581	8	$11,243	NA	$0	$11,243	$1.48
HN 2	109,648	0	$0	0	$0	$0	$0
HN 3	219,701	5	$196,358	2	$0	$196,358	$0.89
HN 4	296,063	2	$108,602	0	$0	$108,602	$0.37
HN 5	287,593	3	$164,558	1	$0	$164,558	$0.57
HN 6	226,055	4	$183,119	4	$0	$183,119	$0.81
HN 7	405,254	4	$315,714	3	$0	$315,714	$0.78
HN 8	741,509	3	$449,735	2	$0	$449,735	$0.61
HN 9	325,998	6	$380,232	0	$0	$380,232	$1.17
HN 10	18,508	2	$7,146	NA	$0	$7,146	$0.39
HN 11	312,981	1	$59,005	0	$0	$59,005	$0.19
HN 12	567,125	3	$343,293	5	$0	$343,293	$0.61

Based upon December, 2016 Prospective Rates

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CalOptima A Public Agency Better. Together.

Medi-Cal Health Network Payments
Clinical Child (No overall CalOptima Improvement)

Health Network	Member Months	Perform Score	Perform Payment	Improv Score	Improv Payment	Clinical Payment	PMPM
CCN	191,455	4	$129,091	NA	$0	$129,091	$0.67
HN 1	981	0	$0	NA	$0	$0	$0
HN 2	1,746,424	4	$1,184,357	0	$0	$1,184,357	$0.68
HN 3	83,468	4	$54,191	0	$0	$54,191	$0.65
HN 4	134,557	3	$65,731	0	$0	$65,731	$0.49
HN 5	145,805	3	$71,172	2	$0	$71,172	$0.49
HN 6	95,644	4	$62,279	0	$0	$62,279	$0.65
HN 7	196,515	4	$127,724	1	$0	$127,724	$0.65
HN 8	351,055	3	$174,356	0	$0	$174,356	$0.50
HN 9	108,542	3	$52,493	0	$0	$52,493	$0.48
HN 10	4,140	0	$0	NA	$0	$0	$0
HN 11	152,720	2	$50,126	0	$0	$50,126	$0.33
HN 12	403,977	3	$197,651	0	$0	$197,651	$0.49

Based upon December, 2016 Prospective Rates

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Medi-Cal Health Network Payments
CAHPS Adult

Health Network	Member Months	Perform Score	Perform Payment	Improv Score	Improv Payment	CAHPS Payment	PMPM
CCN	547,289	5	$619,108	NA	$0	$619,108	$1.13
HN 1	7,581	0	$0	NA	$0	$0	$0
HN 2	109,648	5	$112,358	1	$3,463	$115,821	$1.06
HN 3	219,701	0	$0	0	$0	$0	$0
HN 4	296,063	0	$0	2	$18,826	$18,826	$0.06
HN 5	287,593	0	$0	0	$0	$0	$0
HN 6	226,055	4	$205,961	1	$7,936	$213,897	$0.95
HN 7	405,254	2	$177,548	3	$41,045	$218,593	$0.54
HN 8	741,509	1	$168,611	5	$129,932	$298,543	$0.40
HN 9	325,998	3	$213,831	7	$79,896	$290,727	$0.89
HN 10	18,508	0	$0	NA	$0	$0	$0
HN 11	312,981	0	$0	3	$30,685	$30,685	$0.10
HN 12	567,125	1	$128,705	2	$39,672	$168,377	$0.30

Based upon measurement years 2015 and 2014 results

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CalOptima A Public Agency Better. Together.

Medi-Cal Health Network Payments
CAHPS Child

Health Network	Member Months	Perform Score	Perform Payment	Improv Score	Improv Payment	CAHPS Payment	PMPM
CCN	191,455	2	134,939	NA	$0	$134,939	$0.70
HN 1	981	0	0	NA	$0	$0	$0
HN 2	1,746,424	2	1,238,013	2	$0	$1,238,013	$0.71
HN 3	83,468	0	0	0	$0	$0	$0
HN 4	134,557	0	0	0	$0	$0	$0
HN 5	145,805	0	0	0	$0	$0	$0
HN 6	95,644	0	0	1	$0	$0	$0
HN 7	196,515	0	0	0	$0	$0	$0
HN 8	351,055	0	0	3	$0	$0	$0
HN 9	108,542	2	73,161	5	$0	$73,161	$0.67
HN 10	4,140	0	0	NA	$0	$0	$0
HN 11	152,720	0	0	0	$0	$0	$0
HN 12	403,977	0	0	3	$0	$0	$0

Based upon measurement years 2015 and 2014 results

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CalOptima A Public Agency Better. Together.

Medi-Cal CCN Providers

- Paying over 200 providers
- Clinical Payment
  - Provider clinical performance and membership
- CAHPS Payment
  - Provider membership
- Not all CCN providers will be paid due to:
  - Small membership
  - Did not achieve 50th percentile

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Medi-Cal CCN Health Network Payment

CCN	Member Months	Payment	PMPM
Clinical			
Adult Clinical Performance	547,289	$220,178	$0.40
Adult Clinical Improvement		NA	
Child Clinical Performance	191,455	$129,091	$0.67
Child Clinical Improvement		NA	
Total Clinical Payment	**738,744**	**$349,269**	**$0.47**
CAHPS			
Adult CAHPS Performance	547,289	$619,108	$1.13
Adult CAHPS Improvement		NA	
Child CAHPS Performance	191,455	$134,939	$0.70
Child CAHPS Improvement		NA	
Total CAHPS Payment	**738,744**	**$754,047**	**$1.02**
Total CCN Payment	**738,744**	**1,103,316**	**$1.49**

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Medi-Cal CCN Provider Payment Methodology

Population Included

Total Number of Adult Member Months (MM) and Total Number of Child MM

Payment Calculation

- **Clinical Funds =** Total Clinical Payment for CCN Health Network (adult and child)
- **CAHPS Funds =** Total CAHPS Payment for CCN Health Network (adult and child)

Clinical Provider Payment

- **Clinical Payment =** MM **x** Perform % **x** Clinical % **x** Clinical Funds

CAHPS Provider Payment

- **CAHPS Payment =** Membership Percentage **x** CAHPS Funds

Total CCN Provider Payment

- **Provider Payment =** Clinical Payment **+** CAHPS Payment
  (Minimum payment of $100)

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Medi-Cal P4V Clinical Measures

2016 and 2017 Year Measures	
Adult	**Child**
Adult Access to Preventive Care Services	Adolescent Well-Care Visits
Breast Cancer Screening	Appropriate Testing for Children with Pharyngitis
Cervical Cancer Screening	Appropriate Treatment for Children with URI
Diabetes Care: A1C Testing	Childhood Immunizations: Combo 10
Diabetes Care: Retinal Eye Exams	Children's Access to Primary Care Providers
Medication Management for People with Asthma: Total 75% Compliance	Medication Management for People with Asthma: Total 75% Compliance
	Well-Child Visits 3–6 Years

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Medi-Cal CCN Provider Payment Methodology Clinical Calculation

- Adult and Child P4V Health Network Measures
- Included Measures
  - Number of measures with a minimum denominator of 5
  - 6 adult measures
  - 7 child measures
- Qualified Measures
  - Minimum of 50th percentile

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Medi-Cal CCN Provider Payment
Adult Clinical Calculation Example

Provider C Measure	Denom	Percentile	Included Measure	Qualified Measure
Adult Access to Preventive Care Services	15	75th	1	1
Breast Cancer Screening	20	75th	1	1
Cervical Cancer Screening	25	50th	1	1
Diabetes Care: A1C Testing	10	25th	1	0
Diabetes Care: Retinal Eye Exams	3	75th	0	0
Medication Management for People with Asthma	0	NA	0	0
Total			**4**	**3**

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Medi-Cal CCN Provider Payment
Adult Clinical Calculation Example

Provider	Included Measures	Qualified Measures	MM	Clinical Perform	Perform & MM Weight	Clinical Percent	Clinical Payment
Provider A	6	5	400,000	83.33%	333,333	83.86%	$184,636
Provider B	6	2	80,000	33.33%	26,667	6.71%	$14,770
Provider C	4	3	50,000	75.00%	37,500	9.43%	$20,772
Provider D	2	0	17,289	0%	0	0%	$0
Total					**397,500**		**$220,178**

Provider A

MM * Clinical Perform = Perform & MM Weight
400,000 * 83.33% = 333,333

Perform & MM Weight / Total Perform & MM Weight = Clinical Percent
333,333 / 397,500 = 83.86%

Clinical Percent * CCN Clinical Funds = Clinical Payment
83.86% * $220,178 = $184,636

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Medi-Cal CCN Provider Payment Child Clinical Calculation Example

Provider C Measure	Denom	Percentile	Included Measure	Qualified Measure
Children's Access to Primary Care Providers	25	25th	1	0
Well-Child Visits 3–6 Years	50	50th	1	1
Adolescent Well-Care Visits	10	50th	1	1
Childhood Immunizations: Combo 10	4	75th	0	0
Appropriate Testing for Children with Pharyngitis	2	25th	0	0
Appropriate Treatment for Children with URI	0	NA	0	0
Medication Management for People with Asthma	0	NA	0	0
Total			**3**	**2**

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Medi-Cal CCN Provider Payment
Child Clinical Calculation Example

Provider	Included Measures	Qualified Measures	MM	Clinical Perform	Perform & MM Weight	Clinical Percent	Clinical Payment
Provider A	7	6	60,000	85.71%	51,429	51.18%	$66,075
Provider B	7	2	55,000	28.57%	15,714	15.64%	$20,190
Provider C	3	2	50,000	66.67%	33,333	33.18%	$42,826
Provider D	2	0	26,455	0%	0	0%	$0
Total					**100,476**		**$129,091**

Provider A

MM * Clinical Perform = Perform & MM Weight
60,000 * 85.71% = 51,429

Perform & MM Weight / Total Perform & MM Weight = Clinical Percent
51,429 / 100,476 = 51.18%

Clinical Percent * CCN Clinical Funds = Clinical Payment
51.18% * $129,091 = $66,075

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Medi-Cal CCN Provider Clinical Payment

Provider	Adult and Child Member Months	Adult Payment	Child Payment	Clinical Payment	PMPM
Provider A	460,000	$184,636	$66,075	$250,711	
Provider B	135,000	$14,771	$20,190	$34,960	
Provider C	100,000	$20,772	$42,826	$63,598	
Provider D	43,744	$0	$0	$0	
Total	**738,744**	**$220,178**	**$129,091**	**$349,269**	**$0.47**

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Medi-Cal P4V CAHPS Measures

2016 Measurement Year Measures
Adult and Child Measures
Getting Appointment with a Specialist
Timely Care and Service (composite)
Rating of PCP
Rating of all Health Care

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Medi-Cal CCN Provider Payment CAHPS Calculation Example

Provider	Member Months	Member Month Percent	CAHPS Payment
Provider A	460,000	62.27%	$469,529
Provider B	135,000	18.27%	$137,797
Provider C	100,000	13.54%	$102,071
Provider D	43,744	5.92%	$44,650
Total	**738,744**		**$754,047**

Provider A

MM / Total MM = MM Percent

460,000 / 738,744 = 62.27%

MM Percent * CCN CAHPS Funds = CAHPS Payment

62.27% * $754,047 = $469,529

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Medi-Cal CCN Provider Total Payment

Provider	Member Months	Clinical Payment	CAHPS Payment	Total Payment	PMPM
Provider A	460,000	$250,711	$469,529	$720,240	
Provider B	135,000	$34,960	$137,797	$172,757	
Provider C	100,000	$63,598	$102,071	$165,669	
Provider D	43,744	$0	$44,650	$44,650	
Total	**738,744**	**$349,269**	**$754,047**	**$1,103,316**	**$1.49**

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OneCare Connect Health Network Payment Methodology

Population Included
Total Number of Member Months (MM)
Payment Calculation
• **Allocated Funds =** Total MM for all Health Networks x the Allocated PMPM. • Allocated PMPM for 2016 is **$20**.
Clinical Funds = 100% of Allocated Funds ($20 PMPM) • **Clinical Funds =** Performance Funds ($10 PMPM) + Improvement Funds ($10) • **Performance Payments =** Performance Funds • **Improvement Payments =** Improvement Funds **x** CalOptima Overall Improvement Pct.

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OneCare Connect CCN Health Network Payment

CCN	Payment	PMPM
Clinical		
Clinical Performance	$139,246	$6.15
Clinical Improvement	$0	$0
Total Clinical Payment	**$139,246**	**$6.15**

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OneCare Connect Provider Payment Methodology

Population Included
Total Number Member Months (MM)
Payment Calculation
• **Funds =** Total Clinical Payment for CCN Health Network
Clinical Provider Payment
• **Provider Payment =** Membership Percentage **x** Funds (Minimum payment of $100)

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OneCare Connect P4V Measures

2016 Measurement Year Measures
Antidepressant Medication Management: Effective Acute Phase Treatment
Antidepressant Medication Management: Effective Continuation Phase Treatment
Controlling High Blood Pressure
Part D Medication Adherence for Oral Diabetes Medications
Plan All-Cause Readmissions

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OneCare Connect CCN
Provider Calculation and Payment Example

Provider	MM	MM Percent	Payment	PMPM
Provider A	15,000	66.25%	$92,248	
Provider B	4,000	17.67%	$24,600	
Provider C	2,000	8.83%	$12,300	
Provider D	1,642	7.25%	$10,098	
Total	**22,642**		**$139,246**	**$6.15**

Provider A

MM	/	Total MM	=	MM Percent
15,000	/	22,642	=	66.25%

MM Percent	*	CCN Funds	=	Provider Payment
66.25%	*	$139,246	=	$92,248

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken October 6, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

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

Recommended Action

Approve amendment to Measurement Year CY 2016 Pay for Value (P4V) for Medi-Cal, which defines the allocations, scoring methodology and distribution for both performance and improvement, as described below, subject to regulatory approval, as applicable.

Background

CalOptima has implemented a comprehensive Health Network Performance Measurement System consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care.

The purpose of the Health Network performance measurement system, which includes both delegates and the CalOptima Community Network as previously approved by the Board on April 7, 2016, is three-fold:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance and improvement;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks on their quality improvement efforts.

Staff is now proposing to add additional details on the scoring and payment methodology which was not previously addressed.

Discussion

As indicated, the Board approved the Measurement Year CY 2016 P4V programs for Medi Cal and OneCare Connect at its April 2016 meeting. As indicated at that time, staff recommended that the scoring methodology be based on the following principles:

- Address the need to consider the complexity or member acuity (Seniors and Persons with Disabilities (SPD) compared to Non-SPD members) and the subsequent higher consumption of physician/health network resources to care for SPD members;
- Reward both performance and improvement;
- Improvement funding will be contingent upon CalOptima's overall improvement (New);
- Include both Adult and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and increase the value of these measures in the program, thereby expanding our focus on the member experience.

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Population Included:	
Total # of Adults in Health Network	Total # of Children in Health Network
Apply Acuity Score (SPD Weight 4X, TANF Weight 1X)	
Payment	
50% based on Performance score and 50% based on Improvement score Improvement score will be weighted by CalOptima's overall improvement	
Clinical Measures = 60% of the Total	CAHPS Measures = 40% of the Total
Proposed Scoring for Measure Performance:	
• A relative point system by measure, based on: • NCQA National HEDIS Percentiles (clinical measures) • NCQA National CAHPS Percentiles (satisfaction measures) • Final score is the sum of points for each measure • Improvement score based on improvement from previous year (receiving 1 point for increasing each percentile level and negative 1 point for decreasing)	

P4V Scoring - NEW
Performance Points – HEDIS & CAHPS
1 point: >= 50th percentile 2 points: >= 75th percentile 3 points: >= 90th percentile No points <50th percentile
Improvement points – HEDIS & CAHPS
1 point for increasing 1 percentile level (e.g. 1 point for 25th percentile to 50th percentile; 2 points for 50th percentile to 90th percentile, etc.) Negative one (-1) point for decreasing 1 percentile level (e.g. -1 point for 75th percentile to 50th percentile; -2 points for 50th percentile to 10th percentile, etc.)

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The proposed Measurement Year CY 2016 Medi-Cal Pay for Value program is a one-year program which uses calendar year (CY) 2016 HEDIS and CAHPS measurements and for which payments will be made in 2017.

The program has been shared and vetted with various stakeholder groups including the Quality Improvement Committee, Provider Advisory Committee, and Health Network medical directors and Quality team members.

Staff will recommend the scoring and payment methodology for the approved 2016 OneCare Connect and Windstone Pay-for-Value programs separately. Staff will return to the Quality Assurance Committee with future recommendations.

Distribution of Incentive Dollars

Performance allocations are distributed based on final calculation and validation of each measurement rate. Payment for Medi-Cal P4V will be paid in proportion to acuity level, as determined by aid category. To qualify for payment for each of the clinical and CAHPS measures, the Health Network must have a minimum denominator in accordance with HEDIS principles.

In order to qualify for payments, a physician group must be contracted with CalOptima during the entire measurement period and the period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

Fiscal Impact

The fiscal impact of the Medi-Cal P4V payment methodology for the Measurement Year of January 1, 2016, through December 31, 2016, will not exceed $2 per member per month. This is a budgeted item under the CalOptima Fiscal Year 2016-17 Operating Budget approved by the Board on June 2, 2016. Distribution of budgeted funds for this program will be dependent on actual performance and improvement of Health Network scores.

Rationale for Recommendation

This alignment of the referenced measures with incentive dollars leverages improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima staff has modified each program for applicability to the membership, measurement methodology, strategic priorities and regulatory compliance

Concurrence

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

Attachments

1. PowerPoint Presentation – 2016 Pay for Value Programs
2. Board Action dated April 7, 2016, Approve Measurement Year CY 2016 Pay for Value Programs for Medi-Cal and OneCare Connect

/s/ Michael Schrader — *09/29/2016*
Authorized Signature — **Date**

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CalOptima
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Pay-for-Value 2016

Board of Directors Meeting
October 6, 2016

Richard Helmer, M.D., Chief Medical Officer

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Pay for *Value* - 2016

- Goals of the current program & methodology
  - Adult & Child measures are included for every Health Network
  - Populations are weighted based on the acuity of the membership
  - Payment considers the resources required for the membership
  - Payment methodology scores for performance and improvement
  - Adult & Child CAHPS scores are used in the methodology
  - Payment is not earned for poor performance
  - Design incentive payments to optimize quality improvement

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Medi-Cal P4V Clinical Measures

2016 Measurement Year Measures	
Adult Measures	Child Measures
Adult Access to Preventive Care Services	Children's Access to Primary Care Physicians
Breast Cancer Screening	Well Child Visits 3-6 Years
Cervical Cancer Screening	Adolescent Well Care Visits
Diabetes Care: A1C Testing	Childhood Immunizations (Combo 10)
Diabetes Care: Retinal Eye Exams	Appropriate Testing for Children with Pharyngitis
Medication Management for People with Asthma	Appropriate Treatment for Children with URI
	Medication Management for People with Asthma

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MediCal P4V CAHPS Measures

2016 Measurement Year Measures
Child & Adult Measures
Getting Appointment with a Specialist
Timely Care & Service
Rating of PCP
Rating of all HealthCare

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Introduced Display Measures

- Display Measures are new measures that may be included in future pay for value programs. These measures are not eligible for payment for 2016 measurement year performance.
- Cal Optima has included these measures on the monthly HN HEDIS incentive measures rate reports for monitoring purposes.
- Display Measures:
  - Ambulatory Care (Outpatient and ER visits)
  - Readmissions
  - IHA completion rates

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Payment Methodology

Population Included:	
Total # of Adults in Health Network	Total # of Children in Health Network
Apply Acuity Score (SPD Weight 4X, TANF Weight 1X)	
Payment	
50% based on Performance score and 50% based on Improvement score Improvement score will be weighted by CalOptima's overall improvement	
Clinical Measures = 60% of the Total	CAHPS Measures = 40% of the Total
Proposed Scoring for Measure Performance:	
• A relative point system by measure, based on: • NCQA National HEDIS Percentiles (clinical measures) • NCQA National CAHPS Percentiles (satisfaction measures) • Final score is the sum of points for each measure • Improvement score based on improvement from previous year (receiving 1 point for increasing each percentile level and negative 1 point for decreasing)	

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Recommended Scoring - Amended

P4V Scoring - NEW
Performance Points – HEDIS & CAHPS
1 point: >= 50th percentile 2 points: >= 75th percentile 3 points: >= 90th percentile No points <50th percentile
Improvement points – HEDIS & CAHPS
1 point for increasing 1 percentile level (e.g. 1 point for 25th percentile to 50th percentile; 2 points for 50th percentile to 90th percentile, etc.) Negative one (-1) point for decreasing 1 percentile level (e.g. -1 point for 75th percentile to 50th percentile; -2 points for 50th percentile to 10th percentile, etc.)

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2016 MY OneCare P4P Clinical Measures (Retire Program for MY2016)

Breast Cancer Screening	Diabetes Care: A1 Screening
Colorectal Cancer Screening	Diabetes Care: A1C Good control (<8%)
Adults' Access to Preventive/Ambulatory Health services	Diabetes Care: Retinal Eye Exams
	Diabetes Care: Nephropathy Screening

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OneCare Connect P4V Clinical Measures

2016 Measurement Year Measures – OneCare Connect
1. Plan All Cause Readmissions
2. Behavioral Health: • Antidepressant Medication Management
3. Blood Pressure Control
4. Part D Medication Adherence for Diabetes

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Where Do We Go From Here?

- 2017 & Beyond…..Meaningful Change with Meaningful Improvement
  - Are there new goals?
  - Do we have the right measures?
  - How can we all be successful?
  - Focus on Overall Improvement

- Next Steps

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar
7. Approve Measurement Year CY 2016 Pay for Value Programs for Medi-Cal and OneCare Connect

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

Recommended Action
Approve Measurement Year CY 2016 "Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect (OCC)" which defines measures and allocations for performance, as described in Attachment 1, subject to regulatory approval, as applicable.

Background
CalOptima has implemented a comprehensive Health Network Performance Measurement System consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care.

The purpose of the Health Network performance measurement system, which includes both delegates and the CalOptima Community Network as previously approved by the Board on March 1, 2014, is three-fold:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks on their quality improvement efforts.

Discussion
For the Measurement Year CY 2016 programs, staff recommends maintaining many of the elements from the prior year with some modifications. Changes to measures and scoring methodology address the need to consider the complexity or member acuity (SPD compared to Non-SPD members) and the subsequent higher consumption of physician/health network resources to care for SPD members. Additionally, the scoring methodology will reward performance and improvement. The program will include both Adult and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, thereby expanding our focus on the member experience.

In order to sustain improvements and leverage resources that the health networks have allocated towards improvement in P4V measures, staff recommends the following modifications:

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Medi-Cal Changes:

- All health networks will have performance measures for both adult and child care. This addresses the unique needs of children in all networks.

- Introduction of an "acuity" calculation to address the unique health needs in the populations.

- Addition of access to care measures:
  - Adults Access to Preventative/Ambulatory Care Services
  - Children's Access to Primary Care Physicians

- Retirement of the "provider satisfaction with the health network and UM process" measure.

- The weighting of each domain in the Medi-Cal Pay for Performance program has been adjusted accordingly. Increased weighting has been allocated to member experience. This aligns with CalOptima's increased focus on improving member experience.

The proposed Measurement Year CY 2016 Medi-Cal Pay for Value program is a one year program which uses calendar year (CY) 2016 HEDIS measurements and for which payments will be made in 2017.

OneCare:
The OneCare Pay for value program will be retired due to the transition of the majority of former OneCare members to OneCare Connect. Quality Performance metrics for the One Care population of approximately 1200 members will continue to be reported via our annually required HEDIS submission to CMS. However, the reduced OneCare membership is too small to produce statistically significant results by individual health network. In lieu of an allocated incentive fund, OneCare health network capitation rates were increased 1% on January 1, 2016.

OneCare Connect:

- To incentivize quality care in our new OneCare Connect program and to better align with the CMC Quality withhold program, four new measures are proposed. Included in the proposed measure set for OneCare Connect is also a new measure type with an emphasis on clinical outcomes (blood pressure control).

- OneCare Connect measures are pending regulatory approval.

Windstone:

- Reinstate pay for value measures for Windstone Behavioral Health.

Distribution of Incentive Dollars
Performance allocations are distributed upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid proportional to acuity level, as determined by aid category. To qualify for payment for each of the clinical and CAHPS measures, the Health Network must have a minimum denominator in accordance with statistical principles.

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In order to qualify for payments, a physician group must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

Any separate OCC Quality Withhold incentive dollars earned will be distributed based upon Board of Directors approved methodology developed by staff and approved by CMS.

Fiscal Impact
Staff estimates that the fiscal impact of the Medi-Cal P4V will be no more than $2 pmpm for the Measurement period of January 1, 2016 through December 31, 2016 and expects to present these expenses with the CalOptima FY 2016-2017 Operating Budget.

Staff estimates that the fiscal impact of the OneCare Connect P4V will be no more than $20 pmpm for the Measurement period of January 1, 2016 through December 31, 2016, and expects to present these expenses with the CalOptima FY 2016-2017 Operating Budget.

Rationale for Recommendation
This alignment leverages improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

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

Attachments
2016 Medi-Cal, Windstone, and OneCare Connect Pay for Value Programs
PowerPoint Presentation – 2016 Pay for Value Programs

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

04/01/2016 — **Date**

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Attachment to:
2016 Medi-Cal Pay for Value Program
Measurement Set

Adult Measures	**2016 Measurement Year** **HEDIS 2017 Specifications** **Anticipated Payment Date: Q4 2017**	**Measurement Assessment Methodology**
Clinical Domain-HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	Prevention • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS) Diabetes • HbA1c Testing • Retinal Eye Exams Access to Care: • Adults Access to Preventive/Ambulatory Care Adult & Child Measure: • Medication Management for People with Asthma	A relative point system by measure based on: • NCQA National HEDIS Percentiles • Percent improvement
Patient Experience Domain-CAHPS Weight: 40%	Adult Satisfaction Survey 1. Getting Appointment with a Specialist 2. Timely Care and Service 3. Rating of PCP 4. Rating of All Healthcare	A relative point system by measure based on: • NCQA National CAHPS Percentiles • Percent improvement

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Pediatric Measures	2016 Measurement Year HEDIS 2017 Specifications Anticipated Payment Date: Q4 2017	Measurement Assessment Methodology
Clinical Domain HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	Respiratory • Medication Management for People with Asthma • Appropriate Testing for Children with Pharyngitis (CWP) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) Prevention • Childhood Immunization Status Hepatitis Combo 10 (CIS) • Well-Care Visits in the 3-6 Years of Life (W34) • Adolescent Well-Care Visits (AWC) Access to Care • Children's Access to Primary Care Physicians	A relative point system by measure based on: • NCQA National HEDIS Percentiles • Percent improvement
Patient Experience Domain-CAHPS Weight: 40%	Child Satisfaction Survey (Child CAHPS) 1. Getting Appointment with a Specialist 2. Timely Care and Service 3. Rating of PCP 4. Rating of All Healthcare	A relative point system by measure based on: • NCQA National CAHPS Percentiles • Percent improvement

Windstone Behavioral Health

Calculations for these measures will be the responsibility of CalOptima.

Measures	Allocation CY 2016	Data Source	Anticipated Payment Date	Benchmark
Quality of Care				
1. Follow-up After Hospitalization for Mental Illness • Follow-up Visit after 7 days • Follow-up Visit after 30 days	$15,000 • 50% at 50th percentile- • 100% if score is at or above 75th percentile $15,000 • 50% at 50th percentile	HEDIS 2017	October 2017	Most current NCQA Quality Compass Medicare Percentiles
2. Reduction in ED use for Seriously Mentally Ill and Substance Use Disorders	$30,000	CA State Defined Measure	October 2017	Significant improvement based on CMS methodology.

OneCare Connect	2016 Measurement Year Anticipated Payment Date: (Q4)	Measurement Assessment Methodology
Clinical Domain Weight:100% Each measure weighted equally	Measures: • Plan All Cause Readmissions • Antidepressant Medication Management Outcome Measures: • Blood Pressure Control • Part D Medication Adherence for Diabetes	A relative point system by measure based on: • NCQA National HEDIS Percentiles • Percent improvement **For the Part D Medication Adherence Measure:** A relative point system by measure based on: • CMS Star Rating Percentiles • Percent improvement

Participation in Quality Improvement Initiatives

For each measure in which a Health Network/medical group performs below the 50th percentile, Health Networks/medical groups must submit a corrective action plan to CalOptima which outlines, at a minimum, the following items:

- Interim measures and goals
- Measurement cycle
- Member interventions including education and outreach
- Provider interventions including education and training
- Timeline for interventions

Health networks/medical groups must submit quarterly work plans which document implementation of the corrective action plan and progress made towards goals.
In conjunction with the Health Networks, CalOptima will lead quality improvement initiatives for measures that fall below the 50th percentile. Funding for these initiatives will come from forfeited dollars.

MEASUREMENT DETAILS:

I. Clinical Domain (HEDIS measures)

Program Specific Measurement Sets
Performance measures were selected as appropriate per program based on the following criteria:

- Measures are appropriate for membership covered by the program
- Measures are based on regulatory requirements
- Measures are used by the industry for performance measurement and incentive payment

Criteria
The following criteria were considered in selecting these indicators:

- Each of these indicators measures the delivery of services that are critical to the health of the respective segments of CalOptima's membership. In addition, these measures collectively address the range of age appropriate services.
- The measures use administrative data for all except Blood Pressure only reporting since they are single point of service measures.
- CBP will be captured with a specific chart review activity for this P4V program.

Each measure is calculated per HEDIS methodology except that continuous enrollment is assessed at the health network level instead of at the health plan level

Incentive Measure Definition
Please refer to HEDIS Technical Specifications Volume 2 for measure definitions. For each HEDIS indicator, members will be identified according to the most recent HEDIS technical specifications.

II. Customer Satisfaction

Member Satisfaction

Background

CalOptima conducts annual member satisfaction surveys that are carefully designed to provide network-level satisfaction information to meet precision requirements and to support comparisons between networks and at the CalOptima agency level. The goal is to survey different subsets of the CalOptima membership (e.g. Children, persons with disabilities) on a rotating basis so that we develop 1) trend information over time about individual networks' performance for a specific population and 2) comparable performance information across networks both for a specific time period as well as trended over time.

Survey Methodology

The surveys are administered using the CAHPS protocol, including a mixed-mode methodology of mail and telephone contact to notify members of the study, distribute questionnaires, and encourage participation by non-respondents. Both surveys have been conducted in three threshold languages as defined by our Medi-Cal contract.

CalOptima has worked with outside technical and substantive consultants to refine its survey instruments and sampling and weighting strategies and has employed a nationally known survey research group to conduct both surveys.

The samples consisted of randomly selected Medi-Cal members who met specific requirements for inclusion as specified by the CAHPS and by our interest in targeted subgroups. The sample is a disproportionately stratified random sample with strata defined by health network. CalOptima required sample sizes and allocations across strata be developed to provide estimates of population proportions at the network level that were within 2.5 percentage points of the true value with 95% statistical confidence.

2016 Pay For Value Programs

Board of Directors Meeting

April 7, 2016

Richard Bock, M.D.

Deputy Chief Medical Officer

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Pay for Performance - Current

- We identified opportunities to build on the current P4P program:
  - Half of our children are linked to Health Networks outside of CHOC
  - There wasn't the ability to recognize performance and improvement efforts
  - Only Child CAHPS was used to measure member experience; Adult CAHPS was not included in the program
  - The current methodology resulted in inadequate incentive for improved performance

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Pay for *Value* - 2016

- Goals of the new program and methodology
  - Adult and Child measures are included for every Health Network
  - Populations are weighted based on the acuity of the membership
  - Payment considers the resources required for the membership
  - Payment methodology scores for performance and improvement
  - Adult and Child CAHPS scores are used in the methodology
  - Payment is not earned for poor performance
  - More allocated funds are converted to incentive payments

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Medi-Cal P4V Clinical Measures

2016 Measurement Year Measures	
Adult Measures	Child Measures
Adult Access to Preventive Care Services	Children's Access to Primary Care Physicians
Breast Cancer Screening	Well Child Visits 3-6 Years
Cervical Cancer Screening	Adolescent Well Care Visits
Diabetes Care: A1C Testing	Childhood Immunizations (Combo 10)
Diabetes Care: Retinal Eye Exams	Appropriate Testing for Children with Pharyngitis
Medication Management for People with Asthma	Appropriate Treatment for Children with URI
	Medication Management for People with Asthma

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MediCal P4V CAHPS Measures

2016 Measurement Year Measures
Child and Adult Measures
Getting Appointment with a Specialist
Timely Care & Service
Rating of PCP
Rating of all HealthCare

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Introducing Display Measures

- Display Measures are new measures that may be included in future pay for value programs. These measures are not eligible for payment for 2016 measurement year performance.
- CalOptima will include these measures on the monthly HN HEDIS incentive measures rate reports for monitoring purposes.
- Proposed Measures:
  - Ambulatory Care (Outpatient and ER visits)
  - Readmissions
  - IHA completion rates

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Payment Methodology

Population Included:	
Total # of Adults in Health Network	Total # of Children in Health Network
Apply Acuity Score (SPD Weight 4X, TANF Weight 1X)	
Proposed Scoring for Measure Performance:	
A relative point system by measure, based on: • NCQA National HEDIS Percentiles (clinical measures) • NCQA National CAHPS Percentiles (satisfaction measures) • Percent Improvement year over year	
Final score for each measure is determined by weight and acuity	
Clinical Measures = 60% of the Total	CAHPS Measures = 40% of the Total

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2016 MY OneCare P4P Clinical Measures (Retire Program for MY2016)

Breast Cancer Screening	Diabetes Care: A1 Screening
Colorectal Cancer Screening	Diabetes Care: A1C Good control (<8%)
Adults' Access to Preventive/Ambulatory Health services	Diabetes Care: Retinal Eye Exams
	Diabetes Care: Nephropathy Screening

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OneCare Connect P4V Clinical Measures

2016 Measurement Year Measures – OneCare Connect
1. Plan All Cause Readmissions
2. Behavioral Health: • Antidepressant Medication Management
3. Blood Pressure Control
4. Part D Medication Adherence for Diabetes

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OneCare Connect P4V: Windstone Behavioral Health

2016 Measurement Year Measures – Windstone

1. Follow-up After Hospitalization for Mental Illness:
   - Follow-up Visit after 7 days
   - Follow-up Visit after 30 days

2. Reduction in Emergency Department use for Seriously Mentally Ill and Substance Use Disorders (per CMS-defined standards)

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

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

Contact

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

Recommended Action

Approve the Fiscal Year 2018 (Measurement Year 2017) "Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect" which defines measures and allocations for performance, as described in Attachment 1 and 2, subject to regulatory approval, as applicable.

Background

CalOptima has implemented a comprehensive Health Network Performance Measurement System consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima's mission of providing quality health care.
The purpose of the Health Network performance measurement system, which includes both delegates and the CalOptima Community Network as previously approved by the Board on March 1, 2014, is three-fold:

1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima's performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks on their quality improvement efforts.

Discussion

For the Measurement Year CY 2017 programs, staff recommends maintaining many of the elements from the prior year with some modifications. As described in the 2016 P4V program, measures and scoring methodology address the need to consider the complexity or member acuity (SPD compared to non-SPD members) and the subsequent higher consumption of physician / health network resources to care for SPD members. In addition, the scoring methodology will continue to reward performance and improvement. The program will include both Child and Adult Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures, thereby expanding our focus on the member experience. The proposed MY17 Medi-Cal and OneCare Connect Pay for Value programs are one year programs which use HEDIS 2018 specifications and for which payments will be made in 2018.

In order to sustain improvements and leverage resources that the health networks have allocated towards improvement in P4V measures, staff recommends the following modifications:

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Medi-Cal Changes:

- Revise minimum denominator size from 100 to 30 eligible members for each specified quality measure to be eligible for incentive payment
- Revise CAHPS minimum performance threshold to reflect CA benchmarks

.

OneCare Connect Changes:

To incentivize quality care in our new OneCare Connect program and to better align with the CMS Quality Withhold program, the four clinical incentive measures below remain in the OneCare Connect P4V program:

- Plan All Cause Readmissions
- Controlling Blood Pressure
- Medication Adherence for oral anti-diabetic medications (Part D measure)
- Behavioral Health: Antidepressant Medication Management

Starting in CY 2017, a member experience survey (CAHPS) is added to the program.

Clinical measures are weighted at 60%; member experience is weighted at 40%. In the Board approved 2016 P4V program, only clinical measures were included and were weighted at 100%.

Distribution of Incentive Dollars

Performance allocations are distributed to the Health Networks, including CCN, upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid proportional to acuity level, as determined by aid category. To qualify for payment for each of the clinical and CAHPS measures, the Health Network must have a minimum denominator, as noted.

In order to qualify for payments, a physician group must be contracted with CalOptima during the entire measurement period, period of pay for value accrual, and must be in good standing with CalOptima at the time of disbursement of payment.

Any separate OCC Quality Withhold incentive dollars earned by CalOptima will be distributed based upon a Board-approved methodology to be developed by staff and subject to any needed regulatory approvals.

Fiscal Impact

Since the distribution of incentive dollars for the MY 2017 P4V Programs for Medi-Cal and OneCare Connect will be made in FY 2017-18, there is no fiscal impact to the FY 2016-17 Operating Budget.

Staff estimates that the fiscal impact for the MY 2017 P4V Program will be no more than $2 per member per month (PMPM) for Medi-Cal, and no more than $20 PMPM for OneCare Connect. Staff will include expenses for the MY 2017 P4V Program for Medi-Cal and OneCare Connect in the upcoming FY 2017-18 CalOptima Operating Budget.

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Time of Payment
Payment of any reward under the P4V program will occur after CalOptima receives official notice of HEDIS and CAHPS scores for 2017, which is anticipated to be on or around 4th quarter, 2018. The time of payment is subject to change at CalOptima's discretion.

Rationale for Recommendation
This alignment will leverage improvement efforts and efficiencies that the Health Networks implement for other health plans. CalOptima has modified each program for applicability to the membership, measurement methodology, and strategic priorities.

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

Attachments
1. FY 2018 (MY 2017) Medi-Cal Pay for Value Program
2. FY 2018 (MY 2017) OneCare Connect Pay for Value Program

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

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Attachment 1: FY 2018 (MY 2017) Medi-Cal Pay for Value Program Measurement Set

Adult Measures	**2017 Measurement Year / HEDIS 2018 Specifications** **Anticipated Payment Date: Q3 2018**	**Measurement Assessment Methodology**
Clinical Domain - HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	<u>Prevention:</u> • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS) <u>Diabetes:</u> • HbA1c Testing • Retinal Eye Exams <u>Access to Care</u>: • Adults Access to Preventive/Ambulatory Care <u>Respiratory</u>: • Medication Management for People with Asthma (MMA)	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percentile Improvement
Patient Experience Domain - CAHPS Weight: 40%	<u>Adult Satisfaction Survey (Adult CAHPS):</u> 1. Getting appointment with a Specialist 2. Timely Care and Service 3. Rating of PCP 4. Rating of all Healthcare	A relative point system by measure based on: • NCQA California CAHPS percentiles • Percentile Improvement

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Pediatric Measures	**2017 Measurement Year / HEDIS 2018 Specifications** **Anticipated Payment Date: Q3 2018**	**Measurement Assessment Methodology**
Clinical Domain - HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	<u>Respiratory:</u> • Medication Management for People with Asthma (MMA) • Appropriate Testing for Children with Pharyngitis (CWP) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) <u>Prevention:</u> • Childhood Immunization Status Combo 10 (CIS) • Well-Care Visits in the 3-6 Years of Life (W34) • Adolescent Well-Care Visits (AWC) <u>Access to Care:</u> • Children's Access to Primary Care Physician	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percentile Improvement
Patient Experience Domain - CAHPS Weight: 40%	<u>Child Satisfaction Survey (Child CAHPS)</u> • Getting Appointment with a Specialist • Timely Care and Service • Rating of PCP • Rating of all Healthcare	A relative point system by measure based on: • NCQA California CAHPS percentiles • Percentile Improvement

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Attachment 2: FY 2018 (MY 2017) OneCare Connect Pay for Value Program

OneCare Connect Measures	**2017 Measurement Year / HEDIS 2018 Specifications** **Anticipated Payment Date: Q3 2018**	**Measurement Assessment Methodology**
Clinical Domain - HEDIS Weight: 60.00% Each measure weighted equally	<u>Measures:</u> • Plan All Cause Readmissions • Antidepressant Medication Management Outcome Measures • Blood Pressure Control • Part D Medication Adherence for Diabetes	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percent Improvement **For the Part D Medication Adherence Measure**: A relative point system by measure based on: • CMS Star Rating Percentiles • Percentile Improvement
Patient Experience Domain - CAHPS Weight: 40%	<u>Adult Satisfaction Survey (Adult CAHPS):</u> • Getting appointment with a Specialist • Timely Care and Service • Rating of PCP • Rating of all Healthcare	A relative point system by measure based on: • NCQA California CAHPS percentiles • Percentile Improvement

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Participation in Quality Improvement Initiatives

For each measure in which a Health Network/medical group performs below the 50th percentile, Health Networks/medical groups must submit a Corrective Action Plan (CAP) to CalOptima which outlines, at a minimum, the following items:

- Interim measures and goals
- Measurement cycle
- Member interventions including education and outreach
- Provider interventions including education and training
- Timeline for interventions

Health networks/medical groups must submit quarterly work plans which document implementation of the corrective action plan and progress made towards goals.

In conjunction with the Health Networks, CalOptima will lead quality improvement initiatives for measures that fall below the 50th percentile. Funding for these initiatives will come from forfeited dollars.

MEASUREMENT DETAILS:

1. Clinical Domain (HEDIS measures)

Program Specific Measurement Sets
Performance measures were selected as appropriate per program based on the following criteria:

- Measures are appropriate for membership covered by the program
- Measures are based on regulatory requirements
- Measures are used by the industry for performance measurement and incentive payment

Criteria
The following criteria were considered in selecting these indicators:

- Each of these indicators measures the delivery of services that are critical to the health of the respective segments of CalOptima's membership. In addition, these measures collectively address the range of age appropriate services.
- The measures use administrative data for all except Blood Pressure only reporting since they are single point of service measures.
- CBP will be captured with a specific chart review activity for this P4V program.

  Each measure is calculated per HEDIS methodology except that continuous enrollment is assessed at the health network level instead of at the health plan level.

Incentive Measure Definition
Please refer to HEDIS 2018 Technical Specifications Volume 2 for measure definitions. For each HEDIS indicator, members will be identified according to the most recent HEDIS technical specifications updates.

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II. Customer Satisfaction

Member Satisfaction

Background

CalOptima conducts annual member satisfaction surveys that are carefully designed to provide network-level satisfaction information to meet precision requirements and to support comparisons between networks and at the CalOptima agency level. The goal is to survey different subsets of the CalOptima membership (e.g. Children, Persons with disabilities, and Adults) on a rotating basis so that we develop:

- trend information over time about individual networks' performance for a specific population, and
- comparable performance information across networks both for a specific time period as well as trended over time.

Survey Methodology

The surveys are administered using the CAHPS protocol, including a mixed-mode methodology of mail and telephone contact to notify members of the study, distribute questionnaires, and encourage participation by non-respondents. Both surveys have been conducted in three threshold languages as defined by our Medi-Cal contract.

CalOptima has worked with outside technical and substantive consultants to refine its survey instruments and sampling and weighting strategies and has employed a nationally known survey research group to conduct both surveys.

The samples consisted of systematically selected Medi-Cal members who met specific requirements for inclusion as specified by the CAHPS and by our interest in targeted subgroups. The sample is a disproportionately stratified random sample with strata defined by health network. CalOptima required sample sizes and allocations across strata be developed to provide estimates of population proportions at the network level that were within 2.5 percentage points of the true value with 95% statistical confidence.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

5. Consider Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year (FY) 2018-19

Contact

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

Recommended Action

Adopt the proposed meeting schedule of the CalOptima Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee for the period July 1, 2018 through June 30, 2019.

Background

Section 5.2.(b) (1) of the CalOptima Bylaws specifies that the Board shall conduct an annual organizational meeting at a regular meeting to be designated in advance by the Board. The annual organizational meeting is scheduled for the June Board meeting each year. At the annual organizational meeting, the Board shall adopt a schedule stating the dates, times, and places of the Board's regular meetings for the following year.

Discussion

The proposed schedule of meetings for the period July 1, 2018 through June 30, 2019 is as follows:

1. The Board of Directors will meet at 2 p.m. on the first Thursday of each month, with the following exceptions:
    - Due to the Independence Day holiday, staff recommends that the Board consider not meeting in July. Should unanticipated items arise during July 2018 that requires Board review/approval, the Chief Executive Officer (CEO) will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting
    - Due to the New Year's holiday, staff recommends that the Board consider not meeting in January 2019. Should unanticipated items arise during January requiring Board review/approval, the CEO will confer with the Board Chair or Vice Chair, and items will be presented for ratification at the following regularly scheduled Board meeting.

2. The Finance and Audit Committee will meet quarterly at 2:00 p.m. on the third Thursday in the months of September, November, February and May.

3. The Quality Assurance Committee will meet quarterly at 3:00 p.m. on the third Wednesday in the months of September, November, February and May.

The meetings of the Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee are held at the CalOptima offices located at 505 City Parkway West, 1st Floor, Orange, California, unless notice of an alternate location is provided. The proposed FY 2018-19 Board of Directors Meeting Schedule is attached.

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Fiscal Impact
The fiscal impact for FY 2018-19 Board of Directors Meetings is up to $27,000 in per diem costs, and up to $9,000 in mileage reimbursement for certain Board members. Funding is included as part of the CalOptima FY 2018-19 Operating Budget pending Board approval.

Rationale for Recommendation
The recommended action will confirm the Board's meeting schedule for the next fiscal year as required in Section 5.2 of the Bylaws.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Proposed Schedule of Meetings of the CalOptima Board of Directors, the Finance and Audit Committee, and the Quality Assurance Committee – July 1, 2018 through June 30, 2019

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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Proposed

Board of Directors Meeting Schedule
July 1, 2018 – June 30, 2019

All meetings are held at the following location, unless notice of an alternate location is provided:

505 City Parkway West
Orange, California 92868

Board of Directors **Monthly – First Thursday** **Meeting Time: 2:00 p.m.**	**Finance and Audit Committee** **Quarterly – Third Thursday** **Meeting Time: 2:00 p.m.**	**Quality Assurance Committee** **Quarterly – Third Wednesday** **Meeting Time: 3:00 p.m.**
July 2018^		
August 2, 2018		
September 6, 2018	September 20, 2018	September 19, 2018
October 4, 2018		
November 1, 2018	November 15, 2018	November 21, 2018
December 6, 2018		
January 2019^		
February 7, 2019	February 21, 2019	February 20, 2019
March 7, 2019		
April 4, 2019		
May 2, 2019	May 16, 2019	May 15, 2019
June 6, 2019'		

^No Regular meeting scheduled
' Organizational Meeting

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

6. Consider Adopting Resolution Authorizing and Directing the Chairman of the Board of Directors to Execute Contract MS-18-19-41 with the California Department of Aging for the Multipurpose Senior Services Program (MSSP) for Fiscal Year 2018-19

Contact

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

Recommended Action

Adopt Board Resolution No. 18-0607-01, authorizing and directing the Chairman of the Board to execute Contract MS-18-19-41 with the California Department of Aging for the Multipurpose Senior Services Program.

Background

The Multipurpose Senior Services Program (MSSP) is a home and community-based services program, operated pursuant to a waiver in the State's Medi-Cal program. MSSP provides case management of social and health care services as a cost-effective alternative to institutionalization of the frail elderly.

The California Department of Health Care Services (DHCS), through an Interagency Agreement, delegates the administration of the MSSP to the California Department of Aging (CDA). The CDA contracts with local government entities and private non-profit organizations for local administration of MSSP in various areas of the State.

As the operator of the MSSP site for Orange County, CalOptima improves the quality of care for our aging population by linking frail, elderly members to home and community-based services as an alternative to institutionalization and helps to contain long-term care costs by reducing unnecessary or inappropriate nursing facility placements. CalOptima has successfully implemented the MSSP program over the past seventeen (17) years for up to a maximum of 568 members at any given point in time. Currently, CalOptima serves between 446 to 460 clients.

Discussion

CalOptima has received CDA Contract MS-18-19-41 for execution by the Chairman of the CalOptima Board, which, upon the adoption of a Board resolution and execution of the contract will extend the MSSP program through June 30, 2019, with the maximum amount of the contract set at $1,949,675. The scope of work and other obligations are consistent with existing contract obligations. There are a number of largely administrative proposed changes to the contract language, including the following:

- "Catchment Area Zip Codes", formerly Exhibit E, is now Exhibit G.
- Exhibit E is now a new Exhibit containing "Additional Provisions".
- Health Insurance Portability and Accountability Act (HIPAA) provisions are now housed in Exhibit F.

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- Former references to the "State" have been replaced with DHCS and/or CDA.
- Any reference to "Former Section" or "Former Exhibit" is a reference to that section or exhibit of the FY 2017-18 CDA Standard Agreement.
- Exhibit A contains the following changes:
    - In Article II, reference and link to the Home and Community Based Services (HCBS) waiver were added to the Overview. Reference to the "Interagency Agreement between Department of Health Care Services (DHCS) and California Department of Aging (CDA)" was added from former Exhibit D.
    - In Article III, definition of "Purchased Waiver Services" was added from former Exhibit D (Section C). Reference to MSSP Site Manual was removed (Section C1). Reference to "Adult Day Support Center (ADSC)" was removed (Section C3a). "Level of Care" definition was added from former Exhibit D (Section D). Former language requiring submission of Waiver Participant Count by the 5th of the month was revised to read "*by the 5th working day of the month (unless otherwise specified by CDA)*" (Section E5). "Waiver slot" definition was added from former Exhibit D (Section F).
    - In Article IV, "Definitions Specific to the CCI model" (Coordinated Care Initiative, Member, PLAN(S), Encounter, MSSP Applicant, Wait List and Eligibility Determination) were added from former Exhibit D (Section A).
    - In Article V, Article containing "Medi-Cal Aid Definition and Codes" was added from former Exhibit D.
    - In Article VI, Article containing "Definitions of Services Provided Under the Waiver" was added from former Exhibit D.
- Exhibit B contains the following changes:
    - In Article 1, rate adjustment language was changed to state "*Any rate adjustments must be approved by CDA*" (Section D).
    - In Article II, new language was added stating, "*Any overpayment of funds must be deposited into an interest-bearing account.*" (Section A6).
    - In Article III, language was modified related to reimbursement of categorical expenditures (Section C). Language has been modified as sites are now required to obtain approval from CDA to transfer *any* funds into or out of *any* service category. There is no longer a 5% transfer amount threshold for approval (Section E). The language in former Section F has been added to new Section E.
- Exhibit D contains the following changes:
    - Definitions section has been renumbered
    - In Article I:
        - In Section A, the definition of "Agreement" or "Contract" was modified to include Exhibits (F) and (G) and the language, "*an approved Budget as identified in Exhibit B, and if applicable, a Work Plan or Budget Summary*". The definition of "Manual" has been removed. The definition of "Catalog of Federal Domestic Assistance (CFDA)" has been moved from Article I to Article X, Section A. The definition of "HIPAA" has been moved to Exhibit (F). The definitions of (Wait List, Encounter, Eligibility Determination, Level of Care, MSSP Applicant, Purchased Waiver Services, Coordinated Care Initiative, Member and PLAN(S)) have been moved to Exhibit (A).

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- Former Section (B), "Medi-Cal Aid Codes and Definitions", was moved to Exhibit A, Article V, and re-titled "Medi-Cal Aid Definition & Codes".
- "The Interagency Agreement Terms and Conditions" has been added to the "Resolution of Language Conflicts" order of precedence (Section B2).
- "Definitions of Services Provided Under the Waiver" was moved to Exhibit A, Article VI (Former Section C).

- In Article II, language was removed related to subcontractor licenses, certificates and permits (Former Section A2). The last sentence in former section (K) (1), "*These documents, including minute orders must also identify the action taken*", has been separated from former section (K) (1) to create its own section, (K) (2). Language was slightly modified to add further clarity to DUNS number data entry errors (Section M3). Language added prohibiting expenditures on promotional and marketing items known as "*S.W.A.G." or "Stuff We All Get*" (Section P).
- In Article V, language related to subcontractor application and screening processes was moved to Exhibit (E) and replaced with language related to subcontractor staffing requirements (Former Section H). Language related to subcontractor fraud and abuse reporting requirements, was moved to Exhibit E (Former Section I). Language requiring subcontracts to comply with state and federal laws and the ADA has been removed (Former Section J). Former language referring to HIPAA Business Associate requirements was moved to Exhibit E and replaced with language to define "procurement procedures" (Section K). Language referring to Contractor's "*timely payments to its Subcontractors*" was removed (Section N).
- In Article VI, language pertaining to maintenance of waiver participant records following case closure was removed (Former Section F). Former section (G) is now section (F).
- In Article VII, Section (A) (3) is former section (Q). Former sections (B) (1 & 2) containing language related to the useful life and acquisition cost of property have been combined to form what is now section (B) (1). Language was added stating all computing devices are subject to reporting requirements (Section B2). Language was added stating all portable electronic storage media are subject to reporting requirements (Section B3). Reference to Report of Property Form (CDA 32) has been removed and language updated to address submission of the Property Acquisition Form (CDA 9023) and the Program Property Inventory Certification (CDA 9024) (Section E). The Contractor's obligation to obtain CDA approval to dispose of any property with a unit cost of $500 or more has been moved to section B. Property Disposal reporting requirements language was updated to include the Property Survey Report (STD 152) Certification of Disposition (Section F1). Five-day requirement to investigate and document the loss, destruction or theft of property has been removed (Section G). Provision related to property purchased with waiver services funds, is now section (A) (3) (Former Section Q). Provision regarding taking physical inventory of property was moved to Exhibit E, Article III (Former Section R).
- In Article IX, the title has been changed from "*Monitoring, Assessment, and evaluation"* to *"Monitoring and Evaluation"*. Monitoring and evaluation language was modified to include, "*and when applicable, inspection of food preparation sites*"

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(Section A). Language regarding compliance monitoring was changed from "*each of its major programs"* to *"each of its CDA/DHCS funded programs"* (Section C).

- In Article X, section A paragraph 3, the reference to Section (L) was removed. The Acronym CFDA (Catalog of Federal Domestic Assistance) was defined. "Final Accounting Reconciliation" is now referred to as "Financial Closeout Report" (Section B). Sections (C) through (K) removed from new Exhibit D and Moved to new MSSP Exhibit E, Article IV. New language sections (C) through (I) added via CDA Audits Department.
- In Article XI, reference to PUC General Order No. "115-E" Changed to "115-F" (Section A3). Notation added stating provision applies to "all programs except Title V" (Section A4).
- In Article XII, "Voluntary Termination by Contractor" is now Section (F) and has been retitled "Notice of Intent to Terminate by Contractor". The language has been slightly modified (Former Section A3). Former sections (A) (4) through section (B) (4) have been moved to Exhibit E Article V. Language added related to termination for cause which states, the Notice of Termination shall be effective thirty (30) days from the delivery of the Notice of Termination "*unless the grounds for termination are due to threat to life, health or safety of the public and in that case, the termination shall take effect immediately"* (Section B). "Effective Date" moved from section (C) to section (D) with some language modification (Former Section C). Language was added related to "Voluntary Termination of Area Plan Agreement" and is specific to Title III only (Section E). Language was added related to conditions that must be met prior to termination in the event of a termination notice (Section G).
- In Article XVI, provisions related to a change in contractor's Site Director were moved to Exhibit E, Article VIII (Former Section C).
- In Article XVIII, language updated to require "*128-Bit*" encryption (Section B). A sentence was added related to disclosure of information as required by the Older American's Act (Section C4). A provision was added requiring Contractor to maintain certificates of completion of Security Awareness Training and provide them to CDA upon request (Section D2). Section (E) is new language requiring compliance with HIPAA. Section (G) is new language related to Security Incident Reporting Procedures. Former section (H) has been moved to new Exhibit (E), Article VI (A). Section (H) is new language related to Security Breach Notifications. Provisions of Former Section I are now section (K).
- In Article XIX, in Section B, Sections (1) and (3) contain modified language. Former section (4) has been removed.
- In Article XX, Former Article XX "Reports" has been moved to new Exhibit E Article IX, with modified language. Former Article XXI "Bilingual and Linguistic Program Services" is now article XX.

Staff does not anticipate any of these changes will have a significant operational or financial impact as they are largely already in operation.

With the advent of the Coordinated Care Initiative (CCI) on July 1, 2015, the MSSP program now falls within CalOptima's Long Term Services and Supports (LTSS) Department. While CDA

programmatic requirements remain the same, CalOptima is required to pay MSSP per enrolled member per month based upon a monthly reconciliation. CalOptima is required to continue funding MSSP at the same rate as would have applied had CalOptima not participated in CCI. DHCS provides CalOptima with Medi-Cal revenue for the MSSP program through the established capitation rate setting process.

Fiscal Impact

All revenues and expenses associated with the MSSP program are budgeted items and are included in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval.

Rationale for Recommendation

Adoption of Board Resolution No.18-0607-01, authorizing and directing the Chairman of the Board of Directors to execute the FY 2018-19 contract with the CDA for the MSSP program will allow CalOptima to continue to address the long-term community care needs of some of the frailest older adult CalOptima members by helping them to remain in their homes.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Board Resolution No. 18-0607-01, Execute Contract No. MS-18-19-41 with the State of California Department of Aging for the Multipurpose Senior Services Program (MSSP)

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

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RESOLUTION NO. 18-0607-01

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

EXECUTE CONTRACT NO. MS-18-19-41
WITH THE STATE OF CALIFORNIA
DEPARTMENT OF AGING FOR THE
MULTIPURPOSE SENIOR SERVICES PROGRAM (MSSP)

WHEREAS, The Orange County Health Authority, d.b.a. CalOptima ("CalOptima") continues to provide services as a Multipurpose Senior Service Program Site under contract with the California Department of Aging; and,

WHEREAS, the California Department of Aging notified CalOptima of its intent to contract for the assignment of up to 568 MSSP participant slots to CalOptima; and,

WHEREAS, the California Department of Aging has requested the execution of Contract MS-17-18-41; and,

WHEREAS, the Board of Directors has determined that it is in the best interest of the ongoing development of CalOptima home and community based services to the Medi-Cal beneficiaries residing in Orange County to approve CalOptima executing the Contract.

NOW, THEREFORE, BE IT RESOLVED:

I. That CalOptima is hereby authorized to enter into contract MS-18-19-41with the State of California Department of Aging on the terms and conditions set forth in the form provided to this Board of Directors; and,

II. That the Chair of this Board of Directors is hereby authorized and directed to execute and deliver the Contract by and on behalf of CalOptima on the terms and conditions set forth in the form provided to this Board of Directors.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a. CalOptima, this 7th day of June, 2018.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost, M.D., Chair, Board of Directors

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

7. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Expansion of Behavioral Health Treatment Services

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to the expansion of Behavioral Health Treatment (BHT) services.

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 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

DHCS has informed Plans that it intends to submit an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will expand coverage for Behavioral Health Treatment (BHT) services for CalOptima Medi-Cal members under the age of 21.

Pursuant to federal guidance, DHCS advised MCPs in 2014 to begin to provide Behavioral Health Treatment (BHT) services as a Medi-Cal benefit for individuals under the age of 21 with a diagnosis of Autism Spectrum Disorder (ASD). As a result, DHCS incorporated this requirement into MCP contracts, and authority to execute Amendment 28 (A–28) was granted to the Chair during the October 2014 meeting of the CalOptima Board of Directors to incorporate language requirements and supplemental payments for BHT into CalOptima's Primary Agreement with the DHCS. Subsequently, over the course of 2016, the care for BHT services provided to eligible CalOptima Medi-Cal members with an ASD diagnosis transitioned from the Regional Center of Orange County (RCOC) to CalOptima.

Pursuant to updated federal guidance, DHCS has advised MCPs that they must cover medically necessary BHT services for all individuals under the age of 21 regardless of diagnosis under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, regardless of whether or not there is an ASD diagnosis. As a result, the Department of Developmental Services (DDS) and DHCS have

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developed a plan to transition responsibility and funding for these services to Medi-Cal. Effective no sooner than July 1, 2018, MCPs, including CalOptima, will be responsible for providing all medically necessary BHT services to eligible CalOptima Medi-Cal members under the age of 21 in accordance with the recommendation from a licensed physician and surgeon, or a licensed psychologist as stated in the member's treatment plan and/or continuation of BHT services under continuity of care.

The addition of this contract language is consistent with current DHCS All–Plan Letter (APL) guidance and will bring CalOptima's Primary Agreement with DHCS for Medi-Cal into compliance with EPSDT requirements, as required by Section 1905 of the Social Security Act (SSA) and in accordance with Welfare and Institutions (W&I) Code, Section 14132.56, Health and Safety (H&S) Code, Sections 1374.72 and 1374.73 and California Code of Regulations (CCR), Section 1300.74.72.

The language of the draft contract amendment expands the BHT benefit as described and indicates that the MCP must submit readiness deliverables to DHCS prior to the effective date of the benefit expansion. The proposed amendment will also include updated rates of payment.

In March 2018, after the applicable APLs were finalized, DHCS required MCPs to submit deliverables related to the draft contract amendment. DHCS' requested deliverables included a Memorandum of Understanding (MOU) with the Regional Center of Orange County (RCOC) designed to demonstrate compliance with requirements included in the amendment. Authority to execute this MOU was granted to the Chair during the May 2018 meeting of the CalOptima Board of Directors.

BHT supplemental payment rates for the period of July 1, 2017 through June 30, 2018 were sent to CalOptima in July 2017. These final BHT rates contain the following updates:

- Rates are set at the plan/county level which produces a stronger correlation between plan experience reported in the Calendar Year (CY) 2016 supplemental data request (SDR) and the final Fiscal Year (FY) 2017–18 BHT supplemental payment rates.
- Adjustments made to health plan reported experience, which includes:
    - Blending individual health plan experience with larger populations to improve data credibility; and
    - Adjusting/smoothing data when falling outside reasonable ranges as observed in historical data reporting; and
    - Removing the last two months of experience (November and December 2016) from the base data due to under–reporting.

Once CMS approves DHCS' proposed amendment, DHCS will provide the final contract amendment to CalOptima for prompt signature and return. If the final contract amendment is not consistent with Staff's understanding as presented in this document or if it includes significant and unexpected language changes, staff will return to the Board of Directors for consideration.

Fiscal Impact

The recommended action to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to the expansion of Behavioral Health Treatment (BHT) services is a budgeted item under the FY 2018-19 Operating Budget pending Board approval. Based on rates received from

DHCS in July 2017, the expansion of BHT services is projected to increase revenue by $30 million in FY 2018-19. However, CalOptima's actual revenue will depend on the number of members who are newly eligible to receive BHT services under the updated federal guidance. Staff projects that revenue for the expanded population will be sufficient to cover the costs of services.

Rationale for Recommendation

The addition of the updated BHT contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with federal and state requirements and DHCS APLs.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

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

5/30/2018 — **Date**

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APPENDIX TO AGENDA ITEM

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

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

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

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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
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

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

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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
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

8. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreements with the California Department of Health Care Services (DHCS) Related to Rate Changes

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment(s) to the Primary Agreement between DHCS and CalOptima related to rate changes.

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 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

DHCS has informed Plans that it intends to submit an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate rate changes related to Base Medi-Cal Classic rates, ACA Optional Expansion (OE) and Hyde (Abortion) Proposition 56 rates, Behavioral Health Treatment and Hepatitis–C supplemental payments, Hyde (Abortion) rates, Managed Long–Term Services and Supports (MLTSS) add–on rates, and Proposition 56 directed payments for the period of July 2017 to June 2018 to managed care plan (MCP) contracts.

Rate Changes

DHCS' proposed amendment(s) seeks to incorporate rates related to:

- Base Medi-Cal Classic, ACA Optional Expansion (OE) and Hyde (Abortion) Prop. 56 rates for the period of July 2017 to June 2018, with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, Hyde (Abortion) rates, Managed Long–Term Services and Supports (MLTSS) add–on rates, and Proposition 56 directed payments.

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2017-2018

Base Classic Medi–Cal and ACA Optional Expansion Rates

The base Medi–Cal Classic and ACA OE capitation rates for July 2017 through June 2018 were first sent to CalOptima as draft rates in July 2017. DHCS sent CalOptima finalized rates in April 2018. Highlights regarding these rates are as follows:

- Rates contain final rate ranges including the MCO Tax and Physicians' Proposition 56 per member per month (PMPM) add–ons, detailed build-up of the rates by category of aid and category of service, and program changes applied in the rates.
- Rates include a build-up of health plan submitted base data and prior SFY 16–17 base data, rate summaries, State Fiscal Year (SFY) 16–17 Cost and Reimbursement Comparison Sheets (CRCS), base data adjustments, base data summaries, ACA OE CRCS details, and ACA OE risk adjustment calculation.

Behavioral Health Treatment (BHT) Payments

BHT supplemental payment rates for the period of July 1, 2017 through June 30, 2018 were sent to CalOptima in July 2017. These final BHT rates contain the following updates:

- Rates are set at the plan/county level which produces a stronger correlation between plan experience reported in the Calendar Year (CY) 2016 supplemental data request (SDR) and the final SFY 17–18 BHT supplemental payment rates.
- Adjustments made to health plan reported experience, which includes:
    - Blending individual health plan experience with larger populations to improve data credibility; and
    - Adjusting/smoothing data when falling outside reasonable ranges as observed in historical data reporting; and
    - Removing the last two months of experience (November and December 2016) from the base data due to under–reporting.

Hepatitis–C Payments

Hepatitis–C supplemental payment rates for the period of July 1, 2017 through June 30, 2018 were sent to CalOptima in October 2017. These final Hepatitis–C rates contain the following updates:

- Assumed ramp up results in Mavyret being 10% of therapies for the period of July 1, 2017 through December 31, 2017 and historically–priced therapies comprising 78% of therapies across a six–month period.
- Assumed ramp up results in Mavyret being 75% of therapies for the period of January 1, 2018 through June 30, 2018 and historically–priced therapies comprising 7%.

Non–Medical Transportation (NMT) Payments

Non–Medical Transportation (NMT) PMPM rate increments for the period of July 1, 2017 through June 30, 2018 were sent to CalOptima in September 2017. Both the Classic Medi-Cal and ACA Optional Expansion category of aid (COA) groups are included in these PMPM impacts. These final NMT PMPM rate increments include the following:

- Increase to the SFY 17–18 capitation rates due to the inclusion of NMT as a covered Medi-Cal benefit.

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- Impact of NMT to Medi-Cal managed care covered services effective July 1, 2017 and the impact of NMT to Medi-Cal managed care non-covered services effective October 1, 2017.
- General methodology used for the NMT PMPM increment consisted of calculating a fully mature NMT PMPM amount and subtracting out any NMT currently assumed to be in the rate.
- Considerations for ramp-up were utilized since it is not expected that the fully matured NMT PMPM will be achieved in the first year.
- Data from two other states (one more urban and one more rural) were utilized, which contains varying levels of detail which assisted with development of the fully mature NMT PMPM amount.
- To develop the amounts currently assumed in the rates, health plan questionnaire data and encounter data were utilized.

Proposition 56 Directed Payments

Proposition 56 increases the excise tax rate on cigarettes and tobacco products and allocates the resulting revenue, in part, to increase funding for existing healthcare programs administered by the DHCS. The California Budget Act of 2017 appropriated Proposition 56 funds for SFY 2017–18, including a portion to be used for directed payments for physician services in Medi-Cal managed care according to the payment methodology developed by DHCS.

Consistent with Title 42, Code of Federal Regulations (CFR), Section 438.6(c), MCPs and their delegated entities and subcontractors, as applicable, are required to make directed payments for qualifying services for 13 Current Procedural Terminology (CPT) codes in addition to other payments that eligible network providers receive from MCPs. Please note that Staff's proposed methodology for the distribution of these payments is addressed as a separate agenda item for the June 7, 2018 meeting of the CalOptima Board of Directors. The amount of the directed payments varies by CPT code as outlined below:

CPT	Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval.	$35.00
90792	Psychiatric Diagnostic Eval. with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

All applicable Evaluation & Management (E&M) services outlined above are eligible for this enhanced Prop. 56 funding except for services incurred by members with Medicare Part B coverage

(Full or Partial Duals), and services provided in Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHP) and Cost–Based Reimbursement Clinics (CBRCs). No later than June 30, 2018, and on a quarterly basis thereafter, CalOptima must begin reporting data to DHCS on all directed payments made pursuant to DHCS APLs, either directly by CalOptima, or by CalOptima's delegated entities and subcontractors.

The draft SFY E&M Directed Payment Proposition 56 PMPM add–on rates were sent to CalOptima in January 2018 and finalized in April 2018 as part of CalOptima SFY 17–18 full capitation rates. The Intermediate Care Facility–Developmentally Disabled (ICF–DD) Prop. 56 program changes were also included as part of CalOptima's SFY 17–18 full capitation rates. Highlights regarding these rates are as follows:

- All applicable categories of aid (COA) are now included.
- Development of these add–ons utilized the supplemental data request (SDR) information provided by CalOptima and received encounter data associated with the Prop. 56 procedure codes.
- Adjustments to the final amounts do include offsets for Part B members.
- Rates do not include FQHC/RHC/CBRC/IHS utilization as these providers are exempt from Prop. 56.
- Rates contain CalOptima's projected member months by COA for SFY 17–18 along with the anticipated number of Prop. 56 impacted services.
- Rates include the E&M utilization per 1,000 members, the unit cost (average unit cost of the E&M add–on component that varies by E&M code) and the resulting E&M adjustment PMPM add–on amounts.
- The PMPM add–on amounts include an administrative load of 3.25% and an underwriting gain (UG) of 2.00%.
- Rates only reflect the 13 CPT codes outlined above.

Additionally, CalOptima received Hyde (Abortion) rate ranges and Hyde (Abortion) Proposition 56 add-ons in April 2018.

Coordinated Care Initiative (CCI) Non–Full Dual Rate Ranges

CalOptima received State Fiscal Year (SFY) 2017–18 CCI non-full dual rates in March 2018. Two 6–month rates were developed (July–December 2017 and January–June 2018) to account for the removal of IHSS effective January 1, 2018. For the January–June 2018 HCBS High/Low rates, the IHSS benefits costs were removed. However, to account for the continuing IHSS care coordination requirement, the administrative load associated with the IHSS benefit component was maintained on a per-member-per-month (PMPM) basis and a portion was reallocated in the "All Other" service category to account for the care coordination costs that CalOptima will incur for members that utilize IHSS services.

The anticipated impact of these proposed rate changes is identified in the Fiscal Impact section.

Fiscal Impact

Compared to SFY 2016-17 rates, the capitation rates for the July 1, 2017- June 30, 2018 period (the following year), are 4.4% or $8.88 per member per month lower for Classic Medi-Cal, and a 6.2% or

$27.94 per member per month lower for the Medi-Cal expansion membership. However, because rate decreases were anticipated and included in CalOptima's FY 2017-18 Medi-Cal Operating Budget, Staff projects the net impact to CalOptima will be revenue neutral for the July 1, 2017- June 30, 2018 fiscal year. Staff previously incorporated the rate decreases in the CalOptima FY 2017-18 Medi-Cal Operating Budget.

The revised capitation rates for July 1, 2017, through June 30, 2018, which includes updates for BHT and Hepatitis C supplemental payments, Abortion rates, MLTSS add-on rates, and CCI Non-Full Dual rates is projected to be revenue neutral to CalOptima. Staff previously incorporated the rate adjustments into the CalOptima FY 2017-18 Medi-Cal Operating Budget.

Rate increments for NMT services payments are expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that NMT revenues will be sufficient to cover the total NMT costs during SFY 2017-18. Staff previously incorporated the rate adjustment into the CalOptima FY 2017-18 Medi-Cal Operating Budget.

The add-on rates for the Proposition 56 directed physician services payment is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects that the net fiscal impact will be budget neutral.

Rationale for Recommendation
CalOptima's 2016-17 operating budget was based on anticipated rates for FY 2017-18.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM

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

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

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

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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
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

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

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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
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

9. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Whole Child Model Program

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Whole Child Model (WCM) program.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new five (5) year agreement with DHCS. Amendments to this agreement are summarized in the attached appendix, including Amendment 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

DHCS has informed Plans that it intends to submit an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval in May 2018 that will incorporate language regarding the WCM Program into managed care plan (MCP) contracts, including CalOptima. California Senate Bill (SB) 586 authorized the DHCS to establish the WCM program in designated COHS counties, including CalOptima, to incorporate covered services from the California Children's Services (CCS) program for Medi-Cal eligible CCS children and youth into MCP contracts.

The addition of this contract language is consistent with current All–Plan Letter (APL) and CCS Numbered Letter (NL) guidance, and SB 586. Effective January 1, 2019, CalOptima will be required to provide WCM services to all CalOptima Medi-Cal members under age 21 who meet certain eligibility requirements. Examples of CCS–eligible conditions include, but are not limited to, chronic medical conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, and infectious diseases. Services that eligible CalOptima Medi-Cal members can receive include but are not limited to, diagnostic and treatment services, medical case management, and physical and occupational therapy. The stated goal of the WCM program is to improve care coordination for primary, specialty, and behavioral health services for CCS and non–CCS conditions.

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DHCS has further advised that once the contract amendment and applicable APLs and NLs are finalized, it will require CalOptima to submit readiness deliverables intended to demonstrate compliance with the requirements contained within the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Once CMS approved DHCS' proposed amendment, DHCS will provide the final contract amendment to CalOptima for prompt signature and return. If the final contract amendment is not consistent with Staff's understanding as presented in this document or if it includes substantive and unexpected language changes, staff will return to the Board of Directors for consideration.

Following is a general summary of the major changes expected to be contained within the final contract amendment:

	Requirement
Whole Child Model (WCM) Compliance	Implement the WCM as directed by DHCS, and in accordance with SB 586, DHCS APLs and NLs.
CCS Advisory Committees	<u>CCS Clinical Advisory Committee</u> Create and maintain a CCS clinical advisory committee to advise on clinical issues relating to CCS conditions. <u>CCS Family Advisory Committee</u> The establishment of a CCS family advisory group comprised of CCS–eligible Members' parents, custodial parents, legal guardians, or other authorized representatives.
Provider Network	Maintain an adequate network to ensure timely access to care including CCS providers, hospitals, facilities, licensed acute care hospitals and special care centers.
Provider Compensation	Reimburse physicians and surgeons providing CCS to eligible members at rates that are equal to or exceed the applicable CCS fee-for-service (FFS) rates.
Covered Services	Includes the provision of medically necessary CCS, and continuity of care for out-of-network CCS providers, providers of specialized durable medical equipment (DME), and pharmaceutical services for members determined to be eligible in accordance with CCS program medical eligibility regulations.

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	Requirement
Case Management and Coordination of Care	Provide service authorization, case management, and care coordination for CCS, including, but not limited to risk stratification, pediatric health risk assessments (PHRAs), and Individual Care Plans (ICPs).
Member Rights	Includes Primary Care Provider (PCP) selection, continuity of care, and grievance and appeal requests.
Required Reporting for the WCM Program	Submission of reports for CCS expenditures and savings, CCS providers, and CCS–related grievances and appeals, in a form and manner specified by DHCS.

The amendment is also expected to contain revisions to Plan rates related to the WCM program. CalOptima received draft State Fiscal Year (SFY) 2018–2019 WCM CCS capitation rates in February 2018 and updated draft rates in April 2018. Highlights regarding these rates include the following:

- Rates utilize a two-year base period from CY 2015 and CY 2016 that is a credibility–based blend of cost and utilization experience from supplemental data requests (SDRs), fee-for-service (FFS) data, and encounter data.
- The medical cost of the rate includes both CCS–specific services and standard Medi-Cal services (non–CCS).
- The CCS experience incorporates the larger portion of the rate which includes SDR and FFS submissions; SDR submissions for health plans that covered CCS services previously and CCS FFS experience where CCS services were the responsibility of the CCS FFS delivery system.
- The non–CCS experience was gathered through SDR submissions and encounter data which comprises a smaller portion of the rates.
- Administrative and underwriting gain loads along with case management/care coordination amounts.
- Program changes have been applied for non–medical transportation (NMT) that assume a 100% ramp-up.
- Updated carve-in projections for mental health (MH) at the lower bound for SFY 18–19, which were developed utilizing health plan reported experience for the WCM members in a manner consistent with classic rate cells.
- Neonatal Intensive Care Unit (NICU) amounts have been carved from the base data.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, Staff estimates that the total annual program costs for WCM will be $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be

volatile. CalOptima will closely monitor expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The addition of the WCM contract amendment to CalOptima's Primary Agreement with DHCS is necessary to implement the WCM program and therefore to ensure compliance with the requirements of California legislation and resulting regulatory guidance.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

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

5/30/2018 — **Date**

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APPENDIX TO AGENDA ITEM

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

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

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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
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

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

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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
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

10. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the Health Homes Program

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to incorporation of language related to the Health Homes Program (HHP).

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 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

On October 2, 2017, DHCS submitted an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval that will incorporate language regarding the Health Homes Program (HHP) into managed care plan (MCP) contracts, including CalOptima's.

The Medicaid Health Home State Plan Option, authorized under Section 2703 of the Patient Protection and Affordable Care Act (ACA), allowed states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports (LTSS) needed by members with chronic conditions. Among other goals, the HHP was designed with particular attention paid to its ability to produce positive health outcomes for individuals experiencing homelessness. Specifically, the HHP provides six core services:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care;
- Individual and family support; and

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- Referral to community and social support services, including housing.

Effective July 1, 2019, CalOptima will begin providing HHP services to members with eligible chronic physical conditions and substance use disorder (SUD); effective January 1, 2020, CalOptima will begin providing HHP services for members with Severe Mental Illness (SMI).

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the amendment to CalOptima for prompt signature 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 consideration and/or ratification of staff action.

DHCS has advised that once the contract amendment and applicable APLs are finalized, it will require MCPs to submit readiness deliverables related to the amendment. DHCS' requested deliverables may include Policies and Procedures (P&Ps) designed to demonstrate compliance with requirements included in the amendment. To the extent that CalOptima staff must provide information to DHCS to meet certain deliverables, including the revision or creation of P&Ps that would ordinarily come to the Board of Directors for approval, staff will return to the Board of Directors at a later date for further consideration and/or ratification of staff action.

Following is a general summary of the major changes to expected be addressed in the final contract amendment:

	Requirement
HHP Compliance	Implement the HHP, as directed by DHCS, and in accordance with all State and federal requirements related to HHP and DHCS APLs.
Provider Network	Maintain an adequate network of CB–CMEs to serve HHP members including providers with experience working with people who are chronically homeless. Establish contractual relationships with organizations to provide HHP services including individual housing transition services and individual housing and tenancy sustaining services. Amend the current MOU with the Orange County Health Care Agency to incorporate HHP requirements.
Provider Relations	Ensure that staff providing HHP services complete required training as determined by DHCS and participate in DHCS–operated learning collaboratives.
Eligibility and Enrollment	Enrollment in HHP based on HHP eligibility criteria, as defined by DHCS.

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	Requirement
HHP Member Services	Includes CB–CME selection, and HHP–specific member information and provider directory requirements.
HHP Covered Services	Includes the provision and coordination of HHP services informed by evidence–based clinical practice guidelines.
Information Sharing	Develop and maintain a method to track and share HHP member information between CB–CMEs, CalOptima, and other providers, as warranted.
Quality Improvement System	Include HHP–specific elements in current Quality Improvement system processes and conduct oversight and regular auditing and monitoring of HHP care management requirements.
Payment	CalOptima shall receive an additional monthly payment for each HHP member who receives HHP services.
Required Reports for the HHP	Submission of reports for HHP in a form and manner specified by DHCS.

The final contract amendment is also expected to contain revisions to Plan rates related to the HHP. On April 2, 2018, DHCS provided draft rates applicable for the first two years of the program. Highlights regarding these rates includes the following:

- Updates to the wage inflation factor, existing care coordination (ECC), and partial dual adjustment.
- Build-up of the lower bound HHP services per-member-per-month (PMPM) for chronic conditions (CC) and SMI enrollees, highlights the salary and caseload assumptions by HHP staff member, along with tier mix assumptions and the provider overhead cost. Rates are displayed in six month increments for the first 30 months of the program.
- Build-up of the lower bound engagement period costs for each member on the Targeted Engagement List (TEL), wage and service time assumptions by HHP staff member, and the assumed average number of months of engagement required for each TEL member.
- Combines information from steps 1 and 2 outlined above to produce the statewide lower bound HHP PMPM for the CC only and SMI populations.
- Application of the county-specific wage index, rural area, and wage inflation factors to the statewide rates. Plan-specific existing ECC PMPM and Partial Dual carve–outs are applied to create lower bound non–full dual rates with lower bound full–dual rates created by carving out the ECC and CCM/BHI PMPMs.
- Blending of CC only and SMI rates based on projected HHP enrollment to produce SFY rates.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to incorporate language regarding the HHP program carries significant financial risks. Based on DHCS' proposed rates, staff estimates that the total annual program costs for

HHP will be $12 million. Management has included projected expenses to implement the HHP program effective July 1, 2019, in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval and will include projected revenue and expenses for the HHP program in future operating budgets. Actual utilization associated with the HHP eligible population is still relatively unknown. Therefore, CalOptima will closely monitor program expenses and continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the HHP program.

Rationale for Recommendation

The addition of the HHP contract amendment to CalOptima's Primary Agreement with DHCS is necessary to ensure compliance with the requirements of participation in the Medi-Cal program.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM

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

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

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

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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
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

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

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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
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

11. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to the Primary Agreement with the California Department of Health Care Services (DHCS) Related to the In-Home Supportive Services Benefit

Contact

Silver Ho, Executive Director, Compliance, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between DHCS and CalOptima related to the removal of the In–Home Supportive Services (IHSS) benefit from the Managed Long Term Services and Supports (MLTSS) services.

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 31, which extends the agreement through December 31, 2020. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion

DHCS has informed Plans that it intends to submit an amendment to the Centers for Medicare & Medicaid Services (CMS) for approval in May 2018 that will incorporate language related to the removal of the In–Home Supportive Services (IHSS) benefit from the Managed Long Term Services and Supports (MLTSS) benefits required in Plan contracts. Beginning August 1, 2015, the Coordinated Care Initiative (CCI) prompted the incorporation of MLTSS benefits into Plan contracts. Those benefits included Long–Term Care (LTC) institutional services, IHSS, Community–Based Adult Services (CBAS), Multi–Purpose Program (MSSP) services, and other Home and Community–Based Services (HCBS).

The purpose of this proposed contract amendment is to remove IHSS from Plan contracts that include MLTSS, and rather add IHSS it as a referral service. The 2017 California Budget extended the Cal MediConnect program and the mandatory enrollment of dually eligible individuals, and integration of long–term services and support, except IHSS, into managed care. IHSS was removed from CalOptima's capitation rate payments effective January 1, 2018.

Authority to execute the MLTSS amendment to CalOptima's Primary Agreement with DHCS for Medi-Cal was initially granted to the Chair during the March 2014 meeting of the Board and subsequently updated during the February 2017 meeting of the Board. As noted in the documentation presented to the Board in February 2017, DHCS has never submitted the MLTSS amendment to

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CalOptima for signature. According to DHCS, the delay was related to the finalization of associated rates.

The final contract amendment is expected to contain requirements related to the Plan's Memorandum of Understanding (MOU) for IHSS with the county Social Services Agency, as well as updated rates. CalOptima received final State Fiscal Year (SFY) 2017–18 CCI non-full dual rates in April 2018. Two 6–month rates were developed (July–December 2017 and January–June 2018) to account for the removal of IHSS effective January 1, 2018. For the January–June 2018 HCBS High/Low rates, the IHSS benefits costs were removed. However, to account for the continuing IHSS care coordination requirement, the administrative load associated with the IHSS benefit component was maintained on a per-member-per-month (PMPM) basis and a portion was reallocated in the "All Other" service category to account for the care coordination costs that CalOptima will incur for members that utilize IHSS services.

Once CMS concludes its review of DHCS' proposed amendment, DHCS will provide the final contract amendment to CalOptima for prompt signature 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 consideration and/or ratification of staff action.

Fiscal Impact
The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima related to the removal of the IHSS benefit from MLTSS services is projected to be budget neutral to CalOptima. In 2017, the average monthly IHSS expenses were between $24 million to $25 million. Staff anticipates that DHCS will make a downward adjustment to CCI capitation rates commensurate to the associated IHSS expenses. As such, Management has adjusted the IHSS revenues and expenses in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval.

Rationale for Recommendation
The removal of IHSS from CalOptima's Primary Agreement with DHCS for Medi-Cal is necessary to ensure compliance with the requirements of the Medi-Cal program.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to Primary Agreements with DHCS

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM

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

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

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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
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016
A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
A-34 incorporates revised Adult Optional Expansion rates for January 2015 to June 2015. These rates were revised to include the impact of the Hospital Quality Assurance Fee (HQAF) required by Senate Bill (SB) 239.	June 1, 2017

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

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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
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

12. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute an Amendment to Agreement 16-93274 with the California Department of Health Care Services (DHCS) in Order to Continue Operation of the OneCare and OneCare Connect Programs

Contact

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

Recommended Action

Authorize and direct the Chairman of the Board of Directors to execute an Amendment to Agreement 16-93274 between CalOptima and DHCS, in order to continue operation of the OneCare and OneCare Connect programs.

Background

As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into new five-year Primary and Secondary Agreements with DHCS that have been subsequently extended and amended. Amendments to these agreements are summarized in the attached appendix. Until 2016, the Primary Agreement included language that incorporated provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs).

In 2016, DHCS extracted the MIPPA-compliant language from the Primary agreement and placed it in a standalone agreement, Agreement 16-93274. The Chairman of CalOptima's Board of Directors executed that agreement, an action that was ratified during the August 2016 meeting of the Board.

Subsequently, the Chairman of CalOptima's Board of Directors executed Amendment 01 (A-01) to Agreement 16-93274, an action that was ratified during the August 2017 meeting of the Board. Agreement 16-93274 is set to terminate on December 31, 2018. The agreement contains no rates of payment.

Discussion

Amendment to Agreement 16-93274

On April 24, 2018, DHCS notified CalOptima of its intention to provide CalOptima with a forthcoming amendment to extend Agreement 16-93274 for an additional year, through December 31, 2019. CalOptima has requested that DHCS send the amendment to CalOptima as soon as possible, in order to allow for immediate signature by CalOptima and prompt return to DHCS for countersignature.

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The urgency underlying DHCS' expected request for CalOptima's immediate signature and return of the amendment is tied to a requirement of the Centers for Medicare & Medicaid Services (CMS) that plans renewing their D-SNP programs must submit evidence of a MIPPA-compliant Medicaid contract for the 2019 contract year no later than July 2, 2018. Executing Amendment 02 (A-02) to Agreement 16-93274 is required in order for CalOptima to meet CMS's filing requirements and continue to operate CalOptima's D-SNP "OneCare" and its Cal MediConnect program "OneCare Connect" in contract year 2019.

The amendment is expected to contain no language changes other than the extension of the expiration date. If the amendment contains unexpected language changes, staff will return to the CalOptima Board of Directors to request a revised and updated authority as a matter of ratification. The amendment contains no rates of payment. The Board previously ratified Amendment 01 (A-01) to Agreement 16-93274 during its August 2017 meeting.

Fiscal Impact
The recommended action to execute a contract amendment to extend the termination date for the MIPPA-compliance Medicaid contract through December 31, 2019, has no fiscal impact. The Fiscal Year (FY) 2018-19 Operating Budget pending Board approval includes the continuation of the OneCare and OneCare Connect program through December 31, 2019.

Rationale for Recommendation
CalOptima's execution of Amendment 02 (A-02) to the Agreement 16-93274 with the DHCS is necessary to ensure that CalOptima meets CMS requirements in order for CalOptima to operate the OneCare and OneCare Connect programs during 2019.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Appendix summary of amendments to Agreements with DHCS

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM

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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
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A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
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A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014
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A-32 incorporates base rates for July 2015 to June 2016 with Behavioral Health Treatment (BHT) and Hepatitis–C supplemental payments, and Partial Dual/Medi-Cal only rates, and added aid codes 4U, and 2P–2U as covered aid codes.	February 2, 2017
A-33 incorporates base rates for July 2016 to June 2017.	February 2, 2017
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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

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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
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

The following is a summary of amendments to Agreement 16-93274 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 16-93274	Board Approval
A-01 extends the Agreement 16-93274 with DHCS to December 31, 2018.	August 3, 2017

The following is a summary of amendments to Agreement 17–94488 approved by the CalOptima Board of Directors (Board) to date:

Amendments to Agreement 17-94488	Board Approval
A-01 enables DHCS to fund the development of palliative care policies and procedures (P&Ps) to implement California Senate Bill (SB) 1004.	December 7, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken June 7, 2018
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Consent Calendar

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

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400

Recommended Actions

The MAC recommends:

1. Reappointment of the following individuals to serve two-year terms on the Member Advisory Committee, effective July 1, 2018 through June 30, 2020:
   a. Jaime Muñoz as the Foster Children Representative;
   b. Sally Molnar as the Medically Indigent Persons Representative;
   c. Sr. Mary Therese Sweeney as the Persons with Mental Illness Representative; and
   d. Christine Tolbert as the Persons with Special Needs Representative.

2. Appointment of the following individuals to serve two-year terms on the Member Advisory Committee, effective July 1, 2018 through June 30, 2020:
   a. Luisa Santa as the Children's Representative; and
   b. Elizabeth Anderson as the Long-Term Services and Support (LTSS) Representative.

3. Appointment of Diana Cruz-Toro as the Recipients of CalWORKs Representative for a term ending June 30, 2019.

4. Reappointment of Sally Molnar as the Chair and reappointment of Patty Mouton as the Vice Chair for fiscal year 2018-19.

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, MAC members serve two-year terms with the exception of the two standing seats, which are representatives from the Social Services Agency (SSA) and the Health Care Agency (HCA). The CalOptima Board is responsible for the appointment of all MAC members. With the fiscal year ending on June 30, 2018, seven MAC seats will expire: Children, Consumer, Foster Children, LTSS, Medically Indigent Persons, Persons with Mental Illness and Persons with Special Needs. In addition, the Recipients of CalWORKs seat was vacant due to a mid-term resignation.

Discussion

CalOptima conducted outreach to recruit potential candidates. The recruitment included the following notification methods: sending outreach flyers to Orange County agencies and community-based organizations (CBOs); contacting agencies and CBOs that serve the open positions; and posting recruitment materials on the CalOptima website. CalOptima staff received the applications from

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interested candidates and submitted them to the Nominations Ad Hoc Subcommittee for review. No applications were received for the Consumer seat so that position remains open.

Prior to the Nominations Ad Hoc Subcommittee meeting on April 19, 2018, subcommittee members evaluated each of the applications. The subcommittee, including Members Suzanne Butler, Sandy Finestone and Mallory Vega, recommended a candidate for each of the open seats, as well as the Chair and Vice Chair. The proposed slate of candidates was forwarded to the MAC for consideration.

At the May 10, 2018 meeting, the MAC voted to accept the recommended slate of candidates and Chair and Vice Chair as proposed by the Nominations Ad Hoc.

Candidates for open positions are as follows:

Children's Candidate
Luisa Santa*

Luisa Santa is the Director of Program Development for MOMS Orange County. She has ten years of experience working with the Orange County community in different settings, with all age groups and varied social status. Ms. Santa has extensive experience teaching classes and developing health education programs and curriculum, including teaching health education to children in the slums of Kenya and Brazil.

Foster Children Candidate
Jaime Muñoz*

Jaime Muñoz is an Administrative Manager for Children and Family Services at the Social Services Administration where he manages a specialized program that focuses on improving the well-being and outcomes of transitional age youth and young adults in foster care. Mr. Munoz has 27 years of experience serving as a child welfare services practitioner. Mr. Munoz serves on several community boards that serve under-resourced communities, including foster children.

Long Term Services and Supports Candidate
Elizabeth Anderson*

Elizabeth Anderson serves as the Long-Term Care Ombudsman Program Director at the Council on Aging, Southern California, which advocates for elderly and developmentally disabled adults and assists long-term care residents with resolution of issues related to health care and coverage. Ms. Anderson manages the Ombudsman program, including overseeing the development and implementation of continuing education programs and materials.

*Indicates MAC recommendation

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Medically Indigent Persons Candidates
Sally Molnar*
Amber Brown

Sally Molnar advocates for breast health screenings and treatment programs that provide a safety net for under-insured and uninsured women in Orange County. She currently serves as the Public Policy Chair and advocates for breast cancer services at the state and federal level. She has volunteered with Susan G. Komen in Orange County for 27 years in various capacities. Ms. Molnar believes her service on the MAC is important as safety net services continue to shrink.

Amber Brown is a Case Management Supervisor with Monarch HealthCare and supports a team of nurses that serve CalOptima members. As a public health nurse, Ms. Brown's career has been focused on medically under-served populations, including low-income, poor health literate or those at the end of life. Serving on the MAC would support her commitment to providing quality health care to the medically indigent and under-served.

Persons with Mental Illness Candidate
Sister (Sr.) Mary Therese Sweeney*

Sr. Mary Therese Sweeney is the Director of Mental Health for St. Joseph Health. She has served the mentally ill for over 20 years, especially those with limited access to services. Sr. Sweeney is sensitive to the needs of the mentally ill and believes that direct contact with those served is essential. She often visits service sites and spends considerable time talking to people with mental illness at meetings, at drop-in centers and in the community.

Persons with Special Needs Candidate
Christine Tolbert*

Christine Tolbert's current work for the State Council on Developmental Disabilities has allowed her to advocate for hundreds of people dealing with an expansive number of medical and/or special needs' conditions. She has helped transition people from the state hospital into the community necessitating her involvement in their transition to managed care and accessing health care services.

Recipients of CalWORKs Candidate
Diana Toro-Cruz*

Diana Toro-Cruz is an Administrative Manager for Family Self-Sufficiency and Adult Services at the Social Services Administration where she has worked directly with clients for over 30 years. Having worked in various positions, she has experience in the development, implementation and oversight of medical and employment programs funded by state and federal funding. She has analyzed data to support services and programs to help families in need, including the CalWORKs program.

*Indicates MAC recommendation

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MAC Chair Candidate
Sally Molnar*

Sally Molnar advocates for breast health screenings and treatment programs that provide a safety net for under-insured and uninsured women in Orange County. She currently serves as the Public Policy Chair and advocates for breast cancer services at the state and federal level. She has volunteered with Susan G. Komen in Orange County for 27 years in various capacities. Ms. Molnar believes her service on the MAC is important as safety net services continue to shrink.

MAC Vice Chair Candidate
Patty Mouton*

Patty Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County and has worked in health care for over thirty years. She oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy forming activities. Ms. Mouton is active in the community, speaking on many issues impacting seniors, including hospice, dementia and palliative care.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy, the MAC established a Nominations Ad Hoc to review potential candidates for vacancies on the Committee. The MAC met to discuss the recommended slate of candidates, Chair and Vice Chair and concurred with the Subcommittee's recommendations. The MAC forwards the recommended slate of candidates and Chair/Vice Chair 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 — **Authorized Signature**

5/30/2018 — **Date**

*Indicates MAC recommendation

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400

Recommended Actions

The OCC MAC recommends:

1. Reappointment of the following individuals to serve two-year terms on the OneCare Connect Member Advisory Committee, effective July 1, 2018 through June 30, 2020:
   a. Gio Corzo as the Community-Based Adult Services (CBAS) Provider Representative;
   b. Patty Mouton as the Home and Community-Based Services (HCBS) Seniors Representative;
   c. Ted Chigaros as the Long-Term Care (LTC) Facility Representative; and
   d. Christine Chow as the Member Advocate Representative.

2. Appointment of Keiko Gamez as the OneCare Connect Member/Family Member Representative for a two-year term ending June 30, 2020.

3. Reappointment of Gio Corzo as Chair and Patty Mouton as Vice Chair for a one-year term ending June 30, 2019.

Background

The CalOptima Board of Directors welcomes community stakeholder involvement and benefits from their input in the form of advisory committees. The Center for Medicare & Medicaid Services (CMS) and the State of California Department of Health Care Services (DHCS) established requirements for the implementation of the Cal MediConnect program, including a requirement for the establishment of a Cal MediConnect Member Advisory Committee. The CalOptima Board of Directors established the OneCare Connect Member Advisory Committee (OCC MAC) by resolution on February 5, 2015 to provide input and recommendations to the CalOptima Board relative to the OneCare Connect program, the Cal MediConnect program administered by CalOptima.

The OCC MAC is comprised of ten voting members, seven of whom represent community seats and three of whom are OneCare Connect members or family of members. There are also four non-voting members representing Orange County agencies. OCC MAC voting members serve two-year terms, with no limit on the number of terms a representative may serve. The five seats due to expire on June 30, 2018 include the CBAS Provider, Seniors representative, LTC Facility representative, Member Advocate and an OCC Member/Family Member seat.

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Discussion

CalOptima conducted recruitment, including sending notification flyers to community-based organizations (CBOs), placing articles in newsletters and conducting targeted community outreach to agencies and CBOs serving the various open positions. Upon receipt of the applications from interested candidates, CalOptima staff submitted them to the Nominations Ad Hoc Subcommittee for review.

The OCC MAC Nominations Ad Hoc Subcommittee, composed of OCC MAC members Jyothi Atluri, Sandy Finestone and Kristin Trom, evaluated each of the applications for the impending openings and forwarded the proposed slate of candidates to the OCC MAC for consideration.

At the April 26, 2018 meeting, OCC MAC voted to accept the recommended slate of candidates, Chair and Vice Chair as proposed by the Nominations Ad Hoc and forwarded the proposed slate of candidates to the CalOptima Board for consideration.

The candidates for the open positions are as follows:

CBAS Provider Representative Candidates

Gio Corzo*
Shelle Malm

Mr. Corzo is the Vice President of Home & Care Services for SeniorServ. He has twenty years of health care experience and expertise in strategic planning, development and operations of multiple health facilities, including CBAS centers, Day Programs and residential long-term care facilities. Mr. Corzo was instrumental in working on the State transition of Adult Day Health Care (ADHC) to CBAS.

Ms. Malm is the Corporate Director of Business Development and Contracting at KPC Healthcare, Inc. In that capacity she develops hospital programs for seniors in the four Orange County hospitals that KPC manages. A health care veteran with over 25 years of executive experience in business development and contracting of hospital systems, Ms. Malm's desire is to serve seniors.

Seniors Representative Candidate

Patty Mouton*

Ms. Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County and has worked in health care for over thirty years. She oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy forming activities. Ms. Mouton is active in the community, speaking on many issues impacting seniors, including hospice, dementia and palliative care.

Long-Term Care Facility Representative Candidate

Ted Chigaros*

Mr. Chigaros is the Senior Vice President of Managed Care for Rockport Healthcare Services. He has over thirty-two years of experience contracting with managed care plans for acute rehab facilities and

*Indicates OCC MAC recommendation

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skilled nursing facilities (SNFs). Representing four skilled nursing health care providers in Orange County, Mr. Chigaros is a tireless advocate on behalf of the needs of members in skilled nursing facilities.

Member Advocate Representative Candidates
Christine Chow*
Alonso Moreno

Ms. Chow is the Executive Director of the Orange County Strategic Plan for Aging at Alzheimer's Orange County. In that position, she coordinates collaborative projects with nonprofits and county agencies to provide services and education on the diverse needs of older adults in Orange County. Ms. Chow has a heart for older adults and understands the importance of collaboration to better meet the needs in the community.

Mr. Moreno is a Student/Patient Financial Advocate at the Anaheim Regional Medical Center. In that position, he works with patients and the community, helping gather information for Medi-Cal applications, answering questions about commercial/government health benefits and providing resources. Mr. Moreno is also a graduate student at California State University, Los Angeles.

OneCare Connect Member/Family Member Representative Candidate
Keiko Gamez*

Ms. Gamez is an OneCare Connect member who is interested in serving others. She has experienced many difficulties in her life, but overcoming these experiences provides her the opportunity to make valuable contributions to the committee. Ms. Gamez also wants to help others who experience difficulties accessing care. She describes herself as a problem solver with skills to resolve difficult tasks.

OCC MAC Chair
Gio Corzo*

Mr. Corzo is the Vice President of Home & Care Services for SeniorServ. He has twenty years of health care experience and expertise in strategic planning, development and operations of multiple health facilities, including CBAS centers, Day Programs and residential long-term care facilities. Mr. Corzo was instrumental in working on the State transition of Adult Day Health Care (ADHC) to CBAS.

OCC MAC Vice Chair
Patty Mouton*

Ms. Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County and has worked in health care for over thirty years. She oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy forming activities. Ms. Mouton is active in the community, speaking on many issues impacting seniors, including hospice, dementia and palliative care.

*Indicates OCC MAC recommendation

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Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
As stated in policy, the OCC MAC established a Nominations Ad Hoc to review potential candidates for the OneCare Connect MAC. The OCC MAC met to discuss the Ad Hoc's recommended slate of candidates, including the Chair and Vice Chair and concurred with the Subcommittee's recommendations. The OCC MAC forwards the recommended slate of candidates, Chair and Vice Chair to the Board of Directors for consideration.

Concurrence
OneCare Connect Member Advisory Committee Nominations Ad Hoc
OneCare Connect Member Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

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

5/30/2018 — **Date**

*Indicates OCC MAC recommendation

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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15. Consider Appointments to the CalOptima Board of Directors' Provider Advisory Committee (PAC); Consider Appointment of PAC Chair and Vice Chair

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

The PAC recommends:

1. Reappointment of the Teri Miranti, Health Network Representative to serve an additional three (3) year term on the PAC, effective July 1, 2018.

2. Appointment of the following individuals to serve a three (3) year term on the PAC effective July 1, 2018:
    a. Brian S. Lee, L.Ac., Ph.D. as the Allied Health Representative
    b. Junelyn Lazo, Ph.D. as the Behavioral Health Representative
    c. Pamela Pimentel, R.N. as the Nurse Representative

3. Appointment of John Nishimoto, O.D., PAC Chairperson effective July 1, 2018; and

4. Appointment of Teri Miranti, PAC Vice-Chairperson effective July 1, 2018

Background

The CalOptima Board of Directors established the Provider Advisory Committee (PAC) by resolution on February 14, 1995 to provide input to the Board. The PAC is comprised of fifteen voting members. Pursuant to Resolution No. 15-0806-03, PAC members serve three-year terms with the exception of the one standing seat, which is a representative from Health Care Agency (HCA). The CalOptima Board is responsible for the appointment of all PAC members. With the fiscal year ending on June 30, 2018, four (4) PAC seats will expire: one (1) Allied Health Services seat, one (1) Behavioral Health seat, one (1) Health Network seat, and one (1) Nurse seat. There were three (3) applicants for the Chairperson and one (1) applicant for Vice Chairperson.

Discussion

CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included notification methods, such as: sending outreach flyers to community-based organizations (CBOs) and targeting community outreach to agencies and CBOs serving the various open positions. CalOptima staff received the applications from interested candidates and submitted them to the Nominations Ad Hoc Subcommittee for review.

Prior to the Nominations Ad Hoc Subcommittee meeting on April 18, 2018, subcommittee members evaluated each of the applications. The subcommittee, consisted of Members Flood, Jensen and Sweidan

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who selected a candidate for each of the open seats and forwarded the proposed slate of candidates to the PAC for consideration.

At the May 10, 2018 meeting, the PAC voted to accept the recommended slate of candidates as proposed by the Nominations Ad Hoc Subcommittee.

The slate of candidates are as follows:

Allied Health Representative
Brian S. Lee, L.Ac., Ph.D.*
Jonathan Aryan
Triet Kieu
Pamela Pimentel, R.N.

Dr. Brian S. Lee is the Medical Director at Cornerstone Acupuncture Institute, Inc in Irvine and their Fullerton location. Prior to Cornerstone, Dr. Lee served as the Dean of Clinical Education at Yo San University of Chinese Medicine in Los Angeles. Dr. Lee is a board-certified Acupuncturist and holds a BA from Arizona State University and an MS from South Baylo University. He also holds a Ph.D. from the American Liberty University, Fellowship and Residency in Korea. Currently, Dr. Lee's practice is contracted with many of CalOptima's contracted health networks and physician groups.

Jonathan Ayran currently serves as Director, Business Operation for Maxim Healthcare Services in Orange, where he is responsible for leading and managing Maxim's field offices. He previously held the position of Accounts Manager and Backup Administrator at Maxim from 2016-2017. Mr. Ayran holds a Bachelor of Science degree in Marketing and Management from the University of the Philippines.

Triet Kieu is a certified Nursing Home Administrator and is also certified in the State of California and at the Federal level in long-term care. Currently Ms. Kieu is the Executive Director of Royal Care in Long Beach, CA as well as the Chief Operating Officer of 360 MSO in Fountain Valley, CA. She holds a Master's in Business Administration from Webster University, Irvine and a Bachelor of Arts in Psychology from California State University, Fullerton, CA.

Pamela Pimentel, R.N. has served on the PAC since 2009, most currently as the Allied Health Services Representative. Ms. Pimentel is Chief Executive Officer of MOMS Orange County and has many years of experience in Maternal Child Health Nursing, both clinical and executive leadership. Under her direction, over 2,500 CalOptima members receive services annually from MOMS Orange County and she often collaborates with CalOptima, as a nurse, and as health care executive. She holds a Bachelor of Science Degree in Health Sciences from Chapman University

*Indicates PAC recommendation

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Behavioral Health Representative
Junelyn F. Lazo-Pearson, Ph.D., BCBA-D*
Khang Joseph Nguyen, BCBA

Dr. Lazo-Pearson is the Executive Advisor to Advanced Behavioral Health, Inc a CalOptima contracted behavioral health group. Dr. Lazo-Pearson also serves part-time as an Adjunct Professor, for the Chicago School of Professional Psychology, Irvine Campus, Irvine, CA. Dr. Lazo-Pearson holds a Ph.D. in Developmental and Child Psychology and is a Board-Certified Behavior Analyst, certified through the Behavior Analyst Certification Board.

Khang Joseph Nguyen is the Executive Director of Hearts of ABA in Garden Grove a CalOptima contracted Applied Behavioral Analysis (ABA) provider. Mr. Nguyen holds a Master of Science in Counseling from California State University, Fullerton and is Board Certified in Behavior Analysis through the Florida Institute of Technology in Melbourne, Florida.

Health Network Representative
Teri Miranti*
Lourdes Alberto
Jasmine Frank

Teri Miranti is the Executive Director of Government Programs for Monarch Healthcare. She has served on the PAC since 2015 as the Health Network Representation and has been the PAC Chair since 2016. Ms. Miranti holds a Bachelor's of Art in English Literature with a minor in Psychology.

Lourdes Alberto is Senior Vice President, Provider Network Management and MSO for Prospect Medical Systems. She plays a key role in company operations and facilitates processes across regions. Ms. Alberto holds a Bachelor of Arts in Social Science with an emphasis in Psychology.

Jasmine Frank is Senior Vice President, Regional Operations South of Regal Medical Group where she leads the organization in growth and management of their network in the Southern California market. She holds a Master's Degree in Health Care Administration.

Nurse
Pamela Pimentel*

Pamela Pimentel, RN has served on the PAC since 2009, most currently as the Allied Health Services Representative. Ms. Pimentel is Chief Executive Officer of MOMS Orange County and has many years of experience in Maternal Child Health Nursing, both clinical and executive leadership. Under her direction over 2,500 CalOptima members receive services annually from MOMS Orange County and she often collaborates with CalOptima, as a nurse, and as health care executive. She holds a Bachelor of Science Degree in Health Sciences from Chapman University.

*Indicates PAC recommendation

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Chairperson
Anjan Batra, M.D.
John Nishimoto, O.D., M.B.A., F.A.A.O.*
Suzanne Richards, MBA

Anjan Batra, M.D.
Dr. Batra currently serves as Division Chief of Pediatric Cardiology, Vice Chair of Pediatrics and Professor of Pediatrics at UC Irvine School of Medicine. In addition, he is also the Director of Electrophysiology at Children's Hospital of Orange County (CHOC) and has served on the Board of Directors of Pediatric Subspecialty Faculty at CHOC for six (6) years. Locally, he has been involved in the Children's Specialty Care Coalition, Orange County Medical Association and the American Academy of Pediatrics. Dr. Batra has served on the PAC since 2016 as a Physician Representative.

John Nishimoto, O.D., M.B.A., F.A.A.O.
Dr. Nishimoto is currently a professor at Marshall B. Ketchum University and Southern California College of Optometry. He is also a Senior Associate Dean for Professional Affairs at the Southern California College of Optometry and Marshall B. Ketchum University. He has active engagements with the leadership of the California Optometric Association (COA), the COA Health Care Delivery Systems Committee and the leadership of the American Academy of Optometry and the California Academy of Physician Assistants. He is the Chair for the Board of Integrated Health Care Solutions which included collaborative organizations such as Giving Children Hope and the Illumination Foundation. Dr. Nishimoto has served on the PAC since 2016 as the Non-Physician Medical Practitioner Representative.

Suzanne Richards, M.B.A., FACHE
Ms. Suzanne Richards has served on the PAC since October 2014 and is the CEO of Health Operations, KPC Healthcare and CEO of Orange County Global Medical Center. In addition to her duties as a corporate and hospital CEO, Ms. Richards is an active surveyor for The Joint Commission and has conducted accreditation surveys of health care entities throughout the United States since 2005. Ms. Richards has served as the PAC Vice Chair for two (2) consecutive terms. Ms. Richards is the PAC Hospital Representative.

The PAC held a roll call vote at their May 10, 2018 meeting and recommends John Nishimoto, O.D., Non-Physician Medical Practitioner Representative, to serve as the Chairperson for FY 2018-2019.

Vice Chairperson
Teri Miranti*

The PAC recommends Teri Miranti, Health Network Representative, to serve as the Vice Chairperson for FY 2018-2019. Ms. Miranti has been a PAC member since 2015 and has served as Chair for two (2) consecutive terms, 2016-17 and 2017-18.

Fiscal Impact
There is no fiscal impact.

*Indicates PAC recommendation

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Rationale for Recommendation
As stated in policy, the PAC established a Nominations Ad Hoc Subcommittee to review potential candidates for vacancies on the Committee. The PAC met to discuss the recommended slate of candidates and concurred with the Subcommittee's recommendation. The Chairperson had three candidates who applied for the Chair position and was ultimately decided by a roll call vote. The candidate for Vice Chairperson ran unopposed. The PAC forwards the recommended slate of candidates, Chairperson and Vice Chairperson to the Board of Directors for consideration.

Concurrence
PAC Advisory Committee Nominations Ad Hoc Subcommittee
PAC Advisory Committee
Gary Crockett, Chief Counsel

Attachments
None

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

5/30/2018 — **Date**

*Indicates PAC recommendation

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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Report Item
16. Consider Approval of the CalOptima Fiscal Year 2018-19 Operating Budget

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions
1. Approve the CalOptima Fiscal Year (FY) 2018-19 Operating Budget; and
2. Authorize the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy

Background
The CalOptima FY 2018-19 Operating Budget provides revenues and appropriations for the period of July 1, 2018, through June 30, 2019, and includes the following budget categories:

- Medi-Cal;
- OneCare Connect;
- OneCare;
- Program for All-Inclusive Care for the Elderly (PACE);
- Facilities; and
- Investment income.

Staff is submitting the complete budget for all lines of business for approval with assumptions based on available information to date. Pursuant to CalOptima Policies GA. 3202: CalOptima Signature Authority, GA. 5002: Purchasing Policy, and GA.5003: Budget and Operations Forecasting, the Board's approval of the budget authorizes the expenditure and appropriates the funds requested for the item without further Board action to the extent the Board has or is, as indicated in the Budget attachments, delegating authority to Management.

The primary revenue source is the State of California. As of this writing, the Legislature continues to meet in hearings to discuss the Governor's budget proposal released in January. The January budget proposal would increase the state's share to fund Affordable Care Act's optional Medi-Cal expansion effective January 1, 2018, proposes to restrict 340B drug reimbursement in the Medi-Cal program, and continues implementation of federal Medicaid managed care regulations.

On May 11, 2018, the Governor released the revised state budget (May Revise). Compared to the January budget proposal, the state is projected to receive $8 billion in higher revenues through FY 2018-19. The Governor continued to focus on the primary short-term fiscal goal of fully funding state reserves in preparation for the next recession. The May Revise made several budget adjustments, but did not introduce any new benefit expansions or reductions to the Medi-Cal program. The Legislature will take final actions and pass the budget by June 15, 2018. Until the final budget is enacted, CalOptima's budget will have a level of uncertainty.

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- FY 2018-19 rates for Medi-Cal, including rates for both the Classic and Expansion populations, were made available in draft form on April 27, 2018. However, draft rates are subject to change, and are not finalized until the California Department of Health Care Services (DHCS) receives federal approval and CalOptima executes a signed contract amendment with DHCS; and

- FY 2018-19 rates for Medi-Cal supplemental benefits, such as Managed Long Term Services and Supports (MLTSS) have not yet been released.

CalOptima Budget Overview

I. Consolidated Operating Budget

The FY 2018-19 consolidated operating budget is a combined income and spending plan for all CalOptima programs and activities.

Table 1: FY 2018-19 Consolidated Operating Budget

	FY 2018-19 Budget
Average Monthly Enrollment	783,865
Revenue	$3,460,562,644
Medical Costs	$3,289,519,514
Administrative Costs	$152,735,888
Operating Income/Loss	**$18,307,242**
Investments, Net	$5,000,000
Change in Net Assets	**$23,307,242**
Medical Loss Ratio (MLR)	95.1%
Administrative Loss Ratio (ALR)	4.4%

Budget Assumptions

Medical Cost: Several methods were utilized to develop the medical expense forecasts. Predominantly, projections were based on trends calculated from historical experience. In addition, adjustments were applied to account for any known changes to operations, program structure, benefits, and regulatory policies. For new programs, staff used historical data, proxy data and industry benchmarks, and checked results for reasonability.

Administrative Cost: To take into consideration seasonal and cyclical spending patterns, FY 2018-19 was forecasted on a 12 month rolling actual. To ensure inclusion in the budget, Staff reviewed all contract encumbrances. Lastly, internal departments identified resource requirements based on changes to enrollment, regulatory and organizational needs. Staff considered:

- Salaries, Wages & Benefits for current staff, unfilled budgeted positions and new budgeted positions;
- Professional Fees, Purchased Services, Printing & Postage and Other Operating Costs based on the needs and priorities of providing care to members;
- Depreciation & Amortization on current assets and projected assets according to Generally Accepted Accounting Principles (GAAP); and
- Indirect Cost Allocation primarily based on revenue and adjusted where necessary.

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Of note, CalOptima has several contracts for claims administration, credit balance recovery, and Social Security Income conversion that are paid on a contingency basis. The following table provides a comparison of consolidated general and administrative expenses from the previous fiscal year.

Table 2: Comparison of Consolidated General and Administrative Expenses

	FY 2016-17 Actual	FY 2017-18 Forecast*	FY 2018-19 Budget	FY 2018-19 Budget vs. FY 2017-18 Forecast
Revenues	**$3,549,751,437**	**$3,326,530,002**	**$3,460,562,644**	**$134,032,642**
Salaries, Wages & Benefits	**$73,303,786**	**$78,632,015**	**$97,406,401**	**$18,774,386**
Non-Salaries & Wages	**$38,775,816**	**$41,127,173**	**$55,329,487**	**$14,202,314**
Professional Fees	$1,259,140	$2,307,813	$5,033,200	$2,725,387
Purchased services	$11,324,446	$10,669,537	$15,125,894	$4,456,357
Printing & Postage	$3,770,719	$4,689,860	$6,397,746	$1,707,886
Depreciation & Amortization	$5,948,304	$6,899,904	$7,525,209	$625,305
Other Operating Exp/Indirect Cost Allocation, Occupancy	$16,473,207	$16,560,059	$21,247,438	$4,687,379
Total G&A	**$112,079,601**	**$119,759,188**	**$152,735,888**	**$32,976,700**
ALR	**3.2%**	**3.6%**	**4.4%**	**0.8%**
ALR Breakdown:				
Salaries, Wages & Benefits	2.1%	2.4%	2.8%	**0.4%**
Non-Salaries & Wages	1.1%	1.2%	1.6%	**0.4%**

* Forecasted as of March 2018
Note: FY 2017-18 forecasted figures does not include unfilled open positions

Attachment B: Administrative Budget Details provides additional information regarding all general and administrative expenses included in the FY 2018-19 Operating Budget.

II. Enrollment by Line of Business

The following table provides a comparison of total average enrollment for the past two (2) fiscal years with the projected enrollment for FY 2018-19.

Table 3: Total Average Enrollment by Program

Program	FY 2016-17 Actual*	FY 2017-18 Forecast*	FY 2018-19 Budget*	% Change 18 v. 19
Medi-Cal	773,732	768,750	766,070	-0.3%
OneCare Connect	15,558	14,943	14,866	-0.5%
OneCare	1,350	1,324	1,324	0.0%
PACE	212	265	351	32.5%
Total	**790,852**	**785,282**	**782,611**	**-0.3%**

* Enrollment as of June of every fiscal year when available, otherwise most current month

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III. Operating Budget by Line of Business

A. Medi-Cal Program

Through a contract with DHCS, CalOptima has administered the Medi-Cal program for Orange County since October 1995. CalOptima's current contract expires on December 31, 2020. The table below illustrates the Consolidated Medi-Cal Operating Budget.

Table 4: FY 2018-19 Medi-Cal Consolidated Operating Budget – Includes MSSP

	FY 2016-17 Actual	FY 2017-18 Forecast*	FY 2018-19 Budget
Average Monthly Enrollment	777,057	774,053	767,359
Revenue	$3,144,012,925	$2,950,310,063	$3,105,673,528
Medical Costs	$3,014,868,476	$2,860,665,674	$2,951,687,294
Administrative Costs	$88,649,070	$96,348,364	$126,348,995
Operating Income/Loss	$40,495,380	($6,703,976)	$27,637,239
MLR	95.9%	97.0%	95.0%
ALR	2.8%	3.3%	4.1%

* Forecasted as of March 2018
Change in net assets excludes net other income and grant income

For FY 2018-19, Medi-Cal membership is defined into three main categories: Classic, Expansion, and Whole Child Model (WCM). The following table illustrates the Medi-Cal Operating Budget by each of these categories.

Table 5: FY 2018-19 Medi-Cal Operating Budget by Group

	Medi-Cal Classic	Medi-Cal Expansion	Medi-Cal WCM	Total
Average Monthly Enrollment	518,107	243,001	6,251	767,359
Revenue	$1,634,445,510	$1,334,029,135	$137,198,883	$3,105,673,528
Medical Costs	$1,578,666,340	$1,243,068,856	$129,952,098	$2,951,687,294
Administrative Costs				$126,348,995
Operating Income/Loss				$27,637,239
MLR	96.6%	93.2%	94.7%	95.0%
ALR				4.1%

* WCM enrollment begins January 1, 2019 with an estimated 12,502 members

DHCS uses Category of Aid (COA) to classify Medi-Cal enrollment into cohorts of similar acuity. DHCS develops CalOptima's capitation rates based on these cohorts. The following table shows the projected enrollment distribution by COA.

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Table 6: FY 2018-19 Medi-Cal Enrollment Projection

	FY 2017-18 Forecast*	FY 2018-19 Budget*	Variance	
			Diff	%
BCCTP	620	620	-	0.0%
Disabled	47,093	44,161	(2,932)	-6.2%
Long Term Care	3,437	3,569	132	3.8%
Aged	63,546	66,234	2,688	4.2%
TANF <= 18 (Child)	317,228	302,269	(14,959)	-4.7%
TANF > 18 (Adult)	96,172	91,886	(4,286)	-4.5%
Medi-Cal Classic Subtotal	**528,096**	**508,739**	**(19,357)**	**-3.7%**
Medi-Cal Expansion	240,655	244,830	4,175	1.7%
WCM	0	12,502	12,502	N/A
Total	**768,751**	**766,071**	**(2,680)**	**-0.3%**

* Enrollment as of June of every fiscal year

General Budget Assumptions – Medi-Cal

Consolidated Enrollment: Enrollment projections are based on actual data through March 2018 and trended through June 2019. The budget assumes continued slight growth of Aged and Medi-Cal Expansion enrollment, offset by small decreases in the Child and Adult aid categories. Beginning in January 2019, some enrollment will migrate from the Child and Disabled populations to the WCM population.

Classic Revenue: The FY 2018-19 Operating Budget applies draft FY 2018-19 capitation rates received from DHCS on April 27, 2018. Rates reflect an increase of 2.59% from the prior fiscal year. In addition, the following has been incorporated into the revenue assumptions:

- WCM implementation beginning January 1, 2019; draft rates received from DHCS on May 1, 2018;
- Non-Medical Transportation (NMT) benefit;
- Coordinated Care Initiative rates are based on Calendar Year (CY) 2017 draft rates for the dual eligible population, and removes In-Home Supportive Services (IHSS) as a managed care benefit effective January 1, 2018;
- Capitation rates for Behavioral Health Treatment for autism services are based on FY 2017-18 rates; and
- Proposition 56 physician services supplemental payments.

Classic Medical Cost: Provider capitation payments were based on capitation rates and enrollment distribution as of February 2018. Fee-for-service (FFS) costs were based on historical claims trended to June 2019, and were developed by network type, COA, and category of service. Provider reimbursement rates for Classic members were kept at FY 2017-18 levels. Reinsurance attachment points remained at $17,000 for Professional and $150,000 for Hospital, with coinsurance at 20%. Mental health expenses were converted from a capitation to a FFS reimbursement methodology. The budget incorporates projections for the WCM program and NMT benefit, and Proposition 56 physician services supplemental payments. It also reflects the removal of IHSS as a managed care benefit (effective January 1, 2018), and includes projected expenses for quality improvement programs.

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Expansion Revenue: The FY 2018-19 Operating Budget applies draft FY 2018-19 capitation rates received from DHCS on April 27, 2018. Rates reflect an increase of 3.24% from prior fiscal year.

Expansion Medical Cost: Provider capitation payments for both Professional and Hospital Services were kept at FY 2017-18 levels. However, analysis continues to show that the current capitation reimbursement levels paid by CalOptima to providers for this population is above what is supported by membership and utilization data. FFS cost trends were developed by network type, COA, and category of service. Staff maintained current FFS reimbursement levels for inpatient and outpatient hospital, clinic, and primary care and specialist contract rates. Reinsurance attachment points remained at $17,000 for Professional and $150,000 for Hospital, with coinsurance at 20%. The budget includes projected expenses for quality improvement programs.

Whole Child Model Revenue: The FY 2018-19 Operating Budget applies draft FY 2018-19 capitation rates received from DHCS on May 1, 2018. Draft rates reflect reimbursement for both California Children's Services (CCS) and non-CCS services. The budget assumes that the WCM program transitions to CalOptima effective January 2019.

Whole Child Model Medical Cost: Costs are based on the program assumptions developed by DHCS as there was limited experience data available to forecast medical expenses. Staff utilized draft rates as a proxy for actual experience. 91.9% of revenue is expected to go towards medical costs, 2.8% for medical management, and 5.3% for administrative expenses. Other assumptions include the continuity of existing medical care delivery arrangements and that aggregate costs will be equivalent to revenue.

B. OneCare Connect

Through a three-way contract with the Center for Medicare & Medicaid Services (CMS), DHCS, and CalOptima, CalOptima began the OneCare Connect Program in July 2015. The Cal MediConnect program is a three-year Medicare and Medicaid demonstration program that promotes coordinated health care delivery to seniors and persons with disabilities who are dually eligible for Medicare and Medi-Cal services. The initial demonstration period began October 1, 2013 and ends December 31, 2019. The table below illustrates the OneCare Connect Operating Budget.

Table 7: FY 2018-19 OneCare Connect Operating Budget

	FY 2016-17 Actual	FY 2017-18 Forecast*	FY 2018-19 Budget
Average Monthly Enrollment	16,834	15,143	14,873
Revenue	$371,630,947	$340,603,831	$308,598,939
Medical Costs	$355,225,238	$314,092,828	$294,602,890
Administrative Costs	$20,540,042	$20,767,424	$22,698,581
Operating Income/Loss	($4,134,333)	$5,743,579	($8,702,532)
MLR	95.6%	92.2%	95.5%
ALR	5.5%	6.1%	7.4%

* Forecasted as of March 2018

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General Budget Assumptions – OneCare Connect

Enrollment: Average OneCare Connect membership is projected to decline by approximately 1.8% from FY 2017-18 through FY 2018-19.

Revenue: The FY 2018-19 Operating Budget applies actual rates from CY 2018 and draft rates for CY 2019 for Medicare Parts C and D. Part C base rates will increase by 4.76% effective January 2019. Staff applied a projected Risk Adjustment Factor (RAF) score of 1.28 to Part C revenue. The budget does not include projections for CMS risk adjustment reconciliation. In addition, the budget assumes a Year 3 savings target of 5.5% and a quality withhold of 3%.

Staff applied Medi-Cal CY 2017 draft rates from DHCS and adjusted by forecasted enrollment in the specified population cohorts. The final Medi-Cal revenue will be adjusted to reflect the actual population mix.

Medical Cost: Provider capitation payments were based on Percent of Premium (POP) rates for the Medicare component and fixed per member per month (PMPM) rates for the Medi-Cal component. FFS expenses were projected based on actual OneCare Connect experience, trended through June 2019. Staff applied the projected enrollment mix for Physician Hospital Consortia (PHC), Shared Risk Groups (SRG), Health Maintenance Organizations (HMO), and the CalOptima Community Network (CCN) taking into account prior health network risk arrangement changes (e.g. a health network changing from PHC to HMO). In addition, the budget includes expenses for approved supplemental benefits.

MLTSS costs were based on historical experience. The budget reflects the removal of IHSS as a managed care benefit effective January 1, 2018, and projected expenses for quality improvement programs.

C. OneCare

Through a contract with the CMS, CalOptima has administered a Medicare Advantage Dual Eligible Special Needs Plan since October 2005. OneCare will continue to provide services for beneficiaries not eligible for the OneCare Connect program. The table below illustrates the OneCare Operating Budget.

Table 8: FY 2018-19 OneCare Operating Budget

	FY 2016-17 Actual	FY 2017-18 Forecast*	FY 2018-19 Budget
Average Monthly Enrollment	1,237	1,367	1,324
Revenue	$18,615,729	$15,521,459	$19,357,913
Medical Costs	$16,424,251	$14,657,796	$18,497,977
Administrative Costs	$1,225,310	$1,131,584	$1,585,022
Operating Income/Loss	$966,168	($267,922)	($725,086)
MLR	88.2%	94.4%	95.6%
ALR	6.6%	7.3%	8.2%

* Forecasted as of March 2018

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General Budget Assumptions – OneCare

Enrollment: The FY 2018-19 Operating Budget assumes enrollment will remain flat compared to current membership levels.

Revenue: Staff based Medicare Parts C and D rates on CY 2018 Monthly Membership Report (MMR) actuals and projected a 3.4% increase to Part C base rates effective January 2019. Staff applied a projected RAF score of 1.08 to Part C revenue. The budget does not include projections for CMS risk adjustment reconciliation.

Medical Cost: Provider capitation payments were based on 38.7% POP (inclusive of quality incentive payments). FFS medical expenses were based on historical claims incurred through February 2018. In addition, the budget includes expenses for approved supplemental benefits, which reflects a decrease to the Part D member cost sharing amounts.

D. PACE

Through a contract with CMS, CalOptima began Orange County's first PACE program on October 1, 2013. The PACE program provides coordinated care for persons age 55 and older who need a higher level of care to remain in their homes. The table below illustrates the PACE Operating Budget.

Table 9: FY 2018-19 PACE Operating Budget

	FY 2016-17 Actual	FY 2017-18 Forecast*	FY 2018-19 Budget
Average Monthly Enrollment	190	232	309
Revenue	$15,202,259	$19,887,414	$26,932,264
Medical Costs	$14,159,096	$17,167,062	$24,731,353
Administrative Costs	$1,433,065	$1,376,717	$2,103,290
Operating Income/Loss	($389,902)	$1,343,635	$97,620
MLR	93.1%	86.3%	91.8%
ALR	9.4%	6.9%	7.8%

* Forecasted as of March 2018

Although PACE has reached an operational surplus during FY 2017-18, Management will continue to focus on several areas of opportunities to improve the PACE program, including:

- Service area expansion through Alternative Care Settings (ACS) for improved member access;
- Ensure accurate reporting of experience and cost data through the Rate Development Template (RDT) filing;
- More acute management of medical utilization, mix, and expense;
- Implement initiatives to gain greater administrative efficiencies and operational economies of scale; and
- Improve coding and submission of diagnostic data.

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General Budget Assumptions – PACE

Enrollment: The FY 2018-19 Operating Budget assumes PACE enrollment is projected to increase on average of 7 members per month (ending at 351 members by June 2019). This is higher than the prior year's growth due to the ACS expansion. Population is projected to consist of 53% dual eligible members and 47% Medi-Cal only members.

Revenue: The FY 2018-19 Operating Budget applies rates from CY 2018 actuals for Medicare Parts C and D, and projects a 2.0% increase to Part C base rates effective January 2019. Medicare Part D rates and subsidies were based on CY 2018 payments. Staff applied a projected RAF score of 2.26 to Part C revenue. No additional trend assumptions were applied. Medi-Cal PMPM rates are based on CY 2018 RDT rates provided by DHCS on February 15, 2018.

Medical Cost: Medical expenses were projected using a combination of actual experience and industry benchmarks. The budget includes material depreciation costs associated with start-up capital expenses. Staff reclassified 96% of some administrative expenses as medical expenses to better reflect the actual costs of delivering medical care.

E. Investment Income

The table below illustrates projected net investment income.

Table 10: Investment Income

	FY 2016-17 Actual	FY 2017-18 YTD Forecast*	FY 2018-19 Budget
Investment Income	$15,064,815	$18,118,208	$5,000,000

* Forecasted as of March 2018

Budget Assumptions – Investment Income

The FY 2018-19 budget projects $5,000,000 in net investment income. The budget is lower than FY 2017-18 Forecast due to forecasted cash outflows from CalOptima's portfolio in FY 2018-19. This includes the Medi-Cal Expansion rate adjustment from DHCS' recoupment of overpayment, a contingency payable to DHCS due to the 85% MLR reconciliation, and the FY 2016-17 and FY 2017-18 shared risk pool payout.

Fiscal Impact

As outlined above and more detailed information contained in Attachment A: FY 2018-19 Budget for all Lines of Business, the FY 2018-19 Operating Income reflects a projected gain of $18.3 million. In addition, the budget includes projected investment income of $5 million, resulting in a projected total gain of $23.3 million in changes to net assets.

Rationale for Recommendation

Management submits the FY 2018-19 Operating Budget for all program areas using the best available assumptions to provide health care services to CalOptima's forecasted enrollment.

Concurrence

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

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Attachments

1. Attachment A: FY 2018-19 Budget for all Lines of Business
2. Attachment B: Administrative Budget Details
3. PowerPoint Presentation: Fiscal Year 2018-19 Proposed Operating and Capital Budget

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

5/30/2018 — **Date**

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Attachment A

CalOptima Fiscal Year 2018-19 Budget
By Line of Business

	Medi-Cal (Classic)	Medi-Cal (Expansion)	Medi-Cal (WCM)	Total	OCC	OneCare	PACE	Facilities	Other	Consolidated
Member Months	6,217,281	2,916,015	75,012	9,208,308	178,472	15,888	3,708	-		**9,406,376**
Avg Members	518,107	243,001	6,251	767,359	14,873	1,324	309	-		**783,865**
Revenues										
Capitation revenue	$ 1,634,445,510	$ 1,334,029,135	$ 137,198,883	$ 3,105,673,528	$ 308,598,939	$ 19,357,913	$ 26,932,264	$ -		**$ 3,460,562,644**
Total	$ 1,634,445,510	$ 1,334,029,135	$ 137,198,883	$ 3,105,673,528	$ 308,598,939	$ 19,357,913	$ 26,932,264	$ -		**$ 3,460,562,644**
Medical Costs										
1 Provider capitation	$ 423,848,466	$ 619,600,772	$ 72,446,519	$ 1,115,895,758	$ 142,376,175	$ 5,402,693	$ -	$ -		**$ 1,263,674,625**
2 Claims Payments	$ 491,680,078	$ 330,196,847	$ 18,309,820	$ 840,186,745	$ 51,966,785	$ 7,294,551	$ -	$ -		**$ 899,448,081**
3 LTC/Skilled Nursing Facilities	$ 401,472,982	$ 33,600,389	$ 1,267,322	$ 436,340,693	$ 19,326,362	$ -	$ -	$ -		**$ 455,667,055**
4 Prescription Drugs	$ 229,359,629	$ 235,472,276	$ 34,119,887	$ 498,951,792	$ 63,562,845	$ 5,293,104	$ -	$ -		**$ 567,807,742**
5 Case Mgmt & Oth Medical	$ 32,305,185	$ 24,198,571	$ 3,808,549	$ 60,312,305	$ 17,370,723	$ 507,629	$ 24,731,353	$ -		**$ 102,922,010**
Total	$ 1,578,666,340	$ 1,243,068,856	$ 129,952,098	$ 2,951,687,294	$ 294,602,890	$ 18,497,977	$ 24,731,353	$ -		**$ 3,289,519,514**
MLR	***96.6%***	***93.2%***	***94.7%***	***95.0%***	***95.5%***	***95.6%***	***91.8%***		*	***95.1%***
Gross Margin	$ 55,779,170	$ 90,960,279	$ 7,246,785	$ 153,986,234	$ 13,996,049	$ 859,936	$ 2,200,911	$ -		**$ 171,043,130**
Administrative Expenses										
Salaries, Wages, & Employee Benefits				$ 84,796,466	$ 10,519,014	$ 480,071	$ 1,610,850	$ -		**$ 97,406,401**
Professional Fees				$ 4,281,000	$ 515,000	$ 235,200	$ 2,000	$ -		**$ 5,033,200**
Purchased services				$ 11,371,714	$ 3,016,981	$ 209,100	$ 252,320	$ 275,779		**$ 15,125,894**
Printing & Postage				$ 5,079,715	$ 1,034,420	$ 158,471	$ 125,140	$ -		**$ 6,397,746**
Depreciation & Amortization				$ 5,544,907	$ 0	$ -	$ 25,088	$ 1,955,214		**$ 7,525,209**
Other Operating Expenses				$ 17,958,288	$ 924,438	$ 82,600	$ 46,304	$ 2,288,253		**$ 21,299,883**
Indirect Cost Allocation, Occupancy Expense				$ (2,683,095)	$ 6,688,728	$ 419,580	$ 41,588	$ (4,519,246)		**$ (52,445)**
Total				$ 126,348,995	$ 22,698,581	$ 1,585,022	$ 2,103,290	$ 0		**$ 152,735,888**
ALR				***4.1%***	***7.4%***	***8.2%***	***7.8%***		*	***4.4%***
Operating Income/(Loss)				$ 27,637,239	$ (8,702,532)	$ (725,086)	$ 97,620	$ (0)	$ -	**$ 18,307,242**
Investment Income									$ 5,000,000	$ 5,000,000
MCO Tax Revenue				$ 130,244,985						$ 130,244,985
MCO Tax Expense				$ (130,244,985)						$ (130,244,985)
CHANGE IN NET ASSETS				**$ 27,637,239**	**$ (8,702,532)**	**$ (725,086)**	**$ 97,620**	**$ (0)**	**$ 5,000,000**	**$ 23,307,242**

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Attachment B

	Medi-Cal: Professional Fees			
Specific Type	Objective of the Item Proposed	Budget FY2019 Input	Authorization	Appropriation
Legal	General and Adversarial Legal Fees	1,200,000	X	X
Consulting	Consulting Services Related to Information System Training and Implementation	315,000	X	X
Consulting	Executive Office Internal Audit	300,000	X	X
Professional Fees	Compensation Study	300,000	X	X
Consulting	Government Affairs Contract and Management of State and Federal Lobbyists	246,000	X	X
Audit Fees	Medical Loss Ratio Audit	205,500	X	X
Professional Fees	Legal Support to Human Resources Matters	200,000	X	X
Audit Fees	Financial Audit Annual Contract	180,000	X	X
Consulting	Health Insurance Portability and Accountability Act (HIPAA) Security and Miscellaneous Consulting/Professional Services	158,000	X	X
Professional Fees	Core System (Facets) Upgrade Consultation and Other Core Application Support	157,000	X	X
Consulting	Rebasing, Network Support and Other Related Actuarial Consulting Services	150,000	X	X
Consulting	Consulting Fees To Support Program Outreach, Website Redesign Efforts, Acquisition Of Data For Strategic Direction, And Digital Initiatives	100,000	X	X
Professional Fees	External Medical Reviewer	83,000	X	X
Professional Fees	Professional Services Required for Corporate Applications and Systems	81,000	X	X
Consulting	Investment Advisory Annual Contract	77,500	X	X
Professional Fees	Professional Fees for Various Accounting Projects and Consulting Services	75,000	X	X
Professional Fees	Employee Engagement Survey, Executive Recruiter Expenses and Ad-Hoc Consulting	70,000	X	X
Consulting	Support for New Projects Related to Whole Child Model, Health Home, Whole Person Care and New Requirements for Behavioral Health	60,000	X	X
Professional Fees	Consulting Services to Provide Outreach to the Vietnamese and Latino Community	55,000	X	X
Consulting	Consultant for Medi-Cal Mock Audit and Other Required Audits	50,000	X	X
Consulting	Annual IBNR Certification Review	50,000	X	X
Consulting	Consultant for Development of Covered CA Product	50,000	X	X
Professional Fees	Professional Fees for Various Capital Project Training & Consulting Related Expenses	40,200	X	X
Consulting	Semi-Annual Chronic Illness and Disability Payment System (CDPS) Risk Adjustment	30,000	X	X
Consulting	Space Planning Services	22,000	X	X
Consulting	Provider Reimbursement Development	15,000	X	X
Consulting	Required Annual A-133 Audit	9,000	X	X

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Attachment B

	Medi-Cal: Professional Fees			
Specific Type	**Objective of the Item Proposed**	**Budget FY2019 Input**	**Authorization**	**Appropriation**
Consulting	General Consulting Services for Audit and Oversight	1,800	X	X
	Total Professional Fees	**4,281,000**		

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Attachment B

	Medi-Cal: Purchased Services			
Specific Type	Objective of the Item Proposed	Budget FY2019 Input	Authorization	Appropriation
Purchased Services	Pharmacy Benefits Management Fees	2,760,000	X	X
Claims Review	Claims Web Based Fraud, Waste, and Abuse Services	1,690,500	X	X
Claims Review	Coordination Of Benefits (COB) Project	1,030,000	X	X
Claims Review	Forensic Validation Review Services	865,000	X	X
EDI Claims Clearinghouse	Electronic Data Interchange Institutional Claims	844,000	X	X
Interpretive Services	Language Interpreter Services, Language Translation Services of Written Materials, Video Interpretative Services and Design Software for Regulatory Mandated Annual Member Materials	542,569	X	X
Claims Review	Long-Term Care Rate Adjustments	435,000	X	X
Purchased Services	Conversion Of Temporary Assistance To Needy Families (TANF) to Supplemental Security Income (SSI)	400,000	X	X
Bank Fees	Business Bank Fees	348,000	X	X
Purchased Services	Third Party Check Printing and Mailing Fees	300,000	X	X
Imaging Services	Claims Imaging and Indexing Services	288,000	X	X
Purchased Services	Disaster Recovery Technology Services	240,000	X	X
Advertising	Radio, Television, Print, Outdoor and Digital Advertising to Promote and Support Enrollment and Participation	170,000	X	X
Advertising	Recruitment Advertisement and Sourcing	135,000	X	X
Claims Review	Credit Balance Recovery	135,000	X	X
Broker Services	Insurance Broker Services	134,250	X	X
Purchased Services	Stack Parking Services	125,000	X	X
Claims Review	Recovery of Third Party Liability (Subrogation)	120,000	X	X
Purchased Services	Benefit Broker Services	105,000	X	X
Purchased Services	Cloud E-Mail Security and Data Loss Prevention Cloud Service for O365 Excahange Online	89,000	X	X
Purchased Services	Electronic Human Resources Files	80,000	X	X
Purchased Services	Claims Pricing Automation Enhancements	65,000	X	X
Purchased Services	Healthcare Productivity Automation Services	50,000	X	X
Purchased Services	Regulatory 508 Compliance Remediation Services for PDF Files to Make Them Accessible to People with Disabilities on the Website as Required by the Centers for Medicare & Medicaid Services (CMS), Department of Health Care Services (DHCS) and Section 508 Regulations	50,000	X	X
Purchased Services	Offsite Backup Tape Storage and Services	48,000	X	X
Purchased Services	OCSD (Orange County Sheriff Department) Armed Security Services for Board and Other Meetings, Restacking Services, Flu Shots and Tuberculosis (TB) Tests	43,900	X	X
Purchased Services	Retirement Funds Advisory	41,500	X	X
Employee Benefits	Flexible Spending Accounts (FSA)/ Consolidated Omnibus Budget Reconciliation Act (COBRA)	31,500	X	X
Purchased Services	Employee Assistance Program	30,000	X	X
Purchased Services	Executive Coaching	30,000	X	X
Purchased Services	Photography Services and Stock Photograph Purchases for Use in Member, Provider, Marketing, Outreach and Other Community Oriented Materials	20,000	X	X

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Attachment B

	Medi-Cal: Purchased Services			
Specific Type	**Objective of the Item Proposed**	**Budget FY2019 Input**	**Authorization**	**Appropriation**
Purchased Services	Wellness and Ad-Hoc Programs	19,000	X	X
Purchased Services	Tax Form Processing Fees and Other General Purchased Services	18,500	X	X
License fees	Compensation System Subscription Fee	15,000	X	X
Purchased Services	Background Screening	15,000	X	X
Purchased Services	Member Survey	15,000	X	X
Purchased Services	General Services for Customer Services, Member Liaison, Provider Data Management Services, Operations Management, Executive Office, and Other Various Departments	13,910	X	X
Purchased Services	Destruction of Electronic Media	12,000	X	X
Purchased Services	Online Phishing Testing Service, Security Newsletter Subscription and Other Services	6,200	X	X
Purchased Services	Drug Screenings	6,000	X	X
Purchased Services	Imaging Services	4,885	X	X
	Total Purchased Services	**11,371,714**		

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	Medi-Cal: Printing & Postage			
Specific Type	**Objective of the Item Proposed**	**Budget FY2019 Input**	**Authorization**	**Appropriation**
Printing	Print, Fulfillment and Postage for Regular Monthly Mailings	2,418,900	X	X
Printing	Print Fulfillment and Postage for Quarterly Newsletters	974,000	X	X
Printing	Print Fulfillment and Postage for New Member/Enrollment Packages	789,000	X	X
Postage	General Postage for Outgoing Mail	625,000	X	X
Printing	Printing of the Annual Report to the Community, Holiday Cards, CalOptima Brochures, Marketing Materials, Ad Hoc Materials, Provider Press Mailings, and Community Events Materials	80,100	X	X
Printing	Miscellaneous Member Materials, Printing Expenses and Supplies For Various Departments	77,615	X	X
Printing	Programming Changes for New And Existing Packets	53,100	X	X
Courier	Mail Services Charges, Courier/Delivery of Materials	37,000	X	X
Printing	Printing Services for Facilities Projects and Events, Safety and Security, Other CalOptima Departments Printing Needs)	25,000	X	X
	Total Printing & Postage	**5,079,715**		

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	Medi-Cal: Other Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY2019 Input**	**Appropriation**	**Authorization**
Maintenance	CalOptima Link Software Licenses, an Online System for Provider Networks to Submit and View Authorizations, Check Claim Status and Remittance Payment Advice, and to Verify Member Eligibility for Point of Service and Care	1,584,000	X	X
Equipment	Telecommunications and Network Connectivity Expenses, Business Telephones and Accessories (Desk Phones, Headsets, Tablets Accessories)	1,534,000	X	X
Maintenance	Facets Core System (Enrollment, Claims, Authorizations, and Other Modules) License Renewal and Maintenance	1,459,500	X	X
Maintenance	Operating Systems and Office Software Suite License Costs to Support Entire Organization	1,124,500	X	X
Maintenance	Network Connectivity Maintenance and Support for CalOptima Sites (Network Monitoring Tools, Web Filters, All Main Distribution Frame and Intermediate Distribution Frame Batteries, Internet Optimizers, Routers, Wireless Application Protocol Devices, Other Tools)	1,042,700	X	X
Maintenance	Corporate Software Maintenance (Provider Sanctioning and Analytics, Data Warehouse Cleansing, Analytics, Business Application Workflow, Website Content Management, Compliance Applications)	1,015,850	X	X
Maintenance	Clinical Editing Tool and Maintenance	887,600	X	X
Professional Dues	Association Membership Dues (Provide Advocacy, Program Support, Technical Support Regarding State and Federal Regulatory Issues)	727,500	X	X
Maintenance	Server Connectivity Maintenance and Support for Server Equipment (Servers, Storage, Virtual Machine Licenses, Backup Software)	679,800	X	X
Equipment	Replacement Hardware for Operating System Upgrade, Desktop Software Licenses, and Other Minor Computer Equipment	652,500	X	X
Maintenance	Information Security Data Loss Prevention Solution Annual Maintenance	530,000	X	X
Maintenance	Database Administrator License Renewals, Maintenance, and Support	465,000	X	X
Insurance	Directors and Officers Liability Insurance	405,000	X	X
Insurance	Errors and Omissions Professional Liability Insurance	400,000	X	X
Repair & Maintenance	Maintenance for Windows and Carpet Cleaning, Furniture Repair, Refreshment, Doors, Audio Visual Equipment, Plumbing and Other General Maintenance Needs	353,600	X	X
Maintenance	Human Resources Corporate Application Software Maintenance (Training, Recruitment, Performance Evaluation, HR Benefits, Employee Time and Attendance and Payroll)	338,100	X	X
Subscriptions	Healthcare Information Research and Analysis and Information Systems Audit and Control Association Subscription Renewal	338,000	X	X
Maintenance	Application Software Maintenance - IT Development Tools (Data Modeling, Architecture, Technical Libraries, Documentation, Technical Frameworks, Electronic Data Interchange, Software Development Testing)	334,570	X	X
Office Supplies	Office Supplies (Paper, Toner, Batteries, Mouse Pads, Keyboards, Environmental Health And Safety, Disaster Recovery, Other Miscellaneous Items) for Company-Wide Usage	291,500	X	X
Maintenance	Contract Management System	267,000	X	X
Maintenance	Maintenance and Support Annual Renewal for the Telecommunications Network Systems	257,800	X	X

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	Medi-Cal: Other Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY2019 Input	Appropriation	Authorization
Maintenance	Additional Software License and Upgrade Costs for Operating Systems and Office Software Suite	250,000	X	X
Maintenance	Finance Corporate Applications Software Maintenance (Accounting and Finance, Procurement, Bids, Accounting, Administrative Contract Management, Budget Systems)	230,703	X	X
Maintenance	Facets Software True-Up Maintenance	222,000	X	X
Maintenance	24/7 Support to Assist CalOptima's Operating Systems and Office Software Suite Related Questions and Issues	192,000	X	X
Insurance	General Liabilities Insurance	192,000	X	X
Maintenance	Maintenance and Support for the Production/Development of Citrix Operating System/Software Environments	153,000	X	X
Maintenance	Software to Generate and Interface with Facets Letters	144,800	X	X
Maintenance	User Licenses for Claims Medicare Pricing Software	140,000	X	X
Equipment	Purchases and Installation of Office Furniture for Adds, Moves, Furniture, Fixture And Equipment, and Various Other Articles of Minor Equipment	135,000	X	X
Education	Tuition Reimbursement for Staff Development, Organizational Development Programs (CalOptima Special Speakers, Trainers, Computer Classes, Other Training Events)	120,000	X	X
Training	System and Software Update Training	101,235	X	X
Training & Seminar	Professional Development and Education related to Department Functions (Staff Training, Seminars/Conferences, Professional Certifications, Additional Development Opportunities)	101,200	X	X
Maintenance	Provider and Physician Credentialing System Maintenance and License Renewal	94,600	X	X
Public Activities*	Sponsorship, Registration Fees and Other Related Costs for New and Anticipated Community Events and Health Fairs	84,500	X	X
Office Supplies	Office Supplies for Various Departments' Needs for Everyday Operations	67,638	X	X
Training	Board Member Stipends, Memberships, Conferences and Training	66,000	X	X
Maintenance	Information Services Corporate Software Maintenance - Enterprise Help Desk Management Application	65,000	X	X
Training & Seminar	Training and Seminars for Professional Development and Education to Provide Additional Support	60,000	X	X
Maintenance	Capital Project Related Maintenance	57,658	X	X
Training & Seminar	Training and Seminars for Professional Development and Education	50,164	X	X
Training & Seminar	Human Resources Conferences and Training Supplies for Staff	49,600	X	X
Maintenance	Annual Maintenance for MSSP Software License	38,600	X	X
Subscriptions	Subscription Fees for Various Licenses, Literature and Organizations	38,370	X	X
Travel	Travel Expenses for Conferences/Seminars and Meetings	32,650	X	X
Maintenance	Subscription Renewal for Standard Medical Coding Schedules and Multiple User Licenses	28,350	X	X
Professional Dues	Professional Dues and Member Fees for Various Professional Associations	27,562	X	X
Maintenance	Maintenance of Computer Software and Hardware	26,075	X	X
Food Services	Employee Appreciation Events	25,000	X	X
Telephone	Field Staff Phone Service and Other Telephone Expenses	23,020	X	X

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	Medi-Cal: Other Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY2019 Input	Appropriation	Authorization
Training & Seminar	Training and Seminars for Professional Development and Education	22,200	X	X
Travel	Mileage Reimbursement for Duties Required by Job Function and Travel to Community Presentations, Provider Offices, and Member Enrollment	20,600	X	X
Insurance	Crime Insurance, Property Insurance, Commercial Auto Insurance	20,600	X	X
Food Services	Food Services Allowances as Needed for Sponsoring Member and Provider Meetings, Conferences and Other Events	20,485	X	X
Public Activities	Orange County Community Indicators Report	20,000	X	X
Training & Seminar	Training and Seminars for Certifications, Continuing Legal Education and Staff Development	18,800	X	X
Training & Seminar	Training, Seminars and Conferences for Staff Development	18,000	X	X
Travel	Travel Expenses for State Meetings, Regulatory and Legislative Issues, Strategic Development, Conferences/Seminars and Association Meetings	17,400	X	X
Food Services	Food Services for Provider Advisory Committee, CalOptima Community Network Lunch and Learn Events and CCN Anniversary Event	17,000	X	X
Public Activities	Supplies and Costs Associated with Various Outreach, Community Events, Sponsorships and Health Fairs	15,800	X	X
Public Activities	Employee Engagement Events	15,000	X	X
Travel	Staff Mileage and Travel Expenses (Airfare, Hotel, Food) for Sacramento Meetings Three Times per Year	13,500	X	X
Training & Seminar	Training and Seminars for Professional Development And Education	13,200	X	X
Public Activities	Promotional/Marketing and Outreach Activities to Help Elevate the CalOptima Brand in the Community to Support Enrollment	13,000	X	X
Public Activities	Physician Forums for California Children's Services (CCS) Transition	13,000	X	X
Public Activities	Orange County Strategic Plan for Aging	12,500	X	X
Maintenance	Accounting Software Annual Maintenance	12,400	X	X
Maintenance	Maintenance and Support for Printers	12,000	X	X
Maintenance	Maintenance and Support for Batch Scheduler System	12,000	X	X
Food Services	Food Services for Community Events and Department Training	12,000	X	X
Training	Process Improvement Training and Personnel Development	11,700	X	X
Professional Dues	Medical Licenses and Required Certifications	10,700	X	X
Subscriptions	Subscription Fees for Both Clinical and Programmatic Support, and Normal Maintenance of Certification Licensure	10,500	X	X
Subscriptions	Subscriptions for Existing Software and Databases	10,358	X	X
Training & Seminar	Training and Seminars for Professional Development and Education	10,000	X	X
Software	Computer Software for Medical Coding and Design of Print Materials and Other Related Expenses	9,900	X	X
Travel	Travel Expenses for Conferences/Seminars and Meetings	9,400	X	X
Subscriptions	Subscription Fees for Various Professional Organizations, Institutes and Associations	8,900	X	X

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	Medi-Cal: Other Operating Expenses			
Specific Type	**Objective of the Item Proposed**	**Budget FY2019 Input**	**Appropriation**	**Authorization**
Training & Seminar	Training for Facilities Staff in International Facilities Management Association (IFMA) Classes, Environmental Health & Safety (EH&S) Classes, OSHA Classes, Floor Warden Training and Other Training Courses	8,000	X	X
Incentives	Incentive Items for Provider Outreach and Employee Engagement Events	7,500	X	X
Maintenance	Maintenance and Renewal for Procurement Software	6,900	X	X
Training & Seminar	Accounting and Reporting Software Upgrade and Other Training	6,500	X	X
Travel	Travel Expenses for Annual Audits, Training, Conferences/Seminars and Meetings	6,000	X	X
Food Services	Food Services for CalOptima Informational Series, Legislative Luncheon Events, Member and Provider Meetings/Conferences, Board Meetings and Other Events	5,700	X	X
Other Expenses	Committee Members Stipends	5,400	X	X
Other Expenses	State Non-Reimbursable Funds for Services and Items for MSSP Clients	4,600	X	X
Food Services	General Supplies for CalOptima Staff	1,500	X	X
	Total Other Operating Expenses	**17,958,288**		

* All Community Events and Activities Involving Financial Support from CalOptima of Over $1,000 Requires Prior Explicit Board Approval

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OneCare Connect: Professional Fees				
Specific Type	**Objective of the Item Proposed**	**Budget FY2019 Input**	**Appropriation**	**Authorization**
Consulting	Annual Mock Audit Using Centers for Medicare & Medicaid Services (CMS) Audit Protocols	350,000	X	X
Consulting	Annual Compliance Program Effectiveness (CPE) Audit	100,000	X	X
Actuary	Provider Capitation Development, Revenue Capitation Review and Other Related Actuarial Consulting Services	65,000	X	X
	Total Professional Fees	**515,000**		

OneCare Connect: Purchased Services				
Specific Type	**Objective of the Item Proposed**	**Budget FY2019 Input**	**Appropriation**	**Authorization**
Purchased Services	Behavioral Health Contractual Administrative Fees	1,250,000	X	X
Purchased Services	Pharmacy Benefits Management	1,017,000	X	X
Interpreter Services	Language Interpretation and Translation of Member Materials	275,000	X	X
Advertising	Advertising and Media Buys (Newspapers, Magazines, Radio, Bus Shelter, Other Media)	200,000	X	X
Data Transmission	Claims Processing through Automation Data Flow	118,581	X	X
Purchased Services	Analytic Services to Project Sweeps Risk Adjustment Factors (RAF) Adjustments and Other Purchased Services	79,000	X	X
Data Transmission	Data Submission To and From Centers For Medicare & Medicaid Services (CMS) for Enrollment and Regulatory Reporting and Hierarchical Condition Category (HCC) Scores Analytics	72,000	X	X
Purchased Services	Services to Support Customer Services, Audit & Oversight and Office of Compliance Operations	5,400	X	X
	Total Purchased Services	**3,016,981**		

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OneCare Connect: Printing & Postage

Specific Type	Objective of the Item Proposed	Budget FY2019 Input	Appropriation	Authorization
Member Communications	Maintenance of Enrolled Members (Printing, Fulfillment, Postage), Member Routine Annual and Quarterly Mailings, Other Related Printing & Postage Expenses	550,000	X	X
Printing & Postage	Marketing Materials Including Sales Brochures, Posters, Handouts and Other Member and Provider Oriented Materials and Postage	400,000	X	X
Printing & Postage	Printing of Enrollment Materials and Other Related Printing Expenses	80,000	X	X
Member Communications	Member and Provider Materials and Other Printing Fees for Various Departments	4,420	X	X
	Total Printing & Postage	**1,034,420**		

OneCare Connect: Other Operating Expenses

Specific Type	Objective of the Item Proposed	Budget FY2019 Input	Appropriation	Authorization
Maintenance	User Licenses for Claims Medicare Pricing Automation	523,250	X	X
Public Activities	Marketing and Outreach Activities and Promotional Items for Various Events	235,400	X	X
Travel	Travel Expenses for Visits to Provider Offices, Presentations, Health Fairs, Community Events, Annual Audits and Conferences	61,470	X	X
Public Activities	Fees for Registration, Sponsorships, Promotional Items for Community Events, Resource Fairs, Health Fairs and Other Events; Costs Tied to Supplies to Prepare and Participate	34,500	X	X
Training & Seminars	Training and Seminars for Professional Development and Education	31,199	X	X
Food Services	Food Services Allowances as Needed for Sponsoring Member and Provider Meetings, Conferences and Other Events	21,070	X	X
Office Supplies	Office Supplies Needed for Everyday Department Operations, Phone Accessories and Services	8,970	X	X
Subscriptions	Subscriptions and Professional Dues	8,579	X	X
	Total Other Operating Expenses	**924,438**		

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OneCare: Professional Fees

Specific Type	Objective of the Item Proposed	Budget FY2019 Input	Appropriation	Authorization
Consulting	Annual Contract Bid for OneCare	201,200	X	X
Consulting	Consulting Services Related to Required Audits	34,000	X	X
	Total Professional Fees	**235,200**		

OneCare: Purchased Services

Specific Type	Objective of the Item Proposed	Budget FY2019 Input	Appropriation	Authorization
Purchased Services	Pharmacy Benefits Management	135,500	X	X
Interpreter Services	Language Interpretation and Translation of Member Materials	73,600	X	X
	Total Purchased Services	**209,100**		

OneCare: Printing & Postage

Specific Type	Objective of the Item Proposed	Budget FY2019 Input	Appropriation	Authorization
Member Communications	Maintenance of Enrolled Members (Printing, Fulfillment, Postage)	145,971	X	X
Member Communications	Member Marketing Materials	12,500	X	X
	Total Printing & Postage	**158,471**		

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	OneCare: Other Operating Expenses			
Specific Type	Objective of the Item Proposed	Budget FY2019 Input	Appropriation	Authorization
Maintenance	User Licenses for Claims Medicare Pricing Automation	67,500	X	X
Public Activities	Marketing and Outreach Activities and Promotional Items for Various Events	14,000	X	X
Office Supplies	Office Supplies Needed for Everyday Operations	1,100	X	X
	Total Other Operating Expenses	**82,600**		

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PACE: Professional Fees				
Specific Type	**Objective of the Item Proposed**	**Budget FY2019 Input**	**Appropriation**	**Authorization**
Professional Fees	Part D Actuarial Services and Other Consulting Fees	2,000	X	X
	Total Professional Fees	**2,000**		

PACE: Purchased Services				
Specific Type	**Objective of the Item Proposed**	**Budget FY2019 Input**	**Appropriation**	**Authorization**
Purchased Services	Advertising (Radio, Television, Print, Outdoor, Digital) to Promote and Support Enrollment and Participation	250,000	X	X
Purchased Services	Health Outcomes Survey, Satisfaction Survey, Translation Services and Other Related Expenses	2,320	X	X
	Total Purchased Services	**252,320**		

PACE: Printing & Postage				
Specific Type	**Objective of the Item Proposed**	**Budget FY2019 Input**	**Appropriation**	**Authorization**
Printing & Postage	Communication (Mass Mailers, Fliers, Letterheads, Envelopes, Brochures In Multiple Languages)	125,140	X	X
	Total Printing & Postage	**125,140**		

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PACE: Other Operating Expenses

Specific Type	Objective of the Item Proposed	Budget FY2019 Input	Appropriation	Authorization
Repairs & Maintenance	Repairs and Maintenance of Minor Equipment, Building and Unforeseen Incidentals and Building Security Services	18,640	X	X
Public Activities	Outreach Events and Promotional Marketing Items to Help Elevate PACE Center and Support Program Enrollment and Expansion	12,640	X	X
Travel	Staff Travel and Mileage For Home Visits, Marketing and Enrollment	4,088	X	X
Utilities	Electricity, Gas, Water and Other Related Expenses	3,320	X	X
Insurance	General Liability, Property, Earthquake, and Other Insurance Fees	2,640	X	X
Telephone	Business Telephone Accessories	1,648	X	X
Property Tax	Property Tax Assessment	1,032	X	X
Training	Staff Development Training (Registration Fees, Travel, Accommodations, Incidentals)	640	X	X
Food Services	Food Services Allowances, As Needed, for Sponsoring Member and Provider Meetings and Conferences	600	X	X
Minor Equipment & Supplies	Minor Equipment and Supplies (Kitchen, Rehab, Social Day, Staff Break Room, Clinic Small Equipment)	480	X	X
Supplies	Office Supplies for Staff	400	X	X
Subscriptions	Subscriptions, Membership, Registration for Dietetic and Other Discipline Specific Memberships	176	X	X
	Total Other Operating Expenses	**46,304**		

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Facilities: Purchased Services				
Specific Type	**Objective of the Item Proposed**	**Budget FY2019 Input**	**Appropriation**	**Authorization**
Building Administration	Property Management Company Fee	187,632	X	X
Building Administration	Management Fee	72,000	X	X
Building Administration	Various Administration Expenses (Telephone, Office Supplies, Permits, Licenses, Fees, Furniture, Equipment Lease, Postage, Courier)	16,147	X	X
	Total Purchased Services	**275,779**		

Facilities: Other Operating Expenses				
Specific Type	**Objective of the Item Proposed**	**Budget FY2019 Input**	**Appropriation**	**Authorization**
Utilities	Electricity	491,000	X	X
Janitorial	Janitorial Night Contract	301,000	X	X
Insurance	Property, Liability, and Earthquake Insurance	191,000	X	X
Fire/Life Safety Security	Security Contract	190,817	X	X
Janitorial	Janitorial Day Contract	121,616	X	X
Janitorial	Janitorial Supplies	80,400	X	X
Fire/Life Safety Security	Other Fire/Life Safety Expenses (Phone, Emergency Generator, Other Expenses)	53,770	X	X
Landscape	Exterior Landscape Contract	40,600	X	X
Fire/Life Safety Security	Security Equipment and Maintenance	28,724	X	X
Landscape	Landscape Extras	21,100	X	X
Utilities	Water-Building	20,766	X	X
Property Tax	Property Tax Assessments	19,620	X	X
Building Expenses	Various Building Expenses (Trash, Water For Irrigation, Interior Plants)	16,612	X	X
Utilities	Gas	8,580	X	X
	Total Other Operating Expenses	**1,585,605**		

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Facilities: Repairs & Maintenance

Specific Type	Objective of the Item Proposed	Budget FY2019 Input	Appropriation	Authorization
Repairs & Maintenance	Engineering Contract	264,049	X	X
Repairs & Maintenance	Plumbing	85,090	X	X
Repairs & Maintenance	Other Repair and Maintenance (Signage, Steam Cleaning, Roof, Locksmith, Pest Control Contract, Other Maintenance)	75,080	X	X
Repairs & Maintenance	HVAC Miscellaneous	72,800	X	X
Repairs & Maintenance	Electrical Repairs and Supplies	43,950	X	X
Repairs & Maintenance	Windows	38,274	X	X
Repairs & Maintenance	Elevator Maintenance Contract	24,846	X	X
Repairs & Maintenance	Painting	24,800	X	X
Repairs & Maintenance	Walls/Ceilings/Floors/Sidewalks/Railings	21,475	X	X
Parking Lot Maintenance	Parking Lot Maintenance	17,140	X	X
Repairs & Maintenance	HVAC Maintenance Contract	15,532	X	X
Repairs & Maintenance	Water Treatment	13,612	X	X
Repairs & Maintenance	Door Maintenance and Repair	6,000	X	X
	Total Repairs & Maintenance	**702,648**		

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A Public Agency

CalOptima

Better. Together.

Fiscal Year 2018-19
Proposed Operating and Capital Budget

Board of Directors Meeting
June 7, 2018

Greg Hamblin, Chief Financial Officer

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Overview

- FY 2018-19 Major Changes
- Consolidated Operating Budget
- Operating Budgets by Line of Business
  - Medi-Cal
  - OneCare Connect
  - OneCare
  - PACE
- Capital Budget

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Lines of Business

	Start Date	Program Type	Contractor/ Regulator
Medi-Cal CalOptima Better. Together.	October 1995	California's Medicaid program	California Department of Health Care Services (DHCS)
OneCare (HMO SNP) CalOptima Better. Together.	October 2005	Medicare Advantage Special Needs Plan (SNP)	Centers for Medicare & Medicaid Services (CMS)
PACE CalOptima Better. Together.	October 2013	Medicare and Medicaid Program	Three-way contract: CMS, DHCS and CalOptima
OneCare Connect CalOptima Better. Together.	July 2015	Medicare and Medicaid Duals Demonstration	Three-way contract: CMS, DHCS and CalOptima

- Medi-Cal program includes: (1) Classic, (2) Expansion (3) Whole Child Model (WCM)

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FY 2018-19 Major Changes

- New Programs
  - Jan 2019: Whole-Child Model (CCS Redesign)
  - July 2019: Health Homes Program (HHP)
    - Start up costs in FY 2018-19 budget

- Operational Updates
  - Oct 2017: Non-medical transportation (NMT) added as a managed care benefit for all Medi-Cal services
  - Jan 2018: In-Home Supportive Services (IHSS) financing removed from managed care
  - Jan 2018: Internal management of mental health benefit began
  - July 2018: Members without an autism diagnosis will transition from the Regional Center to CalOptima for Behavioral Health Treatment (BHT) services

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FY 2018-19 Major Changes (cont.)

- Other Budget Updates
  - 2.95% average increase in Medi-Cal capitation rates from DHCS
    - Inpatient hospital rates were increased to take into account annual changes in the APR-DRG base rates used in hospital reimbursement
    - Long-Term Care (LTC) component of the Medi-Cal capitation rates were increased by 7.5% to account for the annual LTC rate changes
    - Hospice rates were increased by 6.7% to account for the annual increases to hospice service rates and room and board rates
    - Pharmacy unit costs were increased by approximately 6.4% to reflect cost trends

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FY 2018-19 Major Changes (cont.)

- Other Budget Updates
  - Proposition 56 physician supplemental payments
    - Provides additional payment to providers for services delivered for 13 designated Current Procedural Terminology (CPT) codes
    - Total annual payments estimated at $30 million
  - Child Health and Disability Prevention (CHDP) services: Payment for CHDP services to contracted health networks will be included in the monthly capitation

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Comparative Budget - Consolidated

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Forecast*	FY 2018-19 Budget
Average Monthly Enrollment	783,038	795,318	790,795	783,865
Revenue	$3,163,128,771	$3,549,751,437	$3,326,530,002	$3,460,562,644
Medical Costs	$3,037,911,046	$3,400,677,061	$3,206,583,360	$3,289,519,514
Administrative Costs	$107,574,166	$112,079,601	$119,759,188	$152,735,888
Operating Income/Loss	**$18,643,559**	**$36,994,775**	**$187,454**	**$18,307,242**
Investments, Net	$13,879,371	$15,064,815	$18,118,208	$5,000,000
Change in Net Assets**	**$32,522,930**	**$52,059,590**	**$18,305,662**	**$23,307,242**
Medical Loss Ratio	96.0%	95.8%	96.4%	95.1%
Administrative Loss Ratio	3.4%	3.2%	3.6%	4.4%

* Forecasted as of March 2018
** Change in net assets excludes net other income and grant income

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FY 2018-19 Consolidated Enrollment

Program	FY 2015-16 Actual*	FY 2016-17 Actual*	FY 2017-18 Forecast*	FY 2018-19 Budget*	% Change 18 v. 19
Medi-Cal	776,608	773,732	768,750	766,070	-0.3%
OneCare Connect	18,368	15,558	14,943	14,866	-0.5%
OneCare	1,174	1,350	1,324	1,324	0.0%
PACE	167	212	265	351	32.5%
Total	**796,317**	**790,852**	**785,282**	**782,611**	**-0.3%**

* Enrollment as of June of every fiscal year when available, otherwise most current month

Enrollment Assumptions

- Medi-Cal: Continued slight growth of Aged and Medi-Cal Expansion enrollment will offset small decreases in the Child and Adult aid categories
- OneCare Connect: Increased sales efforts, combined with an improving disenrollment rate projected to stabilize enrollment starting in Jan 2019
- OneCare: Projected to remain flat compared to current membership levels
- PACE: Consists of approximately 53% dual eligibles and 47% Medi-Cal only members; net monthly enrollment projected to increase on average by 7 members

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Consolidated Budget Highlights

- Revenue and Enrollment

	Revenue	Revenue %	Enrollment	Enrollment %
Medi-Cal	$3.1B	89.7%	767,359	97.9%
OneCare Connect	$308.6M	8.9%	14,873	1.9%
OneCare	$19.4M	0.6%	1,324	0.2%
PACE	$26.9M	0.8%	309	0.0%

- Medical and Administrative Expenses

	FY 2018-19 Budget	MLR/ALR
Medical Expenses	$3.3B	95.1%
Administrative Expenses	$152.7M	4.4%

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Consolidated Budget Highlights (cont.)

- Medical Expenses Breakdown

	FY 2018-19 Budget	% of Total
Provider Capitation	$1.3B	38.4%
Claims Payments	$0.9B	27.3%
LTC/ SNF	$0.5B	13.9%
Prescription Drugs	$0.5B	17.3%
Other Medical, including Medical Management	$0.1B	3.1%
Total Medical Expense	$3.3B	100.0%

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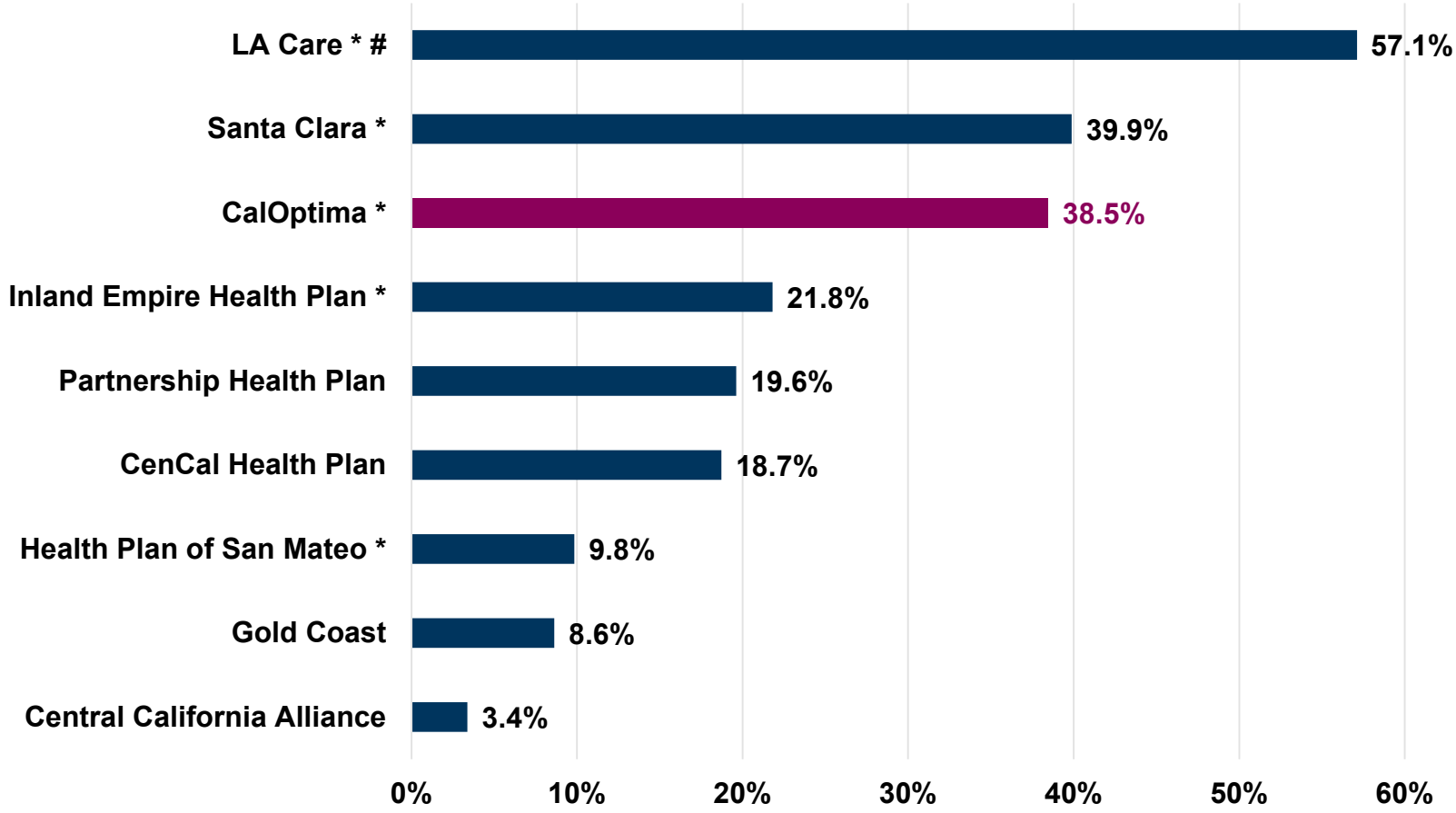
Capitation Expense as Percentage of Total Medical Expense – All Product Lines



Source: DMHC financial statements for Quarter 1/1/18 - 3/31/18
* CCI counties include Managed Long Term Services and Supports (MLTSS) services
# LA Care is predominately a Global Sub-Capitation Model

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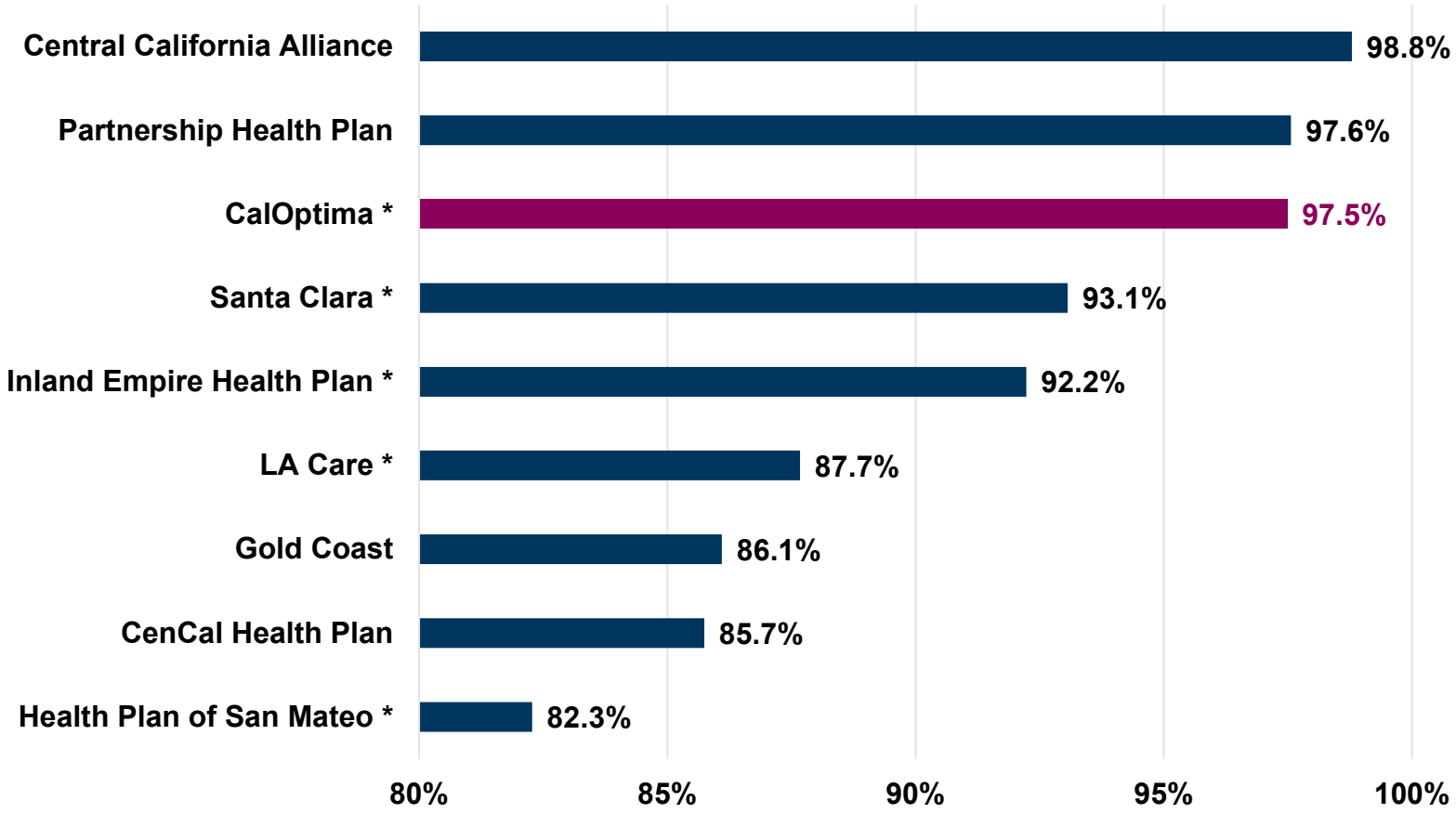
MLR Benchmark Comparison
All Product Lines



Source: DMHC financial statements for Quarter 1/1/18 - 3/31/18
Note: Excludes all IHSS services
* CCI counties include MLTSS services

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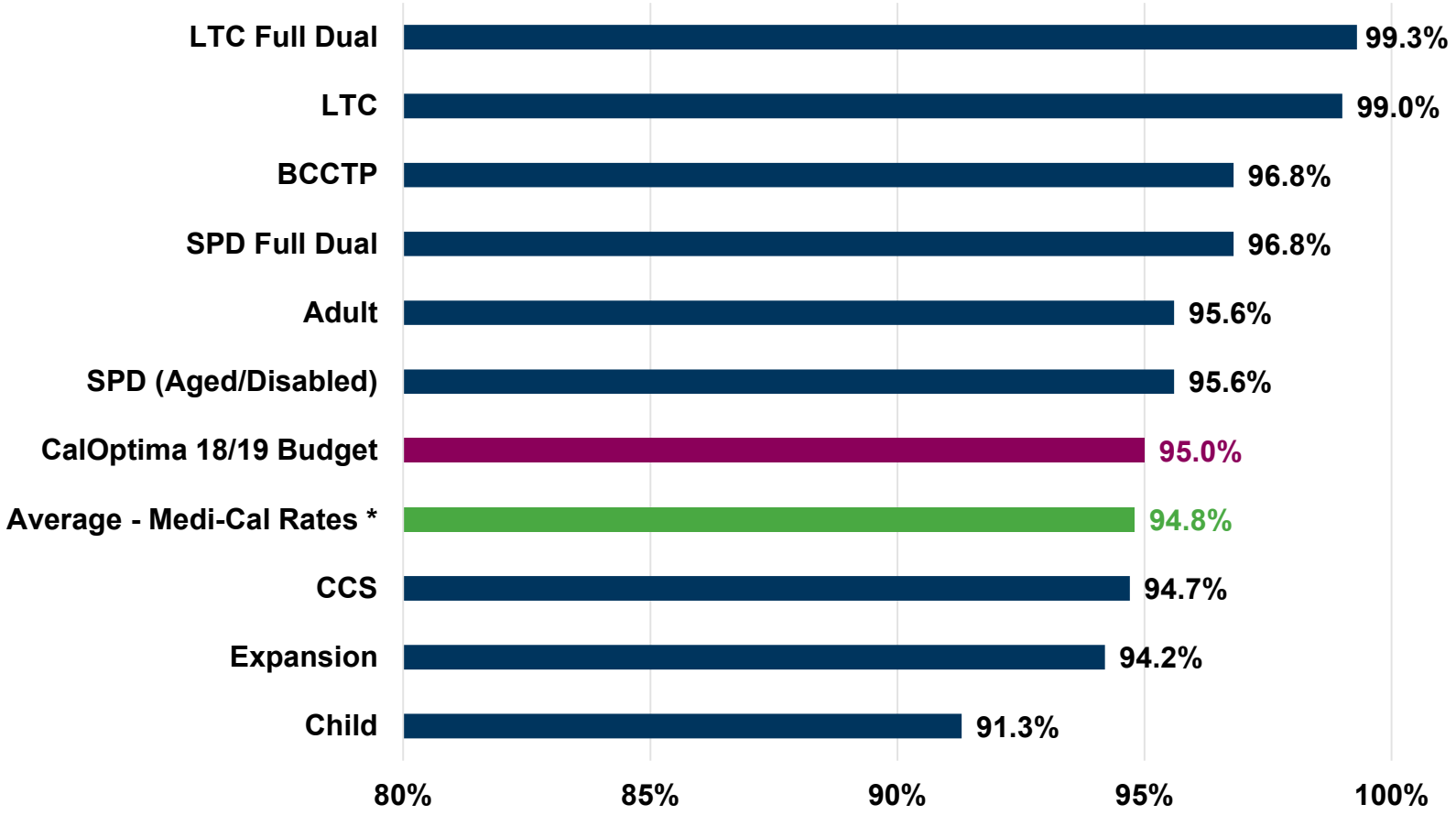
FY 2018-19 DHCS Medical Expense MLR % by Rate Category: Medi-Cal Only



Note: Medical Expense % includes underwriting gain and contingency - 2% for all categories.
* Average is based on CalOptima member mix between the various rate categories

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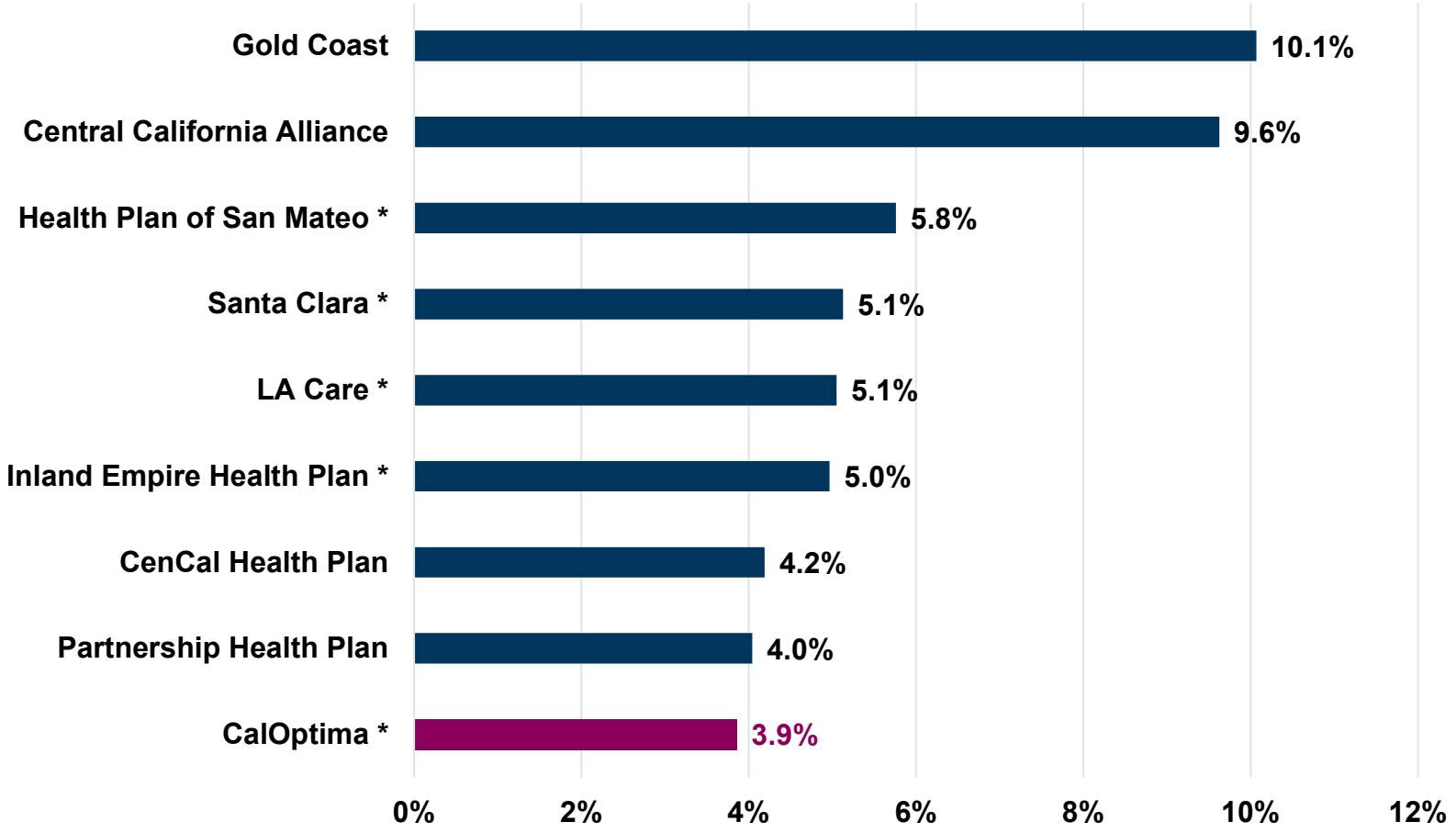
ALR Benchmark Comparison
All Product Lines



Source: DMHC financial statements for Quarter 1/1/18 - 3/31/18
Note: Excludes all IHSS services
* CCI counties include MLTSS services

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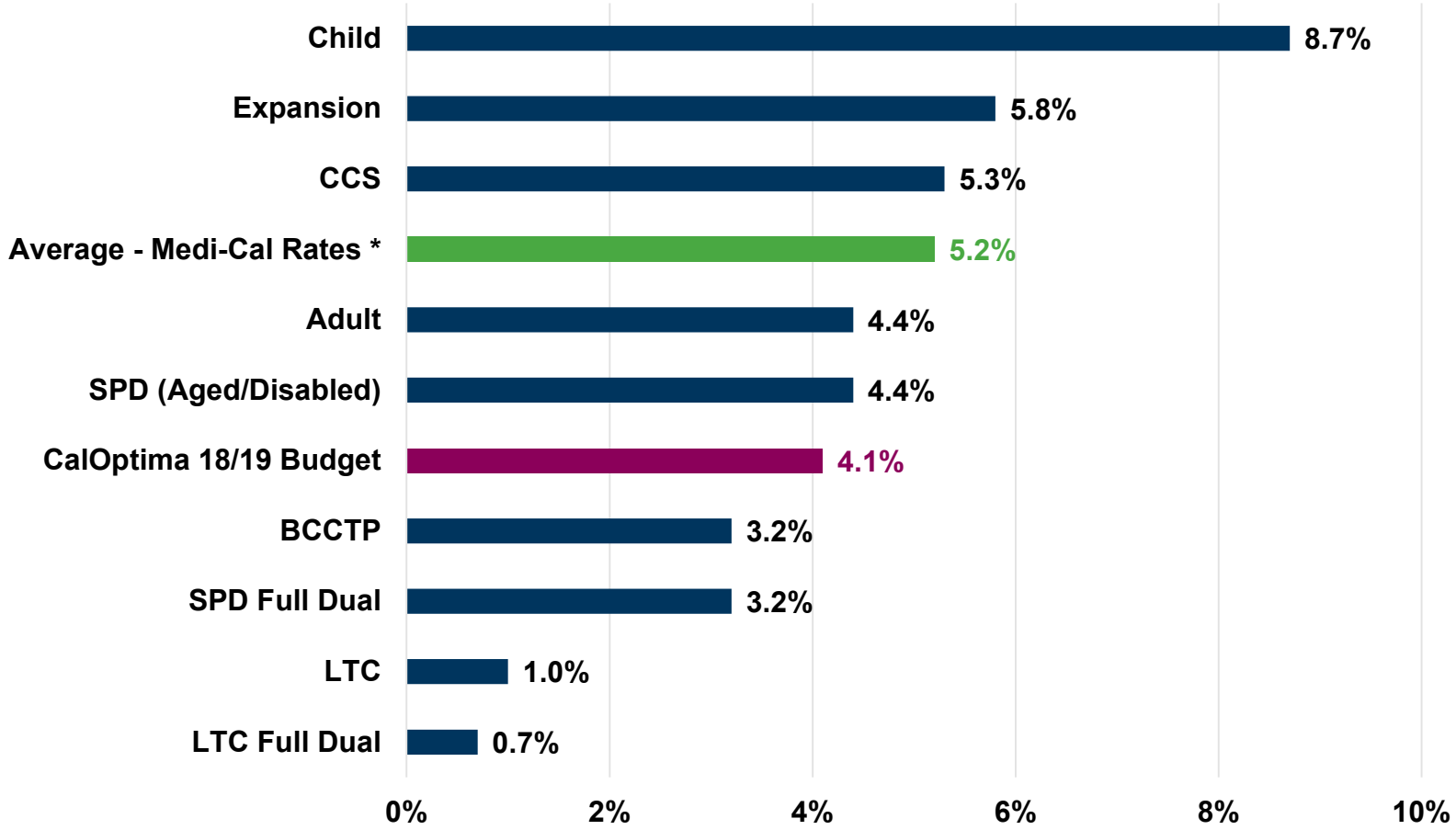
FY 2018-19 DHCS G&A Expense
ALR % by Rate Category: Medi-Cal Only



Note: Administrative % excludes underwriting gain and contingency - 2% for all categories.
* Average is based on CalOptima member mix between the various rate categories

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Consolidated General and Administrative Expenses

	FY 2016-17 Actual	FY 2017-18 Forecast*	FY 2018-19 Budget	FY 2018-19 Budget vs. FY 2017-18 Forecast
Revenues	**$3,549,751,437**	**$3,326,530,002**	**$3,460,562,644**	**$134,032,642**
Salaries, Wages & Benefits	**$73,303,786**	**$78,632,015**	**$97,406,401**	**$18,774,386**
Non-Salaries & Wages	**$38,775,816**	**$41,127,173**	**$55,329,487**	**$14,202,314**
Professional Fees	$1,259,140	$2,307,813	$5,033,200	$2,725,387
Purchased Services	$11,324,446	$10,669,537	$15,125,894	$4,456,357
Printing & Postage	$3,770,719	$4,689,860	$6,397,746	$1,707,886
Depreciation & Amortization	$5,948,304	$6,899,904	$7,525,209	$625,305
Other Operating Exp/Indirect Cost Allocation, Occupancy	$16,473,207	$16,560,059	$21,247,438	$4,687,379
Total G&A	**$112,079,601**	**$119,759,188**	**$152,735,888**	**$32,976,700**
ALR	**3.2%**	**3.6%**	**4.4%**	**0.8%**

* Forecasted as of March 2018

Note: FY 2017-18 Forecast figures do not include unfilled open positions

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General and Administrative Expense ALR Analysis

- IHSS revenue
  - Pass through payment (i.e., revenue = expense)
  - DHCS removed from CalOptima's rates effective 1/1/18
  - Annual fiscal impact of IHSS revenue on ALR is approximately 0.3% on a restated basis

	FY 2015-16 Actual	FY 2016-17 Actual	FY 2017-18 Forecast*	FY 2018-19 Budget
Revenue	$3,163,128,771	$3,549,751,437	$3,326,530,002	$3,460,562,644
Total G&A	$107,574,166	$112,079,601	$119,759,188	$152,735,888
ALR*	**3.4%**	**3.2%**	**3.6%**	**4.4%**
Total IHSS Revenue	($259,813,725)	($334,224,427)	($167,968,132)	$0*
Revised Revenue less IHSS	$2,903,315,046	$3,215,527,010	$3,158,561,870	$3,460,562,644
Revised ALR less IHSS	**3.7%**	**3.5%**	**3.8%**	**4.4%**
ALR % Variance	0.3%	0.3%	0.2%	--

* FY 2015-16 ALR included IHSS revenue for 12 months; FY 2017-18 ALR included 6 months of IHSS revenue; FY 2018-19 Budget ALR does not include IHSS revenue (removed from capitation rates on 1/1/18)

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General and Administrative Expense
FY 2017-18 Budget vs FY 2018-19 Budget

	FY 2017-18 Budget	FY 2018-19 Budget
Average Monthly Enrollment	803,499	783,865
Revenue	$3,186,646,826	$3,460,562,644
Medical Costs	$3,047,176,463	$3,289,519,514
Administrative Costs	$144,164,516	$152,735,888
Operating Income/Loss	**($4,694,154)**	**$18,307,242**
Investments, Net	$3,000,000	$5,000,000
Change in Net Assets*	**($1,694,154)**	**$23,307,242**
MLR	95.6%	95.1%
ALR**	4.5%	4.4%
Revised ALR Less IHSS	4.7%	4.4%

* Change in net assets excludes net other income and grant income
** FY 2017-18 Budgeted ALR includes 6 months of IHSS revenue; FY 2018-19 Budgeted ALR does not include IHSS revenue (removed from capitation rates on 1/1/18)

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General and Administrative Expense ALR % Analysis (cont.)

(in millions)	FY 2018-19 Budget	Less WCM Program	Revised FY 2018-19 Less WCM	G&A Expense at 3.8% of Revenue	Variance
Revenue	$3,460.6	($137.2)	$3,323.4	$3,323.4	--
Total G&A	$152.7	($7.2)	$145.5	$126.3	**$19.2**
ALR	4.4%	(0.2%)	4.2%	3.8%	**0.4%**

- G&A Expense at 3.8% ALR
  - Based on Revised FY 2018-19 Budget Less WCM Revenue and G&A Expense at 3.8% of Revenue
  - 3.8% ALR based on FY 2017-18 Revenue Less IHSS revenue
  - Current G&A expense run rate at $10.5 million annualized for 12 months approximates $126.3 million
- Total amount to bridge from previous year is $19.2 million or 0.4% ALR

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General and Administrative Expense Bridge for Total G&A Increase

G&A Expense	Bridge	Notes
Current Open Positions	$6.0	60 positions at time of budget (As of 6/1/18, 49 positions are open)
Claims Recovery/Claims Edits	$2.5	Increased edits and claims review services - % savings contracts
Market Adjustment	$2.0	Estimate based on results of compensation study
Merit Increase 3%	$1.6	3% average pool on those eligible for merit increases
Computer/Software Licenses and maintenance	$1.4	Leases/Licenses and maintenance agreements
Postage/Printing	$1.3	Member materials/notifications, redesign materials - new services
Behavioral Health Treatment	$0.8	New service effective 7/1/18
Depreciation & Amortization	$0.6	FY 2017-18 and FY 2018-19 capital items placed in service
Internal Audit/Audit Fees	$0.5	Internal audit function and increased scope for new services
Insurance	$0.3	New policy and policy increases
Compensation Study	$0.3	New study of compensation ranges
Employer/Employee Relations	$0.3	Increased legal support for human resources matters
Legal Fees	$0.3	Litigation services consistent with prior budget amounts
Health Homes Program	$0.1	New service effective 7/1/19
All Other Items	$1.2	Aggregate of all other items
Total	**$19.2**	

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General and Administrative Expense Detail on Open Positions

Number of open positions at time of budget creation	60
Number of open positions as of 6/1/18	49

Management Open Positions as of 6/1/18

Executive Director Human Resources	1
Executive Director Quality Analytics	1
Director Program Implementation	1
Director Claims Administration	1
Director Human Resources	1
Director Regulatory Affairs and Compliance	1
Staff Attorney	2
Manager - Finance	1
Supervisor - Customer Service	1
Total	**10**

FY 2018-19 Budget: Salaries, Wages and Benefits	**$2.2 M**

Note: Turnaround time (i.e., date of job posting to date position filled) is approximately 54 business days on average

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CalOptima Consolidated Income Statement: Attachment A

Attachment A

CalOptima Fiscal Year 2018-19 Budget
By Line of Business

	Medi-Cal (Classic)	Medi-Cal (Expansion)	Medi-Cal (WCM)	Total	OCC	OneCare	PACE	Facilities	Other	Consolidated
Member Months	6,217,281	2,916,015	75,012	9,208,308	178,472	15,888	3,708	-		9,406,376
Avg Members	518,107	243,001	6,251	767,359	14,873	1,324	309	-		783,865
Revenues										
Capitation revenue	$ 1,634,445,510	$ 1,334,029,135	$ 137,198,883	$ 3,105,673,528	$ 308,598,939	$ 19,357,913	$ 26,932,264	$ -		$ 3,460,562,644
Total	$ 1,634,445,510	$ 1,334,029,135	$ 137,198,883	$ 3,105,673,528	$ 308,598,939	$ 19,357,913	$ 26,932,264	$ -		$ 3,460,562,644
Medical Costs										
1 Provider capitation	$ 423,848,466	$ 619,600,772	$ 72,446,519	$ 1,115,895,758	$ 142,376,175	$ 5,402,693	$ -	$ -		$ 1,263,674,625
2 Claims Payments	$ 491,680,078	$ 330,196,847	$ 18,309,820	$ 840,186,745	$ 51,966,785	$ 7,294,551	$ -	$ -		$ 899,448,081
3 LTC/Skilled Nursing Facilities	$ 401,472,982	$ 33,600,389	$ 1,267,322	$ 436,340,693	$ 19,326,362	$ -	$ -	$ -		$ 455,667,055
4 Prescription Drugs	$ 229,359,629	$ 235,472,276	$ 34,119,887	$ 498,951,792	$ 63,562,845	$ 5,293,104	$ -	$ -		$ 567,807,742
5 Case Mgmt & Oth Medical	$ 32,305,185	$ 24,198,571	$ 3,808,549	$ 60,312,305	$ 17,370,723	$ 507,629	$ 24,731,353	$ -		$ 102,922,010
Total	$ 1,578,666,340	$ 1,243,068,856	$ 129,952,098	$ 2,951,687,294	$ 294,602,890	$ 18,497,977	$ 24,731,353	$ -		$ 3,289,519,514
MLR	*96.6%*	*93.2%*	*94.7%*	*95.0%*	*95.5%*	*95.6%*	*91.8%*		*	*95.1%*
Gross Margin	$ 55,779,170	$ 90,960,279	$ 7,246,785	$ 153,986,234	$ 13,996,049	$ 859,936	$ 2,200,911	$ -		$ 171,043,130
Administrative Expenses										
Salaries, Wages, & Employee Benefits				$ 84,796,466	$ 10,519,014	$ 480,071	$ 1,610,850	$ -		$ 97,406,401
Professional Fees				$ 4,281,000	$ 515,000	$ 235,200	$ 2,000	$ -		$ 5,033,200
Purchased services				$ 11,371,714	$ 3,016,981	$ 209,100	$ 252,320	$ 275,779		$ 15,125,894
Printing & Postage				$ 5,079,715	$ 1,034,420	$ 158,471	$ 125,140	$ -		$ 6,397,746
Depreciation & Amortization				$ 5,544,907	$ 0	$ -	$ 25,088	$ 1,955,214		$ 7,525,209
Other Operating Expenses				$ 17,958,288	$ 924,438	$ 82,600	$ 46,304	$ 2,288,253		$ 21,299,883
Indirect Cost Allocation, Occupancy Expense				$ (2,683,095)	$ 6,688,728	$ 419,580	$ 41,588	$ (4,519,246)		$ (52,445)
Total				$ 126,348,995	$ 22,698,581	$ 1,585,022	$ 2,103,290	$ 0		$ 152,735,888
ALR				*4.1%*	*7.4%*	*8.2%*	*7.8%*		*	*4.4%*
Operating Income/(Loss)				$ 27,637,239	$ (8,702,532)	$ (725,086)	$ 97,620	$ (0)	$ -	$ 18,307,242
Investment Income									$ 5,000,000	$ 5,000,000
MCO Tax Revenue				$ 130,244,985						$ 130,244,985
MCO Tax Expense				$ (130,244,985)						$ (130,244,985)
CHANGE IN NET ASSETS				$ 27,637,239	$ (8,702,532)	$ (725,086)	$ 97,620	$ (0)	$ 5,000,000	$ 23,307,242

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CalOptima A Public Agency Better. Together.

FY 2018-19 Operating Budget

Budgets by Line of Business

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Medi-Cal Program

Start Date	October 1995
Program Type	California's Medicaid Program
Contractor/ Regulator	California Department of Health Care Services (DHCS)
Eligibility	• Child and family • Senior • Persons with disabilities • Low-income (includes Medi-Cal Expansion)
Services	• Comprehensive health • Prescriptions • Vision • Mental Health • MLTSS • (Dental provided by DHCS)

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Medi-Cal Budget

	FY 2016-17 Actual	FY 2017-18 Forecast*	FY 2018-19 Budget
Average Monthly Enrollment	777,057	774,053	767,359
Revenue	$3,144,012,925	$2,950,310,063	$3,105,673,528
Medical Costs	$3,014,868,476	$2,860,665,674	$2,951,687,294
Administrative Costs	$88,649,070	$96,348,364	$126,348,995
Operating Income/Loss	**$40,495,380**	**($6,703,976)**	**$27,637,239**
Medical Loss Ratio	95.9%	97.0%	95.0%
Administrative Loss Ratio	2.8%	3.3%	4.1%

* Forecasted as of March 2018
Change in net assets excludes net other income and grant income

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Medi-Cal Revenue

- Used most current rates available

	Medi-Cal Classic	Medi-Cal Expansion	Medi-Cal WCM*
Capitation rates	Draft FY 18-19 rates • Reflects 2.59% increase	Draft FY 18-19 rates • Reflects 3.24% increase	Draft FY 18-19 rates • Includes CCS and non-CCS services
BHT Rates	FY 2017-18 rates		
CCI Rates	Draft Calendar Year (CY) 2017 rates for duals • IHSS benefit removed 1/1/18		NA

* WCM program effective date is 1/1/19

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Medi-Cal Medical Costs

- Medi-Cal Classic and Expansion
  - Health Network and Fee-for-service (FFS) provider capitation rates kept at FY 2017-18 levels
  - FFS cost trends developed by network type, aid category, service category
  - Reinsurance attachment points remained at $17K (Professional) and $150K (Hospital); coinsurance at 20%
  - Mental health expense converted from capitation to FFS reimbursement
  - Removed IHSS as a managed care benefit effective January 1, 2018
  - Includes approximately $2.8M (for 9 months) related to Personal Care Coordinators (PCC) that was previously funded by intergovernmental transfer (IGT) funds

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Medi-Cal Medical Costs

- WCM
  - Limited experience data available; used DHCS' program assumptions
  - Assumes implementation using existing medical care delivery model
  - Assumes aggregate costs will be equivalent to revenue

Category	Cost	% of Revenue
Medical	$126,143,549	91.9%
Medical Management	$3,808,549	2.8%
Administrative	$7,246,785	5.3%
Total	$137,198,883	100%

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OneCare Connect Program

Start Date	July 2015
Program Type	Medicare and Medicaid Duals Demonstration
Contractor/ Regulator	CMS and DHCS
Eligibility	Medi-Cal member who also has Medicare (i.e., dual eligible)
Services	• Comprehensive health • Prescriptions • Vision • MLTSS • Assessment • Care planning • Care coordination • Supplemental benefits

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OneCare Connect Budget

	FY 2016-17 Actual	FY 2017-18 Forecast*	FY 2018-19 Budget
Average Monthly Enrollment	16,834	15,143	14,873
Revenue	$371,630,947	$340,603,831	$308,598,939
Medical Costs	$355,225,238	$314,092,828	$294,602,890
Administrative Costs	$20,540,042	$20,767,424	$22,698,581
Operating Income/Loss	($4,134,333)	$5,743,579	($8,702,532)
Medical Loss Ratio	95.6%	92.2%	95.5%
Administrative Loss Ratio	5.5%	6.1%	7.4%

* Forecasted as of March 2018

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OneCare Connect Revenue

- Used most current rates available
  - ➢ Applies Year 3 savings targets of 5.5% and quality withhold of 3%

Medicare Part C	Medicare Part D	Medi-Cal**
CMS CY 2018 rate report* Draft CY 2019 rates • Applies 4.76% increase to base rate eff. 1/1/19 • Applies improved Risk Adjustment Factor (RAF) score of 1.28	CMS CY 2018 rate report Draft CY 2019 rates	Draft CY 2017 rates • Adjusts for forecasted population mix

* OCC Medicare rates are not developed from a bid process that uses actual plan data
** DHCS plan rates uses Rate Development Template (RDT) base data that has a two-year lag
Note: FY 2017-18 included IHSS benefit for 6 months. Impact on FY 2018-19: reduces revenue and increases ALR %

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OneCare Connect Medical Costs

- Provider Capitation
  - Medicare component: Based on percent of premium rates
  - Medi-Cal component: Based on fixed PMPM rates
- FFS expenses: Based on actual experience trended through June 2019
- Enrollment: Applied projected mix for PHC, SRG, HMO, and CCN networks
- Includes expenses for Medicare supplemental benefits to align with OneCare supplemental benefits
- Other adjustments
  - Removes IHSS as a managed care benefit effective January 1, 2018
  - Includes approximately $1.4M (for 9 months) related to PCCs that was previously funded by IGT funds

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OneCare Program

Start Date	October 2005
Program Type	Medicare Advantage Special Needs Plan (SNP)
Contractor/ Regulator	Centers for Medicare & Medicaid Services (CMS)
Eligibility	Medi-Cal member who also has Medicare (i.e., dual eligible)
Services	• Comprehensive health • Prescriptions • Vision • Mental Health • Supplemental Benefits

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OneCare Budget

	FY 2016-17 Actual	FY 2017-18 Forecast*	FY 2018-19 Budget
Average Monthly Enrollment	1,237	1,367	1,324
Revenue	$18,615,729	$15,521,459	$19,357,913
Medical Costs	$16,424,251	$14,657,796	$18,497,977
Administrative Costs	$1,225,310	$1,131,584	$1,585,022
Operating Income/Loss	**$966,168**	**($267,922)**	**($725,086)**
Medical Loss Ratio	88.2%	94.4%	95.6%
Administrative Loss Ratio	6.6%	7.3%	8.2%

* Forecasted as of March 2018

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OneCare Assumptions

- Revenue: Used most current rates available

Medicare Part C	Medicare Part D
CMS CY 2018 Monthly Membership Report actuals • Applies 3.4% increase to base rate eff. 1/1/19 • Applies improved RAF score of 1.08	CMS CY 2018 Monthly Membership Report actuals

- Medical Costs
  - Provider capitation: Based on 38.7 percent of premium
  - FFS expenses: Based on historical claims through Feb 2018
  - Includes expenses for approved supplemental benefits

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PACE Program

Start Date	October 2013
Program Type	Medicare and Medicaid Program
Contractor/ Regulator	CMS and DHCS
Eligibility	Member who is: • ≥ 55; • Meet nursing facility level of care; and • Live in a PACE service area
Services	• All Medicare and Medicaid services • 16 additional services, such as social services, nursing facility care, personal care, nutritional counseling and recreational therapy

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PACE Budget

Program	FY 2016-17 Actual	FY 2017-18 Forecast*	FY 2018-19 Budget
Average Monthly Enrollment	190	232	309
Revenue	$15,202,259	$19,887,414	$26,932,264
Medical Costs	$14,159,096	$17,167,062	$24,731,353
Administrative Costs	$1,433,065	$1,376,717	$2,103,290
Operating Income/Loss	**($389,902)**	**$1,343,635**	**$97,620**
Medical Loss Ratio	93.1%	86.3%	91.8%
Administrative Loss Ratio	9.4%	6.9%	7.8%

* Forecasted as of March 2018

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PACE Assumptions

- Used most current rates available

Medicare Part C	Medicare Part D	Medi-Cal
2018 Actuals • Applies 2.0% increase to base rate eff. 1/1/19 • Applies RAF score of 2.26 (assumes improved coding and data submission)	2018 Actuals • Rates and subsidies based on CY 2018 payments	PMPM rates based on CY 2018 RDT rates

- Medical cost
  - Based on mix of actual experience and industry benchmarks
  - Includes material depreciation costs related to start-up capital expenses
  - Based on DHCS rate development, state rate benchmark MLR is 92%

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Recommended Actions

1. Approve the CalOptima FY 2018-19 Operating Budget
2. Authorize the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details
   - Items will be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy

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FY 2018-19 Capital Budget

Capital Budget by Category

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Overview of Capital Budget

Category	FY 2018-19 Budget	% of Total
Information Systems		
Hardware	$1,789,500	18.2%
Software	$2,475,600	25.2%
Professional fees related to implementation	$2,604,000	26.5%
Subtotal	$6,869,100	69.9%
505 Building Improvements	$2,796,356	28.5%
PACE	$156,300	1.6%
Total	**$9,821,756**	**100%**

- Departments submit requests for capital projects based on strategic and operational needs
- Information Services Department reviews technology requests

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Information Systems Budget

Project Type	FY 2018-19 Budget
Infrastructure (i.e., network, upgrades, storage, security)	$1,593,500
Applications Management (e.g., claims, medical management, HR systems)	$1,034,600
Applications Development (e.g., provider portal, data warehouse, member portal, website, electronic HR)	$4,241,000
Total	**$6,869,100**

- Represents nearly 69.9% of total Capital Budget
- Addresses information technology infrastructure needs
- Supports internal operations
- Ensures compliance with state and federal statutory, regulatory and contractual requirements

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505 Building Improvements

Project Type	FY 2018-19 Budget
10th Floor Improvements	$2,285,000
Replace Master Control Center for HVAC	$130,000
Copier Capital Lease	$125,156
Replace Deteriorating Cast Iron Pipes	$110,000
Upgrade Sound Recording in Conference Room 108	$50,000
Convert Remaining Pneumatic Controls to Direct Digital Controls	$45,200
Resurface and Fill Cooling Tower for Leak Prevention	$25,000
Equipment and Furniture Upgrades for 6th Floor Training Room	$18,000
Inspect and Correct Emergency Electrical Panels	$8,000
Total	**$2,796,356**

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PACE Center Budget

Project Type	FY 2018-19 Budget
New Furniture, Data and Phones to Maximize Workstations	$112,000
New Optometry Equipment	$25,000
Dishwasher Replacement	$11,000
High Resolution and Color LCD Touchscreen EKG Machine	$4,300
Patio Shade – Outdoor Umbrellas and Furniture for the PACE Center	$4,000
Total	**$156,300**

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Recommended Actions

1. Approve the CalOptima FY 2018-19 Capital Budget
2. Authorize the expenditure and appropriate the funds for items listed in Attachment A: Fiscal Year 2018-19 Capital Budget by Project
   - Items will be procured in accordance with CalOptima policy

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
17. Consider Approval of the CalOptima Fiscal Year 2018-19 Capital Budget

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions
1. Approve the CalOptima Fiscal Year (FY) 2018-19 Capital Budget; and
2. Authorize the expenditure and appropriate the funds for the items listed in Attachment A: Fiscal Year 2018-19 Capital Budget by Project, which shall be procured in accordance with CalOptima policy.

Background
As of March 31, 2018, CalOptima has recorded gross capital assets of $90.3 million in the 505 building, building improvements, furniture, equipment, and information systems. To account for these fixed assets wearing out over time, Staff has charged against the cost of these assets an accumulated depreciation totaling $40.1 million. Staff will record capital assets acquired in FY 2018-19 at acquisition cost and will depreciate the value on a straight-line basis over their estimated useful lives as follows:

- Five (5) years for office furniture and fixtures;
- Three (3) years for computer equipment and software;
- The lesser of fifteen (15) years or remaining term of lease for leasehold improvements; and
- Ten (10) to twenty (20) years based on components for building improvements.

The resulting net book value of these fixed assets was $50.2 million as of March 31, 2018. Prior board-approved capital budgets were $8.4 million in FY 2017-18, and $10.1 million in FY 2016-17 respectively.

Pursuant to CalOptima Policies GA. 3202: CalOptima Signature Authority, GA. 5002: Purchasing Policy, and GA. 5003: Budget and Operations Forecasting, the Board's approval of the budget authorizes the expenditure of the item and appropriates the funds requested without further Board action.

Discussion
Management proposes a Capital Budget of $9.8 million for FY 2018-19 for the following asset types within three (3) asset categories:

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Category	Amount	% of Total
Information Systems		
Hardware	$1,789,500	18.2%
Software	$2,475,600	25.2%
Professional fees related to implementation	$2,604,000	26.5%
Subtotal	$6,869,100	69.9%
505 Building Improvements	$2,796,356	28.5%
PACE	$156,300	1.6%
Total	**$9,821,756**	**100%**

1. Information Systems

Information Systems represent nearly $6.9 million or 69.9% of the Capital Budget. This asset category primarily addresses CalOptima's information technology infrastructure needs.

Project Type	Amount	% of Total
Infrastructure	$1,593,500	23.2%
Applications Management	$1,034,600	15.1%
Applications Development	$4,241,000	61.7%
Total	**$6,869,100**	**100%**

The Capital Budget includes hardware, software, and professional fees related to implementation to fund multiple systems upgrades. More detailed information is provided in Attachment A: Fiscal Year 2018-19 Capital Budget by Project. These upgrades are necessary to support internal operations, and to continue to comply with state and federal contractual, regulatory and statutory requirements.

2. 505 Building Improvements

505 Building Improvements represent $2.8 million or 28.5% of the Capital Budget. The largest item of $2.3 million or 81.7% of the 505 Building capital expenditures is to fund the 10th Floor Improvements.

Project Type	Amount	% of Total
10th Floor Improvements	$2,285,000	81.7%
Replace Master Control Center for HVAC	$130,000	4.7%
Copier Capital Lease	$125,156	4.5%
Replace Deteriorating Cast Iron Pipes	$110,000	3.9%
Upgrade Sound Recording in Conference Room 108	$50,000	1.8%
Convert Remaining Pneumatic Controls to Direct Digital Controls (DDC)	$45,200	1.6%
Resurface and Fill Cooling Tower for Leak Prevention	$25,000	0.9%
Equipment and Furniture Upgrades for 6th Floor Training Room	$18,000	0.6%
Inspect and Correct Emergency Electrical Panels	$8,000	0.3%
Total	**$2,796,356**	**100%**

3. Program for All-Inclusive Care for the Elderly (PACE)

The remaining portion of $156,300 or 1.6% of the Capital Budget is for capital expenditures at the PACE center.

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Project Type	Amount	% of Total
New Furniture, Data and Phones to Maximize Workstations	$112,000	71.7%
New Optometry Equipment	$25,000	16.0%
Dishwasher Replacement	$11,000	7.0%
High Resolution and Color LCD Touchscreen EKG Machine	$4,300	2.7%
Patio Shade - Outdoor Umbrellas and Furniture for PACE Center	$4,000	2.6%
Total	**$156,300**	**100%**

Fiscal Impact

Investment in the Capital Budget will reduce CalOptima's investment principal by $9,821,756. At a 1% return rate, this would reduce annual interest income by approximately $98,218. Depreciation expense for Current Program Infrastructure and 505 Building Improvements is reflected in CalOptima's operating budget.

Rationale for Recommendation

The FY 2018-19 Capital Budget will enable necessary system upgrades, enhance operational efficiencies, support strategic initiatives, comply with federal and state requirements, and provide expansion of building capacity to accommodate CalOptima's growth.

Concurrence

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

Attachments

Attachment A: Fiscal Year 2018-19 Capital Budget by Project

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

5/30/2018 — **Date**

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Attachment A
Fiscal Year 2018-19 Capital Budget by Project

INFRASTRUCTURE	HARDWARE	SOFTWARE	PROFESSIONAL FEES	BUDGET FY2019 INPUT	APPROPRIATION	AUTHORIZATION
Network	903,500	30,000	42,000	975,500	X	X
Upgrades/Replacements	300,000	-	-	300,000	X	X
Storage	275,000	-	23,000	298,000	X	X
Security	-	-	20,000	20,000	X	X
TOTAL INFRASTRUCTURE	**$ 1,478,500**	**$ 30,000**	**$ 85,000**	**$ 1,593,500**		

APPLICATIONS MANAGEMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	BUDGET FY2019 INPUT	APPROPRIATION	AUTHORIZATION
Hierarchical Condition Categories (HCC) Risk Adjustment	25,000	250,000	75,000	350,000	X	X
Workforce Management	-	180,000	60,000	240,000	X	X
Clinical Editing Solution			100,000	100,000	X	X
Facets Workflow Implementation	-	-	100,000	100,000	X	X
Cactus Facets Interface	-	-	100,000	100,000	X	X
Healthcare Process Automation (HPA) Robots Virtual Machine (VM) Server	76,000	-	-	76,000	X	X
Health Network Credentialing Data	-	15,000	5,000	20,000	X	X
Cactus Solution Interface	-	15,000	5,000	20,000	X	X
Altruista - New Platform for Enterprise Analytics	-	-	15,000	15,000	X	X
Provider Monitoring Module	-	8,600	5,000	13,600	X	X
TOTAL APPLICATIONS MANAGEMENT	**$ 101,000**	**$ 468,600**	**$ 465,000**	**$ 1,034,600**		

APPLICATIONS DEVELOPMENT	HARDWARE	SOFTWARE	PROFESSIONAL FEES	BUDGET FY2019 INPUT	APPROPRIATION	AUTHORIZATION
Provider Portal	50,000	700,000	300,000	1,050,000	X	X
Data Warehouse Expansion	-	-	750,000	750,000	X	X
Provider Data Management Solution	-	400,000	100,000	500,000	X	X
Medication Therapy Management (MTM)	100,000	175,000	50,000	325,000	X	X
CalOptima Member Portal	-		300,000	300,000	X	X
Electronic Human Resource Employee Files	60,000	150,000	80,000	290,000	X	X
CalOptima Website Redesign	-	-	240,000	240,000	X	X
Texting Software for Member/Provider Outreach	-	175,000	25,000	200,000	X	X
Software Solution to Capture Members Gaps in Care	-	200,000	-	200,000	X	X
Online Provider Directory Attestation	-	-	150,000	150,000	X	X
Budget Tool Implementation	-	65,000	39,000	104,000	X	X
Legal File Tracking Software System	-	90,000	10,000	100,000	X	X
Human Resource Recruiting Module	-	22,000	10,000	32,000	X	X
TOTAL APPLICATIONS DEVELOPMENT	**$ 210,000**	**$ 1,977,000**	**$ 2,054,000**	**$ 4,241,000**		

505 BUILDING IMPROVEMENTS	BUILDING	EQUIPMENT	PROFESSIONAL FEES	BUDGET FY2019 INPUT	APPROPRIATION	AUTHORIZATION
10th Floor Improvement	1,865,000	270,000	150,000	2,285,000	X	
Replace Master Control Center for HVAC	130,000	-	-	130,000	X	X
Copier Capital Lease	125,156	-	-	125,156	X	X
Replace Deteriorating Cast Iron Pipes	110,000	-	-	110,000	X	X
Upgrade Sound Recording in Conference Room 108	50,000	-	-	50,000	X	X
Convert Remaining Pneumatic Controls to Direct Digital Controls (DDC)	45,200	-	-	45,200	X	X
Resurface and Fill Cooling Tower for Leak Prevention	25,000	-	-	25,000	X	X
Equipment and Furniture Upgrades for 6th Floor Training Room	18,000	-	-	18,000	X	X
Inspect and Correct Emergency Electrical Panels	8,000	-	-	8,000	X	X
TOTAL 505 BUILDING IMPROVEMENTS	**$ 2,376,356**	**$ 270,000**	**$ 150,000**	**$ 2,796,356**		

PACE	EQUIPMENT	PROFESSIONAL FEES	BUDGET FY2019 INPUT	APPROPRIATION	AUTHORIZATION
New Furniture, Data and Phones to Maximize Workstations	97,000	-	15,000	112,000	X	X
New Optometry Equipment	25,000	-	-	25,000	X	X
Dishwasher Replacement	11,000	-	-	11,000	X	X
High Resolution and Color LCD Touchscreen EKG Machine	4,300	-	-	4,300	X	X
Patio Shade - Outdoor Umbrellas and Furniture for PACE Center	4,000	-	-	4,000	X	X
TOTAL PACE	**$ 141,300**	**$ -**	**$ 15,000**	**$ 156,300**		

TOTAL FY19 NEW CAPITAL BUDGET	**$ 4,307,156**	**$ 2,745,600**	**$ 2,769,000**	**$ 9,821,756**		

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

18. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Except Those Associated With the University of California, Irvine, Children's Hospital of Orange County or St. Joseph Healthcare and its Affiliates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts through June 30, 2019, except those associated with the University of California, Irvine, Children's Hospital of Orange County or St. Joseph Healthcare and its affiliates;
2. Amend contracts to reflect change in Child Health and Disability Prevention (CHDP) Program billing requirements to the extent authorized by the Board of Directors in a separate Board action;
3. Amend contracts to reflect the additional payments to be received by Clinics for Medi-Cal services as a result of Proposition 56 to the extent the Clinic is specifically eligible to receive such payments and as authorized by the Board of Directors in a separate Board action; and
4. Amend these contract terms to reflect applicable regulatory changes and other requirements.

Background/Discussion

Contract Extensions: CalOptima currently contracts with several clinics to provide primary care services to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

CHDP Transition: CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or diagnose health issues through regular health check-ups. Since the inception of the program, the Department of Health Care Services has required providers to bill with defined procedure codes on a designated claim form (PM 160). Completion of the PM 160 is a burden to providers who must submit claims using a separate process from other services billed by Primary Care Physicians (PCP).

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As of January 1, 2018, the State required fee-for-service Medi-Cal providers of CHDP services to comply with HIPAA standards for health care electronic transactions and code sets. Effective July 1, 2018, with Board approval, CalOptima will require PCPs to submit claims on the CMS-1500, UB-04 claim form, or electronic equivalent using HIPAA standardized procedure coding which mirrors the submission of claims for all other PCP services.

Proposition 56: Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which provides guidance to Medi-Cal Managed Care Plans, on how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Providers and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. However, the APL specified that Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics are not eligible for this funding. The document also specifies the timeframe and reporting requirements for such payments.

Therefore, in accordance with the guidance provided in the DHCS issued APL, CalOptima will make additional payments to Clinics which are specifically eligible to receive Proposition 56 additional payments, for Dates of Services (DOS) July 1, 2017 through June 30, 2018. Should the State decide to continue payments for services beyond the DOS June 30, 2018, CalOptima will leverage existing processes to continue Clinic payments.

Regulations: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. Staff requests authority to amend the clinic contracts to include the regulatory requirements, as applicable and in accordance with DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima clinic contracts except those associated with the University of California, Irvine, Children's Hospital of Orange County or St. Joseph Healthcare and its affiliates

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Fiscal Impact
Management has included expenses associated with the extended contracts in the proposed CalOptima Fiscal Year 2018-19 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend clinic contracts, except for those associated with the University of California, Irvine. Children's Hospital of Orange County or St. Joseph Healthcare and its affiliates, for one year is a budgeted item with no additional fiscal impact. In addition, the recommended actions to amend contracts to reflect changes in the CHDP program billing requirements and applicable regulatory requirements are not expected to have any additional fiscal impact to CalOptima.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

19. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated With the University of California, Irvine

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts associated with the University of California, Irvine through June 30, 2019;
2. Amend contracts to reflect change in Child Health and Disability Prevention (CHDP) Program billing requirements to the extent authorized by the Board of Directors in a separate Board action;
3. Amend contracts to reflect the additional payments to be received by Clinics for Medi-Cal services as a result of Proposition 56 to the extent the Clinic is specifically eligible to receive such payments and as authorized by the Board of Directors in a separate Board action; and
4. Amend these contract terms to reflect applicable regulatory changes and other requirements.

Background/Discussion

CalOptima currently contracts with several clinics to provide Primary Care services to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

CHDP Transition: CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or diagnose health issues through regular health check-ups. Since the inception of the program, the Department of Health Care Services has required providers to bill with defined procedure codes on a designated claim form (PM 160). Completion of the PM 160 is a burden to providers who must submit claims using a separate process from other services billed by PCPs.

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As of January 1, 2018, the State required fee-for-service Medi-Cal providers of CHDP services to comply with HIPAA standards for health care electronic transactions and code sets. Effective July 1, 2018, with Board approval, CalOptima will require PCPs to submit claims on the CMS-1500, UB-04 claim form, or electronic equivalent using HIPAA standardized procedure coding which mirrors the submission of claims for all other PCP services.

Proposition 56: Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which provides guidance to Medi-Cal Managed Care Plans, on how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Providers and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. However, the APL specified that Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics are not eligible for this funding. The document also specifies the timeframe and reporting requirements for such payments.

Therefore, in accordance with the guidance provided in the DHCS issued APL, CalOptima will make additional payments to Clinics which are specifically eligible to receive Proposition 56 additional payments, for Dates of Services (DOS) July 1, 2017 through June 30, 2018. Should the State decide to continue payments for services beyond the DOS June 30, 2018, CalOptima will leverage existing processes to continue Clinic payments.

Regulations: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. Staff requests authority to amend the clinic contracts to include the regulatory requirements, as applicable and in accordance with DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima FFS clinic contracts associated with the University of California, Irvine.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima Fiscal Year 2018-19 Operating Budget. Assuming extension of the contracts are under the same terms

and conditions, the recommended action to extend clinic contracts associated with the University of California, Irvine, for one year is a budgeted item with no additional fiscal impact.

In addition, the recommended actions to amend contracts to reflect changes in the CHDP program billing requirements and applicable regulatory requirements are not expected to have any additional fiscal impact to CalOptima.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

20. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated With St. Joseph Healthcare and its Affiliates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE clinic contracts through June 30, 2019, associated with St. Joseph Healthcare and its affiliates;
2. Amend contracts to reflect change in Child Health and Disability Prevention (CHDP) Program billing requirements to the extent authorized by the Board of Directors in a separate Board action;
3. Amend contracts to reflect the additional payments to be received by Clinics for Medi-Cal services as a result of Proposition 56 to the extent the Clinic is specifically eligible to receive such payments and as authorized by the Board of Directors in a separate Board action; and
4. Amend these contract terms to reflect applicable regulatory changes and other requirements.

Background/Discussion

Contract Extensions: CalOptima currently contracts with several clinics to provide Primary Care services to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

CHDP Transition: CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or diagnose health issues through regular health check-ups. Since the inception of the program, the Department of Health Care Services has required providers to bill with defined procedure codes on a designated claim form (PM 160). Completion of the PM 160 is a burden to providers who must submit claims using a separate process from other services billed by PCPs.

As of January 1, 2018, the State required fee-for-service Medi-Cal providers of CHDP services to comply with HIPAA standards for health care electronic transactions and code sets. Effective July 1, 2018, with Board approval, CalOptima will require PCPs to submit claims on the CMS-1500, UB-04

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claim form, or electronic equivalent using HIPAA standardized procedure coding which mirrors the submission of claims for all other PCP services.

CHDP Transition: CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or diagnose health issues through regular health check-ups. Since the inception of the program, the Department of Health Care Services has required providers to bill with defined procedure codes on a designated claim form (PM 160). Completion of the PM 160 is a burden to providers who must submit claims using a separate process from other services billed by PCPs.

Proposition 56: Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which provides guidance to Medi-Cal Managed Care Plans, on how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Providers and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. However, the APL specified that Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics are not eligible for this funding. The document also specifies the timeframe and reporting requirements for such payments.

Therefore, in accordance with the guidance provided in the DHCS issued APL, CalOptima will make additional payments to Clinics which are specifically eligible to receive Proposition 56 additional payments, for Dates of Services (DOS) July 1, 2017 through June 30, 2018. Should the State decide to continue payments for services beyond the DOS June 30, 2018, CalOptima will leverage existing processes to continue Clinic payments.

Regulations: As of January 1, 2018, the State required fee-for-service Medi-Cal providers of CHDP services to comply with HIPAA standards for health care electronic transactions and code sets. Effective July 1, 2018, with Board approval, CalOptima will require PCPs to submit claims on the CMS-1500, UB-04 claim form, or electronic equivalent using HIPAA standardized procedure coding which mirrors the submission of claims for all other PCP services. In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. Staff requests authority to amend the clinic contracts to include the regulatory requirements, as applicable and in accordance with DHCS guidance.

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The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima clinic contracts associated with St. Joseph Healthcare and its affiliates

Fiscal Impact
Management has included expenses associated with the extended contracts in the proposed CalOptima Fiscal Year 2018-19 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend clinic contracts associated with St. Joseph Healthcare and its affiliates, for one year is a budgeted item with no additional fiscal impact.
In addition, the recommended actions to amend contracts to reflect changes in the CHDP program billing requirements and applicable regulatory requirements are not expected to have any additional fiscal impact to CalOptima.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

21. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts Associated With the Children's Hospital of Orange County

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend the Medi-Cal, OneCare, OneCare Connect and PACE contracts associated with the Children's Hospital of Orange County (CHOC) through June 30, 2019;
2. Amend contracts to reflect change in Child Health and Disability Prevention (CHDP) Program billing requirements to the extent authorized by the Board of Directors in a separate Board action;
3. Amend contracts to reflect the additional payments to be received by Clinics for Medi-Cal services as a result of Proposition 56 to the extent the Clinic is specifically eligible to receive such payments and as authorized by the Board of Directors in a separate Board action; and
4. Amend these contract terms to reflect applicable regulatory changes and other requirements.

Background/Discussion

CalOptima currently contracts with several clinics to provide Primary Care services to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

CHDP Transition: CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or diagnose health issues through regular health check-ups. Since the inception of the program, the Department of Health Care Services has required providers to bill with defined procedure codes on a designated claim form (PM 160). Completion of the PM 160 is a burden to providers who must submit claims using a separate process from other services billed by primary care physicians.

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As of January 1, 2018, the State required fee-for-service Medi-Cal providers of CHDP services to comply with HIPAA standards for health care electronic transactions and code sets. Effective July 1, 2018, with Board approval, CalOptima will require PCPs to submit claims on the CMS-1500, UB-04 claim form, or electronic equivalent using HIPAA standardized procedure coding which mirrors the submission of claims for all other PCP services.

Proposition 56: Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which provides guidance to Medi-Cal Managed Care Plans, on how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Providers and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. However, the APL specified that Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics are not eligible for this funding. The document also specifies the timeframe and reporting requirements for such payments.

Therefore, in accordance with the guidance provided in the DHCS issued APL, CalOptima will make additional payments to Clinics which are specifically eligible to receive Proposition 56 additional payments, for Dates of Services (DOS) July 1, 2017 through June 30, 2018. Should the State decide to continue payments for services beyond the DOS June 30, 2018, CalOptima will leverage existing processes to continue Clinic payments.

Regulations: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. Staff requests authority to amend the clinic contracts to include the regulatory requirements, as applicable and in accordance with DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima clinic contracts associated with the Children's Hospital of Orange County.

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Fiscal Impact
Management has included expenses associated with the extended contracts in the proposed CalOptima Fiscal Year 2018-19 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend clinic contracts associated with Children's Hospital of Orange County for one (1) year is a budgeted item with no additional fiscal impact. In addition, the recommended actions to amend contracts to reflect changes in the CHDP program billing requirements and applicable regulatory requirements are not expected to have any additional fiscal impact to CalOptima.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

22. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service (FFS) Primary Care Physician (PCP) Contracts, Except Those Associated With the University of California – Irvine or St. Joseph Healthcare and its Affiliates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care (PCP) contracts through June 30, 2019, except those associated with the University of California-Irvine or St. Joseph Healthcare and its Affiliates;
2. Amend contracts to reflect change in Child Health and Disability Prevention (CHDP) Program billing requirements to the extent authorized by the Board of Directors in a separate Board action;
3. Amend contracts to reflect the additional payments to be received by PCPs for Medi-Cal services as a result of Proposition 56 to the extent authorized by the Board of Directors in a separate Board action; and
4. Amend contract terms to reflect applicable Medi-Cal regulatory changes and other requirements.

Background/Discussion

Contract Extensions: CalOptima currently contracts with many individual physicians and physicians' groups to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one-year term, upon approval by the Board.

CHDP Transition: CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or diagnose health issues through regular health check-ups. Since the inception of the program, the Department of Health Care Services has required providers to bill with defined procedure codes on a designated

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claim form (PM 160). Completion of the PM 160 is a burden to providers who must submit claims using a separate process from other services billed by PCPs.

As of January 1, 2018, the State required fee- for- service Medi-Cal providers of CHDP services to comply with HIPAA standards for health care electronic transactions and code sets. Effective July 1, 2018, with Board approval, CalOptima will require PCPs to submit claims on the CMS-1500, UB-04 claim form, or electronic equivalent using HIPAA standardized procedure coding which mirrors the submission of claims for all other PCP services.

Proposition 56: Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which provides guidance to Medi-Cal Managed Care Plans, on how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Providers and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. The document also specifies the timeframe and reporting requirements for such payments.

In accordance with the guidance provided in the DHCS issued APL, CalOptima will make additional payments to PCPs for Dates of Services (DOS) July 1, 2017 through June 30, 2018. Should the State decide to continue payments for services beyond the DOS June 30, 2018, CalOptima will leverage existing processes to continue PCP payments.

Regulation: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. The contract term changes include, but are not limited to: new definitions, updated Disclosure Form requirements, audit and record retention standards, updates to non-discrimination language, and other terms. Staff requests authority to amend the PCP contracts to include the regulatory requirements, as applicable and in accordance with DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima FFS PCP contracts except those associated with the University of California-Irvine or St. Joseph Healthcare and its Affiliates.

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Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima Fiscal Year 2018-19 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS PCP contracts, except for those associated with the University of California, Irvine or St. Joseph Healthcare and its affiliates, for one year is a budgeted item with no additional fiscal impact. In addition, the recommended actions to amend contracts to reflect changes in Child Health and Disability Prevention (CHDP) Program billing requirements and applicable regulatory requirements are not expected to have any additional fiscal impact to CalOptima.

The recommended action to amend contracts to reflect the additional payments to be received by PCPs for Medi-Cal services as a result of Proposition 56 is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

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 — *5/30/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

23. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service Primary Care Physician Contracts Associated With St. Joseph Healthcare and its Affiliates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service Primary Care (PCP) contracts through June 30, 2019 associated with St. Joseph Healthcare and its Affiliates;
2. Amend contracts to reflect change in Child Health and Disability Prevention (CHDP) Program billing requirements to the extent authorized by the Board of Directors in a separate Board action;
3. Amend contracts to reflect the additional payments to be received by PCPs for Medi-Cal services as a result of Proposition 56 to the extent authorized by the Board of Directors in a separate Board action; and
4. Amend contract terms to reflect applicable Medi-Cal regulatory changes and other requirements.

Background/Discussion

Contract Extensions: CalOptima currently contracts with many individual physicians and physician groups to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this date, all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

CHDP Transition: CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or diagnose health issues through regular health check-ups. Since the inception of the program, the Department of Health Care Services has required providers to bill with defined procedure codes on a designated claim form (PM 160). Completion of the PM 160 is a burden to providers who must submit claims using a separate process from other services billed by PCPs.

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As of January 1, 2018, the State required FFS Medi-Cal providers of CHDP services to comply with HIPAA standards for health care electronic transactions and code sets. Effective July 1, 2018, with Board approval, CalOptima will require PCPs to submit claims on the CMS-1500, UB-04 claim form, or electronic equivalent using HIPAA standardized procedure coding which mirrors the submission of claims for all other PCP services.

Proposition 56: Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which provides guidance to Medi-Cal Managed Care Plans, on how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Providers and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. The document also specifies the timeframe and reporting requirements for such payments.

In accordance with the guidance provided in the DHCS issued APL, CalOptima will make additional payments to PCPs for Dates of Services (DOS) July 1, 2017 through June 30, 2018. Should the State decide to continue payments for services beyond the DOS June 30, 2018, CalOptima will leverage existing processes to continue PCP payments.

Regulation: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. The contract term changes include, but are not limited to: new definitions, updated Disclosure Form requirements, audit and record retention standards, updates to non-discrimination language, and other terms. Staff requests authority to amend the PCP contracts to include the regulatory requirements, as applicable and in accordance with DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima FFS PCP contracts associated with St. Joseph Healthcare and its Affiliates.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima Fiscal Year 2018-19 Operating Budget. Assuming extension of the contracts are under the same terms

and conditions, the recommended action to extend CalOptima FFS PCP contracts with St. Joseph Healthcare and its affiliates, for one year is a budgeted item with no additional fiscal impact. In addition, the recommended actions to amend contracts to reflect changes in the CHDP program billing requirements and applicable regulatory requirements are not expected to have any additional fiscal impact to CalOptima.

The recommended action to amend contracts to reflect the additional payments to be received by PCPs for Medi-Cal services as a result of Proposition 56 is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

24. Consider Authorizing Extensions and Amendments of the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service Primary Care Physician Contracts Associated With the University of California, Irvine

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Gary Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service Primary Care (PCP) contracts associated with the University of California, Irvine through June 30, 2019;
2. Amend these contracts to reflect change in Child Health and Disability Prevention (CHDP) Program billing requirements to the extent authorized by the Board of Directors in a separate Board action;
3. Amend contracts to reflect the additional payments to be received by PCPs for Medi-Cal services as a result of Proposition 56 to the extent authorized by the Board of Directors in a separate Board action; and
4. Amend contract terms to reflect applicable regulatory changes and other requirements.

Background/Discussion

Contract Extensions: CalOptima currently contracts with many individual physicians and physicians' groups to provide Primary Care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider meeting credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the CalOptima Board of Directors.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

CHDP Transition: CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or diagnose health issues through regular health check-ups. Since the inception of the program, the Department of Health Care Services has required providers to bill with defined procedure codes on a designated claim form (PM 160). Completion of the PM 160 is a burden to providers who must submit claims using a separate process from other services billed by PCPs.

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As of January 1, 2018, the State required fee-for-service Medi-Cal providers of CHDP services to comply with HIPAA standards for health care electronic transactions and code sets. Effective July 1, 2018, with Board approval, CalOptima will require PCPs to submit claims on the CMS-1500, UB-04 claim form, or electronic equivalent using HIPAA standardized procedure coding which mirrors the submission of claims for all other PCP services.

Proposition 56: Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which provides guidance to Medi-Cal Managed Care Plans, on how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Providers and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. The document also specifies the timeframe and reporting requirements for such payments.

In accordance with the guidance provided in the DHCS issued APL, CalOptima will make additional payments to PCPs for Dates of Services (DOS) July 1, 2017 through June 30, 2018. Should the State decide to continue payments for services beyond the DOS June 30, 2018, CalOptima will leverage existing processes to continue PCP payments.

Regulation: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. The contract term changes include, but are not limited to: new definitions, updated Disclosure Form requirements, audit and record retention standards, updates to non-discrimination language, and other terms. Staff requests authority to amend the UCI PCP contracts to include the regulatory requirements, as applicable and in accordance with DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

This staff recommendation impacts all CalOptima FFS PCP contracts associated with the University of California, Irvine.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima Fiscal Year 2018-19 Operating Budget. Assuming extension of the contracts are under the same terms

and conditions, the recommended action to extend CalOptima FFS PCP contracts associated with the University of California, Irvine for one year is a budgeted item with no additional fiscal impact. In addition, the recommended actions to amend contracts to reflect changes in the CHDP program billing requirements and applicable regulatory requirements are not expected to have any additional fiscal impact to CalOptima.

The recommended action to amend contracts to reflect the additional payments to be received by PCPs for Medi-Cal services as a result of Proposition 56 is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

25. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts that Expire During Fiscal Year 2018-19

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Gary Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE ancillary services provider contracts through June 30, 2019; and to
2. Amend these contract terms to reflect applicable regulatory and other requirements.

Background/Discussion

Contract Extension: CalOptima currently contracts with many ancillary providers to provide health care services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE Members. Ancillary services include, but are not limited to, laboratory, imaging, durable medical equipment, home health, and transportation. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon Board approval.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the CalOptima Board of Directors

In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. Staff requests authority to amend ancillary contracts to include the regulatory requirements, as applicable and in accordance with DHCS guidance.

The renewal of these contracts with existing providers will support the stability of CalOptima's contracted provider network. Contract language does not guarantee any provider volume or exclusivity and allows for CalOptima and the providers to terminate the contracts with or without cause.

This staff recommendation impacts FFS ancillary services provider contracts.

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Fiscal Impact
Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2018-19 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend ancillary contracts for one (1) year is a budgeted item with no additional fiscal impact.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
26. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service Hospital Contracts

Contact
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246 8400

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:
1. Extend the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service hospital contracts through June 30, 2019;
2. Amend these contracts and extend the current fee-for-service rates through June 30, 2019; and
3. Amend these contract terms to reflect applicable regulatory changes and other requirements.

Background
CalOptima's current Medi-Cal fee-for-service (FFS) hospital contracts were amended July 1, 2017 to extend the contracts through June 2018.

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

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016 meeting approved a fifteen percent (15%) decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, revised rates effective through June 30, 2017. In June of 2017, the Board authorized a twenty-nine percent (29%) decrease in the MCE capitated hospital rates through June 30, 2018. The FFS hospital rates in effect on June 30, 2017, were extended through June 30, 2018.

Discussion

Extension of the Contract Term: Staff is requesting authority to extend the Medi-Cal, OneCare, OneCare Connect and PACE FFS hospital contracts through June 30, 2019.

MCE Rates: On April 27, 2018, DHCS released draft rates for CalOptima for Fiscal Year (FY) 2018-19. After evaluation of the new rates, Staff does not recommend revision to the FFS hospital MCE

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rates at this time. Staff therefore requests authority to extend the existing MCE member rates through June 30, 2019.

Regulatory Revisions: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. Staff requests authority to amend FFS hospital contracts to include the regulatory requirements as applicable and in accordance with state and federal guidance.

Fiscal Impact
Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2018-19 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima's FFS hospital contracts for one (1) year is a budgeted item with no additional fiscal impact.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

27. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service Specialist Physician Contracts Except Those Associated With the University of California, Irvine, Children's Hospital of Orange County or St. Joseph Healthcare and its Affiliates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the CalOptima Community Network Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service specialist physician contracts through June 30, 2019, except those associated with the University of California, Irvine, Children's Hospital of Orange County or St. Joseph Healthcare and its affiliates;
2. Extend current compensation rates through June 30, 2019 to the extent authorized by the Board of Directors in a separate Board action;
3. Amend contracts to reflect change in Child Health and Disability Prevention (CHDP) Program billing requirements to the extent authorized by the Board of Directors in a separate Board action;
4. Amend contracts to reflect the additional payments to be received by Specialists for Medi-Cal services as a result of Proposition 56 to the extent authorized by the Board of Directors in a separate Board action; and
5. Amend contract terms to reflect applicable regulatory changes and other requirements.

Background

CalOptima currently contracts with many individual physicians and physician groups to provide Specialist services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

In support of Medi-Cal Expansion (MCE), the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to specialist physicians. CalOptima, in order to maintain the higher funding level for MCE members, had to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's

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MLR did not support the continued level of funding established in 2014 and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in specialist physician FFS rates in a Board action on September 3, 2015.

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016 meeting approved a 15% decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017. The Board extended the rates effective on June 30, 2017, through June 30, 2018.

CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or diagnose health issues through regular health check-ups. Since the inception of the program, the DHCS has required providers to bill with defined procedure codes on a designated claim form (PM 160). Completion of the PM 160 is a burden to providers who must submit claims using a separate process from other services billed by specialists.

Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which provides guidance to Medi-Cal Managed Care Plans, on how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Providers and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. The document also specifies the timeframe and reporting requirements for such payments

Discussion

Extension of the Contract Term: Staff is requesting authority to extend and amend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts except those associated with the University of California, Irvine, Children's Hospital of Orange County, or St. Joseph Healthcare and its affiliates through June 30, 2019.

Rates: In April 2018, DHCS released draft capitation rates for CalOptima for Fiscal Year (FY) 2018-19. After evaluation of the new rates, Staff does not recommend revision to the FFS specialist physician rates at this time. Staff therefore requests authority to extend and amend the FFS specialist physician contracts, except those for the University of California, Irvine, Children's Hospital of Orange County or St. Joseph Healthcare and its affiliates at the existing rates through June 30, 2019.

CHDP: As of January 1, 2018, the State required fee-for-service Medi-Cal providers of CHDP services to comply with HIPAA standards for health care electronic transactions and code sets.

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Effective July 1, 2018, with Board approval, CalOptima will require specialists to submit claims on the CMS-1500, UB-04 claim form, or electronic equivalent using HIPAA standardized procedure coding which mirrors the submission of claims for all other specialist services.

Proposition 56: In accordance with the guidance provided in the DHCS issued APL, CalOptima will make additional payments to Specialists for Dates of Services (DOS) July 1, 2017 through June 30, 2018. Should the State decide to continue payments for services beyond the DOS June 30, 2018, CalOptima will leverage existing processes to continue PCP payments.

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. The contract term changes include, but are not limited to: new definitions, updated Disclosure Form requirements, audit standards, and other terms. Staff requests authority to amend FFS specialist physician contracts, except those associated with the University of California, Irvine, Children's Hospital of Orange County or St. Joseph Healthcare and its affiliates, to include regulatory requirements as applicable and in accordance with CMS and DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2018-19 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS specialist physician contracts, except for those associated with the University of California, Irvine, Children's Hospital of Orange County, or St. Joseph Healthcare and its affiliates for one (1) year is a budgeted item with no additional fiscal impact. In addition, the recommended actions to amend contracts to reflect changes in the CHDP program billing requirements and applicable regulatory requirements are not expected to have any additional fiscal impact to CalOptima.

The recommended action to amend contracts to reflect the additional payments to be received by specialists for Medi-Cal services as a result of Proposition 56 is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

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Rationale for Recommendation

CalOptima staff recommends these actions to maintain and continue the contractual relationship with the specialist provider network and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

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

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

28. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect, and PACE Fee-For-Service Specialist Physician Contracts Associated With the University of California, Irvine

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service specialist physician contracts associated with the University of California, Irvine through June 30, 2019;
2. Extend current compensation rates through June 30, 2019 to the extent authorized by the Board of Directors in a separate Board action;
3. Amend contracts to reflect change in Child Health and Disability Prevention (CHDP) Program billing requirements to the extent authorized by the Board of Directors in a separate Board action;
4. Amend contracts to reflect the additional payments to be received by Specialists for Medi-Cal services as a result of Proposition 56 to the extent authorized by the Board of Directors in a separate Board action; and
5. Amend contract terms to reflect applicable regulatory changes and other requirements.

Background

CalOptima currently contracts with many individual physicians and physician groups to provide Specialist services on a fee-for-service (FFS) basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

In support of Medi-Cal Expansion (MCE), the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to specialist physicians. CalOptima, in order to maintain the higher funding level for MCE members, had to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014 and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in specialist physician FFS rates in a Board action on September 3, 2015.

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DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016 meeting approved a fifteen percent (15%) decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017. The Board extended the rates effective on June 30, 2017, through June 30, 2018.

CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or diagnose health issues through regular health check-ups. Since the inception of the program, the Department of Health Care Services has required providers to bill with defined procedure codes on a designated claim form (PM 160). Completion of the PM 160 is a burden to providers who must submit claims using a separate process from other services billed by specialists.

Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which provides guidance to Medi-Cal Managed Care Plans, on how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Providers and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. The document also specifies the timeframe and reporting requirements for such payments

Discussion

Extension of the Contract Term: Staff is requesting authority to extend and amend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with the University of California, Irvine, through June 30, 2019.

MCE Rates: In April 2018, DHCS released draft capitation rates for CalOptima for Fiscal Year (FY) 2018-19. After evaluation of the new rates, Staff does not recommend revision to the FFS specialist physician MCE rates at this time. Staff therefore requests authority to extend through June 30, 2019 and amend the FFS specialist physician contracts, for the University of California, Irvine

CHDP: As of January 1, 2018, the State required fee-for-service Medi-Cal providers of CHDP services to comply with HIPAA standards for health care electronic transactions and code sets. Effective July 1, 2018, with Board approval, CalOptima will require specialists to submit claims on the CMS-1500, UB-04 claim form, or electronic equivalent using HIPAA standardized procedure coding which mirrors the submission of claims for all other specialist services.

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Proposition 56: In accordance with the guidance provided in the DHCS issued APL, CalOptima will make additional payments to Specialists for Dates of Services (DOS) July 1, 2017 through June 30, 2018. Should the State decide to continue payments for services beyond the DOS June 30, 2018, CalOptima will leverage existing processes to continue PCP payments.

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. The contract term changes include, but are not limited to: new definitions, updated Disclosure Form requirements, audit standards, and other terms. Staff requests authority to amend FFS specialist physician contracts with the University of California, Irvine to include regulatory requirements as applicable and in accordance with CMS and DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2018-19 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS specialist physician contracts associated with the University of California, Irvine for one (1) year is a budgeted item with no additional fiscal impact. In addition, the recommended actions to amend contracts to reflect changes in the CHDP program billing requirements and applicable regulatory requirements are not expected to have any additional fiscal impact to CalOptima.

The recommended action to amend contracts to reflect the additional payments to be received by specialists for Medi-Cal services as a result of Proposition 56 is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
None

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

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

29. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service Specialist Physician Contracts Associated With St. Joseph Healthcare and its Affiliates

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Extend the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service specialist physician contracts associated with St. Joseph Healthcare and its affiliates through June 30, 2019;
2. Extend current compensation rates through June 30, 2019 to the extent authorized by the Board of Directors in a separate Board action;
3. Amend contracts to reflect change in Child Health and Disability Prevention (CHDP) Program billing requirements to the extent authorized by the Board of Directors in a separate Board action;
4. Amend contracts to reflect the additional payments to be received by Specialists for Medi-Cal services as a result of Proposition 56 to the extent authorized by the Board of Directors in a separate Board action; and
5. Amend contract terms to reflect applicable regulatory changes and other requirements.

Background

CalOptima currently contracts with many individual physicians and physicians' groups to provide specialist services on a FFS basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

In support of Medi-Cal Expansion (MCE), the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to specialist physicians. CalOptima, in order to maintain the higher funding level for MCE members, had to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014 and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in specialist physician FFS rates in a Board action on September 3, 2015.

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HCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016 meeting approved a fifteen percent (15%) decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017. The Board extended the rates effective on June 30, 2017, through June 30, 2018.

Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which provides guidance to Medi-Cal Managed Care Plans, on how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Providers and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. The document also specifies the timeframe and reporting requirements for such payments

CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or diagnose health issues through regular health check-ups. Since the inception of the program, the Department of Health Care Services has required providers to bill with defined procedure codes on a designated claim form (PM 160). Completion of the PM 160 is a burden to providers who must submit claims using a separate process from other services billed by specialists.

Discussion

Extension of the Contract Term: Staff is requesting authority to extend and amend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with St. Joseph Healthcare and its Affiliates, through June 30, 2019.

MCE Rates: In April 2018, DHCS released draft capitation rates for CalOptima for Fiscal Year (FY) 2018-19. After evaluation of the new rates, Staff does not recommend revision to the FFS specialist physician MCE rates at this time. Staff therefore requests authority to extend through June 30, 2019 the FFS specialist physician contracts, for St. Joseph Healthcare and its Affiliates.

CHDP: As of January 1, 2018, the State required fee-for-service Medi-Cal providers of CHDP services to comply with HIPAA standards for health care electronic transactions and code sets. Effective July 1, 2018, with Board approval, CalOptima will require specialists to submit claims on the CMS-1500, UB-04 claim form, or electronic equivalent using HIPAA standardized procedure coding which mirrors the submission of claims for all other specialist services.

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Proposition 56: In accordance with the guidance provided in the DHCS issued APL, CalOptima will make additional payments to Specialists for Dates of Services (DOS) July 1, 2017 through June 30, 2018. Should the State decide to continue payments for services beyond the DOS June 30, 2018, CalOptima will leverage existing processes to continue PCP payments.

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. The contract term changes include, but are not limited to: new definitions, updated Disclosure Form requirements, audit standards, and other terms. Staff requests authority to amend FFS specialist physician contracts with St. Joseph Healthcare and its Affiliates to include regulatory requirements as applicable and in accordance with CMS and DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2018-19 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS specialist physician contracts associated with St. Joseph Healthcare and its Affiliates for one (1) year is a budgeted item with no additional fiscal impact. In addition, the recommended actions to amend contracts to reflect changes in the CHDP program billing requirements and applicable regulatory requirements are not expected to have any additional fiscal impact to CalOptima.

The recommended action to amend contracts to reflect the additional payments to be received by specialists for Medi-Cal services as a result of Proposition 56 is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
None

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

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

30. Consider Authorizing Extensions and Amendments of the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service Specialist Physician Contracts Associated with Children's Hospital of Orange County

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel to:

1. Extend the CalOptima Community Network, Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts associated with Children's Hospital of Orange County through June 30, 2019;
2. Extend current compensation rates through June 30, 2019 to the extent authorized by the Board of Directors in a separate Board action;
3. Amend contracts to reflect change in Child Health and Disability Prevention (CHDP) Program billing requirements to the extent authorized by the Board of Directors in a separate Board action;
4. Amend contracts to reflect the additional payments to be received by Specialists for Medi-Cal services as a result of Proposition 56 to the extent authorized by the Board of Directors in a separate Board action; and
5. Amend contract terms to reflect applicable Medi-Cal regulatory changes and other requirements.

Background

CalOptima currently contracts with many individual physicians and physicians' groups to provide Specialist services on a FFS basis to Medi-Cal, OneCare, OneCare Connect and PACE members. A contract is offered to any willing provider, as long as they meet credentialing and participation requirements. These provider contracts extend on an annual basis contingent upon approval from the Board.

Extending contracts per Board approval was first approved in 2010. Prior to this all contracts included firm termination dates. In 2012, CalOptima added contract language indicating that contracts will be renewed under the same terms and conditions for an additional one (1) year term, upon approval by the Board.

In support of Medi-Cal Expansion (MCE), the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to specialist physicians. CalOptima, in order to maintain the higher funding level for MCE members, had to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014 and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in specialist physician FFS rates in a Board action on September 3, 2015.

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DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016 meeting approved a fifteen percent (15%) decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017. The Board extended the rates effective on June 30, 2017, through June 30, 2018.

CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or diagnose health issues through regular health check-ups. Since the inception of the program, the Department of Health Care Services has required providers to bill with defined procedure codes on a designated claim form (PM 160). Completion of the PM 160 is a burden to providers who must submit claims using a separate process from other services billed by specialists.

Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which provides guidance to Medi-Cal Managed Care Plans, on how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Providers and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. The document also specifies the timeframe and reporting requirements for such payments

Discussion

Extension of the Contract Term: Staff is requesting authority to extend and amend the Medi-Cal, OneCare, OneCare Connect and PACE FFS specialist physician contracts associated with Children's Hospital of Orange County, through June 30, 2019.

MCE Rates: In April 2018, DHCS released draft capitation rates for CalOptima for Fiscal Year (FY) 2018-19. After evaluation of the new rates, Staff does not recommend revision to the FFS specialist physician MCE rates at this time. Staff therefore requests authority to extend through June 30, 2019 and amend the FFS specialist physician contracts, for Children's Hospital of Orange County

CHDP: As of January 1, 2018, the State required fee-for-service Medi-Cal providers of CHDP services to comply with HIPAA standards for health care electronic transactions and code sets. Effective July 1, 2018, with Board approval, CalOptima will require specialists to submit claims on the CMS-1500, UB-04 claim form, or electronic equivalent using HIPAA standardized procedure coding which mirrors the submission of claims for all other specialist services.

Proposition 56: In accordance with the guidance provided in the DHCS issued APL, CalOptima will make additional payments to Specialists for Dates of Services (DOS) July 1, 2017 through June 30,

2018. Should the State decide to continue payments for services beyond the DOS June 30, 2018, CalOptima will leverage existing processes to continue PCP payments.

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. The contract term changes include, but are not limited to: new definitions, updated Disclosure Form requirements, audit standards, and other terms. Staff requests authority to amend FFS specialist physician contracts with Children's Hospital of Orange County to include regulatory requirements as applicable and in accordance with CMS and DHCS guidance.

The continued renewal of the contracts will support the stability of CalOptima's contracted provider network and allow the Board to preside over contracting directives. Contract language allows for CalOptima and the providers to terminate individual contracts with or without cause.

Fiscal Impact

Management has included expenses associated with the extended contracts in the proposed CalOptima FY 2018-19 Operating Budget. Assuming extension of the contracts are under the same terms and conditions, the recommended action to extend CalOptima FFS specialist physician contracts associated with Children's Hospital of Orange County for one (1) year is a budgeted item with no additional fiscal impact. In addition, the recommended actions to amend contracts to reflect changes in the CHDP program billing requirements and applicable regulatory requirements are not expected to have any additional fiscal impact to CalOptima.

The recommended action to amend contracts to reflect the additional payments to be received by specialists for Medi-Cal services as a result of Proposition 56 is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
None

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

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

31. Consider Authorizing Extension and Amendment of the CalOptima Medi-Cal Full-Risk Health Network Contract with Kaiser Permanente

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend the current Medi-Cal Full-Risk Health Network contract with Kaiser Permanente contract to June 30, 2019;
2. Extend the current capitation rate for assigned members effective July 1, 2018, through June 30, 2019;
3. Include terms to reflect the responsibility of Kaiser Permanente to pay individual providers Proposition 56 appropriated funds and the obligation of CalOptima to compensate Kaiser Permanente an administrative fee for performance of these responsibilities to the extent authorized by the Board in a separate action; and
4. Amend the contract terms to reflect updated regulatory requirements and other requirements, including changes to the CHDP program as applicable.

Background

CalOptima's current Medi-Cal Full-Risk Health Network Contracts were amended July 1, 2016 to extend the Contracts through December 2016. In December of 2016, the Medi-Cal Full-Risk Health Network Contract for Kaiser Permanente was amended to extend the contract through June 30, 2017.

Kaiser Permanente's compensation was based on terms and conditions outlined in a three-way agreement with DHCS, Kaiser Permanente and CalOptima. The compensation was further defined in a two-way agreement between Kaiser Permanente (Kaiser) and CalOptima. The terms and conditions of both agreements were specifically defined by the State of California.

In early May of 2017, DHCS issued a letter indicating that the terms of the three-way agreement had been fulfilled and stated that the DHCS does not intend to continue to participate in these agreements.

Child Health Disability Prevention (CHDP) Program is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or find health problems through regular health check-ups. Since the inception of the program, the Department of Health Services has required providers to bill with California defined procedure codes on a California designated form.

Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs

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administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which outlines to the Managed Care Plans, how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Providers and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. The document also specifies the timeframe and reporting requirements for such payments.

Discussion

Extension of the Contract Term: Staff is requesting authority to extend the current Medi-Cal Full-Risk Health Network contract with Kaiser Permanente contract to June 30, 2019.

Capitation Rates: The capitation rates in effect for FY 2017-18 will be extended at the same rates through FY 2018-19. As a result, there will be no anticipated change to the compensation rates paid to Kaiser during the upcoming FY 2018-19 fiscal year.

Proposition 56 Payments: In accordance with the guidance provided in the DHCS issued APL, CalOptima is defining the process, timeframes and reporting requirements for making the additional payments to individual providers. Staff requests the authority to amend Kaiser Permanente's contract to specify the methodology for Proposition 56 disbursement of funds by health networks. Staff is also requesting authority to add a term reflecting CalOptima's obligation to pay Kaiser Permanente an administration fee for rendering these payments to their individual providers, if approved in a separate Board action.

Regulatory Revisions: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. Some of the revised regulations such as those dealing with ownership disclosure and record retention requirements, must be incorporated into CalOptima's contracts with providers. Staff requests authority to amend the Kaiser Permanente contract to include the regulatory requirements as applicable and in accordance with DHCS guidance.

Fiscal Impact

Management has included expenses associated with the extended contracts in the CalOptima FY 2018-19 Operating Budget pending Board approval. Since staff proposes that the extension of the contract will be under the same rates, terms and conditions, with the exception of changes for Proposition 56 as addressed in this staff report, the recommended action to extend CalOptima's contract with Kaiser Permanente through, June 30, 2019, is a budgeted item with no additional fiscal impact.

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Payment for CHDP services is already included in Kaiser's capitation rate. Therefore, the recommended action to reflect change in CHDP program responsibility requirements will have no additional fiscal impact to CalOptima.

Disbursement of Proposition 56 funds is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the program.

Rationale for Recommendation
CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory policy requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

32. Consider Authorizing Amendments of the CalOptima Medi-Cal Full-Risk Health Network Contract with Heritage Provider Network, Inc., Monarch Family Healthcare and Prospect Medical Group

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to enter into Medi-Cal full-risk health network contract amendments, with the assistance of Legal Counsel, with Heritage Provider Network, Inc., Monarch Family Healthcare and Prospect Medical Group that:

1. Extends contracts through December 31, 2018;
2. Extends the current capitation rates for assigned members effective July 1, 2018, through December 31, 2018;
3. To reflect change in Child Health and Disability Prevention (CHDP) Program responsibility requirements and rates to the extent authorized by the Board of Directors in a separate Board action;
4. Reflect the responsibilities of the health networks to pay individual providers Proposition 56 appropriated funds and to compensate the health networks an administrative fee for performance of these responsibilities to the extent authorized by the Board in a separate action; and
5. Amend the contract terms to reflect applicable regulatory changes and other requirements.

Background

CalOptima's current Medi-Cal full-risk health network contracts were amended July 1, 2016 to extend the contracts through December 2016. At the November 2016 Board meeting, the Medi-Cal full-risk health network contracts for Heritage was amended to extend the contracts through June 30, 2017. Monarch, a shared risk contractor at that time, became a full-risk contractor effective February 1, 2017. The current term for the full-risk Monarch Family Healthcare runs through the end of June 2018.

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

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016, meeting approved a fifteen percent (15%) decrease in capitation rates for MCE members. Contracts were

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amended to reflect this decrease, with revised rates effective through June 30, 2017. Subsequently, effective July 1, 2017, the Board authorized a twenty-nine (29%) reduction in capitated hospital rates; all other MCE rates were extended through June 30, 2018.

The Child Health Disability Prevention (CHDP) Program is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or find health problems through regular health check-ups. Since the inception of the program, the Department of Health Services has required providers to bill with California defined procedure codes on a California designated form. CalOptima has retained payment responsibility for payment of CHDP services requiring physicians regardless of health network affiliation, to bill CalOptima directly for all services.

Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which outlines to the managed care plans, how the funds from Proposition 56 are to be distributed to providers. The APL specifies that manage care plans and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. The document also specifies the timeframe and reporting requirements for such payments.

Discussion

Extension of the Contract Terms: Staff is requesting authority to extend the referenced Medi-Cal full-risk contracts through December 31, 2018.

Medi-Cal Expansion Rates: In April 2018, DHCS released draft capitation rates for CalOptima for FY 2018-19. Staff has reviewed the draft rates and determined that they support the continued payment of existing health network capitation rates, including those associated with the MCE members. The rates associated with the MCE members were to expire on June 30, 2018. Therefore, Staff recommends extending the current rates through December 30, 2018. This proposal is addressed in Operating Budget presentation and recommended actions. If authorized by the Board in a separate action item, Staff will extend the existing rates effective July 1, 2018 through December 31, 2018.

CHDP: As of January 1, 2018, the State required fee-for-service providers of CHDP services to comply HIPAA standards for health care electronic transactions and code sets. The transition results in providers billing CHDP services using standard CPT codes and CMS 1500 forms, or their electronic equivalent, and is consistent with the billing of all other services. CalOptima proposes to transition the billing and payment of services using the same methodology, effective July 1, 2018. As this transition streamlines the process of billing and paying for these services, CalOptima proposes to transition the responsibility for payment of CHDP services to the health networks. effective July 1, 2018. Staff requests authority to amend health network contracts to reflect this change.

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Proposition 56 Payments: In accordance with the guidance provided in the DHCS issued APL, CalOptima is defining the process, timeframes and reporting requirements for making the additional payments to individual providers. Staff requests the authority to amend the health network contracts to specify the methodology for Proposition 56 disbursement of funds by the health networks. Staff also requests authority to pay the health networks an administration fee for rendering these payments to their individual providers.

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. Staff requests authority to amend Medi-Cal full-risk contracts to include the regulatory requirements, as applicable and in accordance with DHCS guidance.

Fiscal Impact

Management has included expenses associated with the extended contracts in the CalOptima FY 2018-19 Operating Budget pending Board approval. Assuming extension of the contracts are under the same terms and conditions for professional and hospital services capitation, with the exception of changes to CHDP and Proposition 56 as addressed in this COBAR, the recommended action to extend CalOptima's HMO contracts for Heritage Provider Network, Inc., Monarch Family Healthcare and Prospect Medical Group to December 31, 2018, is a budgeted item with no additional fiscal impact.

The proposed transition of CHDP services from CalOptima to health networks is expected to increase CalOptima's total CHDP costs by $4.1 million annually. The increased costs are primarily due to two factors: (1) the application of the contracted CalOptima Direct/CalOptima Community Network Medi-Cal fee schedule for primary care physician services and (2) the application of an administration load to reimburse health networks for increased claims adjudication and management costs. CalOptima will incorporate funding for CHDP services that are currently paid on a FFS basis into an equivalent capitation rate to delegated Health Networks. Management has included expenses associated with the recommended CHDP actions in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval.

Disbursement of Proposition 56 funds is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in Medi-Cal full-risk responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

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Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

33. Consider Authorizing Amendments to the CalOptima Medi-Cal Shared Risk (SRG) Health Network Physician Contracts for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Network

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to enter into Medi-Cal SRG health network physician contract amendments, with the assistance of Legal Counsel, for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Network that:

1. Extend the contracts through December 31, 2018;
2. Extend the current capitation rates for assigned members effective July 1, 2018, through December 31, 2018;
3. To reflect change in Child Health and Disability Prevention (CHDP) Program responsibility requirements and rates to the extent authorized by the Board of Directors in a separate Board action;
4. Reflect the responsibilities of the health networks to pay individual providers Proposition 56 appropriated funds and to compensate the health networks an administrative fee for performance of these responsibilities to the extent authorized by the Board in a separate action; and
5. Amend the contract terms to reflect applicable regulatory changes and other requirements.

Background

CalOptima's current Medi-Cal SRG health network physician contracts were amended July 1, 2016 to extend the contracts through December 2016. In November 2016, the Medi-Cal PHC health network physician contracts were amended to extend the contracts through June 30, 2017.

In support of Medi-Cal expansion (MCE), the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to the health networks. CalOptima, in order to maintain the higher funding level for MCE members, was required to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014, and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in health network capitation rates in a Board action on September 3, 2015.

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016, meeting approved a fifteen percent (15%) decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017. Subsequently,

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effective July 1, 2017, the Board authorized a twenty-nine percent (29%) reduction in capitated hospital rates; all other MCE rates were extended through June 30, 2018.

Child Health Disability Prevention (CHDP) Program is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or find health problems through regular health check-ups. Since the inception of the program, the Department of Health Services has required providers to bill with California defined procedure codes on a California designated form. CalOptima has retained payment responsibility for payment of CHDP services requiring physicians regardless of health network affiliation, to bill CalOptima directly for all services.

Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which outlines to the Managed Care Plans, how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Plans and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. The document also specifies the timeframe and reporting requirements for such payments.

Discussion

Extension of the Contract Term: Staff is requesting authority to amend the Medi-Cal SRG physician contracts for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group and United Care Medical Network to extend the Contracts through December 31, 2018.

MCE Rates: In April 2018, DHCS released draft capitation rates for CalOptima for FY 2018-19. Staff has reviewed the draft rates and determined that they support the continued payment of existing health network capitation rates, including those associated with the MCE members. The rates associated with the MCE members were to expire on June 30, 2018. Therefore, Staff recommends extending the current rates effective July 1, 2018, through December 31, 2018. This proposal is addressed in Operating Budget presentation and recommended actions.

CHDP: As of January 1, 2018, the State required fee-for-service (FFS) providers of CHDP services to comply HIPAA standards for health care electronic transactions and code sets. The transition results in providers billing CHDP services using standard CPT codes and CMS 1500 forms, or their electronic equivalent, and is consistent with the billing of all other services. CalOptima proposes to transition the billing and payment of services using the same methodology, effective July 1, 2018. As this transition streamlines the process of billing and paying for these services, CalOptima proposes to

transition the responsibility for payment of CHDP services to the Health Networks. effective July 1, 2018. Staff requests authority to amend Health Network contracts to reflect this change.

Proposition 56 Payments: In accordance with the guidance provided in the DHCS issued APL, CalOptima is defining the process, timeframes and reporting requirements for making the additional payments to individual providers. Staff requests the authority to amend the health network contracts to specify the methodology for Proposition 56 disbursement of funds by the health networks. Staff also requests authority to pay the health networks an administration fee for rendering these payments to their individual providers.

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. Some of the revised regulations such as those dealing with ownership disclosure and record retention requirements, must be incorporated into CalOptima's contracts with providers. Staff requests authority to amend SRG physician contracts as applicable to include the regulatory requirements as applicable and in accordance with CMS and DHCS guidance.

Fiscal Impact

Management has included expenses associated with the extended contracts in the CalOptima FY 2018-19 Operating Budget pending Board approval. Assuming extension of the contracts are under the same terms and conditions for professional services capitation, with the exception of changes to CHDP and Proposition 56 as addressed in this COBAR, the recommended action to extend CalOptima SRG physician contracts for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Network through December 31, 2018, is a budgeted item with no additional fiscal impact specific to professional services capitation.

The proposed transition of CHDP services from CalOptima to health networks is expected to increase CalOptima's total CHDP costs by $4.1 million annually. The increased costs are primarily due to two factors: (1) the application of the contracted CalOptima Direct/CalOptima Community Network Medi-Cal fee schedule for primary care physician services and (2) the application of an administration load to reimburse health networks for increased claims adjudication and management costs. CalOptima will incorporate funding for CHDP services that are currently paid on a FFS basis into an equivalent capitation rate to delegated Health Networks. Management has included expenses associated with the recommended CHDP actions in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval.

Disbursement of Proposition 56 funds is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the program.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network and to fulfill regulatory requirements.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

34. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Physician Contracts for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to enter into contract amendments of the Physician Hospital Consortium (PHC) health network contracts, with the assistance of Legal Counsel, for AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center to:

1. Extend contracts through December 31, 2018;
2. Extend the current capitation rates for assigned members effective July 1, 2018, through December 31, 2018;
3. To reflect changes in Child Health and Disability Prevention (CHDP) Program responsibilities and rates to the extent authorized by the Board of Directors in a separate Board action;
4. Reflect the responsibilities of the health networks to pay individual providers Proposition 56 appropriated funds and to compensate the health networks an administrative fee for performance of these responsibilities to the extent authorized by the Board in a separate action; and
5. Amend the contract terms to reflect applicable regulatory changes and other requirements.

Background

CalOptima's current Medi-Cal PHC health network contracts were amended July 1, 2016 to extend the contracts through December 2016. In November 2016, the Medi-Cal PHC health network contracts were amended to extend the contracts through June 30, 2017.

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

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016, meeting approved a fifteen percent (15%) decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017. Subsequently,

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effective July 1, 2017, the Board authorized a twenty-nine percent (29%) reduction in capitated hospital rates; all other MCE rates were extended through June 30, 2018.

The Child Health Disability Prevention (CHDP) Program is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or find health problems through regular health check-ups. Since the inception of the program, the Department of Health Services has required providers to bill with California defined procedure codes on a California designated form. CalOptima has retained payment responsibility for payment of CHDP services requiring physicians regardless of health network affiliation, to bill CalOptima directly for all services.

Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which provides guidance to Medi-Cal Managed Care Plans, on how the funds from Proposition 56 are to be distributed to providers. The APL specifies that Manage Care Providers and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. The document also specifies the timeframe and reporting requirements for such payments.

Discussion

Extension of the Contract Term: Staff is requesting authority to amend the Medi-Cal physician PHC contracts for AMVI Care Health Network, Family Choice Network, and Orange County Advantage Medical Group and Fountain Valley Regional Medical Center to extend the contracts through December 31, 2018.

Managed Care Expansion Rates: In April 2018, DHCS released draft capitation rates for CalOptima for FY 2018-19. Staff has reviewed the draft rates and determined that they support the continued payment of existing health network capitation rates, including those associated with the Managed Care Expansion (MCE) members. The rates associated with the MCE members were to expire on June 30, 2018. Therefore, Staff recommends extending the current rates effective July 1, 2018, through December 31, 2018. This proposal is addressed in Operating Budget presentation and recommended actions.

CHDP: As of January 1, 2018, the State required fee for service providers of CHDP services to comply HIPAA standards for health care electronic transactions and code sets. The transition results in providers billing CHDP services using standard CPT codes and CMS 1500 forms, or their electronic equivalent, and is consistent with the billing of all other services. CalOptima proposes to transition the billing and payment of services using the same methodology, effective July 1, 2018. As this

transition streamlines the process of billing and paying for these services, CalOptima proposes to transition the responsibility for payment of CHDP services to the Health Networks. effective July 1, 2018. Staff requests authority to amend Health Network contracts to reflect this change.

Proposition 56 Payments: In accordance with the guidance provided in the DHCS issued APL, CalOptima is defining the process, timeframes and reporting requirements for making the additional payments to individual providers. Staff requests the authority to amend the health network contracts to specify the method, timeframes and reporting requirements for the distribution of Proposition 56 funds by the health networks.

Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. Staff requests authority to amend PHC contracts to include the regulatory requirements, as applicable and in accordance with DHCS guidance.

Fiscal Impact

Management has included expenses associated with the extended contracts in the CalOptima FY 2018-19 Operating Budget pending Board approval. Assuming extension of the contracts are under the same terms and conditions for professional and hospital services capitation, with the exception of changes to CHDP and Proposition 56 as addressed in this COBAR, the recommended action to extend CalOptima's PHC physician and hospital contracts AMVI Care Health Network, Family Choice Network, and Fountain Valley Regional Medical Center Physician Hospital Consortium (PHC) health network through December 31, 2018, is a budgeted item with no additional fiscal impact.

The proposed transition of CHDP services from CalOptima to health networks is expected to increase CalOptima's total CHDP costs by $4.1 million annually. The increased costs are primarily due to two factors: (1) the application of the contracted CalOptima Direct/CalOptima Community Network Medi-Cal fee schedule for primary care physician services and (2) the application of an administration load to reimburse health networks for increased claims adjudication and management costs. CalOptima will incorporate funding for CHDP services that are currently paid on a FFS basis into an equivalent capitation rate to delegated Health Networks. Management has included expenses associated with the recommended CHDP actions in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval.

Disbursement of Proposition 56 funds is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the program.

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Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in PHC responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

35. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Physician Contracts for CHOC Physicians Network and Children's Hospital of Orange County

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to enter into contract amendments for the Physician Hospital Consortium (PHC) health network contracts, with the assistance of Legal Counsel, for CHOC Physicians Network, and Children's Hospital of Orange County to:

1. Extend contracts through December 31, 2018;
2. Extend the current capitation rates for assigned members effective July 1, 2018, through December 31, 2018;
3. To reflect change in Child Health and Disability Prevention Program responsibilities and rates to the extent authorized by the Board of Directors in a separate Board action;
4. Reflect the responsibilities of the health networks to pay individual providers Proposition 56 appropriated funds and to compensate the health networks an administrative fee for performance of these responsibilities to the extent authorized by the Board in a separate action; and
5. Amend the contract terms to reflect applicable regulatory changes and other requirements.

Background

CalOptima's current Medi-Cal PHC health network physician contracts were amended July 1, 2016 to extend the contracts through December 2016. In November 2016, the Medi-Cal PHC health network contracts were amended to extend the contracts through June 30, 2017. In June of 2017, the contracts were extended through June 30, 2018.

In support of Medi-Cal Expansion (MCE), the Board on November 7, 2013 approved the distribution of enhanced federal funding received from the Department of Health Care Services (DHCS), to the health networks. CalOptima, to maintain the higher funding level for MCE members, was required to demonstrate a Medical Loss Ratio (MLR) of eighty-five percent (85%) or higher. CalOptima's MLR did not support the continued level of funding established in 2014 and DHCS gradually reduced the level of MCE funding to CalOptima. The Board subsequently approved a reduction in health network capitation rates in a Board action on September 3, 2015.

DHCS further reduced rates for MCE members. As a result, the Board at the May 5, 2016, meeting approved a fifteen percent (15%) decrease in capitation rates for MCE members. Contracts were amended to reflect this decrease, with revised rates effective through June 30, 2017. Subsequently,

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effective July 1, 2017, the Board authorized a twenty-nine percent (29%) reduction in capitated hospital rates; all other MCE rates were extended through June 30, 2018.

The Child Health Disability Prevention (CHDP) Program is a preventive program that delivers periodic health assessments and services to low income children and youth in California. The program helps to prevent or find health problems through regular health check-ups. Since the inception of the program, the Department of Health Services has required providers to bill with California defined procedure codes on a California designated form. CalOptima has retained payment responsibility for payment of CHDP services requiring physicians regardless of health network affiliation, to bill CalOptima directly for all services.

Proposition 56 increased the excise tax rate on cigarettes and tobacco products for the purposes of funding specified expenditures, including increased funding for existing healthcare programs administered by the DHCS. Assembly Bill 120 (Ting, Chapter 22, Statutes of 2017), Section 3, Item 4260-101-3305, appropriates Proposition 56 funds for Fiscal Year (FY) 2017-18, which included a portion of the funds to be paid for specific managed care services.

On May 1, 2018, the DHCS issued an All Plan Letter (APL) which outlines to the managed care plans, how the funds from Proposition 56 are to be distributed to providers. The APL specifies that manage care plans and their subcontractors, will be required to pay individual providers an additional sum for specified services as defined in the APL by 13 Current Procedural Terminology (CPT) codes. The document also specifies the timeframe and reporting requirements for such payments.

Discussion

Extension of the Contract Term: Staff is requesting authority to amend the Medi-Cal PHC contracts for CHOC Physicians Network and Children's Hospital of Orange County to extend the contracts through December 31, 2018.

Medi-Cal Expansion Rates: In April 2018, DHCS released draft capitation rates for CalOptima for FY 2018-19. Staff has reviewed the draft rates and determined that they support the continued payment of existing health network capitation rates, including those associated with the MCE members. The rates associated with the MCE members were to expire on June 30, 2018. Therefore, Staff recommends extending the current rates effective July 1, 2018, through December 31, 2018. This proposal is addressed in Operating Budget presentation and recommended actions.

CHDP: As of January 1, 2018, the State required fee for service providers of CHDP services to comply HIPAA standards for health care electronic transactions and code sets. The transition results in providers billing CHDP services using standard CPT codes and CMS 1500 forms, or their electronic equivalent, and is consistent with the billing of all other services. CalOptima proposes to transition the billing and payment of services using the same methodology, effective July 1, 2018. As this transition streamlines the process of billing and paying for these services, CalOptima proposes to transition the responsibility for payment of CHDP services to the health networks. effective July 1, 2018. Staff requests authority to amend health network contracts to reflect this change.

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Regulatory Changes: In 2016, the Center for Medicare & Medicaid Services (CMS) released a comprehensive revision of the federal Medicaid managed care and Child Health Insurance Program (CHIP) regulations. The intent of the regulations is to align the managed care requirements of Medicaid with those for Medicare. As specified in the contract with DHCS, CalOptima is required to incorporate some of the revised regulations into CalOptima's contracts with providers. Staff requests authority to amend PHC contracts to include the regulatory requirements, as applicable and in accordance with DHCS guidance.

Fiscal Impact

Management has included expenses associated with the extended contracts in the CalOptima FY 2018-19 Operating Budget pending Board approval. Assuming extension of the contracts are under the same terms and conditions for professional and hospital services capitation, with the exception of changes to CHDP and Proposition 56 as addressed in this COBAR, the recommended action to extend CalOptima's PHC physician and hospital contracts for CHOC Physicians Network, and Children's Hospital of Orange County Physician Hospital Consortium (PHC) health network through December 31, 2018 is a budgeted item with no additional fiscal impact.

The proposed transition of CHDP services from CalOptima to health networks is expected to increase CalOptima's total CHDP costs by $4.1 million annually. The increased costs are primarily due to two factors: (1) the application of the contracted CalOptima Direct/CalOptima Community Network Medi-Cal fee schedule for primary care physician services and (2) the application of an administration load to reimburse health networks for increased claims adjudication and management costs. CalOptima will incorporate funding for CHDP services that are currently paid on a FFS basis into an equivalent capitation rate to delegated Health Networks. Management has included expenses associated with the recommended CHDP actions in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval.

Disbursement of Proposition 56 funds is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the program.

Rationale for Recommendation

CalOptima staff recommends these actions to: reflect changes in PHC responsibilities in accordance with the CalOptima delegated model; to maintain and continue the contractual relationship with the provider network; and to fulfill regulatory requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

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

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

36. Consider Authorizing an Amendment to Extend the Coordination and Provision of Public Health Care Services Contract with the Orange County Health Care Agency

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to execute an amendment to the Coordination and Provision of Public Health Care Services Contract with Orange County Health Care Agency (County) to extend the contract for six (6) months, while contract language changes are finalized.

Background

County provides various public health programs to Medi-Cal members, as provided under State law, including various clinical services. CalOptima completed several MOUs beginning in 1996 through 2004, to delineate the roles and responsibilities between CalOptima and County as they relate to coordination of care and payment for certain services, so that full cooperation could be achieved between the two agencies through collaboration, communication, and free exchange of information.

The Coordination and Provision of Public Health Care Services Contract (Contract) was put in place on June 1, 2013, following Board Authority on May 2, 2013, to combine the following MOUs into one contract:

1. Child Health and Disability Prevention Program (CHDP)
2. California Children's Services (CCS)
3. HIV Programs & HIV Clinic Services
4. Immunization Assistance Project (IAP)
5. Juvenile Health Services-Orangewood (JHS-Orangewood)
6. Maternal, Child & Adolescent Health Program (MCAH)
7. Pulmonary Disease Services (PDS)
8. Sexually Transmitted Diseases Clinical Services

The Contract updated coordination of care and payment of services information specific to the certain services provided by County and allowed CalOptima to be in compliance with the California Department of Health Care Services (DHCS) contract in regards to having a contract in place instead of an MOU for health care covered services that are reimbursed by CalOptima.

The Coordination and Provision of Public Health Care Services Contract was amended on July 1, 2015, following Board Authority September 3, 2015, to incorporate coordination of Targeted Case Management requirements as specified by DHCS.

The Contract expires on July 1, 2018.

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Discussion

The six (6) month extension to the Contract will ensure that the roles and responsibilities between CalOptima and County continue to finalize Contract language, including but not limited to:

1. CHDP claim form transition from the PM-160 form to the CMS-1500 or UB-04 forms or electronic equivalent, per DHCS instruction.
2. The January 1, 2019 CCS transition: language revision to indicate that the current CCS language in the contract shall remain in effect through December 31, 2018; to reference the separate CCS MOU between CalOptima and County that will be effective January 1, 2019; and to reflect that authorized CCS services, with the exception of NICU services, are billable to CalOptima beginning January 1, 2019.
3. Comply with Mega Reg requirements that are applicable to this contract.
4. Update billing and payor information to be consistent with the Medi-Cal Matrix of Financial Responsibility in CalOptima's health network contracts to reflect that County is to bill health networks for members assigned to health networks for:
    a. Adult Immunizations
    b. Pediatric Preventative Services (PPS), including PPS services provided at Orangewood

Fiscal Impact

Management has included expenses associated with the extended contract in the proposed CalOptima FY 2018-19 Operating Budget. The recommended action to execute an amendment to the Coordination and Provision of Public Health Care Services Contract with the County is a budgeted item with no additional fiscal impact.

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue CalOptima's contractual relationship with the County, and to comply with DHCS contract requirements.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated May 2, 2013, Consent Calendar VI.A., Authorize the Chief Executive Officer to Execute the "Coordination and Provision of Public Health Care Services Contract" with the Orange County Health Care Agency.
2. Board Action dated September 3, 2015, Report Item VIII.H., Authorize the Chief Executive Officer to Execute an Amendment to Contract with the Orange County Health Care Agency for the Coordination of Targeted Case Management.

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

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 2, 2013
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

VI. A. Authorize the Chief Executive Officer to Execute the "Coordination and Provision of Public Health Care Services Contract" with the Orange County Health Care Agency

Contact

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

Recommended Action

Authorize the Chief Executive Officer (CEO) to execute the "Coordination and Provision of Public Health Care Services Contract" with the Orange County Health Care Agency to replace various existing Memoranda of Understanding.

Background

The Orange County Health Care Agency (HCA) provides various public health programs to Medi-Cal members, as provided under state law, including various clinical services. CalOptima entered into several Memoranda of Understanding (MOUs) between 1996 and 2004 to delineate the roles and responsibilities between CalOptima and HCA as they relate to coordination of care and payment for certain services.

Discussion

While CalOptima and HCA have coordinated operations based on the MOUs over multiple years, DHCS now requires that CalOptima have contracts instead of MOUs in situations in which the other party (i.e., HCA) is a subcontractor to CalOptima. The following eight (8) Medi-Cal MOUs between CalOptima and HCA will be transitioned to the Coordination and Provision of Public Health Care Services Contract:

a. Child Health and Disability Prevention Program (CHDP)
b. California Children's Services (CCS)
c. HIV Programs & HIV Clinic Services
d. Immunization Assistance Project (IAP)
e. Juvenile Health Services-Orangewood (JHS-Orangewood)
f. Maternal, Child & Adolescent Health Program (MCAH)
g. Pulmonary Disease Services (PDS)
h. Sexually Transmitted Diseases Clinical Services

Fiscal Impact

No material fiscal impact is anticipated from the proposed action.

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Rationale for Recommendation
CalOptima staff recommends approval of the proposed action to maintain continued streamlined coordination of delivery of services with HCA consistent with DHCS requirements.

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

Attachments
None

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

4/26/2013 — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
VIII. H. Authorize the Chief Executive Officer to Execute an Amendment to Contract with the Orange County Health Care Agency for the Coordination of Targeted Case Management

Contact
Terrie Stanley, Executive Director Clinical Operations, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend the Coordination and Provision of Public Health Care Services Contract with the Orange County Health Care Agency (OCHCA) to incorporate the coordination of Targeted Case Management (TCM).

Background
On May 2, 2013, the CalOptima Board authorized execution of the "Coordination and Provision of Public Health Care Services Contract" with the OCHCA to replace various existing Memorandums of Understanding (MOU). The effective date of that contract was June 1, 2013.

California's "Bridge to Reform" Section 1115 Medicaid Demonstration Waiver and the related Medi-Cal Managed Care Expansion requires broader responsibility for care coordination and case management services for beneficiaries by Managed Care Plans (MCP), including CalOptima. This includes coordination and referral of resources for client social support issues. In order to implement a collaborative approach regarding TCM services, the Department of Health Care Services (DHCS) is requiring Local Government Agencies (LGAs) in all Medi-Cal Managed Care counties (including the Orange County Health Care Agency) to enter into MOUs or agreements/amendments with the respective managed care plans. To meet these requirements, DHCS's required provisions must be included in CalOptima's current "Coordination and Provision of Public Health Care Services Contract" with the OCHCA. The proposed amendment will serve to define the respective responsibilities and necessary coordination between the two agencies.

Discussion
DHCS has developed protocols for this coordination. Both CalOptima and the OCHCA's TCM programs are required to comply with Health Insurance Portability and Accountability Act (HIPPA) requirements when sharing medical information. Both agencies will pursue obtaining HIPAA authorization from members and/or clients to allow sharing of medical information. To facilitate this coordination, DHCS will provide electronic information identifying CalOptima members receiving TCM within the last three months.

Case management is defined in the Code of Federal Regulations (CFR). While both CalOptima and OCHCA TCM programs provide case management, there is a distinction between the types of services each must provide.

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CalOptima's TCM program primarily focuses on client medical needs in providing case management as the primary provider of client medical care. This may include management of acute or chronic illness. These services include: (1) coordination of care, (2) medical referrals, (3) continuity of care, (4) follow-up on missed appointments, and (5) communication with specialists.

OCHCA TCM program does not manage illness and are not providers of medical services and case management does not include the direct delivery of underlying medical, social, educational, or other services to which an individual has been referred.

CalOptima will partner with OCHCA to ensure that members receive the appropriate level of case management services. Responsibilities include:

- Oversee the delivery of primary health care and related care coordination
- Be responsible for providing all covered health care identified in the care plan including:
  - Medical education that may be needed
  - Any necessary medical referral authorizations
- Handle medical issues as well as medical referrals and linkages to covered health services will be the responsibility
- Provide members with linkage and care coordination for any identified social support needs identified that do not rise to the level of needing care management
- Refer clients to OCHCA TCM for any necessary case management of non-medical needs identified
- Provide health assessments and care plans for all members as needed.

OCHCA TCM Program will:

- Provide TCM services for medical, social, educational, and other services needing case management
- Refer members with open TCM cases to CalOptima for medical needs when identified by the TCM case manager
- Provide TCM Program services to clients who require services which will assist them in gaining access to needed medical, social, educational or other services per Title 42 CFT Section 440-169.

For members needing immediate case manager intervention, the OC HCA TCM case manager provides all necessary assessments, care plans as appropriate, medical or otherwise, to address the member's immediate medical need, apprising CalOptima as soon as possible.

Fiscal Impact

The recommended action to amend the Coordination and Provision of Public Health Care Services Contract with the OCHCA to incorporate the coordination of TCM is budget neutral to CalOptima.

Rationale for Recommendation

The recommendation to amend the Coordination and Provision of Public Health Care Services Contract with the OCHCA to incorporate the coordination of TCM will ensure that CalOptima is compliant with DHCS's requirements for TCM.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

8/28/2015 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

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

Contact
Ladan Khamseh, Chief Operations Officer, (714) 246-8400

Recommended Action
Adopt Resolution Approving CalOptima's Updated Human Resources Policies: GA.8038 Personal Leave of Absence; GA.8039 Pregnancy Disability Leave of Absence; GA.8040 FMLA and CFRA Leaves of Absence; GA.8041 Worker's Compensation Leave of Absence; GA.8042 Supplemental Compensation and GA.8057 Compensation Program.

Background/Discussion
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.

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

	Policy No./Name	Summary of Changes	Reason for Change
1.	GA.8038 Personal Leave of Absence	• Minor language and formatting changes • Added specificity to language to improve clarification of employee responsibility and timelines. • Update the language regarding status of job position. • Updated employee and HR procedures. • Clarified requirements if a Personal LOA is requested as a reasonable accommodation under the ADA. • Revised definitions consistent with HR policies	• Annual review with minor updates and formatting changes • Clarify expectations and responsibilities • Align with current process • Need to update new terms, definitions and/or revised definitions
2.	GA.8039 Pregnancy Disability Leave of Absence	• Minor language and formatting changes • Updated new CCR codes	• Annual review with minor updates and formatting changes

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	Policy No./Name	Summary of Changes	Reason for Change
		• Revised forms – added additional fields	• Regulatory changes •
3.	GA.8040 FMLA and CFRA Leaves of Absence	• Minor language and formatting changes • Updated new CCR code	• Annual review with minor updates and formatting changes • Regulatory changes
4.	GA.8041 Worker's Compensation Leave of Absence	• Minor language and formatting changes • Added specificity to language to improve clarification of employee responsibilities, including, but not limited to completion of all required forms • Added language regarding Workers' Compensation fraud • Revised scope of responsibility for accommodations and return to work program • Updated attachments	• Annual review with minor updates and formatting changes • Clarify expectations and responsibilities • Plans to adopt return to work program • Replaced older versions of attachments with new versions from ca.gov
5.	GA.8042 Supplemental Compensation	• Revised eligibility requirement and sales incentive dollar amount • Revised sales incentive dollar amount for the manager of the department	• Provider Relations Department changed the incentive structure to remain within budget and create efficiencies with the administration of the sales incentive program
6.	GA.8057 Compensation Program	• Revised Compensation Guidelines attachment to delegate authority to the CEO to approve market adjustments when a recommended change is within the approved pay range for a position as designated in the Board-approved Salary Schedule. Such adjustments shall be reported to the Board.	• Minimize individual market adjustment requests brought to Board of Directors for approval

Specific to the recommended changes to GA.8042, Supplemental Compensation, since the inception of the OneCare and OneCare Connect programs, there has been a sales team and a sales incentive program. The incentive payouts for OneCare / OneCare Connect are monitored on a monthly basis and forecasts project the need to make adjustments to the incentive schedule to remain budget neutral, as approved by the Board.

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Telephonic enrollment into OneCare / OneCare Connect has become the preferred method of enrolling members into the program, as it reduces costs associated with travel and time spent driving to and from appointments. The number of members enrolled by the sales team each month is increasing due in part to use of telephonic enrollment. At the beginning of 2017, the monthly average enrollment for a sales team member was 30 enrollments each month. By the end of 2017 the average had increased to 40 enrollments. With telephonic enrollment, the average enrollment is forecasted to be approximately forty-five each month for each sales team member. Due to the increase in enrollments, management is requesting approval to change the OneCare and OneCare Connect sales incentive structure to remain budget neutral and create efficiencies with the administration of the program. Details of the proposed changes to the sales incentive compensation structure are redlined in the in the attached policy GA.8042. These changes, which include raising the minimum number of monthly sales required to receive commission to 30 and provide increasing commissions per sale as the volume achieved increases above that level, are intended to align incentives and boost OneCare and OneCare Connect enrollments.

Fiscal Impact

Funding for the revisions to CalOptima Policy GA.8042: Supplemental Compensation is a budgeted item under the Fiscal Year 2018-19 Operating Budget pending Board approval. The other policy changes are not anticipated to have a fiscal impact.

Rationale for Recommendation

Approval is recommended to the updated Human Resources Policies to ensure that CalOptima meets its ongoing obligation to provide structure and clarity on employment matters, consistent with applicable federal, state, and local laws and regulations.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 18-0607-02, Approve Revised CalOptima Human Resources Policies
2. Revised CalOptima Policies:
    a. GA.8038 Personal Leave of Absence (redlined and clean copies) with Revised Attachment A
    b. GA.8039 Pregnancy Disability Leave of Absence (redlined and clean copies) with Revised Attachment A
    c. GA.8040 FMLA and CFRA Leaves of Absence (redlined and clean copies) with Revised Attachment A
    d. GA.8041 Worker's Compensation Leave of Absence (redlined and clean copies) with Revised Attachment A-D
    e. GA.8042 Supplemental Compensation (redlined and clean copies) – with Revised Attachment B
    f. GA.8057 Compensation Guidelines (redlined and clean copies) with Revised Attachment A

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

5/30/2018 — **Date**

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RESOLUTION NO. 18-0607-02

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

APPROVE UPDATED HUMAN RESOURCES POLICIES

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

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

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policies: GA.8038 Personal Leave of Absence; GA.8039 Pregnancy Disability Leave of Absence; GA.8040 FMLA and CFRA Leaves of Absence; GA.8041 Worker's Compensation Leave of Absence; GA.8042 Supplemental Compensation; and GA.8057 Compensation Program.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 7th day of June 2018.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

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

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Policy #:	GA.8038
Title:	**Personal Leave of Absence**
Department:	Human Resources
Section:	Not Applicable

CEO Approval:	Michael Schrader		
Effective Date:	~~1/5~~01/05/1	~~Revised~~	~~2/1/14~~
Last Review Date:	2	~~Date:~~	
Last Revised Date:	06/07/18		
	06/07/18		

I. PURPOSE

To outline CalOptima's Leave of Absence (LOA) policy for Personal Leave.

II. POLICY

A. Eligibility: All full-time and part-time employees are eligible to request a Personal Leave of Absence (LOA).

B. General Provisions: CalOptima may grant a Personal LOA~~, without pay,~~ for reasons other than leaves ~~as~~ described in CalOptima Policy GA.8037: Leave of Absence, for a reasonable period of time of up to a total of ninety (90) days per twelve (12) month period. Personal LOAs are entirely dependent on CalOptima's discretion and are only approved when it is determined by the employee's management, in coordination with Human Resources, that granting the leave will not unduly interfere with CalOptima's operations. Requests for Personal LOAs are considered on the basis of responsibility level, the reason for the request, whether other individuals are already out on leave, and the expected impact or potential hardship of the leave on the employer.

C. Expired Leave of Absence: If an employee exhausts all permitted LOAs pursuant to CalOptima Policy ~~#:~~ GA.8037: Leave of Absence, but is not ready to return to work, the employee may request a Personal LOA to extend his or her time away from work. It is the employee's responsibility to request a Personal LOA and provide sufficient documentation in a timely manner prior to the date the employee is scheduled to return to work. CalOptima will consider the request in accordance with this policy. Once an employee exhausts all permitted LOAs pursuant to CalOptima Policy ~~#:~~ GA.8037: Leave of Absence, his or her position is no longer considered protected unless otherwise required by applicable laws. Failure to request a Personal LOA to extend an employee's time away from work and failure to report to work following a permitted LOA shall be considered as the employee's voluntary resignation of his or her position. Reinstatement may be considered in special circumstances where a timely request or return to work may not feasible.

D. Other Provisions:

~~1. CalOptima will consider additional Personal LOA requests pursuant to the requirements of Americans with Disabilities Act (ADA), where applicable.~~

1. Personal LOA requests related to an employee's qualifying disability under the Americans with Disabilities Act (ADA) will be handled pursuant to the requirements of ADA, where applicable. Human Resources will require timely submission of adequate medical documentation and

engage in the interactive process to work with the employee and the employee's management to determine whether a Personal LOA is a reasonable accommodation based on individual circumstances, whether there are alternative reasonable accommodations that might be effective and enable the employee to perform the essential functions of his or her job, and/or whether the Personal LOA will create undue hardship.

2. An employee must use Paid Time Off (PTO) during the Personal LOA unless the employee is receiving disability payments or CalOptima grants special approval. ~~However, the~~ Once the employee's PTO has been exhausted, all remaining time off during the approved Personal LOA will be unpaid. The use of ~~such~~ PTO will not adjust the start date of the Personal LOA, so time covered by PTO will still count as part of the Personal LOA.

3. An employee must request the Personal LOA at least thirty (30) calendar days in advance, except in cases of emergency, wherein, the employee has five (5) calendar days, commencing from the start of the Personal LOA, to submit the request, along with any supporting documentation to HR. Limited exceptions to this requirement will be evaluated and considered on a case-by-case basis, with consideration based on the nature of the request and the circumstances surrounding any delay.

4. Except where required by law, CalOptima does not guarantee that an employee's position will remain vacant while the employee is on an approved Personal LOA. CalOptima may fill the employee's position for business reasons or where undue hardship results from the employee's Personal LOA.

5. If an employee's position is filled while he or she is on an approved Personal LOA for reasons other than disability, the employee may~~,~~ be terminated, and at the conclusion of his or her scheduled leave, the employee may apply for any open position for which he or she is qualified at CalOptima. However, ~~if~~there is no such guarantee that a position ~~is available, employment~~for which the employee is qualified will be ~~terminated.~~available or that the employee will be placed in that open position. If the employee was on Personal LOA due to a ~~medical reason or~~qualifying disability, and his or her position was filled while on leave as a result of undue hardship, CalOptima may reassign the employee to the next suitable position ~~that becomes~~for which the employee is qualified, if such a position is available ~~for which the employee is qualified~~.

6. If an employee's position is not filled during his or her Personal LOA, the employee is expected to return to work at the scheduled conclusion of his or her Personal LOA. If an employee fails to do so, CalOptima will treat the employee as having voluntarily resigned from his or her employment with CalOptima.

7. Status of Employee Benefits during Personal Leave: After an employee exhausts all PTO accruals, CalOptima will not pay for group health insurance premiums during any remaining portion of a Personal LOA. The employee is fully responsible for the employer share and employee share of health insurance premiums during the remaining portion of the Personal LOA. In order to ensure continuation of coverage, an employee must timely pay premiums for the period of the Personal LOA and coordinate the payments through the Human Resources (HR) Department. Failure to pay premiums in a timely manner will result in immediate termination of coverage through the remainder of the Personal LOA. However, reinstatement of coverage will occur on the first (1st) day of the month following the date the employee returns

to work. All other benefits not specified herein provided by CalOptima shall be administered according to HR procedures.

8. To the extent that this policy conflicts with CalOptima Policies GA.8029: Jury Service, GA.~~8038: Personal~~8037: Leave of Absence, ~~-~~GA.8039: Pregnancy Disability Leave or GA.8040: Family and Medical Leave Act and California Family Rights Act Leaves of Absence, those specific policies shall supersede. To the extent this policy conflicts with the CalOptima Employee Handbook, this policy shall supersede.

III. PROCEDURE

Responsible Party	Action
Employee	1. Request a Personal LOA at least thirty (30) calendar days in advance, except in emergencies, wherein, the employee has five (5) calendar days, commencing from the start of the Personal LOA, by completing the Leave of Absence Request Form and submitting it, along with all supporting documentation, to HR. 2. Coordinate health insurance premium payments with HR, if applicable. 3. Return to work on the agreed upon return to work date if employee's position is still available.
Human Resources	1. Process appropriate forms with employee. 2. Help the employee with a plan to transition back to work, when applicable. 3. Discuss requests for Personal LOAs with the employee's management to evaluate and determine if a request for Personal LOA can be granted, if there is an impact to the department, and/or if there is/are undue hardship(s) that will arise. 4. Work closely with the employee's management to determine if there is/are alternative reasonable accommodation(s) that might be effective in allowing an employee to return to work, rather than take a Personal LOA, if applicable. ~~2.~~5. Maintain regular contact with the employee and the employee's management while the employee is on his or her Personal LOA.

IV. ATTACHMENTS

A. Leave of Absence Request Form

~~V. DEFINITIONS~~

~~Not Applicable~~

~~VI.~~V. REFERENCES

A. CalOptima Policy GA.8029: Jury Service
B. CalOptima Policy GA.8037: Leave of Absence
C. CalOptima Policy GA.8039: Pregnancy Disability Leave

D. CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act ~~Leave~~Leaves of Absence
E. CalOptima Employee Handbook

VI. REGULATORY APPROVALS ~~OR~~

None to Date

VII. BOARD ACTION

A. ~~5/1/14~~06/07/18: Regular Meeting of the CalOptima Board ~~Meeting~~of Directors
B. ~~1/5/12: 05/01/14:~~ Regular Meeting of the CalOptima Board ~~Meeting~~of Directors

C. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

~~A. 2/1/14: GA.8038: Discretionary Leave of Absence~~
~~B. 1/5/12: GA.8038: Discretionary Leave of Absence~~

~~IX. KEYWORDS~~

~~California Family Rights Act (CFRA)~~
~~Disability~~
~~Family and Medical Leave Act (FMLA)~~
~~Paid Time Off~~
~~Physician Certification~~

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8038	Discretionary Leave of Absence	Administrative
Revised	02/01/2014	GA.8038	Personal Leave of Absence	Administrative
Revised	06/07/2018	GA.8038	Personal Leave of Absence	Administrative

IX. GLOSSARY

Term	Definition
Leave of Absence	For purposes of this policy, a term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.

CalOptima
A Public Agency
Better. Together.

LEAVE OF ABSENCE REQUEST FORM

SECTION I – EMPLOYEE'S STATEMENT Contact Phone Number: _____

Employee Name: _____ Employee ID #: _____

Mailing Address: ---------- Email Address: ------ ----------

Department: _____ Position: _____

Requested dates of absence: First day off work____/___/____ Expected Return Date:____/____/____

~~I~~ _____ **–Is Illness/Injury Work Related?**

☐ Yes ☐ No

REASON FOR LEAVE

☐ **Employee Medical (FMLA/CFRA)** - Attach Medical Certification

☐ **Pregnancy Disability (PDL)** - Attach Medical Certification

☐ **Family Medical (FMLA/CFRA) -** Attach Medical Certification

☐ **Military Leave (FMLA or Spouse Leave)** - Attach Supporting Documentation

☐ ***Baby Bonding** (within 1 year of birth or placement of adoption/foster care)

☐ **Personal Leave -** Attach Supporting Documentation

☐ **Other -** (Attach Supporting Documentation)

Note: Additional documentation regarding types of leaves of absence can be found on the Human Resources page of the ~~Infonet~~InfoNet.

EXPLANATION: _____

(FOR UNPAID LEAVE REQUESTS) To continue employee paid Health Insurance you should contact Human Resources to make arrangements for payment in advance

Employee's Signature: _____ Date:____/____/____

SECTION II – MANAGER OR DIRECTOR ACKNOWLEDGMENT (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)
~~REVIEW (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)~~

~~Recommend Approval ☐ Recommend Modification as follows: _____~~

~~☐ Recommend Denial (Reason): _____~~
~~**Manager/Director Signature:** _____ Date: ____/___/____~~

Manager/Director Signature: _____ Date: ____/____/____

HUMAN RESOURCES USE ONLY

SECTION III – HUMAN RESOURCES REVIEW

You are ☐ eligible ☐ not eligible for leave under the FMLA/CFRA. FMLA/CFRA Hours Balance Available _____

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Last Day Worked _____ Return from Leave Date _____

Human Resources Signature: _____ Date:_____/____/____

COMMENTS_____

_____

Rev: ~~02200906~~2018

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Policy #: GA.8038
Title: **Personal Leave of Absence**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader
Effective Date: 01/05/12
Last Review Date: 06/07/18
Last Revised Date: 06/07/18

I. PURPOSE

To outline CalOptima's Leave of Absence (LOA) policy for Personal Leave.

II. POLICY

A. Eligibility: All full-time and part-time employees are eligible to request a Personal Leave of Absence (LOA).

B. General Provisions: CalOptima may grant a Personal LOA for reasons other than leaves described in CalOptima Policy GA.8037: Leave of Absence, for a reasonable period of time of up to a total of ninety (90) days per twelve (12) month period. Personal LOAs are entirely dependent on CalOptima's discretion and are only approved when it is determined by the employee's management, in coordination with Human Resources, that granting the leave will not unduly interfere with CalOptima's operations. Requests for Personal LOAs are considered on the basis of responsibility level, the reason for the request, whether other individuals are already out on leave, and the expected impact or potential hardship of the leave on the employer.

C. Expired Leave of Absence: If an employee exhausts all permitted LOAs pursuant to CalOptima Policy GA.8037: Leave of Absence, but is not ready to return to work, the employee may request a Personal LOA to extend his or her time away from work. It is the employee's responsibility to request a Personal LOA and provide sufficient documentation in a timely manner prior to the date the employee is scheduled to return to work. CalOptima will consider the request in accordance with this policy. Once an employee exhausts all permitted LOAs pursuant to CalOptima Policy GA.8037: Leave of Absence, his or her position is no longer considered protected unless otherwise required by applicable laws. Failure to request a Personal LOA to extend an employee's time away from work and failure to report to work following a permitted LOA shall be considered as the employee's voluntary resignation of his or her position. Reinstatement may be considered in special circumstances where a timely request or return to work may not feasible.

D. Other Provisions:

1. Personal LOA requests related to an employee's qualifying disability under the Americans with Disabilities Act (ADA) will be handled pursuant to the requirements of ADA, where applicable. Human Resources will require timely submission of adequate medical documentation and engage in the interactive process to work with the employee and the employee's management to determine whether a Personal LOA is a reasonable accommodation based on individual circumstances, whether there are alternative reasonable accommodations that might be effective and enable the employee to perform the essential functions of his or her job, and/or whether the Personal LOA will create undue hardship.

2. An employee must use Paid Time Off (PTO) during the Personal LOA unless the employee is receiving disability payments or CalOptima grants special approval. Once the employee's PTO has been exhausted, all remaining time off during the approved Personal LOA will be unpaid. The use of PTO will not adjust the start date of the Personal LOA, so time covered by PTO will still count as part of the Personal LOA.

3. An employee must request the Personal LOA at least thirty (30) calendar days in advance, except in cases of emergency, wherein, the employee has five (5) calendar days, commencing from the start of the Personal LOA, to submit the request, along with any supporting documentation to HR. Limited exceptions to this requirement will be evaluated and considered on a case-by-case basis, with consideration based on the nature of the request and the circumstances surrounding any delay.

4. Except where required by law, CalOptima does not guarantee that an employee's position will remain vacant while the employee is on an approved Personal LOA. CalOptima may fill the employee's position for business reasons or where undue hardship results from the employee's Personal LOA.

5. If an employee's position is filled while he or she is on an approved Personal LOA for reasons other than disability, the employee may be terminated, and at the conclusion of his or her scheduled leave, the employee may apply for any open position for which he or she is qualified at CalOptima. However, there is no such guarantee that a position for which the employee is qualified will be available or that the employee will be placed in that open position. If the employee was on Personal LOA due to a qualifying disability, and his or her position was filled while on leave as a result of undue hardship, CalOptima may reassign the employee to the next suitable position for which the employee is qualified, if such a position is available.

6. If an employee's position is not filled during his or her Personal LOA, the employee is expected to return to work at the scheduled conclusion of his or her Personal LOA. If an employee fails to do so, CalOptima will treat the employee as having voluntarily resigned from his or her employment with CalOptima.

7. Status of Employee Benefits during Personal Leave: After an employee exhausts all PTO accruals, CalOptima will not pay for group health insurance premiums during any remaining portion of a Personal LOA. The employee is fully responsible for the employer share and employee share of health insurance premiums during the remaining portion of the Personal LOA. In order to ensure continuation of coverage, an employee must timely pay premiums for the period of the Personal LOA and coordinate the payments through the Human Resources (HR) Department. Failure to pay premiums in a timely manner will result in immediate termination of coverage through the remainder of the Personal LOA. However, reinstatement of coverage will occur on the first (1st) day of the month following the date the employee returns to work. All other benefits not specified herein provided by CalOptima shall be administered according to HR procedures.

8. To the extent that this policy conflicts with CalOptima Policies GA.8029: Jury Service, GA.8037: Leave of Absence,GA.8039: Pregnancy Disability Leave or GA.8040: Family and Medical Leave Act and California Family Rights Act Leaves of Absence, those specific policies shall supersede. To the extent this policy conflicts with the CalOptima Employee Handbook, this policy shall supersede.

III. PROCEDURE

Responsible Party	Action
Employee	1. Request a Personal LOA at least thirty (30) calendar days in advance, except in emergencies, wherein, the employee has five (5) calendar days, commencing from the start of the Personal LOA, by completing the Leave of Absence Request Form and submitting it, along with all supporting documentation, to HR. 2. Coordinate health insurance premium payments with HR, if applicable. 3. Return to work on the agreed upon return to work date if employee's position is still available.
Human Resources	1. Process appropriate forms with employee. 2. Help the employee with a plan to transition back to work, when applicable. 3. Discuss requests for Personal LOAs with the employee's management to evaluate and determine if a request for Personal LOA can be granted, if there is an impact to the department, and/or if there is/are undue hardship(s) that will arise. 4. Work closely with the employee's management to determine if there is/are alternative reasonable accommodation(s) that might be effective in allowing an employee to return to work, rather than take a Personal LOA, if applicable. 5. Maintain regular contact with the employee and the employee's management while the employee is on his or her Personal LOA.

IV. ATTACHMENTS

A. Leave of Absence Request Form

V. REFERENCES

A. CalOptima Policy GA.8029: Jury Service
B. CalOptima Policy GA.8037: Leave of Absence
C. CalOptima Policy GA.8039: Pregnancy Disability Leave
D. CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leaves of Absence
E. CalOptima Employee Handbook

VI. REGULATORY APPROVALS

None to Date

VII. BOARD ACTION

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors
B. 05/01/14: Regular Meeting of the CalOptima Board of Directors
C. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8038	Discretionary Leave of Absence	Administrative
Revised	02/01/2014	GA.8038	Personal Leave of Absence	Administrative
Revised	06/07/2018	GA.8038	Personal Leave of Absence	Administrative

IX. GLOSSARY

Term	Definition
Leave of Absence	For purposes of this policy, a term used to describe an authorized period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.

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LEAVE OF ABSENCE REQUEST FORM

SECTION I – EMPLOYEE'S STATEMENT Contact Phone Number:_____

Employee Name: _____ Employee ID #: _____

Mailing Address: ---------- Email Address: ------__----------

Department: _____ Position: _____

Requested dates of absence: First day off work____/___/____ Expected Return Date:____/____/____

Is Illness/Injury Work Related?

☐ Yes ☐ No

REASON FOR LEAVE

☐ **Employee Medical (FMLA/CFRA)** - Attach Medical Certification

☐ **Pregnancy Disability (PDL)** - Attach Medical Certification

☐ **Family Medical (FMLA/CFRA) -** Attach Medical Certification

☐ **Military Leave (FMLA or Spouse Leave)** - Attach Supporting Documentation

☐ ***Baby Bonding** (within 1 year of birth or placement of adoption/foster care)

☐ **Personal Leave -** Attach Supporting Documentation

☐ **Other** - _____ (Attach Supporting Documentation)

Note: Additional documentation regarding types of leaves of absence can be found on the Human Resources page of the InfoNet.

EXPLANATION: _____

(FOR UNPAID LEAVE REQUESTS) To continue employee paid Health Insurance you should contact Human Resources to make arrangements for payment in advance

Employee's Signature: _____ Date:____/____/____

SECTION II – MANAGER OR DIRECTOR ACKNOWLEDGMENT (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)

Manager/Director Signature: _____ Date:____/___/____

HUMAN RESOURCES USE ONLY

SECTION III – HUMAN RESOURCES REVIEW

You are ☐ eligible ☐ not eligible for leave under the FMLA/CFRA. FMLA/CFRA Hours Balance Available _____

Last Day Worked _____ Return from Leave Date _____

Human Resources Signature: _____ Date:____/____/____

COMMENTS_____

Back to Agenda

Policy #:	GA.8039
Title:	**Pregnancy Disability Leave of Absence**
Department:	Human Resources
Section:	Not Applicable

CEO Approval:	Michael Schrader		
Effective Date:	~~1/5~~01/05/	~~Revised~~	~~2/1/14~~
Last Review Date:	12	~~Date:~~	
Last Revised Date:	06/07/18		
	06/07/18		

I. PURPOSE

To outline the Pregnancy Disability Leave available to eligible employees.

~~II. DEFINITIONS~~

~~Pregnancy Disability Leave (PDL): Any leave, whether paid or unpaid, taken by an employee for any period(s) during which she is disabled by pregnancy.~~

~~III.~~II. POLICY

A. Eligibility: Under the California Fair Employment and Housing Act (FEHA), employees who are disabled by pregnancy, childbirth or a related medical condition are eligible to take a pregnancy disability leave.

B. General provisions:

1. Pregnancy Disability Leave of Absence (PDL) is for any reasonable period or intermittent periods of disability caused by an employee's pregnancy, childbirth or a related medical condition for up to four (4) months, as described further below.

2. A "four (4) month" leave shall be calculated as described in and consistent with Title 2 of the California Code of Regulations, section ~~7291.9~~11042. Specifically, an employee is entitled to the number of days or hours the employee would normally work within four calendar months (or 17 ⅓ weeks). For a full time employee who normally works 40 hours per week, "four months" is calculated as 693 hours of leave entitlement (40 hours/week x 17⅓ weeks). For employees who work more or less than 40 hours per week, or who work on variable work schedules, the number of working days that constitutes four months is calculated on a pro rata or proportional basis. For example, an employee who works 20 hours per week would qualify for 346.5 hours of leave entitlement (20 hours/week x 17⅓ weeks) or an employee who normally works 48 hours per week would qualify for 832 hours of leave entitlement (48 hours/week x 17⅓ weeks). Employees are eligible for up to four months leave per pregnancy, not per year.

3. An employee does not have to take PDL in one (1) continuous period of time~~,~~ but may take PDL on an as-needed intermittent basis. Taking intermittent PDL or a reduced work schedule throughout an employee's pregnancy will affect the number of PDL hours remaining that an employee is entitled to take leading up to and after childbirth.

4. An employee may request to use any accumulated Paid Time Off (PTO) during the PDL. However, the use of such PTO will not adjust the start date of the leave. The time covered by PTO will still count as part of the required leave. Any portion of a PDL that occurs with or without the use of PTO will count against the total hours of PDL entitlement. Once PTO accruals have been exhausted, all remaining time off shall be without pay~~.~~ with the exception of any qualifying disability pay.

5. Returning to Work: An employee returning from a PDL must obtain a release to return to work from her health care provider stating that she is able to resume her original job or duties.

6. An employee may request to extend the PDL from the Human Resources (HR) Department and will receive authorization as long as the employee continues to be disabled and the total PDL per pregnancy does not exceed four (4) months. The employee may need to present an additional physician's certification.

7. As provided in Title 2 of the California Code of Regulations section ~~7291.14~~11047, in the event an employee has exhausted her four month leave under the PDL, an employee who has a physical or mental disability (which may or may not be due to pregnancy, childbirth, or related medical conditions) may be entitled to reasonable accommodation(s) under Government Code section 12940. CalOptima will engage in an interactive process using the standards provided in the disability regulations (Title 2 of the California Code of Regulations section ~~7293.5~~11064 *et seq.*) to determine effective reasonable accommodations, if any, that will not impose an undue hardship on CalOptima (Government Code section 12940(m) and (n)). Where an employee has exhausted her four month leave under the PDL prior to the birth of her child and her health care provider determines that a continuation of the leave is medically necessary, CalOptima may, as a reasonable accommodation that will not impose an undue hardship on CalOptima, allow an employee eligible for CFRA to utilize the CFRA leave prior to the birth of her child (Title 2 of the California Code of Regulations section ~~7291.13, subdivision (c)(2)).~~10046).

8. If an eligible employee wishes to stay home to care for her newborn after her PDL ends, she must apply for a leave of absence (LOA) under the Family and Medical Leave Act (FMLA) or California Family Rights Act (CFRA), as described in CalOptima Policy~~#:~~ GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, at least thirty (30) calendar days before the date the leave will begin, if the need for the leave is foreseeable. If the need is not foreseeable, the employee must provide as much advance notice as practicable.

9. An employee requesting PDL shall provide timely oral or written notice sufficient to make CalOptima aware that the employee needs PDL, and where practicable, the anticipated timing and duration of the PDL. If the PDL is foreseeable, an employee must provide CalOptima at least thirty (30) calendar days advance notice before the start of the PDL. If thirty (30) calendar days advance notice is not practicable, because it is not known when the PDL will be required to begin, or because of a change in circumstances, a medical emergency, or other good cause, notice must be given to CalOptima as soon as practicable.

10. CalOptima shall respond to the PDL request as soon as practicable, and, in no event, later than ten (10) calendar days after receiving the PDL request and shall attempt to respond to the leave request before the date the leave is due to begin as required pursuant to Title 2 of the California Code of Regulations section ~~7291.17~~11050(a)(5). Once given, approval shall be deemed retroactive to the date of the first day of the leave.

11. As a condition of granting the PDL, employees will be required to obtain a medical certification from their health care provider. The certification should include the following information:

    a. The date on which the employee becomes disabled because of pregnancy;

    b. The expected duration of the period or periods of PDL; and

    c. A statement that the employee needs to take PDL because she is disabled by pregnancy, childbirth, or a related medical condition.

C. Health benefits for Pregnancy Disability that run concurrently with FMLA or CFRA LOA:

1. During the duration of the PDL (4 months maximum for disability~~) –)~~ and CFRA (12 weeks maximum for baby bonding), if applicable, except for discretionary LOAs as described in CalOptima Policy ~~#:~~ GA. ~~8039: Discretionary~~8038: Personal Leave of Absence, CalOptima will continue to pay the employer's portion of the health benefit premium for the employee as if she continued as an active employee.

2. While an employee is receiving CalOptima payroll checks because she is exhausting her accrued PTO benefits, the employee's health benefits and other insurance premiums will continue to be deducted from the employee's paycheck at the active employee rate. These benefits include medical, dental, vision and employee assistance program benefits.

3. When an employee is no longer receiving a paycheck or the amount is not sufficient to cover the employee's premium costs, the employee must pay the cost of coverage at the active employee rate, by the first (1st) of the month for that month's benefit coverage. The employee should arrange these payments with HR as soon as she anticipates that the paycheck will not cover the employee's share. The first payment may include any portion of the previous month's premium that was not paid through payroll deduction.

4. The employee is responsible for ensuring timely payment. If the payment is more than thirty (30) calendar days late, insurance coverage for unpaid months will be canceled.

5. CalOptima may recover from the employee the premium paid by CalOptima while the employee was on PDL if the conditions described under Title 2 of the California Code of Regulations section ~~7291.11~~11044(c)(3) occur.

D. Upon return to active employment, regardless of whether the employee's coverage was terminated for failure to pay premiums, the employee's coverage for health and other benefits and payroll deductions will be reinstated without processing an Evidence of Insurance (EOI).

E. An employee who exercises her right to take PDL has a right to reinstatement to the same position, or to a comparable position, pursuant to the conditions, restrictions, and exceptions outlined in Title 2 of the California Code of Regulations section ~~7291.10~~11043.

~~IV.~~III. PROCEDURE

Responsible Party	Action
Employee	1. Request a PDL at least thirty (30) calendar days in advance, when practicable, by completing the Leave of Absence Request Form and submitting it to Human Resources. 2. Provide a medical certification from a health care provider to verify the PDL is required and the anticipated duration of the PDL. 3. Request an extension of the PDL in advance. CalOptima may require another medical certification from a health care provider. 4. Return to work on the agreed upon return to work date.
Human Resources	1. Process appropriate forms with employee. 2. Provide the employee a copy of the notice regarding employee's PDL rights and obligations as soon as practicable after the employee tells CalOptima of her pregnancy or when an employee ~~inquires~~inquiries about reasonable accommodation, transfer, or PDL. 3. Respond to PDL requests within 10 days of receipt. 4. Help the employee with a plan to transition back to work, when applicable. 5. Engage in an interactive process with the employee, where applicable.

~~V.~~IV. ATTACHMENTS

A. Leave of Absence Request Form

~~VI.~~V. REFERENCES

A. CalOptima Policy GA.1001: Glossary of Terms
B. CalOptima Policy GA.~~-~~8038: Discretionary Leave of Absence
C. CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence
D. CalOptima Employee Handbook
E. Title 2, California Code of Regulations section ~~7291.2~~11035 *et seq.* (Pregnancy Regulations)
F. Government Code ~~section~~§§ 12940 and 12945
~~G. Government Code section 12940~~

VI. REGULATORY APPROVALS ~~OR~~

None to Date

VII. BOARD ACTION

A. ~~5/1/14:~~ 06/07/18: Regular Meeting of the CalOptima Board ~~Meeting~~of Directors
B. ~~1/5/12:~~ 05/01/14: Regular Meeting of the CalOptima Board ~~Meeting~~of Directors

C. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

~~A. 2/1/14: GA.8039: Pregnancy Disability Leave of Absence~~

~~IX. KEYWORDS~~

~~California Family Rights Act (CFRA)~~
~~Disability~~
~~Family and Medical Leave Act (FMLA)~~
~~Medical Certification~~
~~Pregnancy Disability Leave (PDL)~~

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8039	Pregnancy Disability Leave of Absence	Administrative
Revised	02/01/2014	GA.8039	Pregnancy Disability Leave of Absence	Administrative
Revised	06/07/2018	GA.8039	Pregnancy Disability Leave of Absence	Administrative

IX. GLOSSARY

Term	Definition
Pregnancy Disability Leave (PDL)	Any leave, whether paid or unpaid, taken by an employee for any period(s) during which she is disabled by pregnancy.

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LEAVE OF ABSENCE REQUEST FORM

SECTION I – EMPLOYEE'S STATEMENT Contact Phone Number: _____

Employee Name: _____ Employee ID #: _____

Mailing Address: ---------- Email Address: ------ ----------

Department: _____ Position: _____

Requested dates of absence: First day off work____/___/____ Expected Return Date:____/____/____

~~I~~ _____ **–Is Illness/Injury Work Related?**

☐ Yes ☐ No

REASON FOR LEAVE

☐ **Employee Medical (FMLA/CFRA)** - Attach Medical Certification

☐ **Pregnancy Disability (PDL)** - Attach Medical Certification

☐ **Family Medical (FMLA/CFRA) -** Attach Medical Certification

☐ **Military Leave (FMLA or Spouse Leave)** - Attach Supporting Documentation

☐ ***Baby Bonding** (within 1 year of birth or placement of adoption/foster care)

☐ **Personal Leave -** Attach Supporting Documentation

☐ **Other -** (Attach Supporting Documentation)

Note: Additional documentation regarding types of leaves of absence can be found on the Human Resources page of the ~~Infonet~~InfoNet.

EXPLANATION: _____

(FOR UNPAID LEAVE REQUESTS) To continue employee paid Health Insurance you should contact Human Resources to make arrangements for payment in advance

Employee's Signature: _____ Date:____/____/____

SECTION II – MANAGER OR DIRECTOR ACKNOWLEDGMENT (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)
~~REVIEW (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)~~

~~Recommend Approval ☐ Recommend Modification as follows: _____~~

~~☐ Recommend Denial (Reason): _____~~
~~**Manager/Director Signature:** _____ Date: ____/___/____~~

Manager/Director Signature: _____ Date: ____/____/____

HUMAN RESOURCES USE ONLY

SECTION III – HUMAN RESOURCES REVIEW

You are ☐ eligible ☐ not eligible for leave under the FMLA/CFRA. FMLA/CFRA Hours Balance Available _____

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Last Day Worked _____ Return from Leave Date _____

Human Resources Signature: _____ Date:_____/____/____

COMMENTS_____

_____

Rev: ~~02200906~~2018

Back to Agenda

Policy #: GA.8039
Title: **Pregnancy Disability Leave of Absence**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader
Effective Date: 01/05/12
Last Review Date: 06/07/18
Last Revised Date: 06/07/18

I. PURPOSE

To outline the Pregnancy Disability Leave available to eligible employees.

II. POLICY

A. Eligibility: Under the California Fair Employment and Housing Act (FEHA), employees who are disabled by pregnancy, childbirth or a related medical condition are eligible to take a pregnancy disability leave.

B. General provisions:

1. Pregnancy Disability Leave of Absence (PDL) is for any reasonable period or intermittent periods of disability caused by an employee's pregnancy, childbirth or a related medical condition for up to four (4) months, as described further below.

2. A "four (4) month" leave shall be calculated as described in and consistent with Title 2 of the California Code of Regulations, section 11042. Specifically, an employee is entitled to the number of days or hours the employee would normally work within four calendar months (or 17 ⅓ weeks). For a full time employee who normally works 40 hours per week, "four months" is calculated as 693 hours of leave entitlement (40 hours/week x 17⅓ weeks). For employees who work more or less than 40 hours per week, or who work on variable work schedules, the number of working days that constitutes four months is calculated on a pro rata or proportional basis. For example, an employee who works 20 hours per week would qualify for 346.5 hours of leave entitlement (20 hours/week x 17⅓ weeks) or an employee who normally works 48 hours per week would qualify for 832 hours of leave entitlement (48 hours/week x 17⅓ weeks). Employees are eligible for up to four months leave per pregnancy, not per year.

3. An employee does not have to take PDL in one (1) continuous period of time but may take PDL on an as-needed intermittent basis. Taking intermittent PDL or a reduced work schedule throughout an employee's pregnancy will affect the number of PDL hours remaining that an employee is entitled to take leading up to and after childbirth.

4. An employee may request to use any accumulated Paid Time Off (PTO) during the PDL. However, the use of such PTO will not adjust the start date of the leave. The time covered by PTO will still count as part of the required leave. Any portion of a PDL that occurs with or without the use of PTO will count against the total hours of PDL entitlement. Once PTO accruals have been exhausted, all remaining time off shall be without pay with the exception of any qualifying disability pay.

5. Returning to Work: An employee returning from a PDL must obtain a release to return to work from her health care provider stating that she is able to resume her original job or duties.

6. An employee may request to extend the PDL from the Human Resources (HR) Department and will receive authorization as long as the employee continues to be disabled and the total PDL per pregnancy does not exceed four (4) months. The employee may need to present an additional physician's certification.

7. As provided in Title 2 of the California Code of Regulations section 11047, in the event an employee has exhausted her four month leave under the PDL, an employee who has a physical or mental disability (which may or may not be due to pregnancy, childbirth, or related medical conditions) may be entitled to reasonable accommodation(s) under Government Code section 12940. CalOptima will engage in an interactive process using the standards provided in the disability regulations (Title 2 of the California Code of Regulations section 11064 *et seq.*) to determine effective reasonable accommodations, if any, that will not impose an undue hardship on CalOptima (Government Code section 12940(m) and (n)). Where an employee has exhausted her four month leave under the PDL prior to the birth of her child and her health care provider determines that a continuation of the leave is medically necessary, CalOptima may, as a reasonable accommodation that will not impose an undue hardship on CalOptima, allow an employee eligible for CFRA to utilize the CFRA leave prior to the birth of her child (Title 2 of the California Code of Regulations section 10046).

8. If an eligible employee wishes to stay home to care for her newborn after her PDL ends, she must apply for a leave of absence (LOA) under the Family and Medical Leave Act (FMLA) or California Family Rights Act (CFRA), as described in CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence, at least thirty (30) calendar days before the date the leave will begin, if the need for the leave is foreseeable. If the need is not foreseeable, the employee must provide as much advance notice as practicable.

9. An employee requesting PDL shall provide timely oral or written notice sufficient to make CalOptima aware that the employee needs PDL, and where practicable, the anticipated timing and duration of the PDL. If the PDL is foreseeable, an employee must provide CalOptima at least thirty (30) calendar days advance notice before the start of the PDL. If thirty (30) calendar days advance notice is not practicable, because it is not known when the PDL will be required to begin, or because of a change in circumstances, a medical emergency, or other good cause, notice must be given to CalOptima as soon as practicable.

10. CalOptima shall respond to the PDL request as soon as practicable, and, in no event, later than ten (10) calendar days after receiving the PDL request and shall attempt to respond to the leave request before the date the leave is due to begin as required pursuant to Title 2 of the California Code of Regulations section 11050(a)(5). Once given, approval shall be deemed retroactive to the date of the first day of the leave.

11. As a condition of granting the PDL, employees will be required to obtain a medical certification from their health care provider. The certification should include the following information:

    a. The date on which the employee becomes disabled because of pregnancy;

    b. The expected duration of the period or periods of PDL; and

c. A statement that the employee needs to take PDL because she is disabled by pregnancy, childbirth, or a related medical condition.

C. Health benefits for Pregnancy Disability that run concurrently with FMLA or CFRA LOA:

1. During the duration of the PDL (4 months maximum for disability) and CFRA (12 weeks maximum for baby bonding), if applicable, except for discretionary LOAs as described in CalOptima Policy GA. 8038: Personal Leave of Absence, CalOptima will continue to pay the employer's portion of the health benefit premium for the employee as if she continued as an active employee.

2. While an employee is receiving CalOptima payroll checks because she is exhausting her accrued PTO benefits, the employee's health benefits and other insurance premiums will continue to be deducted from the employee's paycheck at the active employee rate. These benefits include medical, dental, vision and employee assistance program benefits.

3. When an employee is no longer receiving a paycheck or the amount is not sufficient to cover the employee's premium costs, the employee must pay the cost of coverage at the active employee rate, by the first (1st) of the month for that month's benefit coverage. The employee should arrange these payments with HR as soon as she anticipates that the paycheck will not cover the employee's share. The first payment may include any portion of the previous month's premium that was not paid through payroll deduction.

4. The employee is responsible for ensuring timely payment. If the payment is more than thirty (30) calendar days late, insurance coverage for unpaid months will be canceled.

5. CalOptima may recover from the employee the premium paid by CalOptima while the employee was on PDL if the conditions described under Title 2 of the California Code of Regulations section 11044(c)(3) occur.

D. Upon return to active employment, regardless of whether the employee's coverage was terminated for failure to pay premiums, the employee's coverage for health and other benefits and payroll deductions will be reinstated without processing an Evidence of Insurance (EOI).

E. An employee who exercises her right to take PDL has a right to reinstatement to the same position, or to a comparable position, pursuant to the conditions, restrictions, and exceptions outlined in Title 2 of the California Code of Regulations section 11043.

III. PROCEDURE

Responsible Party	Action
Employee	1. Request a PDL at least thirty (30) calendar days in advance, when practicable, by completing the Leave of Absence Request Form and submitting it to Human Resources. 2. Provide a medical certification from a health care provider to verify the PDL is required and the anticipated duration of the PDL. 3. Request an extension of the PDL in advance. CalOptima may require another medical certification from a health care provider. 4. Return to work on the agreed upon return to work date.
Human Resources	1. Process appropriate forms with employee. 2. Provide the employee a copy of the notice regarding employee's PDL rights and obligations as soon as practicable after the employee tells CalOptima of her pregnancy or when an employee inquiries about reasonable accommodation, transfer, or PDL. 3. Respond to PDL requests within 10 days of receipt. 4. Help the employee with a plan to transition back to work, when applicable. 5. Engage in an interactive process with the employee, where applicable.

IV. ATTACHMENTS

A. Leave of Absence Request Form

V. REFERENCES

A. CalOptima Policy GA.1001: Glossary of Terms
B. CalOptima Policy GA.8038: Discretionary Leave of Absence
C. CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence
D. CalOptima Employee Handbook
E. Title 2, California Code of Regulations section 11035 *et seq*. (Pregnancy Regulations)
F. Government Code §§ 12940 and 12945

VI. REGULATORY APPROVALS

None to Date

VII. BOARD ACTION

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors
B. 05/01/14: Regular Meeting of the CalOptima Board of Directors
C. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8039	Pregnancy Disability Leave of Absence	Administrative
Revised	02/01/2014	GA.8039	Pregnancy Disability Leave of Absence	Administrative
Revised	06/07/2018	GA.8039	Pregnancy Disability Leave of Absence	Administrative

IX. GLOSSARY

Term	Definition
Pregnancy Disability Leave (PDL)	Any leave, whether paid or unpaid, taken by an employee for any period(s) during which she is disabled by pregnancy.

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LEAVE OF ABSENCE REQUEST FORM

SECTION I – EMPLOYEE'S STATEMENT Contact Phone Number:_____

Employee Name: _____ Employee ID #: _____

Mailing Address: ---------- Email Address: ------__----------

Department: _____ Position: _____

Requested dates of absence: First day off work____/___/____ Expected Return Date:____/____/____

Is Illness/Injury Work Related?

☐ Yes ☐ No

REASON FOR LEAVE

☐ **Employee Medical (FMLA/CFRA)** - Attach Medical Certification

☐ **Pregnancy Disability (PDL)** - Attach Medical Certification

☐ **Family Medical (FMLA/CFRA) -** Attach Medical Certification

☐ **Military Leave (FMLA or Spouse Leave)** - Attach Supporting Documentation

☐ ***Baby Bonding** (within 1 year of birth or placement of adoption/foster care)

☐ **Personal Leave -** Attach Supporting Documentation

☐ **Other** - _____ (Attach Supporting Documentation)

Note: Additional documentation regarding types of leaves of absence can be found on the Human Resources page of the InfoNet.

EXPLANATION: _____

(FOR UNPAID LEAVE REQUESTS) To continue employee paid Health Insurance you should contact Human Resources to make arrangements for payment in advance

Employee's Signature: _____ Date:____/____/____

SECTION II – MANAGER OR DIRECTOR ACKNOWLEDGMENT (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)

Manager/Director Signature: _____ Date:____/___/____

HUMAN RESOURCES USE ONLY

SECTION III – HUMAN RESOURCES REVIEW

You are ☐ eligible ☐ not eligible for leave under the FMLA/CFRA. FMLA/CFRA Hours Balance Available _____

Last Day Worked _____ Return from Leave Date _____

Human Resources Signature: _____ Date:____/____/____

COMMENTS_____

Back to Agenda

Policy #:	GA.8040
Title:	**Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence**
Department:	Human Resources
Section:	Not Applicable

CEO Approval:		Michael Schrader
Effective Date:	~~1/5~~01/05/	~~Re~~ ~~08/07/14~~
Last Review Date:	12	~~vi~~
Last Revised Date:	06/07/18	~~se~~
	06/07/18	~~d:~~

I. PURPOSE

To outline the Leave of Absence (LOA) policy for employees eligible under the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA).

~~II. DEFINITIONS~~

~~Qualifying Exigency: The military leave entitlement helps families of military service members manage their affairs while a covered military service member is on active duty or called to covered active duty status (or has been notified of an impending call or order to covered active duty). According to the FMLA, 29 C.F.R. section 825.126, a qualifying exigency could include the following:~~

~~6. Short notice deployment;~~
~~7. Military events and related activities;~~
~~8. Childcare and school activities;~~
~~9. Financial and legal arrangements;~~
~~10. Counseling;~~
~~11. Rest and recuperation;~~
~~12. Post-deployment activities;~~
~~13. Parental care; or~~
~~14. Additional activities not encompassed in the other categories, but agreed to by the employer and employee.~~

~~XVI.~~II. POLICY

A. Eligibility: All full-time and part-time employees employed by CalOptima for a total of at least twelve (12) months with at least one thousand two hundred fifty (1,250) hours of service for CalOptima in the prior twelve (12) months are eligible for an FMLA and/or CFRA leave. If the leave is for FMLA only, the twelve (12) months need not be consecutive, provided that the employee has not had a break in service from the employer for a period of seven (7) years or more. If an employee has had a break of 7 or more years, time prior to the break will not be counted towards eligibility.

B. General provisions: An eligible employee may take an unpaid leave of absence under the FMLA and CFRA for the following reasons:

1. Baby bonding: The birth of a child of the employee and to care for the newborn child;

2. Placement of child: The placement of a child with an employee for adoption or foster care.

3. Family care: To care for the employee's spouse, child, or parent who has a serious health condition.

4. Medical leave: For the employee's own serious health condition that makes him or her unable to work at all, or unable to perform the functions of his or her job. –While an employee disabled by pregnancy, childbirth, or related medical condition may qualify for a LOA under FMLA, such conditions do not qualify the employee for a LOA under CFRA.

~~4.~~5. Leave for a ~~**qualifying exigency**~~Qualifying Exigency: To care for a spouse, child or parent who is a covered military service member on active duty~~,~~ or has been notified of an impending call or order to active duty. (covered only by FMLA)

~~5.~~6. Covered service members (Military): To care for a covered military service member with a qualifying serious injury or illness if the employee is the spouse, child, parent or next of kin of the military service member. CalOptima may approve a LOA for an employee of up to twenty-six (26) weeks, during a single twelve (12) month period, to care for a covered military service member with a qualifying serious injury or illness. (covered only by FMLA)

C. Computation of Time: Unless otherwise specified, an eligible employee is entitled to take up to twelve (12) weeks of leave during a rolling twelve (12) month period measured backward from the date an employee uses any FMLA and/or CFRA leave. Such leave may be taken on a continuous, intermittent or reduced schedule when medically necessary. An employee should~~-~~ schedule an intermittent leave, in cooperation with management to minimize disruption at the workplace. Intermittent leave must be taken in time increments of no less than fifteen (15) minutes, unless such leave is for baby bonding or placement of a child under the CFRA, wherein, the basic minimum duration of the leave shall be two weeks; provided, however, CalOptima will grant a request for CFRA leave of less than two weeks' duration on any two occasions. In most circumstances, FMLA leave will run at the same time as CFRA leave. However, if the employee is disabled by pregnancy, childbirth, or related medical condition, FMLA runs concurrently with Pregnancy Disability Leave (PDL~~),~~) and may run concurrently with CFRA if less than 12 weeks of PDL are taken.

D. Pregnancy Disability Leave: An employee disabled by pregnancy, childbirth, or related medical condition, may take a PDL, which runs concurrently with FMLA leave, and may thereafter qualify for a CFRA leave in addition to the time used for the PDL. Disabilities due to pregnancy, childbirth, or related medical condition are not covered by CFRA as a covered medical condition. The following example demonstrates how the three protected leaves work together. The assumption in this scenario is that the employee is disabled due to pregnancy or childbirth for the entire seventeen (17) weeks and three (3) days that are permitted.

E. Exhaustion of Leave: An employee may be eligible to take a Personal LOA following exhaustion of his or her FMLA or CFRA LOA in accordance with CalOptima Policy GA.8038: Personal ~~LOA.~~Leave of Absence. CalOptima may engage in the interactive process with an employee who has exhausted his or her leave under FMLA and/or CFRA, if applicable, and requires additional time off due to the employee's ~~own medical reason or~~qualifying disability.

F. Use of Paid Time Off: An employee is required to use his or her accrued Paid Time Off (PTO) during the employee's FMLA or CFRA leave (unless deemed otherwise by law, i.e. PDL, receipt of disability benefit, etc.). An employee may request to use accrued PTO during PDL or to coordinate PTO pay with disability benefits, if applicable, to supplement an employee's income, up to one hundred percent (100%) of the employee's total pay. However, the use of such PTO will not adjust the start date of the LOA. The time covered by PTO will still count as part of the LOA. Once all PTO accruals have been exhausted, all remaining time off shall be without pay.

G. Certification: Employees requesting LOA under the FMLA and/or CFRA are required to provide a healthcare provider's certificate that verifies the serious health condition of the employee, employee's child, parent, or spouse, including a covered service member, which satisfies the requirements of FMLA and/or CFRA, as applicable, and outlines the anticipated duration of the leave. Employees requesting LOA under CFRA that is unrelated to serious health conditions, such as the qualified baby bonding time off, do not need to submit healthcare provider certification, but will be required to submit proof of birth, adoption or foster care placement documentation. Employees requesting LOA under FMLA for leave because of a qualifying exigency must provide complete and sufficient certification in support of the request for FMLA, including, but not limited to, written documentation confirming a military member's covered active duty or call to covered active duty status.

H. Appointments: Employees must make every attempt to schedule doctor's visits or other medical appointments as not to unduly disrupt business operations.

I. Health Benefits:

1. Continuation of Health Benefits: CalOptima will continue to pay the employer's portion of employee's health insurance premium at the same level and under the same conditions as coverage would have been if the employee was working during the entire FMLA and/or CFRA LOA period, which may be up to twelve (12) weeks (unless employee also takes PDL in which case the employee will be entitled to continued benefits during the entire period of PDL and CFRA) or up to twenty-six (26) weeks during a leave to care for a covered military service member with a qualifying serious injury or illness.

2. Deductions: While an employee is receiving a CalOptima payroll check because he or she is exhausting his or her accrued PTO benefits, the employee's health benefits and other insurance premiums will continue to be deducted from his or her paycheck at the active employee rate. These benefits include medical, dental, vision and employee assistance program benefits.

3. Continuation of Coverage. When an employee is no longer receiving a paycheck or the amount is not sufficient to cover the employee's~~-~~ portion of the health insurance premium costs, the employee must continue to pay his or her portion of the health insurance premium at the active employee rate for the duration of the FMLA and/or CFRA LOA, by the first (1st) of the month for that month's benefit coverage. The employee should arrange the method of ~~-~~payment with Human Resources (HR) as soon as~~-~~ it is anticipated that his or her pay will be insufficient to cover his or her share of the cost. The first (1st) payment may include any portion of the previous month's premium that was not paid through payroll deduction. If an employee remains on a Personal LOA after exhausting FMLA and/or CFRA, the employee must pay the employer and employee share of health insurance premium consistent with CalOptima Policy GA.8038: Personal Leave of Absence.

4. Timely payment of Premiums. The employee is responsible for ensuring timely payment of health benefit premiums. If payment is more than thirty (30) calendar days late, insurance coverage for unpaid months will be canceled.

5. Reinstatement of Benefits. Upon return to active full or part-time employment, regardless of whether the employee's coverage was terminated for failure to pay premiums due, coverage for health benefits, other benefits, and payroll deductions will be reinstated without processing an Evidence of Insurance (EOI), and the pre-existing clause will not be applicable to conditions treated during the LOA. Health and other benefits will be reinstated on the first (1st) day of the month following the employee's return to work.

6. Recovery of premiums. CalOptima reserves the right to recover from the employee the premium paid by CalOptima while the employee was on FMLA and/or CFRA LOA if the conditions described pursuant to the applicable law occurs entitling the employer to recover the premium that the employer paid.

J. Returning to Work: Employees returning from a LOA arising from the employee's own serious health condition must obtain a release to return to work from his or her health care provider stating that he or she is able to resume work. Where applicable, if an employee has a qualifying disability under the Americans with Disabilities Act (ADA), the employee is responsible for timely requesting a reasonable accommodation, if needed, providing sufficient medical documentation in support of his or her needs for a reasonable accommodation, and engaging in the interactive process. Employees do not have to provide a doctor's certification when returning from baby bonding or other qualified leaves specified under FMLA and/or CFRA. ~~An~~Except in very limited circumstances, an employee who exercises his or her right to take FMLA and/or CFRA leave has a right to reinstatement to the same or comparable position, pursuant to the conditions, restrictions and exceptions outlined under the FMLA and CFRA laws.

~~XVII.~~III. PROCEDURE

Responsible Party	Action
Employee	1. Request an LOA designating FMLA and/or CFRA at least thirty (30) calendar days in advance, where practicable, by completing the Leave of Absence Request Form and submitting it to HR. 2. When applicable, provide a certification by the health care provider meeting the requirements under FMLA and/or CFRA, as applicable, ~~-~~that verifies the serious health condition of the employee, employee's child, parent, or spouse, including a covered service member, and outlines the anticipated duration of the leave. 3. Initiate contact with HR regarding continuation of benefits, use of PTO, where applicable, and any required payment arrangements. 4. Provide required documentation to return to work and return to work on the agreed upon date.
Human Resources (HR)	1. Ensure that all required notices pursuant to FMLA and CFRA are posted and disseminated as required by law. 2. Upon receipt of a request by employee for FMLA and/or CFRA leave, or upon knowledge that an employee's leave may be for an FMLA/CFRA-qualifying reason, respond to the LOA request and notify the employee of the employee's eligibility to take FMLA/CFRA leave **within five business days**. If the employee is not eligible for FMLA/CFRA leave, state at least one reason why the employee is not eligible. 3. Process appropriate forms with employee. 4. Manage and process the LOA request. 5. Help the employee with a plan to transition back to work, when applicable. 6. Engage in an interactive process with the employee, where applicable.

~~XIX.~~IV. ATTACHMENTS

A. Leave of Absence Request Form

~~XX.~~V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.-8018: Paid Time Off
C. CalOptima Policy GA.-8037: Leave of Absence
D. CalOptima Policy GA-.8038: Personal Leave of Absence
E. CalOptima Policy GA.-8039: Pregnancy Disability Leave of Absence
F. CalOptima Policy GA.-8041: Workers Compensation Leave of Absence
G. Title 2, California Code of Regulations ~~section 7291.2~~§ 11035 *et. seq*. (Pregnancy Regulations)
H. Title 2, California Code of Regulations ~~section~~§ 11087 *et seq*. (CFRA Regulations)
I. Title 29, ~~Unite States~~ Code of Federal Regulations (C.F.R.) Part 825 *et seq*. (FMLA Regulations)
J. Government Code ~~section~~§ 12945.2 *et seq*. (CFRA)
K. Title 29, United States Code section 2601 *et seq*. (FMLA)

VI. REGULATORY APPROVALS ~~OR~~

None to Date

~~XXI.~~VII. BOARD ACTION

A. ~~1/5/12:~~ 06/07/18: Regular Meeting of the CalOptima Board ~~Meeting~~of Directors

B. 08/07/14: Regular Meeting of the CalOptima Board of Directors
C. 01/05/12: Regular Meeting of the CalOptima Board of Directors

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

~~Not Applicable~~

~~XXIII. KEYWORDS~~

~~California Family Rights Act (CFRA)~~
~~Disability~~
~~Family and Medical Leave Act (FMLA)~~
~~Physician Certification~~

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act(CFRA) Leaves of Absence	Administrative
Revised	08/07/2014	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Revised	06/07/2018	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative

IX. GLOSSARY

Term	Definition
Qualifying Exigency	The military leave entitlement helps families of military service members manage their affairs while a covered military service member is on active duty or called to covered active duty status (or has been notified of an impending call or order to covered active duty). According to the FMLA, 29 C.F.R. section 825.126, a qualifying exigency could include the following: 1. Short-notice deployment; 2. Military events and related activities; 3. Childcare and school activities; 4. Financial and legal arrangements; 5. Counseling; 6. Rest and recuperation; 7. Post-deployment activities; 8. Parental care; or 9. Additional activities not encompassed in the other categories, but agreed to by the employer and employee.

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LEAVE OF ABSENCE REQUEST FORM

SECTION I – EMPLOYEE'S STATEMENT Contact Phone Number: _____

Employee Name: _____ Employee ID #: _____

Mailing Address: ---------- Email Address: ------ ----------

Department: _____ Position: _____

Requested dates of absence: First day off work____/___/____ Expected Return Date:____/____/____

~~I~~ _____ **–Is Illness/Injury Work Related?**

☐ Yes ☐ No

REASON FOR LEAVE

☐ **Employee Medical (FMLA/CFRA)** - Attach Medical Certification

☐ **Pregnancy Disability (PDL)** - Attach Medical Certification

☐ **Family Medical (FMLA/CFRA) -** Attach Medical Certification

☐ **Military Leave (FMLA or Spouse Leave)** - Attach Supporting Documentation

☐ ***Baby Bonding** (within 1 year of birth or placement of adoption/foster care)

☐ **Personal Leave -** Attach Supporting Documentation

☐ **Other -** (Attach Supporting Documentation)

Note: Additional documentation regarding types of leaves of absence can be found on the Human Resources page of the ~~Infonet~~InfoNet.

EXPLANATION: _____

(FOR UNPAID LEAVE REQUESTS) To continue employee paid Health Insurance you should contact Human Resources to make arrangements for payment in advance

Employee's Signature: _____ Date:____/____/____

SECTION II – MANAGER OR DIRECTOR ACKNOWLEDGMENT (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)
~~REVIEW (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)~~

~~Recommend Approval ☐ Recommend Modification as follows: _____~~

~~☐ Recommend Denial (Reason): _____~~
~~**Manager/Director Signature:** _____ Date: ____/___/____~~

Manager/Director Signature: _____ Date: ____/____/____

HUMAN RESOURCES USE ONLY

SECTION III – HUMAN RESOURCES REVIEW

You are ☐ eligible ☐ not eligible for leave under the FMLA/CFRA. FMLA/CFRA Hours Balance Available _____

Back to Agenda

Last Day Worked _____ Return from Leave Date _____

Human Resources Signature: _____ Date:_____/____/____

COMMENTS_____

_____

Rev: ~~02200906~~2018

Back to Agenda

Policy #:	GA.8040
Title:	**Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	01/05/12
Last Review Date:	06/07/18
Last Revised Date:	06/07/18

I. PURPOSE

To outline the Leave of Absence (LOA) policy for employees eligible under the Family and Medical Leave Act (FMLA) and the California Family Rights Act (CFRA).

II. POLICY

A. Eligibility: All full-time and part-time employees employed by CalOptima for a total of at least twelve (12) months with at least one thousand two hundred fifty (1,250) hours of service for CalOptima in the prior twelve (12) months are eligible for an FMLA and/or CFRA leave. If the leave is for FMLA only, the twelve (12) months need not be consecutive, provided that the employee has not had a break in service from the employer for a period of seven (7) years or more. If an employee has had a break of 7 or more years, time prior to the break will not be counted towards eligibility.

B. General provisions: An eligible employee may take an unpaid leave of absence under the FMLA and CFRA for the following reasons:

1. Baby bonding: The birth of a child of the employee and to care for the newborn child;

2. Placement of child: The placement of a child with an employee for adoption or foster care.

3. Family care: To care for the employee's spouse, child, or parent who has a serious health condition.

4. Medical leave: For the employee's own serious health condition that makes him or her unable to work at all, or unable to perform the functions of his or her job. While an employee disabled by pregnancy, childbirth, or related medical condition may qualify for a LOA under FMLA, such conditions do not qualify the employee for a LOA under CFRA.

5. Leave for a Qualifying Exigency: To care for a spouse, child or parent who is a covered military service member on active duty or has been notified of an impending call or order to active duty. (covered only by FMLA)

6. Covered service members (Military): To care for a covered military service member with a qualifying serious injury or illness if the employee is the spouse, child, parent or next of kin of the military service member. CalOptima may approve a LOA for an employee of up to twenty-

six (26) weeks, during a single twelve (12) month period, to care for a covered military service member with a qualifying serious injury or illness. (covered only by FMLA)

C. Computation of Time: Unless otherwise specified, an eligible employee is entitled to take up to twelve (12) weeks of leave during a rolling twelve (12) month period measured backward from the date an employee uses any FMLA and/or CFRA leave. Such leave may be taken on a continuous, intermittent or reduced schedule when medically necessary. An employee should schedule an intermittent leave, in cooperation with management to minimize disruption at the workplace. Intermittent leave must be taken in time increments of no less than fifteen (15) minutes, unless such leave is for baby bonding or placement of a child under the CFRA, wherein, the basic minimum duration of the leave shall be two weeks; provided, however, CalOptima will grant a request for CFRA leave of less than two weeks' duration on any two occasions. In most circumstances, FMLA leave will run at the same time as CFRA leave. However, if the employee is disabled by pregnancy, childbirth, or related medical condition, FMLA runs concurrently with Pregnancy Disability Leave (PDL) and may run concurrently with CFRA if less than 12 weeks of PDL are taken.

D. Pregnancy Disability Leave: An employee disabled by pregnancy, childbirth, or related medical condition, may take a PDL, which runs concurrently with FMLA leave, and may thereafter qualify for a CFRA leave in addition to the time used for the PDL. Disabilities due to pregnancy, childbirth, or related medical condition are not covered by CFRA as a covered medical condition. The following example demonstrates how the three protected leaves work together. The assumption in this scenario is that the employee is disabled due to pregnancy or childbirth for the entire seventeen (17) weeks and three (3) days that are permitted.

E. Exhaustion of Leave: An employee may be eligible to take a Personal LOA following exhaustion of his or her FMLA or CFRA LOA in accordance with CalOptima Policy GA.8038: Personal Leave of Absence. CalOptima may engage in the interactive process with an employee who has exhausted his or her leave under FMLA and/or CFRA, if applicable, and requires additional time off due to the employee's qualifying disability.

F. Use of Paid Time Off: An employee is required to use his or her accrued Paid Time Off (PTO) during the employee's FMLA or CFRA leave (unless deemed otherwise by law, i.e. PDL, receipt of disability benefit, etc.). An employee may request to use accrued PTO during PDL or to coordinate PTO pay with disability benefits, if applicable, to supplement an employee's income, up to one hundred percent (100%) of the employee's total pay. However, the use of such PTO will not adjust the start date of the LOA. The time covered by PTO will still count as part of the LOA. Once all PTO accruals have been exhausted, all remaining time off shall be without pay.

G. Certification: Employees requesting LOA under the FMLA and/or CFRA are required to provide a healthcare provider's certificate that verifies the serious health condition of the employee,

employee's child, parent, or spouse, including a covered service member, which satisfies the requirements of FMLA and/or CFRA, as applicable, and outlines the anticipated duration of the leave. Employees requesting LOA under CFRA that is unrelated to serious health conditions, such as the qualified baby bonding time off, do not need to submit healthcare provider certification, but will be required to submit proof of birth, adoption or foster care placement documentation. Employees requesting LOA under FMLA for leave because of a qualifying exigency must provide complete and sufficient certification in support of the request for FMLA, including, but not limited to, written documentation confirming a military member's covered active duty or call to covered active duty status.

H. Appointments: Employees must make every attempt to schedule doctor's visits or other medical appointments as not to unduly disrupt business operations.

I. Health Benefits:

1. Continuation of Health Benefits: CalOptima will continue to pay the employer's portion of employee's health insurance premium at the same level and under the same conditions as coverage would have been if the employee was working during the entire FMLA and/or CFRA LOA period, which may be up to twelve (12) weeks (unless employee also takes PDL in which case the employee will be entitled to continued benefits during the entire period of PDL and CFRA) or up to twenty-six (26) weeks during a leave to care for a covered military service member with a qualifying serious injury or illness.

2. Deductions: While an employee is receiving a CalOptima payroll check because he or she is exhausting his or her accrued PTO benefits, the employee's health benefits and other insurance premiums will continue to be deducted from his or her paycheck at the active employee rate. These benefits include medical, dental, vision and employee assistance program benefits.

3. Continuation of Coverage. When an employee is no longer receiving a paycheck or the amount is not sufficient to cover the employee's portion of the health insurance premium costs, the employee must continue to pay his or her portion of the health insurance premium at the active employee rate for the duration of the FMLA and/or CFRA LOA, by the first (1st) of the month for that month's benefit coverage. The employee should arrange the method of payment with Human Resources (HR) as soon as it is anticipated that his or her pay will be insufficient to cover his or her share of the cost. The first (1st) payment may include any portion of the previous month's premium that was not paid through payroll deduction. If an employee remains on a Personal LOA after exhausting FMLA and/or CFRA, the employee must pay the employer and employee share of health insurance premium consistent with CalOptima Policy GA.8038: Personal Leave of Absence.

4. Timely payment of Premiums. The employee is responsible for ensuring timely payment of health benefit premiums. If payment is more than thirty (30) calendar days late, insurance coverage for unpaid months will be canceled.

5. Reinstatement of Benefits. Upon return to active full or part-time employment, regardless of whether the employee's coverage was terminated for failure to pay premiums due, coverage for health benefits, other benefits, and payroll deductions will be reinstated without processing an Evidence of Insurance (EOI), and the pre-existing clause will not be applicable to conditions

treated during the LOA. Health and other benefits will be reinstated on the first (1st) day of the month following the employee's return to work.

6. Recovery of premiums. CalOptima reserves the right to recover from the employee the premium paid by CalOptima while the employee was on FMLA and/or CFRA LOA if the conditions described pursuant to the applicable law occurs entitling the employer to recover the premium that the employer paid.

J. Returning to Work: Employees returning from a LOA arising from the employee's own serious health condition must obtain a release to return to work from his or her health care provider stating that he or she is able to resume work. Where applicable, if an employee has a qualifying disability under the Americans with Disabilities Act (ADA), the employee is responsible for timely requesting a reasonable accommodation, if needed, providing sufficient medical documentation in support of his or her needs for a reasonable accommodation, and engaging in the interactive process. Employees do not have to provide a doctor's certification when returning from baby bonding or other qualified leaves specified under FMLA and/or CFRA. Except in very limited circumstances, an employee who exercises his or her right to take FMLA and/or CFRA leave has a right to reinstatement to the same or comparable position, pursuant to the conditions, restrictions and exceptions outlined under the FMLA and CFRA laws.

K.

III. PROCEDURE

Responsible Party	Action
Employee	1. Request an LOA designating FMLA and/or CFRA at least thirty (30) calendar days in advance, where practicable, by completing the Leave of Absence Request Form and submitting it to HR. 2. When applicable, provide a certification by the health care provider meeting the requirements under FMLA and/or CFRA, as applicable, that verifies the serious health condition of the employee, employee's child, parent, or spouse, including a covered service member, and outlines the anticipated duration of the leave. 3. Initiate contact with HR regarding continuation of benefits, use of PTO, where applicable, and any required payment arrangements. 4. Provide required documentation to return to work and return to work on the agreed upon date.

Responsible Party	Action
Human Resources (HR)	1. Ensure that all required notices pursuant to FMLA and CFRA are posted and disseminated as required by law. 2. Upon receipt of a request by employee for FMLA and/or CFRA leave, or upon knowledge that an employee's leave may be for an FMLA/CFRA-qualifying reason, respond to the LOA request and notify the employee of the employee's eligibility to take FMLA/CFRA leave **within five business days**. If the employee is not eligible for FMLA/CFRA leave, state at least one reason why the employee is not eligible. 3. Process appropriate forms with employee. 4. Manage and process the LOA request. 5. Help the employee with a plan to transition back to work, when applicable. 6. Engage in an interactive process with the employee, where applicable.

IV. ATTACHMENTS

A. Leave of Absence Request Form

V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8018: Paid Time Off
C. CalOptima Policy GA.8037: Leave of Absence
D. CalOptima Policy GA.8038: Personal Leave of Absence
E. CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence
F. CalOptima Policy GA.8041: Workers Compensation Leave of Absence
G. Title 2, California Code of Regulations § 11035 *et. seq.* (Pregnancy Regulations)
H. Title 2, California Code of Regulations § 11087 *et seq.* (CFRA Regulations)
I. Title 29, Code of Federal Regulations (C.F.R.) Part 825 *et seq.* (FMLA Regulations)
J. Government Code § 12945.2 *et seq.* (CFRA)
K. Title 29, United States Code section 2601 *et seq.* (FMLA)

VI. REGULATORY APPROVALS

None to Date

VII. BOARD ACTION

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors
B. 08/07/14: 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	Version Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act(CFRA) Leaves of Absence	Administrative
Revised	08/07/2014	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative
Revised	06/07/2018	GA.8040	Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence	Administrative

IX. GLOSSARY

Term	Definition
Qualifying Exigency	The military leave entitlement helps families of military service members manage their affairs while a covered military service member is on active duty or called to covered active duty status (or has been notified of an impending call or order to covered active duty). According to the FMLA, 29 C.F.R. section 825.126, a qualifying exigency could include the following: 1. Short-notice deployment; 2. Military events and related activities; 3. Childcare and school activities; 4. Financial and legal arrangements; 5. Counseling; 6. Rest and recuperation; 7. Post-deployment activities; 8. Parental care; or 9. Additional activities not encompassed in the other categories, but agreed to by the employer and employee.

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LEAVE OF ABSENCE REQUEST FORM

SECTION I – EMPLOYEE'S STATEMENT Contact Phone Number:_____

Employee Name: _____ Employee ID #: _____

Mailing Address: ---------- Email Address: ------__----------

Department: _____ Position: _____

Requested dates of absence: First day off work____/___/____ Expected Return Date:____/____/____

Is Illness/Injury Work Related?

☐ Yes ☐ No

REASON FOR LEAVE

☐ **Employee Medical (FMLA/CFRA)** - Attach Medical Certification

☐ **Pregnancy Disability (PDL)** - Attach Medical Certification

☐ **Family Medical (FMLA/CFRA) -** Attach Medical Certification

☐ **Military Leave (FMLA or Spouse Leave)** - Attach Supporting Documentation

☐ ***Baby Bonding** (within 1 year of birth or placement of adoption/foster care)

☐ **Personal Leave -** Attach Supporting Documentation

☐ **Other** - _____ (Attach Supporting Documentation)

Note: Additional documentation regarding types of leaves of absence can be found on the Human Resources page of the InfoNet.

EXPLANATION: _____

(FOR UNPAID LEAVE REQUESTS) To continue employee paid Health Insurance you should contact Human Resources to make arrangements for payment in advance

Employee's Signature: _____ Date:____/____/____

SECTION II – MANAGER OR DIRECTOR ACKNOWLEDGMENT (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)

Manager/Director Signature: _____ Date:____/___/____

HUMAN RESOURCES USE ONLY

SECTION III – HUMAN RESOURCES REVIEW

You are ☐ eligible ☐ not eligible for leave under the FMLA/CFRA. FMLA/CFRA Hours Balance Available _____

Last Day Worked _____ Return from Leave Date _____

Human Resources Signature: _____ Date:____/____/____

COMMENTS_____

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Policy #:	GA.8041
Title:	**Workers' Compensation Leave of Absence**
Department:	Human Resources
Section:	Not Applicable

CEO Approval:		Michael Schrader	
Effective Date:	~~1/5~~01/05/	~~Re~~	~~8/7/14~~
Last Review Date:	12	~~vis~~	
Last Revised Date:	06/07/18	~~ed~~	
	06/07/18		

I. PURPOSE

To outline CalOptima's policy for employees who are unable to work due to a work-related injury or illness compensable under the California Workers' Compensation Act.

~~II.~~I. ~~DEFINITIONS~~

~~Workers' Compensation: An insurance policy covering work-related injury and illness.~~

~~III.~~II. POLICY

A. In accordance with state law, CalOptima provides Worker's Compensation insurance coverage for employees in case of a work-related injury or illness. CalOptima is financially responsible for payment of Workers' Compensation insurance, which is intended to provide medical benefits and wage replacement to employees injured in the course of employment.

B. Workers' Compensation benefits provided to injured employees may include:

1. Medical, Surgical and Hospital Treatment;

2. Partial payment for lost earnings that result from work related injuries; or

3. Rehabilitation services to help injured employees return to suitable employment.

C. Employees are required to report all on-the-job injuries to their supervisor and the Human Resources (HR) Department immediately, regardless of how minor the injury may be. Any serious injury or illness, or death of an employee on CalOptima property must also be immediately reported to CalOptima's Environmental Health and Safety Manager. Employees who experience a work-related accident, illness, or injury will be required to complete the appropriate forms and cooperate with CalOptima in complying with its recording, reporting and investigation obligations.

D. Voluntary participation in any off-duty community, recreational, social, or athletic activity arranged by CalOptima ~~will~~and/or the Employee Activities Committee is not covered under this policy.

~~D.~~E. If the work-related accident, injury or illness results in the employee being placed on a leave of absence, CalOptima may grant a Leave of Absence (LOA) consistent with CalOptima's various leave policies to any employee who is unable to work due to a work-related injury or illness compensable under the California Workers' Compensation Act. Subject to any limitations

permitted by law~~, time~~ including, but not limited to, business necessity or undue hardship, time off for a work-related condition ~~will~~may be extended to the employee for the duration of the work-related injury or illness, until the employee has recovered sufficiently to perform the duties of his or her job or a modified light duty position if one is offered by CalOptima, or the employee's condition is declared permanent and stationary and he/she is unable to perform the essential functions of his or her job, with or without reasonable accommodation. CalOptima may engage in the interactive process (where applicable) with the employee to determine if there are any reasonable accommodations available that may be effective in allowing the employee to return to work or whether ~~or not~~ extended time off will be a reasonable accommodation or create an undue hardship on CalOptima. While employees are on a leave of absence, they should stay in contact with CalOptima's Human Resources Department and their supervisors regarding their expected return to work.

~~E.~~F. There is a three (3) day waiting period that is unpaid when an employee is on a LOA resulting from a Workers' Compensation injury or illness. An employee may use accumulated paid time off (PTO) during the three (3) day waiting period. If an employee misses more than fourteen (14) days from work, or the employee is hospitalized immediately after the work-related injury, the three (3) day waiting period is waived. An employee may elect to use accrued paid time off (PTO) to supplement his or her income during the employee's LOA.

~~F.~~G. A LOA authorized under the Family and Medical Leave Act (FMLA) and/or the California Family Rights Act (CFRA) will run concurrently with a LOA taken for an injury or illness under the Workers' Compensation Act.

~~G.~~H. Employees returning from a LOA under the Workers' Compensation Act, taken at the same time as a LOA under FMLA and/or CFRA, will be reinstated to the same or comparable position unless the employee can no longer perform the essential functions of the job. Employees who do not qualify for FMLA and/or CFRA LOAs or whose qualified LOA exceeded the twelve (12-)-week time period permitted under FMLA and/or CFRA, may be reinstated to their prior position unless it has been filled due to a reasonable business necessity or undue hardship, if applicable, in which case, the employee may be considered for any open position for which he or she is qualified. An employee returning from a Workers' Compensation LOA must present a physician's certificate releasing the employee to perform the essential functions of the job to which he or she is being reinstated, with or without reasonable accommodation. Where applicable, CalOptima will participate in a timely, good faith, interactive process with returning employees to determine effective reasonable accommodations, if any, that can be made in response to a request for accommodations.

~~H.~~I. Employees returning to work or who are still working after a work-related injury or illness under the Workers' Compensation Act are required to coordinate with their supervisor to use accrued PTO or make up time away from work, consistent with CalOptima's time keeping requirements, for follow-up medical appointments. Employees who do not have sufficient PTO accruals may take unpaid time off for follow-up medical appointments. ~~-~~Appointments should be scheduled in a manner that provides the least disruption to the employee's normal work schedule.

~~I.~~J. An employee's Workers' Compensation LOA will be terminated if one (1) or more of the following occurs:

1. The employee is released for full duty and fails to return on the appointed date.

2. After exhausting all available LOA under FMLA and/or CFRA, the employee is released for light duty or modified duty, CalOptima engages in an interactive process and offers an alternative position the employee is qualified to perform, and the employee fails to accept the alternative position and return on the appointed date.

3. The employee is declared to be permanent and stationary by the Workers' Compensation Appeals Board and his or her condition is such that he or she will not be able to perform the essential functions of the job to which he or she is to be reinstated with or without reasonable accommodation. In such case, the LOA will be terminated, and the disability or industrial disability retirement process will be initiated.

4. The employee has accepted a permanent position elsewhere or has unequivocally resigned.

K. Workers' Compensation fraud will be investigated. Employees who suspect Workers' Compensation fraud or see it happening should notify the Human Resources Department immediately.

~~IV.~~III. PROCEDURE

Responsible Party	Action
Employee	1. Report the work-related injury to supervisor and Human Resources (HR) immediately after sustaining the injury/illness or as soon as practicable. 2. Complete or submit all the appropriate forms, including, but not limited to, the following forms: • ~~Employee~~ Accident/Incident Investigation Report • ~~Employee's Claim for~~ Workers' Compensation ~~Benefits~~Claim Form (DWC- 1) • ~~LOA~~ Leave Of Absence Request Form: Required for a LOA that is expected to last more than five (5) business days. For a LOA that is five (5) days or less, an oral notice to the manager is sufficient. If applicable, designate leave as FMLA/CFRA. • A health care provider's certificate that verifies the employee's injury or illness and the anticipated duration of his or her injury or illness requiring time off of work. 3. If the injury will cause the employee to miss work, employee must keep his/her supervisor and HR informed as to when he/she expects to return to work. Medical documentation to justify all absences due to work-related injury/illness must be submitted to HR. 4. Keep supervisor and HR regularly informed of any updates or changes in the status of recovery.

Responsible Party	Action
	5. Cooperate with CalOptima's Workers' Compensation claims administrator and provide all necessary information, documentation, and statements, as applicable. 6. Return to work as soon as medically possible. If modified/light duty or temporary work is available within the employee's ability to perform while he/she is recovering, the employee must accept the work and return to duty. Upon return to work, employee must present a physician's certificate releasing them to either perform the essential functions of the job to which he or she is being reinstated and/or perform the functions of the modified/temporary job.
Manager	1. Immediately report all work-related injuries to HR and assist the employee in receiving first aid or medical attention when applicable. 2. Partner with HR and the employee upon their return to work to plan the employee's transition back to work. 3. Complete Accident/Incident Investigation Report ~~Form~~ within twenty-four (24) hours after the Manager becomes aware of an accident involving one or more employees.
Human Resources (HR)	1. Ensure that the Notice to Employees Poster for Workers' Compensation is posted as required by law~~,~~ and provide all new employees with a Workers' Compensation pamphlet explaining their rights and responsibilities. 2. Within one working day of receiving notice or knowledge of an injury, provide (personally or by first-class mail) a claim form and notice of potential eligibility for benefits to the injured employee, or in the case of death, to the employee's dependents. 3. Within one working day of receiving the claim form from the injured employee, provide a dated copy of the completed form to the injured employee and CalOptima's insurance claims administrator. 4. Within one working day of the claim form being filed, authorize medical treatment up to $10,000 in appropriate medical treatment and continue to provide treatment until liability for the claim is accepted or rejected. 5. Process appropriate forms with employee. 6. Promptly coordinate and assist CalOptima's claims administrator in obtaining all applicable and relevant information, documentation, and/or witness statements relevant to the injury or illness. 7. Work with CalOptima's claims administrator to ensure the claim is either accepted or denied within 90 days of the date of the filing of

Responsible Party	Action
	the claim form, and follow-up regularly with the claims administrator to ensure timely updates and resolution of claims. 8. Manage and process the injured employee's request for time off and/or LOA and respond to employee within five (5) business days of receiving a request for FMLA/CFRA leave, when applicable. 9. ~~Help~~Once HR is aware of the need for an accommodation, engage with the employee in an interactive process to identify possible reasonable accommodations that might be effective in enabling the employee to return to work, with or without an accommodation, and help the employee with a plan to transition back to work, when applicable.
Environmental Health and Safety Manager	1. Investigate all work-related accidents and keep on file copies of all Accident/Incident Investigation Reports submitted. 2. Take all necessary actions to ensure appropriate response or corrective action. 3. For any serious injury or illness, or death of an employee, complete the Serious Incident Report Fax Form and fax to the nearest District Office of the Division of Occupational Safety and Health (OSHA) as soon as practically possible, but no later than eight hours after the incident.

~~V.~~IV. ATTACHMENTS

~~A. Employee Accident/Incident Report~~
~~A. Employee's Claim for~~ Employer's Report of Occupational Injury or Illness (Form 5020)
B. Workers' Compensation ~~Benefits~~Claim Form (DWC- 1)
C. Leave of Absence Request Form
D. Accident/Incident Investigation ~~Form~~Report

~~VI.~~V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy -GA.-8016: Unusual Occurrence
C. CalOptima Policy GA.-8037: Leave of Absence
D. CalOptima Policy GA.-8040: Family and Medical Leave Act and California Family Rights Act Leave
E. ~~CalOptimat~~CalOptima Employee Handbook
F. California Labor Code ~~sections~~§§ 132a, and 5400 *et seq*.
G. Title 8, California Code of Regulations, ~~Section~~§ 342

VI. REGULATORY APPROVALS ~~OR~~

None to Date

VII. BOARD ACTION

A. ~~1/5/12:~~ 06/07/18: Regular Meeting of the CalOptima Board ~~Meeting~~of Directors

B. 08/07/14: 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	Version Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8041	Worker's Compensation Leave of Absence	Administrative
Revised	08/07/2014	GA.8041	Worker's Compensation Leave of Absence	Administrative
Revised	06/07/2018	GA.8041	Worker's Compensation Leave of Absence	Administrative

IX. DEFINITIONS

~~Not Applicable~~

~~IX. KEYWORDS~~

- ~~California Family Rights Act (CFRA)~~
- ~~Disability~~
- ~~Family and Medical Leave Act (FMLA)~~
- ~~Physician Certification~~
- ~~Workers' Compensation~~
- ~~Injury or Illness~~

Term	Definition
Workers' Compensation	An insurance policy covering work-related injury and illness.

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34 SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)
Signature & Title
Date (mm/dd/yy)

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

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FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

DO NOT USE THIS COLUMN
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Use the attached form to file a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered. Within one working day after you file the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, and send one to the claims administrator.

Medical Care: Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
- If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
- If your employer is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you predesignated your personal physician or a medical group.
- If your employer has not put up a poster describing your rights to workers' compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to $10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

Switching to a Different Doctor as Your PTP:

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).
- If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Utilice el formulario adjunto para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran dependiendo de la índole de su reclamo. Si usted presenta un reclamo, l administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos.

Atención Médica: Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quiropráctica, física y otras visitas de terapia ocupacional.

El Médico Primario que le Atiende *(Primary Treating Physician- PTP)* es el médico con la responsabilidad total para tratar su lesión o enfermedad.

- Si usted designó previamente a su médico personal o a un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
- Si su empleador está utilizando una red de proveedores médicos (*Medical Provider Network- MPN)* o una Organización de Cuidado Médico *(Health Care Organization- HCO)*, en la mayoría de los casos, usted será tratado en la *MPN* o *HCO* a menos que usted hizo una designación previa de su médico personal o grupo médico. Una *MPN* es un grupo de proveedores de asistencia médica quien da tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una *HCO* o una *MPN*. Hable con su empleador para más información.
- Si su empleador no está utilizando una *MPN* o *HCO*, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que lo atiende primero a menos de que usted hizo una designación previa de su médico personal o grupo médico.
- Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta $10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

Cambiando a otro Médico Primario o *PTP*:

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Problems with Medical Care and Medical Reports: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see "Learn More About Workers' Compensation," below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP's opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Stay at Work or Return to Work: Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

Payment for Permanent Disability: If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

Supplemental Job Displacement Benefit (SJDB): If you were injured on or after 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

Death Benefits: If the injury or illness causes death, payments may be made to a

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes serán revelados. Si usted solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Problemas con la Atención Médica y los Informes Médicos: En algún momento durante su reclamo, podría estar en desacuerdo con su *PTP* sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una *MPN*, *HCO* o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su *PTP*, puede solicitar una revisión médica independiente *(Independent Medical Review-IMR)*, utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la *IMR* es parecido al proceso de la *IMR* de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la *IMR*. La *IMR* no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su *PTP* en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesg perder el derecho a objetar a la opinión de su *PTP* a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado *(Qualified Medical Evaluator-QME)* para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado *(Agreed Medical Evaluator- AME)*. Si el administrador de reclamos no está de acuerdo con su *PTP* sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un *QME* o *AME*.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no puede trabajar durante más de 14 días.

Permanezca en el Trabajo o Regreso al Trabajo: Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

spouse and other relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Resolving Problems or Disputes: You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website at www.edd.ca.gov.

You Can Contact an Information & Assistance (I&A) Officer: State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their website at **www.californiaspecialist.org**.

Learn More About Workers' Compensation: For more information about the workers' compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

Pago por Incapacidad Permanente: Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

Beneficio Suplementario por Desplazamiento de Trabajo *(Supplemental Job Displacement Benefit- SJDB)*: Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo un curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a un cónyuge y otros parientes o a las personas que viven en el hogar que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (Código Laboral, sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Resolviendo problemas o disputas: Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatalde Incapacidad *(State Disability Insurance- SDI)* o beneficios del desempleo *(Unemployment Insurance- UI)*. Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en www.edd.ca.gov.

Puede Contactar a un Oficial de Información y Asistencia *(Information & Assistance- I&A)*: Los Oficiales de Información y Asistencia *(I&A)* estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a www.dwc.ca.gov o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, o consulte su página Web en www.californiaspecialist.org.

Aprenda Más Sobre la Compensación de Trabajadores: Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a www.dwc.ca.gov. En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.

PRINT CLEAR

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt**" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.

You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*

9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
16. Insurance Policy Number. *El número de la póliza de Seguro.* _____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/*Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

Rev. 1/1/2016

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LEAVE OF ABSENCE REQUEST FORM

SECTION I – EMPLOYEE'S STATEMENT Contact Phone Number: _____

Employee Name: _____ Employee ID #: _____

Mailing Address: ---------- Email Address: ------ ----------

Department: _____ Position: _____

Requested dates of absence: First day off work____/___/____ Expected Return Date:____/____/____

~~I~~ _____ **–Is Illness/Injury Work Related?**

☐ Yes ☐ No

REASON FOR LEAVE

☐ **Employee Medical (FMLA/CFRA)** - Attach Medical Certification

☐ **Pregnancy Disability (PDL)** - Attach Medical Certification

☐ **Family Medical (FMLA/CFRA) -** Attach Medical Certification

☐ **Military Leave (FMLA or Spouse Leave)** - Attach Supporting Documentation

☐ ***Baby Bonding** (within 1 year of birth or placement of adoption/foster care)

☐ **Personal Leave -** Attach Supporting Documentation

☐ **Other -** (Attach Supporting Documentation)

Note: Additional documentation regarding types of leaves of absence can be found on the Human Resources page of the ~~Infonet~~InfoNet.

EXPLANATION: _____

(FOR UNPAID LEAVE REQUESTS) To continue employee paid Health Insurance you should contact Human Resources to make arrangements for payment in advance

Employee's Signature: _____ Date:____/____/____

SECTION II – MANAGER OR DIRECTOR ACKNOWLEDGMENT (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)
~~REVIEW (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)~~

~~Recommend Approval ☐ Recommend Modification as follows: _____~~

~~☐ Recommend Denial (Reason): _____~~
~~**Manager/Director Signature:** _____ Date: ____/___/____~~

Manager/Director Signature: _____ Date: ____/____/____

HUMAN RESOURCES USE ONLY

SECTION III – HUMAN RESOURCES REVIEW

You are ☐ eligible ☐ not eligible for leave under the FMLA/CFRA. FMLA/CFRA Hours Balance Available _____

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Last Day Worked _____ Return from Leave Date _____

Human Resources Signature: _____ Date:_____/____/____

COMMENTS_____

_____

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Accident/Incident Investigation Report

505 City Parkway West | Orange, CA 92868

SECTION 1 – EMPLOYEE INFORMATION (WHO)

Name	Home Address	DOB

Gender	Job Title	Supervisor Name

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 4 – CORRECTIVE ACTION AND DISPOSITION

1. Disposition:

a) First aid? ☐ Yes ☐ No

b) If first aid, describe

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

d) Returned to work? ☐Yes ☐No

e) Returned to work modified duty ☐

Emergency room / hospital address

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

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

If yes, please describe

4. Employee recommendations / suggestions

5. Supervisor comments / recommendations

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

Policy #:	GA.8041
Title:	**Workers' Compensation Leave of Absence**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	01/05/12
Last Review Date:	06/07/18
Last Revised Date:	06/07/18

I. PURPOSE

To outline CalOptima's policy for employees who are unable to work due to a work-related injury or illness compensable under the California Workers' Compensation Act.

II. POLICY

A. In accordance with state law, CalOptima provides Worker's Compensation insurance coverage for employees in case of a work-related injury or illness. CalOptima is financially responsible for payment of Workers' Compensation insurance, which is intended to provide medical benefits and wage replacement to employees injured in the course of employment.

B. Workers' Compensation benefits provided to injured employees may include:

1. Medical, Surgical and Hospital Treatment;

2. Partial payment for lost earnings that result from work related injuries; or

3. Rehabilitation services to help injured employees return to suitable employment.

C. Employees are required to report all on-the-job injuries to their supervisor and the Human Resources (HR) Department immediately, regardless of how minor the injury may be. Any serious injury or illness, or death of an employee on CalOptima property must also be immediately reported to CalOptima's Environmental Health and Safety Manager. Employees who experience a work-related accident, illness, or injury will be required to complete the appropriate forms and cooperate with CalOptima in complying with its recording, reporting and investigation obligations.

D. Voluntary participation in any off-duty community, recreational, social, or athletic activity arranged by CalOptima and/or the Employee Activities Committee is not covered under this policy.

E. If the work-related accident, injury or illness results in the employee being placed on a leave of absence, CalOptima may grant a Leave of Absence (LOA) consistent with CalOptima's various leave policies to any employee who is unable to work due to a work-related injury or illness compensable under the California Workers' Compensation Act. Subject to any limitations permitted by law including, but not limited to, business necessity or undue hardship, time off for a work-related condition may be extended to the employee for the duration of the work-related injury or illness, until the employee has recovered sufficiently to perform the duties of his or her job or a modified light duty position if one is offered by CalOptima, or the employee's condition is declared permanent and stationary and he/she is unable to perform the essential functions of his or her job,

with or without reasonable accommodation. CalOptima may engage in the interactive process (where applicable) with the employee to determine if there are any reasonable accommodations available that may be effective in allowing the employee to return to work or whether extended time off will be a reasonable accommodation or create an undue hardship on CalOptima. While employees are on a leave of absence, they should stay in contact with CalOptima's Human Resources Department and their supervisors regarding their expected return to work.

F. There is a three (3) day waiting period that is unpaid when an employee is on a LOA resulting from a Workers' Compensation injury or illness. An employee may use accumulated paid time off (PTO) during the three (3) day waiting period. If an employee misses more than fourteen (14) days from work, or the employee is hospitalized immediately after the work-related injury, the three (3) day waiting period is waived. An employee may elect to use accrued paid time off (PTO) to supplement his or her income during the employee's LOA.

G. A LOA authorized under the Family and Medical Leave Act (FMLA) and/or the California Family Rights Act (CFRA) will run concurrently with a LOA taken for an injury or illness under the Workers' Compensation Act.

H. Employees returning from a LOA under the Workers' Compensation Act, taken at the same time as a LOA under FMLA and/or CFRA, will be reinstated to the same or comparable position unless the employee can no longer perform the essential functions of the job. Employees who do not qualify for FMLA and/or CFRA LOAs or whose qualified LOA exceeded the twelve (12)-week time period permitted under FMLA and/or CFRA, may be reinstated to their prior position unless it has been filled due to a reasonable business necessity or undue hardship, if applicable, in which case, the employee may be considered for any open position for which he or she is qualified. An employee returning from a Workers' Compensation LOA must present a physician's certificate releasing the employee to perform the essential functions of the job to which he or she is being reinstated, with or without reasonable accommodation. Where applicable, CalOptima will participate in a timely, good faith, interactive process with returning employees to determine effective reasonable accommodations, if any, that can be made in response to a request for accommodations.

I. Employees returning to work or who are still working after a work-related injury or illness under the Workers' Compensation Act are required to coordinate with their supervisor to use accrued PTO or make up time away from work, consistent with CalOptima's time keeping requirements, for follow-up medical appointments. Employees who do not have sufficient PTO accruals may take unpaid time off for follow-up medical appointments. Appointments should be scheduled in a manner that provides the least disruption to the employee's normal work schedule.

J. An employee's Workers' Compensation LOA will be terminated if one (1) or more of the following occurs:

1. The employee is released for full duty and fails to return on the appointed date.

2. After exhausting all available LOA under FMLA and/or CFRA, the employee is released for light duty or modified duty, CalOptima engages in an interactive process and offers an alternative position the employee is qualified to perform, and the employee fails to accept the alternative position and return on the appointed date.

3. The employee is declared to be permanent and stationary by the Workers' Compensation Appeals Board and his or her condition is such that he or she will not be able to perform the

essential functions of the job to which he or she is to be reinstated with or without reasonable accommodation. In such case, the LOA will be terminated, and the disability or industrial disability retirement process will be initiated.

4. The employee has accepted a permanent position elsewhere or has unequivocally resigned.

K. Workers' Compensation fraud will be investigated. Employees who suspect Workers' Compensation fraud or see it happening should notify the Human Resources Department immediately.

III. PROCEDURE

Responsible Party	Action
Employee	1. Report the work-related injury to supervisor and Human Resources (HR) immediately after sustaining the injury/illness or as soon as practicable. 2. Complete or submit all the appropriate forms, including, but not limited to, the following forms: • Accident/Incident Investigation Report Workers' Compensation Claim Form (DWC 1) Leave Of Absence Request Form: Required for a LOA that is expected to last more than five (5) business days. For a LOA that is five (5) days or less, an oral notice to the manager is sufficient. If applicable, designate leave as FMLA/CFRA. • A health care provider's certificate that verifies the employee's injury or illness and the anticipated duration of his or her injury or illness requiring time off of work. 3. If the injury will cause the employee to miss work, employee must keep his/her supervisor and HR informed as to when he/she expects to return to work. Medical documentation to justify all absences due to work-related injury/illness must be submitted to HR. 4. Keep supervisor and HR regularly informed of any updates or changes in the status of recovery. 5. Cooperate with CalOptima's Workers' Compensation claims administrator and provide all necessary information, documentation, and statements, as applicable. 6. Return to work as soon as medically possible. If modified/light duty or temporary work is available within the employee's ability to perform while he/she is recovering, the employee must accept the work and return to duty. Upon return to work, employee must present a physician's certificate releasing them to either perform the essential functions of the job to which he or she is being reinstated and/or perform the functions of the modified/temporary job.

Responsible Party	Action
Manager	1. Immediately report all work-related injuries to HR and assist the employee in receiving first aid or medical attention when applicable. 2. Partner with HR and the employee upon their return to work to plan the employee's transition back to work. 3. Complete Accident/Incident Investigation Report within twenty-four (24) hours after the Manager becomes aware of an accident involving one or more employees.
Human Resources (HR)	1. Ensure that the Notice to Employees Poster for Workers' Compensation is posted as required by law and provide all new employees with a Workers' Compensation pamphlet explaining their rights and responsibilities. 2. Within one working day of receiving notice or knowledge of an injury, provide (personally or by first-class mail) a claim form and notice of potential eligibility for benefits to the injured employee, or in the case of death, to the employee's dependents. 3. Within one working day of receiving the claim form from the injured employee, provide a dated copy of the completed form to the injured employee and CalOptima's insurance claims administrator. 4. Within one working day of the claim form being filed, authorize medical treatment up to $10,000 in appropriate medical treatment and continue to provide treatment until liability for the claim is accepted or rejected. 5. Process appropriate forms with employee. 6. Promptly coordinate and assist CalOptima's claims administrator in obtaining all applicable and relevant information, documentation, and/or witness statements relevant to the injury or illness. 7. Work with CalOptima's claims administrator to ensure the claim is either accepted or denied within 90 days of the date of the filing of the claim form, and follow-up regularly with the claims administrator to ensure timely updates and resolution of claims. 8. Manage and process the injured employee's request for time off and/or LOA and respond to employee within five (5) business days of receiving a request for FMLA/CFRA leave, when applicable. 9. Once HR is aware of the need for an accommodation, engage with the employee in an interactive process to identify possible reasonable accommodations that might be effective in enabling the employee to return to work, with or without an accommodation, and

Responsible Party	Action
	help the employee with a plan to transition back to work, when applicable.
Environmental Health and Safety Manager	1. Investigate all work-related accidents and keep on file copies of all Accident/Incident Investigation Reports submitted. 2. Take all necessary actions to ensure appropriate response or corrective action. 3. For any serious injury or illness, or death of an employee, complete the Serious Incident Report Fax Form and fax to the nearest District Office of the Division of Occupational Safety and Health (OSHA) as soon as practically possible, but no later than eight hours after the incident.

IV. ATTACHMENTS

A. Employer's Report of Occupational Injury or Illness (Form 5020)
B. Workers' Compensation Claim Form (DWC 1)
C. Leave of Absence Request Form
D. Accident/Incident Investigation Report

V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8016: Unusual Occurrence
C. CalOptima Policy GA.8037: Leave of Absence
D. CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave
E. CalOptima Employee Handbook
F. California Labor Code §§ 132a, and 5400 *et seq*.
G. Title 8, California Code of Regulations, § 342

VI. REGULATORY APPROVALS

None to Date

VII. BOARD ACTION

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors
B. 08/07/14: 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	Version Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8041	Worker's Compensation Leave of Absence	Administrative

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Revised	08/07/2014	GA.8041	Worker's Compensation Leave of Absence	Administrative
Revised	06/07/2018	GA.8041	Worker's Compensation Leave of Absence	Administrative

1

IX. DEFINITIONS

Term	Definition
Workers' Compensation	An insurance policy covering work-related injury and illness.

State of California
EMPLOYER'S REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Please complete in triplicate (type if possible) Mail two copies to:

OSHA CASE NO.

FATALITY ☐

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers compensation benefits or payments is guilty of a felony.

California law requires employers to report within **five days** of knowledge every occupational injury or illness which results in lost time beyond the date of the incident **OR** requires medical treatment beyond first aid. If an employee subsequently dies as a result of a previously reported injury or illness, the employer must file within **five days** of knowledge an amended report indicating death. In addition, every serious injury, illness, or death must be **reported immediately** by telephone or telegraph to the nearest office of the California Division of Occupational Safety and Health.

EMPLOYER

1. FIRM NAME
1a. Policy Number
2. MAILING ADDRESS: (Number, Street, City, Zip)
2a. Phone Number
3. LOCATION if different from Mailing Address (Number, Street, City and Zip)
3a. Location Code
4. NATURE OF BUSINESS; e.g.. Painting contractor, wholesale grocer, sawmill, hotel, etc.
5. State unemployment insurance acct.no
6. TYPE OF EMPLOYER: ☐ Private ☐ State ☐ County ☐ City ☐ School District ☐ Other Gov't, Specify: _____

INJURY OR ILLNESS

7. DATE OF INJURY / ONSET OF ILLNESS (mm/dd/yy)
8. TIME INJURY/ILLNESS OCCURRED _____ AM _____ PM
9. TIME EMPLOYEE BEGAN WORK _____ AM _____ PM
10. IF EMPLOYEE DIED, DATE OF DEATH (mm/dd/yy)
11. UNABLE TO WORK FOR AT LEAST ONE FULL DAY AFTER DATE OF INJURY? ☐ Yes ☐ No
12. DATE LAST WORKED (mm/dd/yy)
13. DATE RETURNED TO WORK (mm/dd/yy)
14. IF STILL OFF WORK, CHECK THIS BOX: ☐
15. PAID FULL DAYS WAGES FOR DATE OF INJURY OR LAST DAY WORKED? ☐ Yes ☐ No
16. SALARY BEING CONTINUED? ☐ Yes ☐ No
17. DATE OF EMPLOYER'S KNOWLEDGE /NOTICE OF INJURY/ILLNESS (mm/dd/yy)
18. DATE EMPLOYEE WAS PROVIDED CLAIM FORM FORM (mm/dd/yy)
19. SPECIFIC INJURY/ILLNESS AND PART OF BODY AFFECTED, MEDICAL DIAGNOSIS if available, e.g.. Second degree burns on right arm, tendonitis on left elbow, lead poisoning
20. LOCATION WHERE EVENT OR EXPOSURE OCCURRED (Number, Street, City, Zip)
20a. COUNTY
21. ON EMPLOYER'S PREMISES? ☐ Yes ☐ No
22. DEPARTMENT WHERE EVENT OR EXPOSURE OCCURRED, e.g.. Shipping department, machine shop.
23. Other Workers injured or ill in this event? ☐ Yes ☐ No
24. EQUIPMENT, MATERIALS AND CHEMICALS THE EMPLOYEE WAS USING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Acetylene, welding torch, farm tractor, scaffold
25. SPECIFIC ACTIVITY THE EMPLOYEE WAS PERFORMING WHEN EVENT OR EXPOSURE OCCURRED, e.g.. Welding seams of metal forms, loading boxes onto truck.
26. HOW INJURY/ILLNESS OCCURRED. DESCRIBE SEQUENCE OF EVENTS. SPECIFY OBJECT OR EXPOSURE WHICH DIRECTLY PRODUCED THE INJURYIILLNESS, e.g.. Worker stepped back to inspect work and slipped on scrap material. As he fell, he brushed against fresh weld, and burned right hand. USE SEPARATE SHEET IF NECESSARY
27. Name and address of physician (number, street, city, zip)
27a. Phone Number
28. Hospitalized as an inpatient overnight? ☐ No ☐ Yes If yes then, name and address of hospital (number, street, city, zip)
28a. Phone Number
29. Employee treated in emergency room? ☐ Yes ☐ No

ATTENTION This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes. See CCR Title 8 14300.29 (b)(6)-(10) & 14300.35(b)(2)(E)2.
Note: Shaded boxes indicate confidential employee information as listed in CCR Title 8 14300.35(b)(2)(E)2*.

EMPLOYEE

30. EMPLOYEE NAME
31. SOCIAL SECURITY NUMBER
32. DATE OF BIRTH (mm/dd/yy)
33. HOME ADDRESS (Number, Street, City,Zip)
33a. PHONE NUMBER
34 SEX ☐ Male ☐ Female
35. OCCUPATION (Regular job title, NO initials, abbreviations or numbers)
36. DATE OF HIRE (mm/dd/yy)
37. EMPLOYEE USUALLY WORKS _____ hours per day, _____ days per week, _____ total weekly hours
37a. EMPLOYMENT STATUS ☐ regular, full-time ☐ part-time ☐ temporary ☐ seasonal
37b. UNDER WHAT CLASS CODE OF YOUR POLICY WHERE WAGES ASSIGNED
38. GROSS WAGES/SALARY $ _____ per _____
39. OTHER PAYMENTS NOT REPORTED AS WAGESISALARY (e.g. tips, meals, overtime, bonuses, etc.)? ☐ Yes ☐ No

Completed By (type or print)
Signature & Title
Date (mm/dd/yy)

• Confidential information may be disclosed only to the employee, former employee, or their personal representative (CCR Title 8 14300.35), to others for the purpose of processing a workers' compensation or other insurance claim; and under certain circumstances to a public health or law enforcement agency or to a consultant hired by the employer (CCR Title 8 14300.30). CCR Title 8 14300.40 requires provision upon request to certain state and federal workplace safety agencies.

Back to Agenda

FILING OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

DO NOT USE THIS COLUMN
CASE NUMBER
OWNERSHIP
INDUSTRY
OCCUPATION
SEX
AGE
DAILY HOURS
DAYS PER WEEK
WEEKLY HOURS
WEEKLY WAGE
COUNTY
NATURE OF INJURY
PART OF BODY
SOURCE
EVENT
SECONDARY SOURCE
EXTENT OF INJURY

Workers' Compensation Claim Form (DWC 1) & Notice of Potential Eligibility

Formulario de Reclamo de Compensación de Trabajadores (DWC 1) y Notificación de Posible Elegibilidad

If you are injured or become ill, either physically or mentally, because of your job, including injuries resulting from a workplace crime, you may be entitled to workers' compensation benefits. Use the attached form to file a workers' compensation claim with your employer. **You should read all of the information below.** Keep this sheet and all other papers for your records. You may be eligible for some or all of the benefits listed depending on the nature of your claim. If you file a claim, the claims administrator, who is responsible for handling your claim, must notify you within 14 days whether your claim is accepted or whether additional investigation is needed.

To file a claim, complete the "Employee" section of the form, keep one copy and give the rest to your employer. Do this right away to avoid problems with your claim. In some cases, benefits will not start until you inform your employer about your injury by filing a claim form. Describe your injury completely. Include every part of your body affected by the injury. If you mail the form to your employer, use first-class or certified mail. If you buy a return receipt, you will be able to prove that the claim form was mailed and when it was delivered. Within one working day after you file the claim form, your employer must complete the "Employer" section, give you a dated copy, keep one copy, and send one to the claims administrator.

Medical Care: Your claims administrator will pay for all reasonable and necessary medical care for your work injury or illness. Medical benefits are subject to approval and may include treatment by a doctor, hospital services, physical therapy, lab tests, x-rays, medicines, equipment and travel costs. Your claims administrator will pay the costs of approved medical services directly so you should never see a bill. There are limits on chiropractic, physical therapy, and other occupational therapy visits.

The Primary Treating Physician (PTP) is the doctor with the overall responsibility for treatment of your injury or illness.

- If you previously designated your personal physician or a medical group, you may see your personal physician or the medical group after you are injured.
- If your employer is using a medical provider network (MPN) or Health Care Organization (HCO), in most cases, you will be treated in the MPN or HCO unless you predesignated your personal physician or a medical group. An MPN is a group of health care providers who provide treatment to workers injured on the job. You should receive information from your employer if you are covered by an HCO or a MPN. Contact your employer for more information.
- If your employer is not using an MPN or HCO, in most cases, the claims administrator can choose the doctor who first treats you unless you predesignated your personal physician or a medical group.
- If your employer has not put up a poster describing your rights to workers' compensation, you may be able to be treated by your personal physician right after you are injured.

Within one working day after you file a claim form, your employer or the claims administrator must authorize up to $10,000 in treatment for your injury, consistent with the applicable treating guidelines until the claim is accepted or rejected. If the employer or claims administrator does not authorize treatment right away, talk to your supervisor, someone else in management, or the claims administrator. Ask for treatment to be authorized right now, while waiting for a decision on your claim. If the employer or claims administrator will not authorize treatment, use your own health insurance to get medical care. Your health insurer will seek reimbursement from the claims administrator. If you do not have health insurance, there are doctors, clinics or hospitals that will treat you without immediate payment. They will seek reimbursement from the claims administrator.

Switching to a Different Doctor as Your PTP:

- If you are being treated in a Medical Provider Network (MPN), you may switch to other doctors within the MPN after the first visit.
- If you are being treated in a Health Care Organization (HCO), you may switch at least one time to another doctor within the HCO. You may switch to a doctor outside the HCO 90 or 180 days after your injury is reported to your employer (depending on whether you are covered by employer-provided health insurance).
- If you are not being treated in an MPN or HCO and did not predesignate, you may switch to a new doctor one time during the first 30 days after your injury is reported to your employer. Contact the claims administrator to switch doctors. After 30 days, you may switch to a doctor of your choice if

Si Ud. se lesiona o se enferma, ya sea físicamente o mentalmente, debido a su trabajo, incluyendo lesiones que resulten de un crimen en el lugar de trabajo, es posible que Ud. tenga derecho a beneficios de compensación de trabajadores. Utilice el formulario adjunto para presentar un reclamo de compensación de trabajadores con su empleador. **Ud. debe leer toda la información a continuación.** Guarde esta hoja y todos los demás documentos para sus archivos. Es posible que usted reúna los requisitos para todos los beneficios, o parte de éstos, que se enumeran dependiendo de la índole de su reclamo. Si usted presenta un reclamo, l administrador de reclamos, quien es responsable por el manejo de su reclamo, debe notificarle dentro de 14 días si se acepta su reclamo o si se necesita investigación adicional.

Para presentar un reclamo, llene la sección del formulario designada para el "Empleado," guarde una copia, y déle el resto a su empleador. Haga esto de inmediato para evitar problemas con su reclamo. En algunos casos, los beneficios no se iniciarán hasta que usted le informe a su empleador acerca de su lesión mediante la presentación de un formulario de reclamo. Describa su lesión por completo. Incluya cada parte de su cuerpo afectada por la lesión. Si usted le envía por correo el formulario a su empleador, utilice primera clase o correo certificado. Si usted compra un acuse de recibo, usted podrá demostrar que el formulario de reclamo fue enviado por correo y cuando fue entregado. Dentro de un día laboral después de presentar el formulario de reclamo, su empleador debe completar la sección designada para el "Empleador," le dará a Ud. una copia fechada, guardará una copia, y enviará una al administrador de reclamos.

Atención Médica: Su administrador de reclamos pagará por toda la atención médica razonable y necesaria para su lesión o enfermedad relacionada con el trabajo. Los beneficios médicos están sujetos a la aprobación y pueden incluir tratamiento por parte de un médico, los servicios de hospital, la terapia física, los análisis de laboratorio, las medicinas, equipos y gastos de viaje. Su administrador de reclamos pagará directamente los costos de los servicios médicos aprobados de manera que usted nunca verá una factura. Hay límites en terapia quiropráctica, física y otras visitas de terapia ocupacional.

El Médico Primario que le Atiende *(Primary Treating Physician- PTP)* es el médico con la responsabilidad total para tratar su lesión o enfermedad.

- Si usted designó previamente a su médico personal o a un grupo médico, usted podrá ver a su médico personal o grupo médico después de lesionarse.
- Si su empleador está utilizando una red de proveedores médicos (*Medical Provider Network- MPN)* o una Organización de Cuidado Médico *(Health Care Organization- HCO)*, en la mayoría de los casos, usted será tratado en la *MPN* o *HCO* a menos que usted hizo una designación previa de su médico personal o grupo médico. Una *MPN* es un grupo de proveedores de asistencia médica quien da tratamiento a los trabajadores lesionados en el trabajo. Usted debe recibir información de su empleador si su tratamiento es cubierto por una *HCO* o una *MPN*. Hable con su empleador para más información.
- Si su empleador no está utilizando una *MPN* o *HCO*, en la mayoría de los casos, el administrador de reclamos puede elegir el médico que lo atiende primero a menos de que usted hizo una designación previa de su médico personal o grupo médico.
- Si su empleador no ha colocado un cartel describiendo sus derechos para la compensación de trabajadores, Ud. puede ser tratado por su médico personal inmediatamente después de lesionarse.

Dentro de un día laboral después de que Ud. Presente un formulario de reclamo, su empleador o el administrador de reclamos debe autorizar hasta $10000 en tratamiento para su lesión, de acuerdo con las pautas de tratamiento aplicables, hasta que el reclamo sea aceptado o rechazado. Si el empleador o administrador de reclamos no autoriza el tratamiento de inmediato, hable con su supervisor, alguien más en la gerencia, o con el administrador de reclamos. Pida que el tratamiento sea autorizado ya mismo, mientras espera una decisión sobre su reclamo. Si el empleador o administrador de reclamos no autoriza el tratamiento, utilice su propio seguro médico para recibir atención médica. Su compañía de seguro médico buscará reembolso del administrador de reclamos. Si usted no tiene seguro médico, hay médicos, clínicas u hospitales que lo tratarán sin pago inmediato. Ellos buscarán reembolso del administrador de reclamos.

Cambiando a otro Médico Primario o *PTP*:

- Si usted está recibiendo tratamiento en una Red de Proveedores Médicos

your employer or the claims administrator has not created or selected an MPN.

Disclosure of Medical Records: After you make a claim for workers' compensation benefits, your medical records will not have the same level of privacy that you usually expect. If you don't agree to voluntarily release medical records, a workers' compensation judge may decide what records will be released. If you request privacy, the judge may "seal" (keep private) certain medical records.

Problems with Medical Care and Medical Reports: At some point during your claim, you might disagree with your PTP about what treatment is necessary. If this happens, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, the steps to take depend on whether you are receiving care in an MPN, HCO, or neither. For more information, see "Learn More About Workers' Compensation," below.

If the claims administrator denies treatment recommended by your PTP, you may request independent medical review (IMR) using the request form included with the claims administrator's written decision to deny treatment. The IMR process is similar to the group health IMR process, and takes approximately 40 (or fewer) days to arrive at a determination so that appropriate treatment can be given. Your attorney or your physician may assist you in the IMR process. IMR is not available to resolve disputes over matters other than the medical necessity of a particular treatment requested by your physician.

If you disagree with your PTP on matters other than treatment, such as the cause of your injury or how severe the injury is, you can switch to other doctors as described above. If you cannot reach agreement with another doctor, notify the claims administrator in writing as soon as possible. In some cases, you risk losing the right to challenge your PTP's opinion unless you do this promptly. If you do not have an attorney, the claims administrator must send you instructions on how to be seen by a doctor called a qualified medical evaluator (QME) to help resolve the dispute. If you have an attorney, the claims administrator may try to reach agreement with your attorney on a doctor called an agreed medical evaluator (AME). If the claims administrator disagrees with your PTP on matters other than treatment, the claims administrator can require you to be seen by a QME or AME.

Payment for Temporary Disability (Lost Wages): If you can't work while you are recovering from a job injury or illness, you may receive temporary disability payments for a limited period. These payments may change or stop when your doctor says you are able to return to work. These benefits are tax-free. Temporary disability payments are two-thirds of your average weekly pay, within minimums and maximums set by state law. Payments are not made for the first three days you are off the job unless you are hospitalized overnight or cannot work for more than 14 days.

Stay at Work or Return to Work: Being injured does not mean you must stop working. If you can continue working, you should. If not, it is important to go back to work with your current employer as soon as you are medically able. Studies show that the longer you are off work, the harder it is to get back to your original job and wages. While you are recovering, your PTP, your employer (supervisors or others in management), the claims administrator, and your attorney (if you have one) will work with you to decide how you will stay at work or return to work and what work you will do. Actively communicate with your PTP, your employer, and the claims administrator about the work you did before you were injured, your medical condition and the kinds of work you can do now, and the kinds of work that your employer could make available to you.

Payment for Permanent Disability: If a doctor says you have not recovered completely from your injury and you will always be limited in the work you can do, you may receive additional payments. The amount will depend on the type of injury, extent of impairment, your age, occupation, date of injury, and your wages before you were injured.

Supplemental Job Displacement Benefit (SJDB): If you were injured on or after 1/1/04, and your injury results in a permanent disability and your employer does not offer regular, modified, or alternative work, you may qualify for a nontransferable voucher payable for retraining and/or skill enhancement. If you qualify, the claims administrator will pay the costs up to the maximum set by state law.

Death Benefits: If the injury or illness causes death, payments may be made to a

(Medical Provider Network- MPN), usted puede cambiar a otros médicos dentro de la MPN después de la primera visita.

- Si usted está recibiendo tratamiento en un Organización de Cuidado Médico (Healthcare Organization- HCO), es posible cambiar al menos una vez a otro médico dentro de la HCO. Usted puede cambiar a un médico fuera de la HCO 90 o 180 días después de que su lesión es reportada a su empleador (dependiendo de si usted está cubierto por un seguro médico proporcionado por su empleador).
- Si usted no está recibiendo tratamiento en una MPN o HCO y no hizo una designación previa, usted puede cambiar a un nuevo médico una vez durante los primeros 30 días después de que su lesión es reportada a su empleador. Póngase en contacto con el administrador de reclamos para cambiar de médico. Después de 30 días, puede cambiar a un médico de su elección si su empleador o el administrador de reclamos no ha creado o seleccionado una MPN.

Divulgación de Expedientes Médicos: Después de que Ud. presente un reclamo para beneficios de compensación de trabajadores, sus expedientes médicos no tendrán el mismo nivel de privacidad que usted normalmente espera. Si Ud. no está de acuerdo en divulgar voluntariamente los expedientes médicos, un juez de compensación de trabajadores posiblemente decida qué expedientes serán revelados. Si usted solicita privacidad, es posible que el juez "selle" (mantenga privados) ciertos expedientes médicos.

Problemas con la Atención Médica y los Informes Médicos: En algún momento durante su reclamo, podría estar en desacuerdo con su *PTP* sobre qué tratamiento es necesario. Si esto sucede, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, los pasos a seguir dependen de si usted está recibiendo atención en una *MPN*, *HCO* o ninguna de las dos. Para más información, consulte la sección "Aprenda Más Sobre la Compensación de Trabajadores," a continuación.

Si el administrador de reclamos niega el tratamiento recomendado por su *PTP*, puede solicitar una revisión médica independiente *(Independent Medical Review-IMR)*, utilizando el formulario de solicitud que se incluye con la decisión por escrito del administrador de reclamos negando el tratamiento. El proceso de la *IMR* es parecido al proceso de la *IMR* de un seguro médico colectivo, y tarda aproximadamente 40 (o menos) días para llegar a una determinación de manera que se pueda dar un tratamiento apropiado. Su abogado o su médico le pueden ayudar en el proceso de la *IMR*. La *IMR* no está disponible para resolver disputas sobre cuestiones aparte de la necesidad médica de un tratamiento particular solicitado por su médico.

Si no está de acuerdo con su *PTP* en cuestiones aparte del tratamiento, como la causa de su lesión o la gravedad de la lesión, usted puede cambiar a otros médicos como se describe anteriormente. Si no puede llegar a un acuerdo con otro médico, notifique al administrador de reclamos por escrito tan pronto como sea posible. En algunos casos, usted arriesg perder el derecho a objetar a la opinión de su *PTP* a menos que hace esto de inmediato. Si usted no tiene un abogado, el administrador de reclamos debe enviarle instrucciones para ser evaluado por un médico llamado un evaluador médico calificado *(Qualified Medical Evaluator-QME)* para ayudar a resolver la disputa. Si usted tiene un abogado, el administrador de reclamos puede tratar de llegar a un acuerdo con su abogado sobre un médico llamado un evaluador médico acordado *(Agreed Medical Evaluator- AME)*. Si el administrador de reclamos no está de acuerdo con su *PTP* sobre asuntos aparte del tratamiento, el administrador de reclamos puede exigirle que sea atendido por un *QME* o *AME*.

Pago por Incapacidad Temporal (Sueldos Perdidos): Si Ud. no puede trabajar, mientras se está recuperando de una lesión o enfermedad relacionada con el trabajo, Ud. puede recibir pagos por incapacidad temporal por un periodo limitado. Estos pagos pueden cambiar o parar cuando su médico diga que Ud. está en condiciones de regresar a trabajar. Estos beneficios son libres de impuestos. Los pagos por incapacidad temporal son dos tercios de su pago semanal promedio, con cantidades mínimas y máximas establecidas por las leyes estales. Los pagos no se hacen durante los primeros tres días en que Ud. no trabaje, a menos que Ud. sea hospitalizado una noche o no puede trabajar durante más de 14 días.

Permanezca en el Trabajo o Regreso al Trabajo: Estar lesionado no significa que usted debe dejar de trabajar. Si usted puede seguir trabajando, usted debe hacerlo. Si no es así, es importante regresar a trabajar con su empleador actual tan

spouse and other relatives or household members who were financially dependent on the deceased worker.

It is illegal for your employer to punish or fire you for having a job injury or illness, for filing a claim, or testifying in another person's workers' compensation case (Labor Code 132a). If proven, you may receive lost wages, job reinstatement, increased benefits, and costs and expenses up to limits set by the state.

Resolving Problems or Disputes: You have the right to disagree with decisions affecting your claim. If you have a disagreement, contact your employer or claims administrator first to see if you can resolve it. If you are not receiving benefits, you may be able to get State Disability Insurance (SDI) or unemployment insurance (UI) benefits. Call the state Employment Development Department at (800) 480-3287 or (866) 333-4606, or go to their website at www.edd.ca.gov.

You Can Contact an Information & Assistance (I&A) Officer: State I&A officers answer questions, help injured workers, provide forms, and help resolve problems. Some I&A officers hold workshops for injured workers. To obtain important information about the workers' compensation claims process and your rights and obligations, go to www.dwc.ca.gov or contact an I&A officer of the state Division of Workers' Compensation. You can also hear recorded information and a list of local I&A offices by calling (800) 736-7401.

You can consult with an attorney. Most attorneys offer one free consultation. If you decide to hire an attorney, his or her fee will be taken out of some of your benefits. For names of workers' compensation attorneys, call the State Bar of California at (415) 538-2120 or go to their website at **www.californiaspecialist.org**.

Learn More About Workers' Compensation: For more information about the workers' compensation claims process, go to www.dwc.ca.gov. At the website, you can access a useful booklet, "Workers' Compensation in California: A Guidebook for Injured Workers." You can also contact an Information & Assistance Officer (above), or hear recorded information by calling 1-800-736-7401.

pronto como usted pueda medicamente hacerlo. Los estudios demuestran que entre más tiempo esté fuera del trabajo, más difícil es regresar a su trabajo original y a sus salarios. Mientras se está recuperando, su *PTP*, su empleador (supervisores u otras personas en la gerencia), el administrador de reclamos, y su abogado (si tiene uno) trabajarán con usted para decidir cómo va a permanecer en el trabajo o regresar al trabajo y qué trabajo hará. Comuníquese de manera activa con su *PTP*, su empleador y el administrador de reclamos sobre el trabajo que hizo antes de lesionarse, su condición médica y los tipos de trabajo que usted puede hacer ahora y los tipos de trabajo que su empleador podría poner a su disposición.

Pago por Incapacidad Permanente: Si un médico dice que no se ha recuperado completamente de su lesión y siempre será limitado en el trabajo que puede hacer, es posible que Ud. reciba pagos adicionales. La cantidad dependerá de la clase de lesión, grado de deterioro, su edad, ocupación, fecha de la lesión y sus salarios antes de lesionarse.

Beneficio Suplementario por Desplazamiento de Trabajo *(Supplemental Job Displacement Benefit- SJDB)*: Si Ud. se lesionó en o después del 1/1/04, y su lesión resulta en una incapacidad permanente y su empleador no ofrece un trabajo regular, modificado, o alternativo, usted podría cumplir los requisitos para recibir un vale no-transferible pagadero a una escuela para recibir un nuevo un curso de reentrenamiento y/o mejorar su habilidad. Si Ud. cumple los requisios, el administrador de reclamos pagará los gastos hasta un máximo establecido por las leyes estatales.

Beneficios por Muerte: Si la lesión o enfermedad causa la muerte, es posible que los pagos se hagan a un cónyuge y otros parientes o a las personas que viven en el hogar que dependían económicamente del trabajador difunto.

Es ilegal que su empleador le castigue o despida por sufrir una lesión o enfermedad laboral, por presentar un reclamo o por testificar en el caso de compensación de trabajadores de otra persona. (Código Laboral, sección 132a.) De ser probado, usted puede recibir pagos por pérdida de sueldos, reposición del trabajo, aumento de beneficios y gastos hasta los límites establecidos por el estado.

Resolviendo problemas o disputas: Ud. tiene derecho a no estar de acuerdo con las decisiones que afecten su reclamo. Si Ud. tiene un desacuerdo, primero comuníquese con su empleador o administrador de reclamos para ver si usted puede resolverlo. Si usted no está recibiendo beneficios, es posible que Ud. pueda obtener beneficios del Seguro Estatalde Incapacidad *(State Disability Insurance- SDI)* o beneficios del desempleo *(Unemployment Insurance- UI)*. Llame al Departamento del Desarrollo del Empleo estatal al (800) 480-3287 o (866) 333-4606, o visite su página Web en www.edd.ca.gov.

Puede Contactar a un Oficial de Información y Asistencia *(Information & Assistance- I&A)*: Los Oficiales de Información y Asistencia *(I&A)* estatal contestan preguntas, ayudan a los trabajadores lesionados, proporcionan formularios y ayudan a resolver problemas. Algunos oficiales de *I&A* tienen talleres para trabajadores lesionados. Para obtener información importante sobre el proceso de la compensación de trabajadores y sus derechos y obligaciones, vaya a www.dwc.ca.gov o comuníquese con un oficial de información y asistencia de la División Estatal de Compensación de Trabajadores. También puede escuchar información grabada y una lista de las oficinas de *I&A* locales llamando al (800) 736-7401.

Ud. puede consultar con un abogado. La mayoría de los abogados ofrecen una consulta gratis. Si Ud. decide contratar a un abogado, los honorarios serán tomados de algunos de sus beneficios. Para obtener nombres de abogados de compensación de trabajadores, llame a la Asociación Estatal de Abogados de California *(State Bar)* al (415) 538-2120, o consulte su página Web en www.californiaspecialist.org.

Aprenda Más Sobre la Compensación de Trabajadores: Para obtener más información sobre el proceso de reclamos del programa de compensación de trabajadores, vaya a www.dwc.ca.gov. En la página Web, podrá acceder a un folleto útil, "Compensación del Trabajador de California: Una Guía para Trabajadores Lesionados." También puede contactar a un oficial de Información y Asistencia (arriba), o escuchar información grabada llamando al 1-800-736-7401.

PRINT CLEAR

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION

Estado de California
Departamento de Relaciones Industriales
DIVISION DE COMPENSACIÓN AL TRABAJADOR

WORKERS' COMPENSATION CLAIM FORM (DWC 1)

PETITION DEL EMPLEADO PARA DE COMPENSACIÓN DEL TRABAJADOR (DWC 1)

Employee: Complete the **"Employee"** section and give the form to your employer. Keep a copy and mark it "**Employee's Temporary Receipt**" until you receive the signed and dated copy from your employer. You may call the Division of Workers' Compensation and hear recorded information at **(800) 736-7401.** An explanation of workers' compensation benefits is included in the Notice of Potential Eligibility, which is the cover sheet of this form. Detach and save this notice for future reference.

You should also have received a pamphlet from your employer describing workers' compensation benefits and the procedures to obtain them. You may receive written notices from your employer or its claims administrator about your claim. If your claims administrator offers to send you notices electronically, and you agree to receive these notices only by email, please provide your email address below and check the appropriate box. If you later decide you want to receive the notices by mail, you must inform your employer in writing.

Empleado: *Complete la sección* ***"Empleado"*** *y entregue la forma a su empleador. Quédese con la copia designada* ***"Recibo Temporal del Empleado"*** *hasta que Ud. reciba la copia firmada y fechada de su empleador. Ud. puede llamar a la Division de Compensación al Trabajador al* ***(800) 736-7401*** *para oir información gravada. Una explicación de los beneficios de compensación de trabajadores está incluido en la Notificación de Posible Elegibilidad, que es la hoja de portada de esta forma. Separe y guarde esta notificación como referencia para el futuro.*

Ud. también debería haber recibido de su empleador un folleto describiendo los benficios de compensación al trabajador lesionado y los procedimientos para obtenerlos. Es posible que reciba notificaciones escritas de su empleador o de su administrador de reclamos sobre su reclamo. Si su administrador de reclamos ofrece enviarle notificaciones electrónicamente, y usted acepta recibir estas notificaciones solo por correo electrónico, por favor proporcione su dirección de correo electrónico abajo y marque la caja apropiada. Si usted decide después que quiere recibir las notificaciones por correo, usted debe de informar a su empleador por escrito.

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Toda aquella persona que a propósito haga o cause que se produzca cualquier declaración o representación material falsa o fraudulenta con el fin de obtener o negar beneficios o pagos de compensación a trabajadores lesionados es culpable de un crimen mayor "felonia".

Employee—complete this section and see note above ***Empleado—complete esta sección y note la notación arriba.***

1. Name. *Nombre.* _____ Today's Date. *Fecha de Hoy.* _____
2. Home Address. *Dirección Residencial.* _____
3. City. *Ciudad.* _____ State. *Estado.* _____ Zip. *Código Postal.* _____
4. Date of Injury. *Fecha de la lesión (accidente).* _____ Time of Injury. *Hora en que ocurrió.* _____a.m. _____p.m.
5. Address and description of where injury happened. *Dirección/lugar dónde occurió el accidente.* _____
6. Describe injury and part of body affected. *Describa la lesión y parte del cuerpo afectada.* _____
7. Social Security Number. *Número de Seguro Social del Empleado.* _____
8. ☐ Check if you agree to receive notices about your claim by email only. ☐ *Marque si usted acepta recibir notificaciones sobre su reclamo solo por correo electrónico.* Employee's e-mail. _____ *Correo electrónico del empleado.* _____.

You will receive benefit notices by regular mail if you do not choose, or your claims administrator does not offer, an electronic service option. *Usted recibirá notificaciones de beneficios por correo ordinario si usted no escoge, o su administrador de reclamos no le ofrece, una opción de servicio electrónico.*

9. Signature of employee. *Firma del empleado.* _____

Employer—complete this section and see note below. ***Empleador—complete esta sección y note la notación abajo.***

10. Name of employer. *Nombre del empleador.* _____
11. Address. *Dirección.* _____
12. Date employer first knew of injury. *Fecha en que el empleador supo por primera vez de la lesión o accidente.* _____
13. Date claim form was provided to employee. *Fecha en que se le entregó al empleado la petición.* _____
14. Date employer received claim form. *Fecha en que el empleado devolvió la petición al empleador.* _____
15. Name and address of insurance carrier or adjusting agency. *Nombre y dirección de la compañía de seguros o agencia adminstradora de seguros.* _____
16. Insurance Policy Number. *El número de la póliza de Seguro.* _____
17. Signature of employer representative. *Firma del representante del empleador.* _____
18. Title. *Título.* _____ 19. Telephone. *Teléfono.* _____

Employer: You are required to date this form and provide copies to your insurer or claims administrator and to the employee, dependent or representative who filed the claim within **one working day** of receipt of the form from the employee.

SIGNING THIS FORM IS NOT AN ADMISSION OF LIABILITY

Empleador: *Se requiere que Ud. feche esta forma y que provéa copias a su compañía de seguros, administrador de reclamos, o dependiente/representante de reclamos y al empleado que hayan presentado esta petición dentro del plazo de* ***un día hábil*** *desde el momento de haber sido recibida la forma del empleado.*

EL FIRMAR ESTA FORMA NO SIGNIFICA ADMISION DE RESPONSABILIDAD

☐ Employer copy/*Copia del Empleador* ☐ Employee copy/*Copia del Empleado* ☐ Claims Administrator/*Administrador de Reclamos* ☐ Temporary Receipt/*Recibo del Empleado*

Rev. 1/1/2016

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CalOptima
A Public Agency
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LEAVE OF ABSENCE REQUEST FORM

SECTION I – EMPLOYEE'S STATEMENT Contact Phone Number:_____

Employee Name: _____ Employee ID #: _____

Mailing Address: ---------- Email Address: ------__----------

Department: _____ Position: _____

Requested dates of absence: First day off work____/___/____ Expected Return Date:____/____/____

Is Illness/Injury Work Related?

☐ Yes ☐ No

REASON FOR LEAVE

☐ **Employee Medical (FMLA/CFRA)** - Attach Medical Certification

☐ **Pregnancy Disability (PDL)** - Attach Medical Certification

☐ **Family Medical (FMLA/CFRA) -** Attach Medical Certification

☐ **Military Leave (FMLA or Spouse Leave)** - Attach Supporting Documentation

☐ ***Baby Bonding** (within 1 year of birth or placement of adoption/foster care)

☐ **Personal Leave -** Attach Supporting Documentation

☐ **Other** - _____ (Attach Supporting Documentation)

Note: Additional documentation regarding types of leaves of absence can be found on the Human Resources page of the InfoNet.

EXPLANATION: _____

(FOR UNPAID LEAVE REQUESTS) To continue employee paid Health Insurance you should contact Human Resources to make arrangements for payment in advance

Employee's Signature: _____ Date:____/____/____

SECTION II – MANAGER OR DIRECTOR ACKNOWLEDGMENT (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)

Manager/Director Signature: _____ Date:____/___/____

HUMAN RESOURCES USE ONLY

SECTION III – HUMAN RESOURCES REVIEW

You are ☐ eligible ☐ not eligible for leave under the FMLA/CFRA. FMLA/CFRA Hours Balance Available _____

Last Day Worked _____ Return from Leave Date _____

Human Resources Signature: _____ Date:____/____/____

COMMENTS_____

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Accident/Incident Investigation Report

505 City Parkway West | Orange, CA 92868

SECTION 1 – EMPLOYEE INFORMATION (WHO)

Name	Home Address	DOB

Gender	Job Title	Supervisor Name

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

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

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

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

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

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

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

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

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

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

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

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

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

SECTION 4 – CORRECTIVE ACTION AND DISPOSITION

1. Disposition:

a) First aid? ☐ Yes ☐ No

b) If first aid, describe

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

d) Returned to work? ☐Yes ☐No

e) Returned to work modified duty ☐

Emergency room / hospital address

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

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

If yes, please describe

4. Employee recommendations / suggestions

5. Supervisor comments / recommendations

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

Policy #: GA.8042
Title: **Supplemental Compensation**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/01/11
Last Review Date: ~~09/07/17~~ 06/07/18
Last Revised Date: ~~09/07/17~~ 06/07/18

~~*Board Approved Policy*~~

I. PURPOSE

This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

II. POLICY

A. CalOptima considers the following as Special Compensation pursuant to Title 2, Section 571 of the California Code of Regulations (CCR):

1. Bilingual pay/Bilingual Premium;

2. Night Shift premium/Shift Differential;

3. Active Certified Case Manager (CCM) Pay/Educational Incentive; and

4. Executive Incentive Program/Bonus Pay.

B. Overtime Pay: As a public agency, CalOptima follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all hours worked in excess of forty (40) in any one (1) workweek at the rate of 1.5 times the employee's base hourly rate of pay. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Bilingual Pay: CalOptima provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima's Threshold Languages. This is considered Bilingual Premium pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Bilingual Pay is based on the following schedule:

Proficiency	Rate Per Pay Period
Bilingual language usage is required in the job description and used more than fifty percent (50%) of the time in the performance of the employee's job duties.	$60.00
Bilingual language usage is preferred in the job description and used less than fifty percent (50%) of the time in the performance of the employee's job duties.	$40.00

D. Translation Pay: In certain circumstances when, for business reasons and for the benefit of CalOptima Members, there is a need to translate documents and other written material into languages other than English, the Exempt Employee providing such service will be paid supplemental pay. Non-Exempt Employees are not eligible for translation pay.

1. A CalOptima Exempt Employee, who does not work in the Cultural & Linguistic Services Department (C&L) and who is not required as part of his or her regular job responsibilities to translate~~,~~ but is qualified to translate ~~-~~based on successfully passing ~~-~~the CalOptima Bilingual Screening Process, may be eligible for Translation Pay for performing translation work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during his or her own personal time based on the rates indicated below. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis.

2. There are two (2) key activities in providing translation services:

   a. Translation of materials from English into the desired language, or from another language into English; and

   b. Review and revision of the translation to ensure quality and consistency in usage of terms.

3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima will reimburse for services at the following rates:

   a. Translation – Thirty-five dollars ($35.00) per page; and

   b. Review and revision of translated materials – Twenty-five dollars ($25.00) per page.

4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or unfeasible due to business constraints.

E. Night Shift: CalOptima provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima management. This is considered a Shift Differential pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Night Shift is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Seven (7) consecutive hours or more, including at least four (4) hours of work between 4 p.m. and 8 a.m.	Non-exempt employees	Second shift employees (start time 3 p.m.) will receive $1.50 per hour. Third shift employees (start time 11 p.m.) will receive $2.00 per hour.

F. Call Back and On Call: CalOptima provides supplemental pay for work performed as part of a Call Back and On Call requirement. Assignments for Call Back and On Call are subject to business

needs and are at the discretion of CalOptima management. The rates for Call Back and On Call Pay are based on the following schedule:

Definition	Eligibility	Rates (per hour)
Call Back – Must physically return to work within one (1) hour when requested by a Supervisor. A Supervisor may assign the employee other work until the guaranteed four (4) hour time elapses.	Non-exempt employees	1.5 times of base hourly rate with a minimum of four (4) hours of pay.
On Call – Must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Non-exempt employees	$3.00/hour for being on-call. If a call is taken, employee is paid 1.5 times the regularly hourly rate with a thirty (30) minute minimum call.
On Call Medical Case Managers (RN or LVN) and Clinical Pharmacists - Must remain accessible to accept or respond to calls within a reasonable time designated by Employee's supervisor. In no event shall Employee's supervisor require a response time less than thirty (30) minutes. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Exempt employees excluding those in supervisory positions	25% of base hourly rate multiplied by the number of hours on call.

G. Active Certified Case Manager (CCM) Pay: CalOptima may recognize supplemental pay of one hundred dollars ($100) per pay period to an RN who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This is considered as an Educational Incentive pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.

H. Executive Incentive Program: The Chief Executive Officer (CEO) may recognize Executive Staff, including interim appointments, using incentive compensation as described in this policy. For Executive Staff who achieve superior performance, the incentive compensation is considered Bonus Pay pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation for Classic Members.

I. Sales Incentive Program: The OneCare Community Partner and Senior (Sr.) Community Partner staff in the OneCare Sales & Marketing Department shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect programs.

1. The licensed Community Partner and Sr. Community Partner staff will receive a monthly ~~-~~Sales Incentive based on the number of eligible members enrolled into the OneCare and OneCare Connect program ~~on the following monthly incentive range:~~ in accordance with the table in Paragraph II.I.2. below. No incentive will be paid for the first thirty (30) enrollments each month, regardless of how many enrollments are made under, at or over thirty (30). For enrollments over thirty (30), licensed Community Partner and Sr. Community Partner staff will

be eligible to receive the incentive payment of one hundred sixty five dollars ($165.00) for each new enrollment within that tier between thirty-one (31) –– fifty (50). In other words, each tier is independent and does not alter the amount paid per enrollment in any other tier. For example, eligible staff who enroll fifty-three (53) members in a month will be eligible to receive payment based on the following calculation (from tier thirty-one (31) –– fifty(50)) twenty (20) members multiplied by one hundred sixty five dollars ($165), plus (from tier fifty-one (51) –– sixty-five (65)) three (3) members multiplied by one hundred seventy-five ($175), which equals an incentive of three thousand eight hundred twenty five dollars ($3,825) for that month.

2. Enrollment is paid per eligible member above the minimum tier at the rate specified within each tier as follows:

~~Enrollments~~Tier Min	~~Incentive per eligible member enrolled~~Tier Max	Payout for Enrollment within Each Tier
1~~ – 25~~	30	**$0.00**
~~26 – 30~~31	50	**$~~50~~165.00**
~~31 – 45~~51	65	**$~~100~~175.00**
~~46 – 50~~66+		**$~~125~~200.00**
~~51+~~	~~$150.00~~	

~~2.~~ 3 The Sales Incentive for the Manager, Member Outreach & Education shall be based on the number of eligible members enrolled into the OneCare and OneCare Connect programs by the Community Partner and Sr. Community Partner in the OneCare Sales & Marketing Department. The Manager, Member Outreach & Education will receive ~~twenty~~ten dollars ($~~20~~10.00) per member enrolled, if and only if, the Community Partner or Sr. Community Partner reporting to the Manager, Member Outreach & Education, enrolls thirty-~~one (31~~six (36) or more ~~-~~members per month. If a Community Partner or Sr. Community Partner fails to enroll at least thirty-~~one (31~~six (36) members per month, the Manager, Member Outreach & Education, would not be eligible for the Sales Incentive for that Community Partner or Sr. Community Partner.

J. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima's business needs and mission, vision, and values.

K. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance and/or strategic imperatives, CalOptima may, at the discretion of the CEO, and on an exception basis, award a retention incentive.

L. Recruitment Incentive: At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the median base pay for the applicable position may be offered to entice an individual to join CalOptima. Recruitment incentives offered for Executive Director and Chief positions require Board of Directors approval.

M. Incentive programs may be modified or withdrawn, at any time. Award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. It is not intended to be a binding contract between Executive Staff or employees and CalOptima.

N. Employer-Paid Member Contribution (EPMC): CalOptima contributes seven percent (7%) of Compensation Earnable, on behalf of eligible employees who hold Management Staff positions as identified in the CalOptima salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a Management Staff position, including interim appointments; and

2. Included in one (1) of the following categories:

   a. A CalPERS Classic Member; or

   b. A member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.

O. Annual Performance Lump Sum Bonus: Employees paid at the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may be eligible for a merit bonus pay delivered as a lump sum bonus in accordance with Section III.J of this policy, provided that their performance meets the goals and objectives set forth by their managers.

P. Automobile Allowance: CalOptima may, at the discretion of the CEO, provide employees in Executive Staff positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars ($500) for the use of their personal vehicle for CalOptima business.

Q. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima's contribution rate for employees to the supplemental retirement benefit (SRB) plan administered by the Public Agency Retirement System (PARS) within the limits of the budget and subject to contribution limits established by applicable laws. With the exception employees in Executive Staff positions, the contribution rate shall be uniform for all employees. For employees in Executive Staff positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to PARS, subject to the limitations of applicable laws. These SRB contribution rates to the PARS retirement plan shall continue from year to year, unless otherwise adjusted or discontinued.

III. PROCEDURE

A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

B. Bilingual Pay: An employee or potential employee shall undergo a written and verbal bilingual evaluation when bilingual proficiency is a part of the employee's or potential employee's job description and used in the performance of the employee's job duties. If the employee or potential employee passes the evaluations, the bilingual pay shall be established.

C. Translation Pay: If an eligible Exempt Employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay, identified above, will be provided depending on the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.

D. Night Shift:

1. Night shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) consecutive hours or more, including at least four (4) hours of work between 4 p.m. and 8 a.m.

2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting make up time or alternative hours, and as a result, would be eligible for night shift pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

E. Call Back and On Call Pay:

1. If an employee is on call or gets called back to work, the employee is responsible for adding this time to their schedule through CalOptima's time keeping system, which is then approved by their Supervisor.

F. Active Certified Case Manager (CCM) Pay:

1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department.

G. Incentive Compensation

1. The Board of Directors approves CalOptima's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the Executive Staff.

2. The CEO may establish an incentive compensation program for Executive Staff based on the Executive Incentive Program attached within budgeted parameters in accomplishing specific results according to the department and individual goals set forth by the CEO and the level of achievement. Executive Staff will receive a performance evaluation based on the Performance Review of Executives Template attached, which measures their performance against the established goals. Based on the level of performance, the Executive Staff member may be eligible for a lump sum bonus payment. The Executive Staff member must still be employed by CalOptima and in good standing at the time the bonus is distributed in order to be eligible to receive the bonus payment. For eligible Executive Staff members who achieve superior performance, CalOptima will report the bonus payment to CalPERS as Special Compensation. The CEO is authorized to make minor revisions to the Executive Incentive Program and Performance Review of Executives Template from time to time, as appropriate.

3. As circumstances warrant and at the discretion of the CEO, employees not at the Executive Staff level, whose accomplishments have provided extraordinary results, may be considered for incentive compensation.

H. Sales Incentive Program

1. The One Care Community Partner and Sr. Community Partner staff, in the OneCare Sales & Marketing Department, shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect Programs.

2. The Community Partner and Sr. Community Partner staff shall be eligible to receive Sales Incentive pay as described in Section II.I.1 of this policy for successfully enrolling new members into the OneCare and OneCare Connect Programs. Sales Incentive pay for the Manager, Member Outreach & Education, shall be based on the number of members enrolled into the OneCare and OneCare Connect Programs by the Community Partner and Sr. Community Partner as described in Section II.I.2 of this policy.

   a. CalOptima shall follow the Medicare Marketing Guidelines (MMGs) charge-back guidelines of ninety (90) calendar day rapid disenrollment and recouping the Sales Incentive with the exceptions as specified under the guidelines and applicable CalOptima policies.

3. CalOptima shall pay the Sales Incentive to the eligible employee on a monthly basis approximately one and a half (1 ½) months after the month in which the eligible employee earned the Sales Incentive.

   a. In the event a OneCare or OneCare Connect member disenrolls from their respective program within ninety (90) calendar days for reasons other than the exceptions specified under the guidelines and applicable CalOptima policies, the Sales Incentive previously earned will be deducted from a future Sales Incentive.

4. The Chief Operating Officer, Executive Director of Network Operations and Director Network Management who oversee the OneCare Sales & Marketing Department shall approve the Sales Incentive payout.

5. Enrollment goals for the Community Partner and Community Partner Sr. staff will be pro-rated for the month if the employee misses one (1) or more full weeks due to vacations, sick days, or a Leave of Absence.

6. The Director, Network Management, Executive Director of Network Operations and the Chief Operations Officer will review the Sales Incentive structure on an annual basis.

I. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met in order to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period. The CEO has the authority to offer retention incentives for up to twelve (12) employees per calendar year in an amount not to exceed ten percent (10%) of the employee's

current base annual salary. Retention incentives that exceed ten percent (10%) of the employee's current base annual salary require Board of Directors approval.

J. Recruitment Incentive: As circumstances warrant, the CEO may offer a recruitment incentive based on the Compensation Administration Guidelines managed by the Human Resources Department to entice an individual to join CalOptima. Board of Directors approval is required for recruitment incentives offered for Executive Director and Chief positions. In order to receive the recruitment incentive, the individual offered the incentive is required to accept and sign an offer letter which contains a "claw-back" provision obligating the recipient of a recruitment incentive to return the full amount of the recruitment incentive if the recipient voluntarily terminates employment with CalOptima within twenty-four (24) months of the date of hire.

K. Annual Performance Lump Sum Bonus: Once an employee has reached the pay range maximum, the employee may be eligible for merit bonus pay delivered as a lump sum bonus, provided that his or her annual performance evaluation meets the established goals and objectives set forth by their managers. Merit bonus pay will not exceed the maximum percentage of the merit increase matrix and reflects the employee's superior performance measured against established objectives. Annual performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when merit salary increases are normally distributed and the second half six (6) months later. The employee must still be employed by CalOptima in order to be eligible to receive the lump sum bonus payments.

L. Automobile Allowance: As circumstances warrant, the CEO may offer to employees in Executive Staff positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that would otherwise apply in the use of their personal vehicle in the performance of their duties. Such automobile allowance will be identified on the Executive Staff's W-2 forms as taxable income. In addition, as a condition of receiving such allowance, the Executive Staff member must comply with the following requirements:

1. He or she must maintain adequate levels of personal vehicle insurance coverage;

2. He or she shall purchase his or her own fuel for the vehicle; and

3. He or she shall ensure that the vehicle is properly maintained.

IV. ATTACHMENTS

A. Executive Incentive Program
B. Performance Review of Executives Template

V. REFERENCES

A. CalOptima Employee Handbook
B. Compensation Administration Guidelines
C. Government Code, §20636 and 20636.1
D. Title 2, California Code of Regulations (CCR), §571

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 09/07/17: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 12/03/15: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 05/01/14: Regular Meeting of the CalOptima Board of Directors
~~D.~~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	01/01/2011	GA.8042	Pay Differentials	Administrative
Revised	01/05/2012	GA.8042	Pay Differentials	Administrative
Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
Revised	12/03/2015	GA.8042	Supplemental Compensation	Administrative
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative
Revised	06/07/2018	GA.8042	Supplemental Compensation	Administrative

IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process~~:~~	Prospective staff translators are identified by Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Classic Director	A Management Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Classic Executive	An Executive Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Compensation Earnable	The pay rate and special compensation as defined in Government Code sections 20636 and 20636.1.
Executive Staff	Staff holding Executive level positions as specifically designated by the Board of Directors.
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.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare or/ OneCare Connect Program.
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).

Term	Definition
Threshold Language	For purposes of this policy, a threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

1

Policy #: GA.8042
Title: **Supplemental Compensation**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/01/11
Last Review Date: 06/07/18
Last Revised Date: 06/07/18

I. PURPOSE

This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

II. POLICY

A. CalOptima considers the following as Special Compensation pursuant to Title 2, Section 571 of the California Code of Regulations (CCR):

1. Bilingual pay/Bilingual Premium;

2. Night Shift premium/Shift Differential;

3. Active Certified Case Manager (CCM) Pay/Educational Incentive; and

4. Executive Incentive Program/Bonus Pay.

B. Overtime Pay: As a public agency, CalOptima follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all hours worked in excess of forty (40) in any one (1) workweek at the rate of 1.5 times the employee's base hourly rate of pay. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Bilingual Pay: CalOptima provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima's Threshold Languages. This is considered Bilingual Premium pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Bilingual Pay is based on the following schedule:

Proficiency	**Rate Per Pay Period**
Bilingual language usage is required in the job description and used more than fifty percent (50%) of the time in the performance of the employee's job duties.	$60.00
Bilingual language usage is preferred in the job description and used less than fifty percent (50%) of the time in the performance of the employee's job duties.	$40.00

D. Translation Pay: In certain circumstances when, for business reasons and for the benefit of CalOptima Members, there is a need to translate documents and other written material into

languages other than English, the Exempt Employee providing such service will be paid supplemental pay. Non-Exempt Employees are not eligible for translation pay.

1. A CalOptima Exempt Employee, who does not work in the Cultural & Linguistic Services Department (C&L) and who is not required as part of his or her regular job responsibilities to translate but is qualified to translate based on successfully passing the CalOptima Bilingual Screening Process, may be eligible for Translation Pay for performing translation work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during his or her own personal time based on the rates indicated below. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis.

2. There are two (2) key activities in providing translation services:

   a. Translation of materials from English into the desired language, or from another language into English; and

   b. Review and revision of the translation to ensure quality and consistency in usage of terms.

3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima will reimburse for services at the following rates:

   a. Translation – Thirty-five dollars ($35.00) per page; and

   b. Review and revision of translated materials – Twenty-five dollars ($25.00) per page.

4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or unfeasible due to business constraints.

E. Night Shift: CalOptima provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima management. This is considered a Shift Differential pursuant to Title 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Night Shift is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Seven (7) consecutive hours or more, including at least four (4) hours of work between 4 p.m. and 8 a.m.	Non-exempt employees	Second shift employees (start time 3 p.m.) will receive $1.50 per hour. Third shift employees (start time 11 p.m.) will receive $2.00 per hour.

F. Call Back and On Call: CalOptima provides supplemental pay for work performed as part of a Call Back and On Call requirement. Assignments for Call Back and On Call are subject to business needs and are at the discretion of CalOptima management. The rates for Call Back and On Call Pay are based on the following schedule:

Definition	Eligibility	Rates (per hour)
Call Back – Must physically return to work within one (1) hour when requested by a Supervisor. A Supervisor may assign the employee other work until the guaranteed four (4) hour time elapses.	Non-exempt employees	1.5 times of base hourly rate with a minimum of four (4) hours of pay.
On Call – Must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Non-exempt employees	$3.00/hour for being on-call. If a call is taken, employee is paid 1.5 times the regularly hourly rate with a thirty (30) minute minimum call.
On Call Medical Case Managers (RN or LVN) and Clinical Pharmacists - Must remain accessible to accept or respond to calls within a reasonable time designated by Employee's supervisor. In no event shall Employee's supervisor require a response time less than thirty (30) minutes. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Exempt employees excluding those in supervisory positions	25% of base hourly rate multiplied by the number of hours on call.

G. Active Certified Case Manager (CCM) Pay: CalOptima may recognize supplemental pay of one hundred dollars ($100) per pay period to an RN who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This is considered as an Educational Incentive pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.

H. Executive Incentive Program: The Chief Executive Officer (CEO) may recognize Executive Staff, including interim appointments, using incentive compensation as described in this policy. For Executive Staff who achieve superior performance, the incentive compensation is considered Bonus Pay pursuant to Title 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation for Classic Members.

I. Sales Incentive Program: The OneCare Community Partner and Senior (Sr.) Community Partner staff in the OneCare Sales & Marketing Department shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect programs.

1. The licensed Community Partner and Sr. Community Partner staff will receive a monthly Sales Incentive based on the number of eligible members enrolled into the OneCare and OneCare Connect program in accordance with the table in Paragraph II.I.2. below. No incentive will be paid for the first thirty (30) enrollments each month, regardless of how many enrollments are made under, at or over thirty (30). For enrollments over thirty (30), licensed Community Partner and Sr. Community Partner staff will be eligible to receive the incentive payment of one hundred sixty five dollars ($165.00) for each new enrollment within that tier between thirty-one

(31) – fifty (50). In other words, each tier is independent and does not alter the amount paid per enrollment in any other tier. For example, eligible staff who enroll fifty-three (53) members in a month will be eligible to receive payment based on the following calculation (from tier thirty-one (31) – fifty(50)) twenty (20) members multiplied by one hundred sixty five dollars ($165), plus (from tier fifty-one (51) – sixty-five (65)) three (3) members multiplied by one hundred seventy-five ($175), which equals an incentive of three thousand eight hundred twenty five dollars ($3,825) for that month.

2. Enrollment is paid per eligible member above the minimum tier at the rate specified within each tier as follows:

Tier Min	**Tier Max**	**Payout for Enrollment within Each Tier**
1	30	**$0.00**
31	50	**$165.00**
51	65	**$175.00**
66+		**$200.00**

3 The Sales Incentive for the Manager, Member Outreach & Education shall be based on the number of eligible members enrolled into the OneCare and OneCare Connect programs by the Community Partner and Sr. Community Partner in the OneCare Sales & Marketing Department. The Manager, Member Outreach & Education will receive ten dollars ($10.00) per member enrolled, if and only if, the Community Partner or Sr. Community Partner reporting to the Manager, Member Outreach & Education, enrolls thirty-six (36) or more members per month. If a Community Partner or Sr. Community Partner fails to enroll at least thirty-six (36) members per month, the Manager, Member Outreach & Education, would not be eligible for the Sales Incentive for that Community Partner or Sr. Community Partner.

J. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima's business needs and mission, vision, and values.

K. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance and/or strategic imperatives, CalOptima may, at the discretion of the CEO, and on an exception basis, award a retention incentive.

L. Recruitment Incentive: At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the median base pay for the applicable position may be offered to entice an individual to join CalOptima. Recruitment incentives offered for Executive Director and Chief positions require Board of Directors approval.

M. Incentive programs may be modified or withdrawn, at any time. Award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. It is not intended to be a binding contract between Executive Staff or employees and CalOptima.

N. Employer-Paid Member Contribution (EPMC): CalOptima contributes seven percent (7%) of Compensation Earnable, on behalf of eligible employees who hold Management Staff positions as identified in the CalOptima salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a Management Staff position, including interim appointments; and

2. Included in one (1) of the following categories:

   a. A CalPERS Classic Member; or

   b. A member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.

O. Annual Performance Lump Sum Bonus: Employees paid at the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may be eligible for a merit bonus pay delivered as a lump sum bonus in accordance with Section III.J of this policy, provided that their performance meets the goals and objectives set forth by their managers.

P. Automobile Allowance: CalOptima may, at the discretion of the CEO, provide employees in Executive Staff positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars ($500) for the use of their personal vehicle for CalOptima business.

Q. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima's contribution rate for employees to the supplemental retirement benefit (SRB) plan administered by the Public Agency Retirement System (PARS) within the limits of the budget and subject to contribution limits established by applicable laws. With the exception employees in Executive Staff positions, the contribution rate shall be uniform for all employees. For employees in Executive Staff positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to PARS, subject to the limitations of applicable laws. These SRB contribution rates to the PARS retirement plan shall continue from year to year, unless otherwise adjusted or discontinued.

III. PROCEDURE

A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

B. Bilingual Pay: An employee or potential employee shall undergo a written and verbal bilingual evaluation when bilingual proficiency is a part of the employee's or potential employee's job description and used in the performance of the employee's job duties. If the employee or potential employee passes the evaluations, the bilingual pay shall be established.

C. Translation Pay: If an eligible Exempt Employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay, identified above, will be provided depending on the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.

D. Night Shift:

1. Night shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) consecutive hours or more, including at least four (4) hours of work between 4 p.m. and 8 a.m.

2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting make up time or alternative hours, and as a result, would be eligible for night shift pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

E. Call Back and On Call Pay:

1. If an employee is on call or gets called back to work, the employee is responsible for adding this time to their schedule through CalOptima's time keeping system, which is then approved by their Supervisor.

F. Active Certified Case Manager (CCM) Pay:

1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department.

G. Incentive Compensation

1. The Board of Directors approves CalOptima's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the Executive Staff.

2. The CEO may establish an incentive compensation program for Executive Staff based on the Executive Incentive Program attached within budgeted parameters in accomplishing specific results according to the department and individual goals set forth by the CEO and the level of achievement. Executive Staff will receive a performance evaluation based on the Performance Review of Executives Template attached, which measures their performance against the established goals. Based on the level of performance, the Executive Staff member may be eligible for a lump sum bonus payment. The Executive Staff member must still be employed by CalOptima and in good standing at the time the bonus is distributed in order to be eligible to receive the bonus payment. For eligible Executive Staff members who achieve superior performance, CalOptima will report the bonus payment to CalPERS as Special Compensation. The CEO is authorized to make minor revisions to the Executive Incentive Program and Performance Review of Executives Template from time to time, as appropriate.

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2. The Community Partner and Sr. Community Partner staff shall be eligible to receive Sales Incentive pay as described in Section II.I.1 of this policy for successfully enrolling new members into the OneCare and OneCare Connect Programs. Sales Incentive pay for the Manager, Member Outreach & Education, shall be based on the number of members enrolled into the OneCare and OneCare Connect Programs by the Community Partner and Sr. Community Partner as described in Section II.I.2 of this policy.

    a. CalOptima shall follow the Medicare Marketing Guidelines (MMGs) charge-back guidelines of ninety (90) calendar day rapid disenrollment and recouping the Sales Incentive with the exceptions as specified under the guidelines and applicable CalOptima policies.

3. CalOptima shall pay the Sales Incentive to the eligible employee on a monthly basis approximately one and a half (1 ½) months after the month in which the eligible employee earned the Sales Incentive.

    a. In the event a OneCare or OneCare Connect member disenrolls from their respective program within ninety (90) calendar days for reasons other than the exceptions specified under the guidelines and applicable CalOptima policies, the Sales Incentive previously earned will be deducted from a future Sales Incentive.

4. The Chief Operating Officer, Executive Director of Network Operations and Director Network Management who oversee the OneCare Sales & Marketing Department shall approve the Sales Incentive payout.

5. Enrollment goals for the Community Partner and Community Partner Sr. staff will be pro-rated for the month if the employee misses one (1) or more full weeks due to vacations, sick days, or a Leave of Absence.

6. The Director, Network Management, Executive Director of Network Operations and the Chief Operations Officer will review the Sales Incentive structure on an annual basis.

I. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met in order to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period. The CEO has the authority to offer retention incentives for up to twelve (12) employees per calendar year in an amount not to exceed ten percent (10%) of the employee's current base annual salary. Retention incentives that exceed ten percent (10%) of the employee's current base annual salary require Board of Directors approval.

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1. He or she must maintain adequate levels of personal vehicle insurance coverage;

2. He or she shall purchase his or her own fuel for the vehicle; and

3. He or she shall ensure that the vehicle is properly maintained.

IV. ATTACHMENTS

A. Executive Incentive Program
B. Performance Review of Executives Template

V. REFERENCES

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B. Compensation Administration Guidelines
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VI. REGULATORY AGENCY APPROVALS

None to Date

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VIII. REVIEW/REVISION HISTORY

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Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
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Bonus Pay	Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Classic Director	A Management Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Classic Executive	An Executive Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Compensation Earnable	The pay rate and special compensation as defined in Government Code sections 20636 and 20636.1.
Executive Staff	Staff holding Executive level positions as specifically designated by the Board of Directors.
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.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare or/ OneCare Connect Program.
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).

Term	Definition
Threshold Language	For purposes of this policy, a threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

1

CALOPTIMA EXECUTIVE INCENTIVE PROGRAM

The Leadership Incentive Plan is an annual plan for the members of CalOptima's executive team that provides a monetary reward for superior performance based on the achievement of predetermined goals and objectives. The amount of incentive awarded to participants is determined based on goal achievement scores and the availability of budget for incentive payments.

A. Purpose: To align the performance of CalOptima's executive staff towards the accomplishment of the agency's long-term strategic plan and to reward superior accomplishment of annual key business strategies and initiatives.

B. Eligibility: To be eligible to participate in the Leadership Incentive Plan, an employee must be in an executive level position with job titles containing the designation of "Chief" or "Executive".

C. Goals and Objectives: Specific performance goals and objectives are established by the Chief Executive Officer and members of the executive team. Each goal is assigned a weighted percentage, and a description/measure of accomplishment. Goals are established using the following guidelines.

- Linkage to organization strategy
- Stretch objectives with a reasonable probability of attainment
- Consistency in approach across the department
- Encouragement of teamwork among leadership team and the organization, and
- Simple to understand, communicate and administer

D. Performance Period: Accomplishment of goals and objectives will be determined based on performance during the fiscal year (July 1 to June 30).

E. Incentive Opportunity: Goals and objectives are assigned accomplishment points. A minimum score of 50 points is required to be eligible for incentive compensation. The maximum points awarded is 100. The maximum incentive award is 10% of the participant's annual base compensation. The amount can be prorated based on the number of months participation in the plan. In order to receive an incentive award, the participant must be an active employee at the time the award is paid out. The range of the potential incentive for Executive Staff is contingent upon a range of performance based upon the goals and objectives established by the Chief Executive Officer. Based upon the total accomplishment points received, the incentive opportunities may be determined based upon a performance matrix, as an example, as follows:

Points	Category	Description	Incentive as Percentage of Base Pay
Below 50	Below Threshold	The minimum level of performance was not achieved	0%

Points	Category	Description	Incentive as Percentage of Base Pay
50-60	Threshold	The minimum level of performance which must be achieved before an incentive is paid	0-4%
60-70	Target	The level of performance which generally equates to the achievement of some but not all goals and objectives	4-6%
70-85	Commendable	The level of performance where the combination of personal effort and business produce an above average return for the organization	6-8%
85-100	Outstanding	The very superior level of performance which occasionally occurs when all circumstances come together to produce very high returns for the organization.	8-10%

F. Modification of Plan: The CEO may modify the plan for business need at any time. Participation in the plan is subject to the approval of the CEO. Participation in any single year does not predict participation in subsequent years.

Sample Form

Executive Incentive Goals for FY____- ____

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
Quality Programs and Services	*Goal XYZ*	*10*	*Implement by Q1. Program rolled out to all users. 0 – 25, 0 if not met, 25 if fully met.*	*15*	*Chief Operating Officer*	*Partial completion.*
Culture, Learning and Innovation						
Financial Stability						
Strong Internal Processes						
Community Outreach						

Strategic Priority	Goals	Weight (%)	Description / Measure(s) of Accomplishment / Points Available	Points Earned	Owner(s)	Comment/Notes
			Total Score			

Performance Review – Executive (Directors and Above)

EMPLOYEE INFORMATION

EMPLOYEE	JOB TITLE	DEPARTMENT
SUPERVISOR/EVALUATOR	REVIEW PERIOD	
	to	

SELF REVIEW: In the following section, provide your responses to the following questions for the review period April 1, 2016 through March 31, 2017.

1) **What did you do well that impacted or demonstrated your performance? (Examples: accomplishments, self-development, projects, productivity, customer service)**
2) **What are you continuing to work on that you set as goal(s) from last year?**
3) **What opportunities for growth, future goals or enhancement to your position will sustain and/or improve your performance?**

1)

2)

3)

Manager Review: ***Below are the Core Competencies to be completed by your manager***

CORE BEHAVIORAL COMPETENCIES

This section describes the core competencies required for successful employee performance for this CalOptima position. In the space provided, mark the appropriate rating with an "x" and provide comments as needed. Evaluate the employee on each factor relevant to the job duties and responsibilities by indicating to what degree the employee demonstrates the overall skill or behavior on the job.

Competency Rating Scale Definitions:

Outstanding – Performance **regularly exceeds** job expectations due to **exceptionally high quality** of work in all essential areas of responsibility, resulting in outstanding contribution. Reserved for truly outstanding performance.

Exceeds Expectations - **Often** demonstrates behaviors that go **above and beyond** expectations in order to achieve exceptional performance or intended results.

Fully Meets Expectations - Demonstrates effective and desired behaviors that **consistently** meet **expected** performance standards.

Needs Development - Demonstrates **some** desired behaviors, or uses behaviors **inconsistently**. Requires some development/improvement.

Unacceptable - Rarely demonstrates competency behaviors. **Does not meet** performance standards. Requires **significant** and **immediate** improvement

COMMUNICATION: • Communicates well with others in both verbal and written form by adapting his/her tone, style and approach based on people's perspectives and situations. Organizes thoughts, expresses them clearly and respectfully. • Listens attentively to ideas of others; cooperates and builds good working relationships with others. • Provides colleagues with regular and reliable information, including updates on his/her own activities/decisions, and is well-prepared when speaking in front of a group; presentations are clear and informative.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Describe specific examples or details of past performance and self development during this review cycle that support the rating:	
CUSTOMER FOCUS (internal and/or external) • Actively listens and follows up/through on customer inquiries/requests in a timely, professional, courteous, and sensitive manner; ensures clear and frequent communication with customers about progress, changes and status; takes responsibility for correcting customer problems. • Demonstrates a good understanding of company/department procedures for handling customer complaints; knows when to bring in help/use the chain of command for problems beyond his/her ability. • Viewed as a team player.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Describe specific examples or details of past performance and self development during this review cycle that support the rating:	
LEADERSHIP: • Communicates high level priorities and objectives, a compelling and strategic vision, which is innovative and future-oriented, and creates buy-in at various levels of the organization for each fiscal year. • Manages, inspires, motivates, develops, reviews, and supports the growth of the organization and department staff.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Describe specific examples or details of past performance and self development during this review cycle that support the rating:	
STRATEGIC THINKING: • Applies the SWOT analysis to CalOptima's changing environment to identify opportunities for success in order to redirect the company's course, create realistic and well-balanced strategic plans, and to meet new targets. Understands the players in our industry, both competitors and allies, and is on top of industry shifts and changes. • Includes key stakeholders in strategic planning. • Is an innovative strategic partner.	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable
Describe specific examples or details of past performance and self development during this review cycle that support the rating:	
DECISION MAKING/PROBLEM SOLVING: • Uses sound and consistent judgment when analyzing situations and making decisions that would impact both the department and the entire organization; able to identify potential problems and offers multiple solutions; is conscientious of the department resources. • Able to make decisions even when conditions are uncertain or information is not available by	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable

using the correct balance of logic and intuition; discusses his/her decision and its impact with those who will be affected; the group benefits from his/her input in problem solving and brainstorming sessions. • Reliable, persistent worker who keeps a positive outlook and does not let unexpected problems stop him/her from successfully completing own work; calm under pressure.	
Describe specific examples or details of past performance and self development during this review cycle that support the rating:	
PREVIOUS MANAGER'S COMMENTS (if applicable):	
List goals that will sustain and/or improve performance, and how they will be measured/evaluated during the next review period:	
FINAL OVERALL RATING	☐ Outstanding ☐ Exceeds Expectations ☐ Fully Meets Expectations ☐ Needs Development ☐ Unacceptable

Manager's/Evaluator's Comments

Manager's/Evaluator's Signature:

_____ _____

Signature Date

Second Level Manager's Comments and Signature:

Signature Date

Employee's Acknowledgement and Comments:

Signature Date

Policy #:	GA.8057
Title:	**Compensation Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	~~03/05/15~~06/07/18
Last Revised Date:	~~06/04/15~~06/07/18

I. PURPOSE

This policy~~o~~ establishes a compensation program for CalOptima job classifications within clearly defined guidelines that promote consistent, competitive and equitable pay practices.

~~II.I. DEFINITIONS~~

~~Not Applicable~~

~~III.~~II. POLICY

A. CalOptima's compensation program is intended to:

1. Provide fair compensation based on organization and individual performance;

2. Attract, retain, and motivate employees;

3. Balance internal equity and market competitiveness to recruit and retain qualified employees; and

4. Be mindful of CalOptima's status as a public agency.

B. The Chief Executive Officer (CEO), in conjunction with the Executive Director of Human Resources, is directed to administer the compensation program consistent with the attached Compensation Administration Guidelines, which is a document that defines the principles upon which CalOptima's compensation practices will be managed, procedural aspects of how compensation administration procedures will be administered, and how the overall compensation administration function will respond to changing market conditions and business demands. Some of these guidelines include, but are not limited to:

1. Establishing pay rates based on the market 50th percentile.

2. Determining appropriate pay rates within the pay range for a position by assessing an employee's or applicant's knowledge, skills, experience, and current pay level, as well as pay rates currently being paid to similarly situated incumbents. Employees may be paid anywhere within the pay range based on proficiency levels. The following criteria shall be considered:

Minimum (Min)	The rate paid to an individual possessing the minimum job qualifications & meeting minimum job performance expectations
Midpoint (Mid) aka: 50th percentile	The rate paid to individuals that are fully proficient in all aspects of the job's requirements & performance expectations
Maximum (Max)	The maximum rate paid to individuals who possess qualifications significantly above market norms & consistently deliver superior performance

3. All new hires and employees should have a pay rate equal to or greater than the pay range minimum, unless the minimum job requirements are not met, then a training rate equal to ten percent (10%) below the salary grade minimum may be used for six (6) months.

4. Base pay for all employees shall be capped at the pay range maximum, and once an employee reaches the base pay maximum, the employee will not be eligible for future base pay increases. However, in lieu of future base pay increases, these employees may be eligible for merit pay delivered as a lump sum bonus provided that the employee's performance warrants this additional compensation.

C. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the CalOptima compensation program and the Compensation Administration Guideline not inconsistent therewith.

~~IV.~~III. PROCEDURE

Not Applicable

~~V.~~IV. ATTACHMENTS

A. Compensation Administration Guidelines

~~VI.~~V. REFERENCES

Not Applicable

VI. REGULATORY AGENCY APPROVALS ~~OR~~

None to Date

VII. BOARD ACTIONS

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 06/04/15: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board Meeting~~
~~B.~~C. 03/05/15: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board Meeting~~
~~C.~~D. 12/04/14: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board Meeting~~

~~D.~~E. 11/06/14: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board Meeting~~

~~E.~~F. 08/07/14: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board Meeting~~

~~F.~~G. 05/01/14: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board Meeting~~

VIII. REVIEW/REVISION HISTORY

Version	~~Version~~ Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	05/01/14	GA.8057	Compensation Program and Salary Schedule	Administrative
~~Revision Date 1~~Revised	08/07/14	GA.8057	Compensation Program and Salary Schedule	Administrative
~~Revision Date 2~~Revised	11/06/14	GA.8057	Compensation Program and Salary Schedule	Administrative
~~Revision Date 3~~Revised	12/04/14	GA.8057	Compensation Program and Salary Schedule	Administrative
~~Revision Date 4~~Revised	06/04/15	GA.8057	Compensation Program	Administrative
Revised	06/07/18	GA.8057	Compensation Program	Administrative

IX. ~~DEFINITIONS~~GLOSSARY

Not Applicable

Policy #:	GA.8057
Title:	**Compensation Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	06/07/18
Last Revised Date:	06/07/18

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III. PROCEDURE

Not Applicable

IV. ATTACHMENTS

A. Compensation Administration Guidelines

V. REFERENCES

Not Applicable

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors
B. 06/04/15: Regular Meeting of the CalOptima Board of Directors
C. 03/05/15: Regular Meeting of the CalOptima Board of Directors
D. 12/04/14: Regular Meeting of the CalOptima Board of Directors
E. 11/06/14: Regular Meeting of the CalOptima Board of Directors
F. 08/07/14: Regular Meeting of the CalOptima Board of Directors
G. 05/01/14: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/14	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/14	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/14	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/14	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/15	GA.8057	Compensation Program	Administrative
Revised	06/07/18	GA.8057	Compensation Program	Administrative

IX. GLOSSARY

Not Applicable

Compensation Administration Guidelines

Pay administration guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These guidelines:

- Help maintain the integrity of the base pay program by introducing a common set of standards
- Assist managers in ongoing compensation program administration
- CEO compensation will be established by the Board of Directors
- Chief and Executive Director compensation will be established by the CEO within proposed guidelines
- The Board will be informed of all Chief and Executive Director hires and compensation changes

Proposed Pay Administration Guidelines

Pay ranges and pay levels

- Pay range targets
- Range minimums and maximums
- Pay above range maximums
- Pay range thirds
- Pay range halves
- Compa-ratio

Annual pay adjustments/increases

- Market adjustment
- Merit pay
- Step increase

Special one-time pay considerations

- Recruitment incentive

Periodic pay adjustments/increases

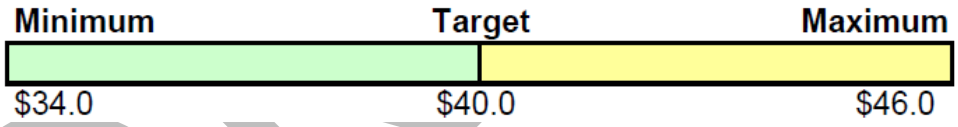
- New hire/Rehire
- Promotion
- Lateral transfer
- Demotion
- Temporary assignment
- Secondary job
- Job Re-evaluation
- Appeal Process
- Register/Certified status
- Base pay program maintenance
  - Salary structure adjustment
  - Annual competitive assessment
  - Market sensitive jobs

Pay Ranges and Pay Levels

Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job's requirements and performance expectations

- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets

- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations

- All employees should have a pay rate equal to or greater than the pay range minimum
- If the minimum job requirements are not met, a training rate equal to 10% below the salary grade minimum may be used for six months while a new incumbent is learning the skills to become proficient in the new role

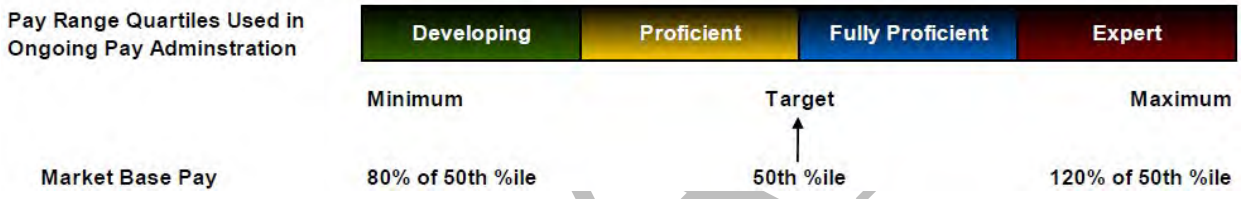
Range Maximum: represents the maximum rate paid to individuals who posses qualifications significantly above market norms and consistently deliver superior performance

- Base pay growth is capped at the pay range maximum

Pay Above Range Maximum: as a rule, employees are not to be paid above the range maximum

- Employees paid above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases
- In lieu of future base pay increases, these individuals may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation
- As the pay structures and pay ranges move (every 12 – 36 months or as necessary), the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable and appropriate pay levels



- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations
- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate 100% proficiency in all aspects of the job's duties, responsibilities and performance expectations
- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills or abilities that far surpass the market s typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities and performance expectations

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness

- Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target
- Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate

- Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target

- Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target

Illustrative Range Shown Below:
Note: Range minimums and maximums will be based on the developed salary range spreads

	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

Annual Pay Adjustments/Increases

Market Adjustment: A market adjustment is an increase or decrease to pay range rates based on market pay practices

- A market adjustment results in base pay increases for full-time, part-time, and some as-needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target)
    - For some market-sensitive jobs, a market adjustment may also be granted to full-time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression

- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum
    - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10%)

Market Adjustment:

- The appropriateness of a market adjustment is determined based on:
    1. A competitive assessment of the pay range target versus market base pay practices;
    2. Market trends and practices relative to average base pay and pay range increases; and
    3. Current recruiting and retention issues

- Market adjustments are made prior to determining merit pay

- Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target

Base Pay Adjustment: All employees who achieve a satisfactory level of performance will be eligible for a merit pay adjustment

- Merit Pay: Merit pay is variable pay that typically affects individuals' base pay; it recognizes individuals' job proficiency and performance of job duties
    - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay
    - To be eligible for merit pay, the employee must have started work on or before March 31st to be eligible for a merit increase in July of the same year and have successfully completed the introductory period (3 months for transfers and new hires) prior to the annual pay adjustment date
    - Merit pay will typically be an increase to base pay; however, it may also be delivered as a onetime lump sum bonus for individuals paid above the pay range maximum
    - The budgeted amount for merit pay, if any, is based on: 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity
    - Merit pay is typically calculated as a percent of base pay, prorated to reflect the number of months an employee worked and the salary earned during those months
    - Managers have the discretion to determine the actual increase amount within the published guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives
    - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in 2 incremental amounts- the first half when merit pay is normally distributed; and the second half 6 months later
    - Merit pay may be held altogether or delayed for 90 days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record
    - Merit pay is typically awarded once a year at a specific time
    - Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at the same time
    - Executive Directors and Chief's must approve all areas they are responsible for

before submitting to HR

- HR has final approval of all merit increases

A Merit Pay Grid similar to the one shown below (assumes a 3% merit increase budget) is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; and,
4. Recruiting and retention issues

	Pay Range Position					
Performance Rating	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	Above Max	Above Max = Lump Sum Bonus
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%	
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%	
Needs Improvement	0%	0%	0%	0%	0%	

** The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay

- The increase may be held all together or delayed 90 days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be retro-active; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase

- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above

Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to 15% of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima
  - Recruitment incentives require the approval of the CEO
  - Board approval is required for recruitment incentives offered to Executive Director and above positions
  - Incentives are provided with a "pay-back" provision if the employee terminates within 24 months of hire

New Hires/Rehires

- A new hire's pay level should correspond to the appropriate pay range but typically should not exceed the pay range target; offers above the pay range target require the approval of the Compensation Analyst in consultation with the Executive Director of Human Resources, and the CEO when necessary

- Factors to be considered in determining an appropriate pay level for a new hire include:
  - Job-related experience: what is the estimated learning curve given the individual's prior work experience?
  - Market conditions: what is the going rate of pay in the external market for the individual's skills and knowledge?
  - Internal equity: is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service
  - For example, an RN having three years of prior job experience is viewed comparably to an RN having three years of job experience at CalOptima

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate)

- Determine appropriate pay rate by assessing candidate's knowledge, skills and experience, current pay level, as well as pay rates currently being paid to similarly situated incumbents

- Candidates with superior knowledge, skills and experience can be paid above the pay range midpoint; starting pay rates above the pay range midpoint must have the appropriate Compensation Analyst, Executive Director of Human Resources, and CEO approval when necessary

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical)

- Pay rates for all management positions must be reviewed with the Compensation Analyst before an offer is made. The Compensation Analyst will review internal equity across the system to ensure that the appropriate offer is made

- Any questions or concerns about new hire offers should be directed to the Compensation Analyst or Executive Director of Human Resources. The Compensation Analyst will review any concerns with the Executive Director of Human Resources as necessary

- Rehires to the same position should be paid at least the same amount they earned prior to termination with adjustments and/or credit for recent additional career experience or education earned while away from CalOptima

- The above policy applies to the current organization structure

- Additional positions at the level of Chief or Executive Director require Board approval

Promotion

Promotion: An employee receives a promotion when he/she applies for and is selected for a job with a higher pay range target

- An employee will receive a promotional increase to at least the pay range minimum of his/her new pay range.

- The amount of a promotional increase will vary and the actual amount will be determined based on the incumbent's qualifications, performance and the internal pay practices of other similarly-situated employees. The typical promotional increase is 4% to 5% of base pay for one grade increase.

- Typically, the promotional increase should not exceed the pay range target.

- When an employee moves from non-exempt to exempt, the loss of overtime pay will be considered. However, the realization that overtime is not guaranteed must also be considered.

- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect.

- The next merit pay adjustment after a promotion may be pro-rated based on the amount of time the employee has spent in the job.

Lateral Transfer

Lateral transfer: It is considered a lateral transfer if an employee moves to a job having the same pay range target

- Lateral job changes will not typically result in a base pay increase or adjustment unless otherwise approved by the Compensation Analyst and Executive Director of Human Resources

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Demotion: An employee is classified as having been demoted if he/she moves to a job with a lower pay range target

- An employee demoted due to an organizational restructure, no pay decrease will be given unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.
    - An involuntary demotion due to performance will follow the guidelines below for reducing base pay
    - A voluntary demotion based on an application for an open position will typically result in a pay decrease between 0 – 4% for each salary grade demoted
        - The demoted employee's base pay will be reduced to the next lower pay grade. Target, or pay grade maximum, whichever is appropriate using the 0 – 4% guideline above
- The pay rate adjustment will be effective on the first day of the pay period in which the job change takes effect
- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.

Temporary Assignment

Temporary assignment: An employee who is asked to assume a full-time temporary assignment in a job having a *higher* pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate
- This increased secondary pay rate is eliminated when the temporary assignment ends
- The amount of the temporary assignment increase should be consistent with the promotion policy

Job Re-Evaluations

Job Re-Evaluations: Job re-evaluations will be reviewed in the following priority order:

1. New Positions
2. Change of 35% or more of duties (any change in responsibilities less than 35% will not be considered)
    - Enhancements must require a higher level of skills, abilities, scope of authority, autonomy, and/or education to qualify for a re-classification

- Additional duties that do not require the above will not be considered for reclassification
- All requests for job re-classification must be documented, signed by the department manager and submitted to the Compensation Analyst
- In the case of management positions being re-classified, the appropriate Chief must sign the documentation
- The request must include the incumbent's current job description and revised job description with enhancements highlighted.
- The request must also include justification that the re-classification supports a business need

If the job is determined to be a priority, the Compensation Analyst will analyze the job according to:

- The job's scope against other jobs in the same discipline
- Available market data
- Appropriate title identification. The Compensation Analyst will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended
- Job family
- FLSA status
- Appropriate pay grade – the job will be fit into one of the pay grades that currently exists- there will be no new pay grades created
- A pay rate will be determined
- A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager

- If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date
- The manager will be informed of the decision to move the job to a higher pay grade by the Compensation Analyst
- The amount of the pay increase should follow the guidelines in the promotion section
- If the upgrade and a pay change occurs less than six months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated
- If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director of Human Resources
- If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed
- If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed

- Job evaluations and re-evaluations will occur throughout the year; all priority jobs will be evaluated within one month of the request
- If a job is not a priority or does not meet the guidelines, the manager will be notified

Base Pay Program Maintenance

Salary Structure Adjustment

- The salary structure should be reviewed on a regular basis either annually or every other year to continue to reflect market competitiveness
- The salary structure updates are designed to relieve any upward pressure on range minimums, midpoints and maximums that may impede the ability to attract, motivate and retain the workforce
- The salary structure is dynamic; it needs to be revised at regular intervals based upon market conditions to maintain market competitiveness. The goal is to keep the structure's market rates on track with market data
- Market adjustments will be applied to the salary schedule as needed at least every two years, using surveyed salary structure adjustment percentages
- The salary structure adjustment approval process includes:
  - The Executive Director of Human Resources makes a recommendation to the CEO for approval
  - CEO takes the recommendation to the Board for final approval

Annual Competitive Assessment

- On an annual basis, HR will identify the current competitiveness of CalOptima's pay practices by comparing: 1) current pay levels to market practices; 2) current pay levels to pay range targets; and, 3) current pay range targets to market practices
  - CalOptima will annually spot check benchmark jobs to determine market fluctuations in benchmark jobs' pay rates
  - Based on market findings, the pay grade and ranges will be updated
  - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations

- The results of theses analyses, along with CalOptima's current financial performance and economic situation will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets

- The following criteria is typically used to determine which jobs to market price each year:
  - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues;
  - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and expenses to identify jobs with potential recruiting issues;
  - Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues;

- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%
- Review all market-sensitive jobs and those on the "watch list"
- Review top 10 highest populated jobs on an annual basis
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced
- It is recommended that at least two jobs be selected from every pay range

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends

- Each year the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments

- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process
  - Adjustments to pay range minimums occur prior to merit pay calculations

Process for Making Market Adjustments

- HR performs an annual review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs

- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues

- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount

- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.)

- HR identifies the cost implications for the market adjustment by identifying the difference between: 1) current pay rates and new pay range minimums, and, 2) current pay rates.

- The market adjustment approval process will work as follows:
  - The Executive Director of Human Resources recommends an adjustment to the CEO for approval
  - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the position as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging

- Premium pay is built into the pay targets for these jobs
  - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need
  - The desired market target rate is established on a job-by-job basis to reflect specific market conditions

- Criteria used to determine if a job is classified as market-sensitive typically includes two or more of the following:
  - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions
  - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates
  - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last 3 to 6 months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs
  - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:
    - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,
    - a competitive market rate significantly higher (approximately 10%) than its current pay range target, or
    - a competitive market rate with significantly higher pay practices (approximately 10%) in the labor market than the average of current internal pay practices.

- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.

- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies
  - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one year
  - When a job is no longer considered market-sensitive, the job's pay range and grade is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time

- Throughout the year, jobs that are not yet considered market sensitive but are showing signs of becoming so are placed on a "watch list" and monitored
  - If necessary, these jobs will be moved to the market-sensitive category and handled accordingly

Compensation Administration Guidelines

Pay administration guidelines

Common pay administration guidelines for CalOptima are detailed in this section. These guidelines:

- Help maintain the integrity of the base pay program by introducing a common set of standards
- Assist managers in ongoing compensation program administration
- CEO compensation will be established by the Board of Directors
- Chief and Executive Director compensation will be established by the CEO within proposed guidelines
- The Board will be informed of all Chief and Executive Director hires and compensation changes

Proposed Pay Administration Guidelines

Pay ranges and pay levels

- Pay range targets
- Range minimums and maximums
- Pay above range maximums
- Pay range thirds
- Pay range halves
- Compa-ratio

Annual pay adjustments/increases

- Market adjustment
- Merit pay
- Step increase

Special one-time pay considerations

- Recruitment incentive

Periodic pay adjustments/increases

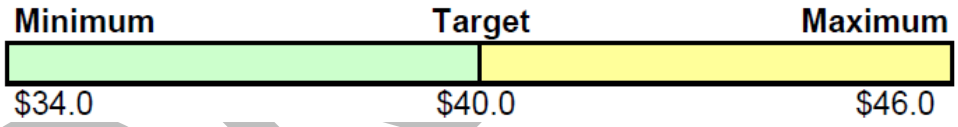
- New hire/Rehire
- Promotion
- Lateral transfer
- Demotion
- Temporary assignment
- Secondary job
- Job Re-evaluation
- Appeal Process
- Register/Certified status
- Base pay program maintenance
  - Salary structure adjustment
  - Annual competitive assessment
  - Market sensitive jobs

Pay Ranges and Pay Levels

Range Target: internal "going market rate" for the job (50th percentile); represents the rate paid to individuals that are fully proficient in all aspects of the job's requirements and performance expectations

- For benchmark jobs, the pay range (i.e. pay grade) is determined based on the comparability of values between market median base pay rates and the pay range targets

- For non-benchmark jobs, the pay range is determined based on comparability of the job to benchmark jobs within the same job family or other internal positions in terms of knowledge, skills, complexity and organizational impact



Range Minimum: represents the rate paid to individuals possessing the minimum job qualifications and meeting minimum job performance expectations

- All employees should have a pay rate equal to or greater than the pay range minimum
- If the minimum job requirements are not met, a training rate equal to 10% below the salary grade minimum may be used for six months while a new incumbent is learning the skills to become proficient in the new role

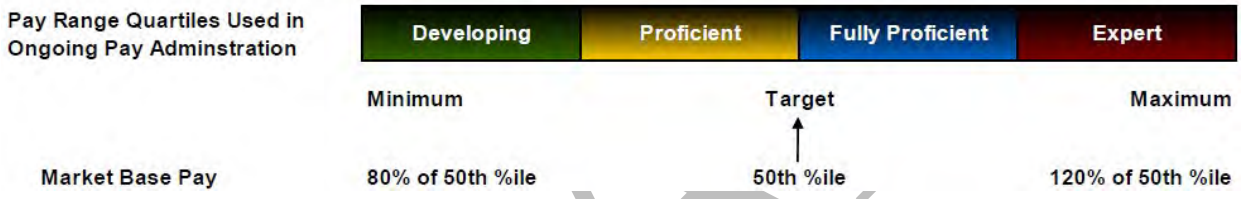
Range Maximum: represents the maximum rate paid to individuals who posses qualifications significantly above market norms and consistently deliver superior performance

- Base pay growth is capped at the pay range maximum

Pay Above Range Maximum: as a rule, employees are not to be paid above the range maximum

- Employees paid above the pay range maximum will have their base pay frozen and will not be eligible for future base pay increases
- In lieu of future base pay increases, these individuals may be eligible for merit pay delivered as a lump sum bonus providing their performance warrants this additional compensation
- As the pay structures and pay ranges move (every 12 – 36 months or as necessary), the employees paid above the pay range maximum will eventually be paid below the pay range maximum and will then be eligible to receive base pay increases, as appropriate

Pay Range: Employees may be paid anywhere within the open pay range; the pay range is divided into equal quartiles to assist in achieving competitive, equitable and appropriate pay levels



- Developing Area – Below market pay; this area is used for employees possessing minimum job requirements and/or for those having significant learning curves to become fully proficient in the job's duties, responsibilities and performance expectations
- Proficient/Fully Proficient Area – Market competitive pay; this area is used for employees possessing preferred job requirements and consistently demonstrate 100% proficiency in all aspects of the job's duties, responsibilities and performance expectations
- Expert Area – Above market pay; this area is used for employees possessing unique knowledge, skills or abilities that far surpass the market s typical requirements and consistently demonstrate superior performance in all aspects of the job's duties, responsibilities and performance expectations

Compa-Ratio: In addition to pay range quartiles, this is a metric also used to communicate pay competitiveness

- Compa-Ratio: A compa-ratio is calculated by taking the employee's base pay divided by his/her pay range target
- Compa-Ratio of 100%: This ratio indicates the employee's base pay equals the pay range target, or the market rate

- Compa-Ratio <100%: This ratio indicates the employee's base pay is less than the pay range target

- Compa-Ratio >100%: This ratio indicates the employee's base pay is greater than the pay range target

Illustrative Range Shown Below:
Note: Range minimums and maximums will be based on the developed salary range spreads

	Minimum	Target	Maximum
Compa-Ratio RNs	87.5%	100.0%	117.0%
Compa-Ratio Non-Exempt	88.0%	100.0%	117.0%
Compa-Ratio Exempt	83.0%	100.0%	118.0%

Annual Pay Adjustments/Increases

Market Adjustment: A market adjustment is an increase or decrease to pay range rates based on market pay practices

- A market adjustment results in base pay increases for full-time, part-time, and some as-needed and limited term staff paid at or below the pay range target (there is no base pay increase between target and maximum for non-market sensitive jobs unless compression exists at the target)
    - For some market-sensitive jobs, a market adjustment may also be granted to full-time, part-time, and some as-needed and limited term staff paid above the pay range target but below the pay range maximum to maintain competitiveness and minimize pay compression

- A market adjustment may result in a base pay increase to some staff to ensure employees are paid a base pay rate at least equal to the new pay range minimum
    - If a market adjustment is made, employees paid below the new range minimum receive an increase to their base pay to ensure it is at least equal to the pay range minimum before any merit pay is awarded (cap at 10%)

Market Adjustment:

- The appropriateness of a market adjustment is determined based on:
    1. A competitive assessment of the pay range target versus market base pay practices;
    2. Market trends and practices relative to average base pay and pay range increases; and
    3. Current recruiting and retention issues

- Market adjustments are made prior to determining merit pay

- Newly hired employees will be eligible for any market adjustments granted at the annual pay increase date if the employee is paid at or below the pay range target

Base Pay Adjustment: All employees who achieve a satisfactory level of performance will be eligible for a merit pay adjustment

- Merit Pay: Merit pay is variable pay that typically affects individuals' base pay; it recognizes individuals' job proficiency and performance of job duties
    - Merit pay is applicable to full-time and part-time employees paid below, at, or above the pay range target; Per diem employees are not eligible for merit pay
    - To be eligible for merit pay, the employee must have started work on or before March 31st to be eligible for a merit increase in July of the same year and have successfully completed the introductory period (3 months for transfers and new hires) prior to the annual pay adjustment date
    - Merit pay will typically be an increase to base pay; however, it may also be delivered as a onetime lump sum bonus for individuals paid above the pay range maximum
    - The budgeted amount for merit pay, if any, is based on: 1) the organization's financial status; 2) market trends relative to average base pay increases; 3) competitiveness of current base pay practices; and, 4) recruiting and retention issues

Merit Pay – Staff Paid At and Above Pay Range Target

- The combination of an individual's performance rating, the position of his/her pay within the pay range, the number of months he/she has been working, and the salary earned during those months determines the individual's merit pay opportunity
    - Merit pay is typically calculated as a percent of base pay, prorated to reflect the number of months an employee worked and the salary earned during those months
    - Managers have the discretion to determine the actual increase amount within the published guidelines; the appropriate merit pay amount will reflect the manager's internal equity, pay competitiveness, and performance recognition objectives
    - Adjustments to employees' base pay are capped at the pay range maximums; therefore, some employees may receive a portion of their merit pay as a base pay increase up to the pay range maximum and also receive a lump sum amount for the remaining portion of the merit pay. Employees paid over the pay range maximum may be eligible to receive merit pay as a lump sum payment paid out in 2 incremental amounts- the first half when merit pay is normally distributed; and the second half 6 months later
    - Merit pay may be held altogether or delayed for 90 days if employees do not achieve a satisfactory level of performance or if a written warning or suspension/final written warning is active in their record
    - Merit pay is typically awarded once a year at a specific time
    - Full-time and part-time employees may receive both a market adjustment and a merit pay adjustment at the same time
    - Executive Directors and Chief's must approve all areas they are responsible for

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before submitting to HR

- HR has final approval of all merit increases

A Merit Pay Grid similar to the one shown below (assumes a 3% merit increase budget) is often used to provide managers with a guideline as to what merit pay increase may be appropriate based upon performance and to reflect:**

1. The organization's financial status;
2. Market trends relative to average base pay increases;
3. Competitiveness of current base practices; and,
4. Recruiting and retention issues

	Pay Range Position					
Performance Rating	1st Quartile	2nd Quartile	3rd Quartile	4th Quartile	Above Max	Above Max = Lump Sum Bonus
Highly Effective	6% - 5%	5% - 4%	4% - 3%	3% - 2%	3% - 2%	
Effective	5% - 4%	4% - 3%	3% - 2%	3% - 2%	0%	
Needs Improvement	0%	0%	0%	0%	0%	

** The Merit Pay Grid is a sample only. Actual merit increase percentages will depend upon the salary distribution across the salary structure.

- Employees who do not achieve a satisfactory level of performance at the time of their annual pay increase will not receive any type of pay increase – market adjustment, or merit pay

- The increase may be held all together or delayed 90 days until the written performance improvement plan is complete and performance is judged to be acceptable by the manager; the pay increase will be effective at the time performance is judged to be acceptable (beginning of applicable pay period) and will not be retro-active; the manager is responsible for informing the employee in this situation and is responsible for notifying HR to initiate the increase

- Employees on any type of leave of absence who are eligible for a market adjustment, and/or merit pay, may receive these adjustments upon their return to active status with a completed performance appraisal that is competent or above

Special One-time Pay Considerations

Recruitment Incentive

- Recruitment incentives up to 15% of an employee's base pay may be provided on an exception basis to entice an employee to join CalOptima
  - Recruitment incentives require the approval of the CEO
  - Board approval is required for recruitment incentives offered to Executive Director and above positions
  - Incentives are provided with a "pay-back" provision if the employee terminates within 24 months of hire

New Hires/Rehires

- A new hire's pay level should correspond to the appropriate pay range but typically should not exceed the pay range target; offers above the pay range target require the approval of the Compensation Analyst in consultation with the Executive Director of Human Resources, and the CEO when necessary

- Factors to be considered in determining an appropriate pay level for a new hire include:
  - Job-related experience: what is the estimated learning curve given the individual's prior work experience?
  - Market conditions: what is the going rate of pay in the external market for the individual's skills and knowledge?
  - Internal equity: is the proposed pay level lower, higher or in line with the pay levels of current employees having comparable skill and experience levels?

- At hire, external service is typically valued comparable to internal service
  - For example, an RN having three years of prior job experience is viewed comparably to an RN having three years of job experience at CalOptima

- Internal equity (how this position and compensation compares relative to existing employees) must be considered when making hiring decisions

Process for Determining a New Hire Starting Pay Rate

HR determines applicable pay rate:

- Starting pay rate is at or near the minimum of the pay range for a candidate who only meets the job's minimum qualifications

- Starting pay rate cannot be below the minimum of the pay range (unless it is viewed as a training rate)

- Determine appropriate pay rate by assessing candidate's knowledge, skills and experience, current pay level, as well as pay rates currently being paid to similarly situated incumbents

- Candidates with superior knowledge, skills and experience can be paid above the pay range midpoint; starting pay rates above the pay range midpoint must have the appropriate Compensation Analyst, Executive Director of Human Resources, and CEO approval when necessary

- There are certain positions that will usually be placed near the salary grade minimum (all entry level service and clerical)

- Pay rates for all management positions must be reviewed with the Compensation Analyst before an offer is made. The Compensation Analyst will review internal equity across the system to ensure that the appropriate offer is made

- Any questions or concerns about new hire offers should be directed to the Compensation Analyst or Executive Director of Human Resources. The Compensation Analyst will review any concerns with the Executive Director of Human Resources as necessary

- Rehires to the same position should be paid at least the same amount they earned prior to termination with adjustments and/or credit for recent additional career experience or education earned while away from CalOptima

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Demotion: An employee is classified as having been demoted if he/she moves to a job with a lower pay range target

- An employee demoted due to an organizational restructure, no pay decrease will be given unless the employee is above the maximum on the new pay range; if so, the employee will be reduced to the maximum of the new pay range.
    - An involuntary demotion due to performance will follow the guidelines below for reducing base pay
    - A voluntary demotion based on an application for an open position will typically result in a pay decrease between 0 – 4% for each salary grade demoted
        - The demoted employee's base pay will be reduced to the next lower pay grade. Target, or pay grade maximum, whichever is appropriate using the 0 – 4% guideline above
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- Future merit increases and market adjustments will not be affected by a demotion unless competent performance is not achieved.

Temporary Assignment

Temporary assignment: An employee who is asked to assume a full-time temporary assignment in a job having a *higher* pay range target is eligible for a temporary base pay increase. The employee must assume some or all of the responsibilities of the new job to qualify for a temporary assignment increase

- The employee's base pay rate prior to the assignment will be maintained and the higher temporary assignment rate will be added as a secondary job title and pay rate
- This increased secondary pay rate is eliminated when the temporary assignment ends
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- Appropriate title identification. The Compensation Analyst will determine if the title fits within the hierarchy; if not, a benchmark title will be recommended
- Job family
- FLSA status
- Appropriate pay grade – the job will be fit into one of the pay grades that currently exists- there will be no new pay grades created
- A pay rate will be determined
- A recommendation will be made to the Executive Director of Human Resources for approval, and the decision will be communicated to the appropriate manager

- If a job is reassigned to a higher grade, the change will be effective on the first day of the pay period following the evaluation. The pay increase is not retroactive to any earlier date
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- If the upgrade and a pay change occurs less than six months before the annual pay increase date, the employee's next merit pay adjustment may be pro-rated
- If the job is not reassigned to a higher pay grade, the manager will be notified. If dissatisfied with the decision, the manager may file an appeal with the Executive Director of Human Resources
- If a job is reassigned to a lower pay grade as a result of a job re-evaluation due to available market data, without a change in job responsibilities, the involuntary demotion due to organizational restructuring protocol will be followed
- If a job is reassigned to a lower pay grade due to a job evaluation and change in job responsibilities, the voluntary demotion protocol will be followed

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  - Based on market findings, the pay grade and ranges will be updated
  - Any jobs in which reasonable benchmark data is not available can be slotted into the salary structure based on internal equity considerations

- The results of theses analyses, along with CalOptima's current financial performance and economic situation will determine the appropriate market adjustments (i.e., pay range adjustments) and merit pay budgets

- The following criteria is typically used to determine which jobs to market price each year:
  - Review job-level turnover statistics for jobs with above-average separation rates to identify jobs with potential retention issues;
  - Review the time-to-fill metrics for jobs requiring above-average recruiting efforts and expenses to identify jobs with potential recruiting issues;
  - Review the applicant tracking reports (if available) for jobs with a high level of initial/ subsequent offer rejections to identify additional potential recruiting issues;

- Review jobs with pay-to-pay range target compa-ratios in excess of 110% or below 90%
- Review jobs with market-to-pay range target compa-ratios in excess of 110% or below 90%
- Review all market-sensitive jobs and those on the "watch list"
- Review top 10 highest populated jobs on an annual basis
- Jobs are ranked by degree of severity for each of the preceding criteria; the jobs that are most frequently identified across all criteria are typically market priced
- It is recommended that at least two jobs be selected from every pay range

Market Adjustments (Structure and Pay Range Adjustments): Market adjustments to specific pay ranges or the entire pay structure may be made on an annual or as needed basis to reflect current competitiveness or market trends

- Each year the pay range targets are compared to the external market base pay practices and necessary adjustments are made to ensure alignment including job grade changes and range rate adjustments

- Employees falling below the range minimum of the adjusted structures are typically brought to the pay range minimum, assuming the employee has a satisfactory level of performance; any pay compression resulting from structure adjustments should be addressed as part of the annual pay increase process
  - Adjustments to pay range minimums occur prior to merit pay calculations

Process for Making Market Adjustments

- HR performs an annual review of compensation surveys to calculate the average market adjustment to pay structures; HR also analyzes the competitiveness of the current pay range targets to market practices for benchmarked jobs

- HR reviews CalOptima's financial operating conditions and quantifies any recruiting/ retention issues

- HR determines if an adjustment is appropriate (minor variations in the market may be recognized in the following year) and recommends the amount

- HR multiplies the current pay range target of each grade by the necessary adjustment percentage; then HR recalculates the pay range minimum and maximum based on the existing structure design (i.e., pay range minimums = 80% of the new pay range target; pay range maximums = 120% of the new pay range target, etc.)

- HR identifies the cost implications for the market adjustment by identifying the difference between: 1) current pay rates and new pay range minimums, and, 2) current pay rates.

- The market adjustment approval process will work as follows:
  - The Executive Director of Human Resources recommends an adjustment to the CEO for approval
  - If the CEO agrees, the CEO will seek Board approval, unless the market adjustment is within the approved pay range for the position as designated in the Board-approved salary schedule. In such case(s), the CEO may approve the market adjustment and inform the Board of such change(s).

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Market-Sensitive Jobs: Market sensitive jobs are those for which market conditions make recruiting and retention challenging

- Premium pay is built into the pay targets for these jobs
  - Prospectively, the pay range and grade selected for these jobs will reflect the desired market target rate (i.e., 60th or 75th percentile of base pay practices) based on business need
  - The desired market target rate is established on a job-by-job basis to reflect specific market conditions

- Criteria used to determine if a job is classified as market-sensitive typically includes two or more of the following:
  - Time to fill the position – statistics will suggest the average amount of time required to fill a requisition for a market-sensitive position will be significantly higher than the historical norm for this position or similar positions
  - Job offer rejections – statistics will illustrate an increase in the number of employment offers rejected due to low starting rates
  - Turnover – statistics will suggest a higher than typical amount of turnover for the position within the last 3 to 6 months; turnover for the job will be compared to historical results for the same job and to other similarly-situated jobs
  - Market Changes – market-sensitive jobs may experience an excessively large increase in competitive pay rates over the previous year's results; specifically, jobs considered to be market-sensitive may have:
    - a year-to-year increase significantly greater than the average year-to-year increase for other jobs analyzed,
    - a competitive market rate significantly higher (approximately 10%) than its current pay range target, or
    - a competitive market rate with significantly higher pay practices (approximately 10%) in the labor market than the average of current internal pay practices.

- When a job is classified as market-sensitive, typically some form of adjustment is made to employees' base pay rates and is typically referred to as a market adjustment and the pay increase policies noted under the market adjustment section apply.

- Jobs classified as market-sensitive are reviewed annually to determine if this status still applies.
  - Once a job is classified as market-sensitive, it typically remains as such until the recruiting and retention challenges subside and/or the market pay rates adjust themselves – typically not less than one year.
  - When a job is no longer considered market-sensitive, the job's pay range and grade is reassigned to reflect a market median base pay rate target; no changes are typically made to the employees' base pay rates at this time.

- Throughout the year, jobs that are not yet considered market sensitive but are showing signs of becoming so are placed on a "watch list" and monitored.
  - If necessary, these jobs will be moved to the market-sensitive category and handled accordingly.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

38. Consider Actions Related to the Provision of Medi-Cal Perinatal Support Services, Including Withdrawing Request for Proposal (RFP), and Revising Payment Methodology and Contracting Strategy with Providers and Vendors

Contact

Ladan Khamseh, Chief Operating Officer, (714) 246-8400
Richard Bock, Deputy Chief Medical Officer, (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of Legal Counsel to:

1. Withdraw previously authorized Request for Proposal (RFP) to identify community partner(s) experienced with providing Medi-Cal-covered Perinatal Support Services (PSS);
2. Terminate current capitated contract; and
3. Enter into contracts with qualified perinatal support services providers and vendors at CalOptima Medi-Cal Fee Schedule PSS rates.

Background

Medi-Cal Managed Health Care Plans are required to provide access to Comprehensive Perinatal Support Program (CPSP) comparable services for pregnant Medi-Cal eligible recipients. In 1995, CalOptima was mandated by the state to provide CPSP-comparable services. These services were referred to as Perinatal Support Services (PSS). At this time, CalOptima fully delegated this responsibility to its contracted health networks.

In 2008, after a review of variation in usage of PSS among the health networks, the CalOptima Board approved a consolidated capitation contract for Comprehensive Perinatal Services Program with MOMS Orange County (MOMS). In addition to the capitated services provided by MOMS, certified providers have also provided CPSP services and these providers are currently paid by CalOptima at 100% of the CalOptima Medi-Cal Fee Schedule for these services.

Effective April 1, 2017, the CalOptima Board authorized a short-term contract amendment with MOMS to reflect per member per month reimbursement and incentive payments based on the CalOptima Classic Medi-Cal population. In addition, the CalOptima Board authorized the issuance of a Request for Proposals (RFP) to identify community partner(s) experienced with delivering PSS services.

Discussion

CalOptima staff undertook the RFI/RFP process; however, it generated limited responses. Of the responses received, staff determined that only two responders are qualified to provide PSS for CalOptima members. One of the responders is based in La Habra and bid below the Medi-Cal CPSP fee-for-service rates. The other vendor, the current capitated vendor, is based in Santa Ana and provides PSS services through home visits. However, this vendor's proposed compensation was

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significantly higher than what would be reimbursed based on the Medi-Cal CPSP fee-for-service rates. Given the wide variation in vendor compensation proposals, staff also reviewed current County PSS providers/vendors and rate data and confirmed that there are over 250 independent, certified CPSP providers currently serving CalOptima members at the CalOptima Medi-Cal fee-for-service rates. In addition, there are several separate community programs that already provide free perinatal services to women with high risk pregnancies throughout the county. As a result, staff recommends eliminating the capitated structure and contracting with any and all willing and qualified providers/venders and reimbursing these providers/vendors at the CalOptima Medi-Cal fee schedule CPSP rates for the PSS services outlined in the CalOptima PSS Program description.

Fiscal Impact

The recommended action to withdraw the RFP for PSS vendor(s) and authorize contracting with any and all qualified providers at CalOptima Medi-Cal Fee Schedule rates is projected to reduce CalOptima's annual CPSP costs by $2.4 million. Management has included expenses associated with the current MOMS contract rates in the proposed CalOptima FY 2018-19 Operating Budget. However, elimination of the capitated arrangement and increased utilization of providers reimbursed at 100% of the CalOptima Medi-Cal Fee Schedule rates for PSS services will result in a reduction in medical expenses from the budgeted levels.

Rationale for Recommendation

Based on the results of the RFP process to date and the PSS service reimbursement data, staff believes that a more comprehensive approach to PSS services will increase access and utilization, improve HEDIS results, enhance coordination of services and member engagement, and significantly lower CalOptima's medical expenses related to the services as compared with the current model. To successfully achieve a more comprehensive approach in a fiscally responsible manner, staff seeks authority to contract with any and all willing and qualified PSS provider(s) throughout the county.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Power Point Presentation – Perinatal Support Services Program Update
2. Board Action dated March 2, 2017, Authorize Issuance of Request for Proposal (RFP) for Medi-Cal Perinatal Support Services (PSS), Contracts with Qualifying RFP Responders
    a. Board Action dated May 6, 2008, Approve the CalOptima PSS Program and Ratify CalOptima's Contract with MOMS (Maternal Outreach Management System) for PSS

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

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Perinatal Support Services Program Update

Board of Directors Meeting
June 7, 2018

Ladan Khamseh, Chief Operating Officer
Richard Bock, M.D., Deputy Chief Medical Officer

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Perinatal Support Services (PSS)

- DHCS requires Contractors to provide the following Comprehensive Perinatal Support Program (CPSP) services:
  - All medically necessary services for pregnant members per the most current standards or American College of Obstetricians and Gynecologists (ACOG) guidelines
  - A comprehensive risk assessment
  - Individual care plans addressing obstetrical, nutrition, psychosocial, and health education
  - Timely high risk clinical referrals to appropriate specialists and for delivery services
  - Referrals to other CalOptima and community-based resources

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Our Current Program Model

Per 2008 Board Action:

Approval of capitated contract for Perinatal Support Services with MOMS Orange County

- MOMS Orange County utilizes a home visitation program model to provide CPSP as well as care coordination services

Community obstetricians continue to provide CPSP services on a fee-for-service basis at Medi-Cal rates.

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Capitation vs. Fee-for-Service Model

CY 2016			
Model	Members	Cost	Cost/ Member
Capitated	1,397	$4.1 million	$2,914
Fee-for-Service	3,966	$1.0 million	$251

CY 2017			
Model	Members	Cost	Cost/ Member
Capitated	1,364	$3.2 million	$2,290
Fee-for-Service	3,967	$1.0 million	$258

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Timeline Review

- Proposed Program revision presented to QAC (Nov. 2016) and FAC (Feb. 2017)
- March 2017: Board of Directors approved changes:
  - Issue a Request for Proposal (RFP)
  - Amend-capitated contract with existing PSS vendor to carve out Medi-Cal Expansion population
- April 2018: RFI, RFP, literature review and PSS provider community survey completed
- May 2018: Update presented to QAC

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RFI/RFP Findings

- Only two qualified respondents to RFP.
- Current authority allows contracting with only these two vendors for non-CPSP PSS services.
- Limited program participation with non-CPSP vendor in parts of the county.
- Analysis identified >250 current CPSP providers as well as one of the responding vendors willing to participate at or below Medi-Cal rates.

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Next Steps

- Authorize the Chief Executive Officer, with the assistance of legal counsel to:
  - Withdraw previously authorized Request for Proposal (RFP) to identify community partner(s) experienced with providing Medi-Cal-covered Perinatal Support Services;
  - Terminate current capitated contract; and
  - Enter into contracts with qualified perinatal support services providers and vendors at CalOptima Medi-Cal rates.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the issuance of a Request for Proposal (RFP) to identify community partner(s) experienced with providing Medi-Cal-covered educational and care management services supporting pregnancies (pre and postpartum)—specifically, these services are referred to as perinatal support services (PSS) and are consistent with CPSP services, but have additional CalOptima-identified requirements;
2. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:
    a. Contract with qualifying RFP responders and in compliance with CalOptima's PSS program and Medi-Cal requirements established by the California Department of Health Care Services (DHCS); and
    b. Amend the contract with the current vendor to reflect per member per month and incentive payment based only on the CalOptima Classic Medi-Cal population, effective April 1, 2017 through the completion of the RFP process.

Background

The Comprehensive Perinatal Support Program (CPSP) provides a wide range of culturally competent services to Medi-Cal pregnant women, from conception through 60 days postpartum. In addition to standard obstetric services, women receive enhanced services in the areas of nutrition, psychosocial and health education. The Legislature enacted the CPSP in 1984 in response to findings from the OB Access Project which indicated that a comprehensive approach reduced both low birth weight rates and health care costs in women and infants. CPSP became a Medi-Cal benefit in 1987. Medi-Cal Managed Health Care Plans are required to provide access to CPSP-comparable services for pregnant Medi-Cal eligible recipients. In 1995, CalOptima was mandated by the State to provide CPSP- comparable services. These services were referred to as Perinatal Support Services (PSS). CalOptima, in turn, fully delegated this responsibility to its contracted health networks.

In 2006, a review of health network data revealed areas of concern due to marked variation in usage of PSS. The variation resulted from a fragmented referral process, eligibility timing issues, and challenges related to coordination of referrals between OB physicians and PSS providers. The resulting recommendation post review was to consolidate the referral process and transition responsibility from the health networks back to CalOptima. On May 6, 2008, the CalOptima Board approved a consolidated capitation contract for Comprehensive Perinatal Services Program with

[1] CA.GOV MO-07-0074 CPSP

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MOMS Orange County (MOMs). CalOptima initially entered into a one year capitated agreement with MOMS in 2008, at a capitation rate of $.55 per member per month (pmpm) based on the total CalOptima Medi-Cal membership. The contract included two extension options of one year each. The contract was subsequently amended (Amendment II) effective May 1, 2011 to renew automatically on an annual basis upon Board approval. This agreement also included monetary incentives, projected at $234,000 annually, for early referrals, completed initial assessments and increased participation.

In addition to the capitated services provided by MOMs, non-MOMs CPSP-certified providers have also been providing services and are paid by CalOptima at 100% of the CalOptima Medi-Cal fee schedule. These CPSP providers include but are not limited to physicians, Ob/GYNs, certified nurse mid-wives, medical groups, clinics, and PPOs and are certified through the California Department of Public Health.

Due to Medi-Cal expansion and contract language supporting capitation for all Medi-Cal members, program costs have increased year-over-year and more recently from $2 million to $3.5 million for the 2013 - 2015 period (i.e., capitation has been paid based on total CalOptima Medi-Cal membership irrespective of the individual member's potential PSS needs). In comparison, CalOptima member births have increased more modestly during the same period, with approximately 7,000 deliveries in 2013, compared to 8,500 deliveries in 2015. Additionally, records indicate that member engagement with PSS providers decreased dramatically during the same 2013 - 2015 period, after the first encounter from 50% of identified pregnancy referrals to 15%, with continued declines reported throughout the remaining trimesters and through postpartum.

Discussion

The proposed new program will be designed to provide a more comprehensive approach, and strategically increase utilization, coordination of services and member engagement. The redesign will include program development, payment methodology, data integration and improved anticipated outcomes. Proposed program components will meet industry standards and regulatory requirements for perinatal care. The program will include additional data analysis, stratification for low, moderate and high risk, as well as engagement strategies to increase identification of need for and utilization of Perinatal Support Services.

Through an RFI process ahead of the RFP, CalOptima staff plans to seek best practices and identify potential partners and providers with the capabilities to deliver PSS to our members to inform the development of the RFP and its scope of work. CalOptima staff plans to take responsibility for the coordination of care with health network case management and OBs for members at high risk for poor pregnancy outcomes, in a similar manner to current process. CalOptima staff or identified vendor(s) from the proposed RFP process will outreach to members each trimester and provide trimester-specific coaching, nutrition education, and reassess changes in pregnancy risk status aligned with CPSP requirements. Third trimester outreach will include support and coordination of post partum visits, including member incentives for visits completed within the HEDIS-specified time period. After delivery, members will receive support resources and reminders on the importance of the Well Child Visit and Initial Health Visit during the first 15 months of life. Vendor/partner activities are expected to include real-time data-sharing and interventions consistent

with program content and will be an integral part of our efforts in providing these services and achieving optimal outcomes.

The proposed RFP could result in awarding contracts to multiple vendors and/or providers. We anticipate CPSP providers will participate in the new CalOptima perinatal program; participation will be determined (vendor or provider) as a result of the RFP process.

Staff also recommends amending the contract with the current vendor to reflect per member per month payments based only on the CalOptima Classic membership (i.e., not including the Medi-Cal Expansion (MCE) membership) at the current rate of $0.55 pmpm plus a $100 incentive payment for an initial visit completed within first 16 weeks of pregnancy, effective April 1, 2017 through the completion of the RFP process. For the COD membership, CalOptima will pay $175/assessment. (See attachment "Qualifying Aid Categories for Payment").

While it's understood that a different payment methodology may be adopted as part of the RFP process (e.g., fee-for-service or case rate), management recommends this change to the current vendor's contract to bring payments for these services made to the current vendor into closer alignment with the pre-MCE state. In the event that the current vendor is unwilling to accept such amendment, management plans to exercise CalOptima's right to terminate the contract for convenience with 60 days notice. Should this occur, management would ensure that Perinatal Support Services would be available to all qualifying members through fee-for-service providers in conjunction with CalOptima's Medical Affairs Department.

Fiscal Impact

The recommended action to initiate an RFP for a CPSP vendor(s) is expected to be budget neutral. Management anticipates that new contracts for the vendors and/or providers identified will support the revised CPSP program based on program goals and achievements (e.g. not a capitated model for all members). While the RFP process is expected to result in a more effective quality program, staff will return to the Board with a financial plan if expected expenses exceed those anticipated with the current model.

Rationale for Recommendation

As identified through CalOptima's latest HEDIS results, it is imperative for CalOptima to redefine its PSS program to increase the identification and intersection with the member and provider throughout the member's pregnancy. CalOptima staff proposes to conduct an RFP process to identify partner(s) to meet the requirements of the new program design for Perinatal Care for CalOptima members. The new program is designed to provide a more comprehensive approach, and strategically increase utilization, coordination of services and member engagement.

Concurrence

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

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Attachments

1. Power Point Presentation – Perinatal Support Services (PSS)
2. Board Action dated May 6, 2008, Approve the CalOptima PSS Program and Ratify CalOptima's Contract with MOMS (Maternal Outreach Management System) for PSS
3. Qualifying Aid Categories for Payment to Current Vendor

/s/ Michael Schrader — *2/23/2017*

Authorized Signature — **Date**

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Perinatal Support Services

Board of Directors Meeting
March 2, 2017

Pshyra Jones
Director, Health Education & Disease Management

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Why do we need a Perinatal Support Services program?

- Pregnancy and childbirth can be a common reason for inpatient admissions.
- Perinatal care is important for the mother and the baby — and is underutilized.
- We hope to improve outcomes for mothers and babies.
- CalOptima has contractual requirements to provide members with access to a comprehensive perinatal support program.
- CalOptima is working to improve our member experience.
- We need to improve our HEDIS scores.

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DHCS Perinatal Services Requirements

- Ensure the provision of all medically necessary services for pregnant members.
- Implement a comprehensive risk assessment using standards or guidelines of the American Congress of Obstetricians and Gynecologists.
  - Assessment and care plan should include health education, nutrition and psychosocial risk components.
  - Assessment should be administered at the initial prenatal visit, each trimester thereafter and postpartum.
- Ensure pregnant members at high risk of a poor pregnancy outcome are provided timely referral to specialist and delivery services.

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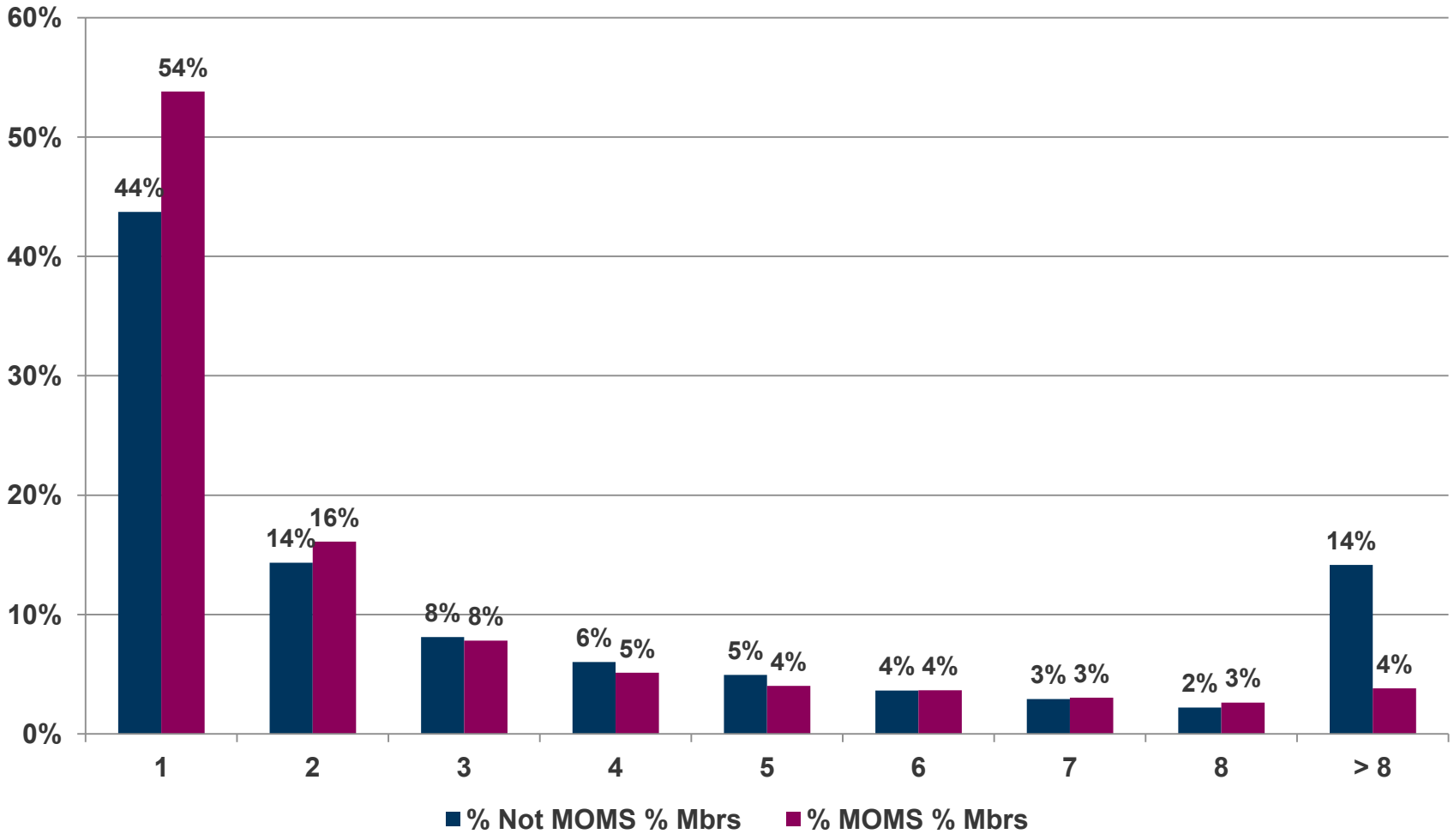
Current Fragmented Program Model

- CalOptima contracts with MOMS Orange County for perinatal support services
- Comprehensive Perinatal Services Program (CPSP) is also provided by fee-for-service OB providers
- Redundancy of services for members assigned to CPSP providers
- Existing model makes minimal contributions toward prenatal and postpartum HEDIS performance
- Single source for program entry—Pregnancy Notification Referral Form (PNR)
- PMPM based on entire CalOptima Medi-Cal membership

Average # Member Visits (2013–15)



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CalOptima A Public Agency Better. Together.

CalOptima Prenatal and Postpartum Services (PPC) HEDIS Rates

HEDIS PPC2016			
	Denominator Count	Prenatal Rate	Postpartum Rate
MOMS	1596	73.5%	48.8%*
Non-MOMS	5912	73.2%	51.7%
Total	7508	73.3%	51.1%

PPC Measure is a QIC Focus Area—CalOptima is currently below the 50th percentile and nearing the 25th percentile.

* Results are statistically significant (p= 0.040)

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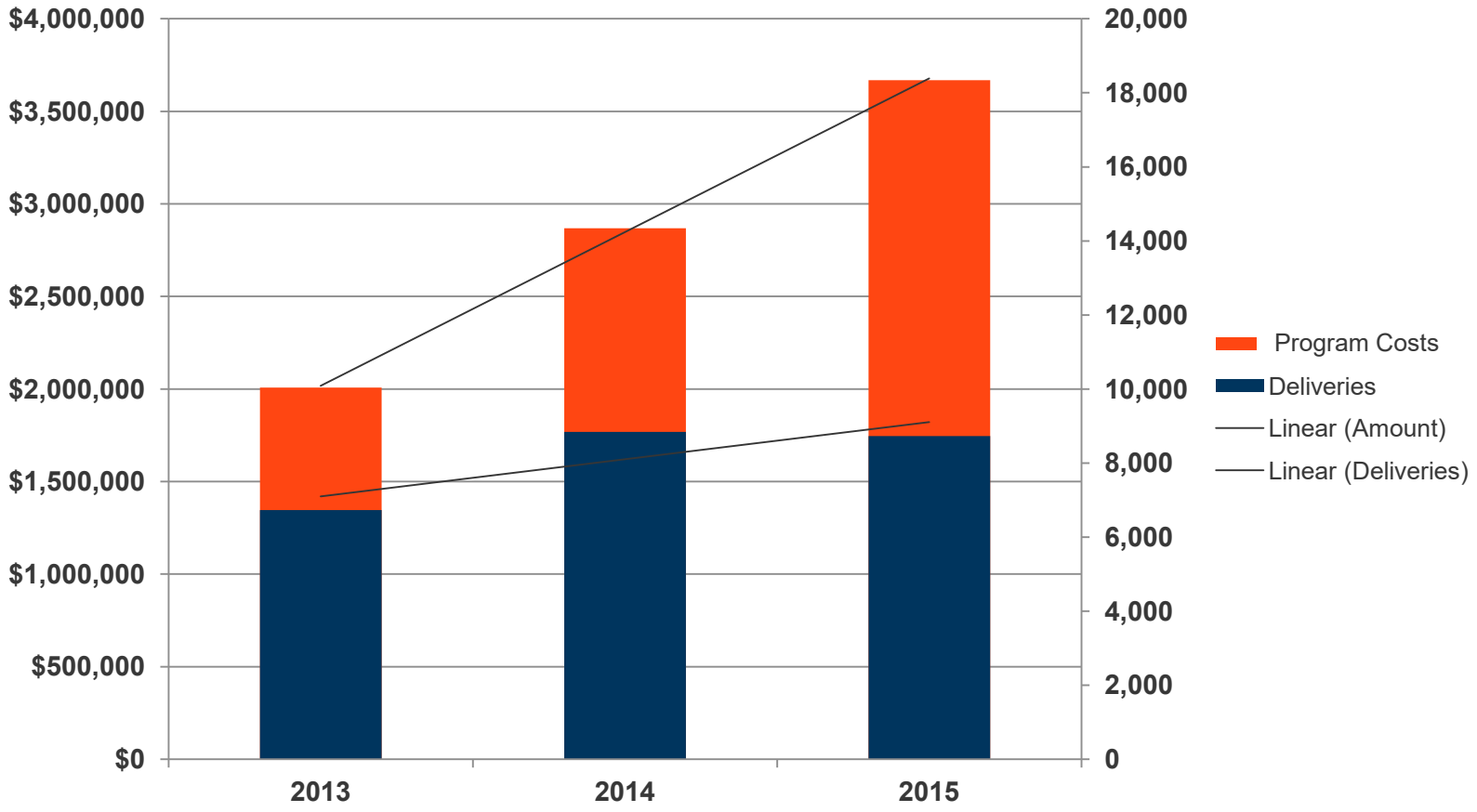
Deliveries vs. Program Costs



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CalOptima
A Public Agency
Better. Together.

The New Approach

- Comprehensive, coordinated program
- More emphasis on member-initiated activity
- Coordination with CPSP providers, OB/GYNs, complex case management and community resources
- Member support with health education, nutrition and psychosocial needs
- Outreach and program marketing strategy to increase identification and member engagement

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Program Components

- Identification of pregnant members
- Assessment
- Health coaching and education*
- High-risk case management
- HEDIS reminders and member outreach*
- Incentives
- Outcomes

* Program components included in RFP

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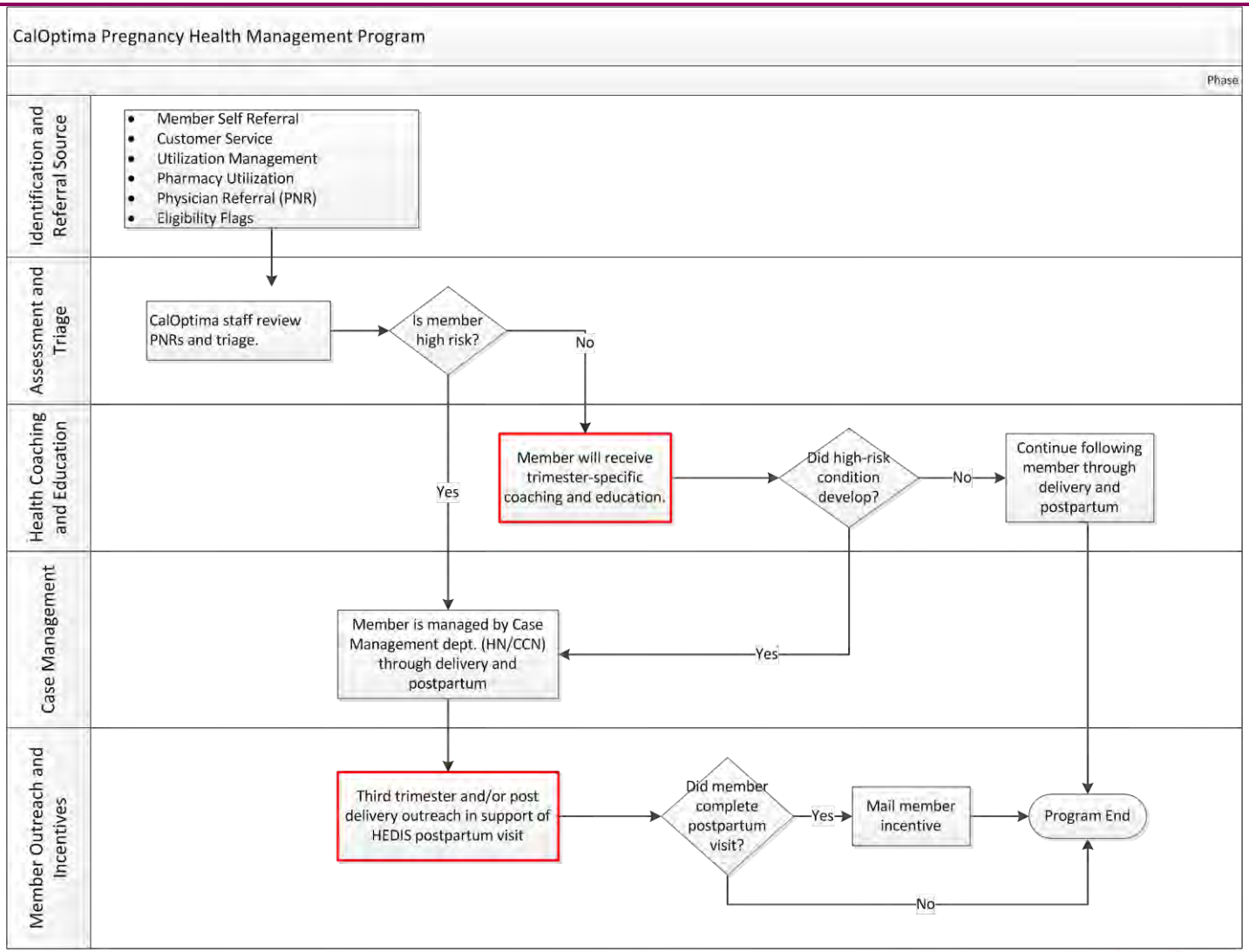
New Program Model



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CalOptima A Public Agency Better. Together.

Recommended Action

- Authorize the issuance of a Request for Proposal (RFP) to identify community partner(s) experienced with providing Medi-Cal-covered educational and care management services supporting pregnancies (pre and postpartum)—specifically, these services are referred to as perinatal support services (PSS) and are consistent with CPSP services, but have additional CalOptima-identified requirements;

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Recommended Action (Cont.)

- Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:
  - Contract with qualifying RFP responders and in compliance with CalOptima's PSS program and Medi-Cal requirements established by the California Department of Health Care Services (DHCS); and
  - Amend the contract with the current vendor to reflect per member per month and incentive payment based only on the CalOptima Classic Medi-Cal population, effective April 1, 2017 through the completion of the RFP process.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 6, 2008
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. C. Approve the CalOptima Perinatal Support Services Program and Ratify CalOptima's Contract with MOMS (Maternal Outreach Management System) for Perinatal Support Services

Contact

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

Recommended Actions

1. Approve the proposed CalOptima Perinatal Support Services Program; and
2. Ratify CalOptima's Contract with MOMS for Perinatal Support Services.

Background

The Comprehensive Perinatal Support Program (CPSP) is a Medi-Cal benefit developed in 1992 by the State of California. This benefit was designed in response to poor birth outcomes in the California Medi-Cal population. The goal of the program is to improve the overall health status of pregnant mothers and their newborn babies. CPSP services are comprised of direct OB physician services and Perinatal Support Services (PSS). The PSS services consist of health education, nutritional and psycho-social counseling and OB-focused case management. In 1995, CalOptima was mandated by the State to provide PSS services. CalOptima in turn fully delegated this responsibility to its contracted health networks.

Last year, a review of health network 2006 data revealed areas of concern with marked variation in usage of PSS services. The variation resulted from a fragmented referral process, eligibility timing issues, and coordination of referrals between OB physician and PSS provider. The resultant recommendation post review was to consolidate the referral process at the CalOptima level.

Discussion

As part of CalOptima's transfer of PSS, the established health network contractual relationships were consolidated into a CalOptima preferred capitation contract with MOMS (Maternal Outreach Management System) and the assumption of network-specific fee-for-service contracts those independent OB physician providers. It was anticipated that this re-contracting effort would recapture funds sufficient to cover the costs of the program. However, upon close review there were additional costs associated with the consolidation. Three factors have contributed to the additional costs of the program: 1) contract costs; 2) preservation of alternatives; and, 3) incentives to increase early referral.

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Contract Costs It was originally anticipated that CalOptima would have an exclusive contract with MOMS on a capitated basis for all PSS services provided to CalOptima members. Outlays under this contract were expected to be equivalent to the original outlays that had been expended by the health networks for PSS services. Effective January 1, 2008, CalOptima entered into a one-year capitated agreement with MOMs with two extension options of one year each. However, upon review it was realized that some coordination activities would need to continue to be performed by the health network and accordingly, a portion of the capitation would have to remain at the health network level to pay for those functions.

Preservation of Alternatives While it was the intent of the revised program to move PSS services into an entirely capitated program under CalOptima as of January 1, 2008, it became evident in the transition planning process that doing so would create potential issues of program access, as well as interference with existing physician-patient relationships for members who had a previous history of receiving PSS services from certain traditional PSS providers. As a result, the original plan was modified to preserve the option for members to see these traditional PSS providers on a fee-for-service basis outside of the capitation arrangement with MOMS to ensure access and preserve physician-patient relationships.

Incentives to Increase Early Referrals Finally, the goals of the program are to improve member access, increase participation rates, and improve coordination. There was recognition that the earliest possible referral to the program provides the chance of the best outcome. To ensure the fastest, most effective results, the decision was made to provide an incentive for early referral. This has proven to be a successful strategy. Results from the first three months of calendar 2008 show first trimester referrals increasing from 21% to 42%, and third trimester visits decreasing from 30% to 12% over prior year levels.

Fiscal Impact

The fiscal impact of decreased health network capitation of $.55 per-member per-month in appropriate aid codes along with increased costs related to contracting, preservation of alternatives, and providing incentives to increase early referrals results in a net increase in costs of a maximum of $117,000 above the budgeted amount for FY08-09, or a projected $234,000 on an annualized basis. Going forward, these additional expenditures will be included in the budget.

Rationale for Recommendation

The Perinatal Support Services benefit was moved from the health network level to the CalOptima level in response to the identification of the need for greater coordination of PSS services. The goal for this realignment of program responsibilities is to improve utilization of PSS services through improved coordination and outreach.

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Concurrence
Procopio, Cory, Hargreaves and Savitch, LLP

Attachments
None

/s/ Richard Chambers — *05/01/2008*
Authorized Signature — **Date**

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Attachment 3: **Capitation**: Qualifying Aid Categories for Payment.

The following Table illustrates the aid code categories for which MOMS will receive capitation and incentive payment as referenced in the Board Action. The table also defines the populations for which MOMS will not receive capitation. The revised basis for capitation payment to the MOMS organization will become effective the first of the month following the execution of an amendment to the existing contract. The effective date is expected to be April 1, 2017.

Aid Code Categories included in Capitation	**Groups excluded from Capitation**
Family & Adult	All Kaiser members regardless of aid code category
Aged/Medi-Cal Only	All COD members
Disabled/Medi-Cal Only	All Medi-Cal Expansion Members
~~Breast and Cervical Cancer Treatment Program (BCCTP)~~	

Fee-For-Service:

Payment for COD Members only: MOMS will continue to receive one hundred seventy five dollars ($175) for each assessment completed and forwarded to CalOptima. This payment methodology is currently in place and there is no change at this time.

[1] CA.GOV MO-07-0074 CPSP

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

39. Consider Authorizing Revision and Expansion of the Program of All Inclusive Care Primary Care (PACE) Provider (PCP) Incentive Program and Related Changes to PCP Contracts

Contact

Richard Helmer, Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director Network Operations, (714) 246-8400

Recommended Actions

Specific to the CalOptima PACE Program, authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to:

1. Revise and expand the CalOptima Program of All Inclusive Care (PACE) Primary Care Physician Incentive Program, subject to applicable regulatory approval(s);
2. Amend CalOptima's contract with the Regents of the University of California on behalf of UC-Irvine (UCI) for PACE PCP services to modify the PACE PCP Incentive Program; and
3. Add the PACE PCP Incentive Program to PCP contracts currently in place and include this program in any future PACE PCP contracts, including those of community-based physicians serving CalOptima PACE members.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to help participants continue to live safely at home in the community for as long as possible and to maintain or improve their functional status. CalOptima's program is the first PACE program offered to Orange County residents

At its September 7, 2017 meeting, the Board authorized the CEO to amend the physician services contract with UCI to include the UCI PACE PCP Incentive Program, as well as contracts with non-UCI PCPs as necessary to provide appropriate primary care coverage for the ongoing operation of PACE. At that meeting, the Board also authorized staff to submit the PACE community-based physician waiver which allows members to continue to see their current PCPs while also participating in the PACE program. This waiver was approved by CMS in March 2018.

PCPs have traditionally provided both clinic and non-clinic based care. Clinic-based services are those services rendered in an outpatient clinic, such as the PACE center clinic. Non-clinic based PCP services are those provided outside of an outpatient clinic such as in an emergency room (ER), nursing facility, hospital, or the participant's home. Although it is less common to find community PCPs who provide both clinic and non-clinic based care, it is common within PACE organizations.

The UCI PACE PCP Incentive Program currently includes both Quality Improvement (QI) and Utilization Management (UM) elements. The program has led to significant improvements in all three of the QI elements including overall PACE satisfaction, satisfaction with medical care and reduced coding errors. In 2017, CalOptima PACE program participant satisfaction with medical care and overall satisfaction improved from the previous year and were higher than both the CalPACE and

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National PACE averages. The current incentive program allocates $3 per member per month (PMPM) to the three QI incentive elements. As a comparison, management's recommended budget for CalOptima's Community Care Network (CCN) allocates $20 PMPM in FY2018-19.

Unlike the QI incentive elements, the UM inpatient cost savings sharing element has not reached the goal set, with inpatient utilization actually increases year over year. Some of this increase is attributed to the severe flu season this winter. However, even without that event, CalOptima's targeted goals would not have been met. After careful analysis, staff has identified a number of opportunities related to the current program. First, only the UCI PACE PCPs are currently able to participate in the incentive program. Second, the UCI PACE PCPs are only involved in clinic-based care. They are not involved in non-clinic based care such as ER, inpatient (IP) and skilled nursing facility(SNF) care. Third, due to the frailty and age of many of CalOptima's pace participants, they are often admitted unnecessarily as the ER physicians and hospitalists are not familiar with the participants or the resources available in the PACE program.

To better incentivize PCPs serving CalOptima PACE members to address these issues, non-UCI PACE PCPs were recently added as an option for CalOptima PACE members, and the role of the PACE PCP has been expanded to include non-clinic based care (including IP, SNF, ER, and Home Visits) in line with a number of other PACE programs. It is anticipated that these PCPs will provide enhanced, real-time evaluations in the evenings, weekends and on holidays which will include home visits, nursing home evaluations and emergency room evaluations.

Discussion

CalOptima has a long history of incentivizing community partners who go above and beyond in the provision of care to our members. Staff is proposing to revise the UCI PACE PCP Incentive Program (now the PACE PCP Incentive Program) as the PACE PCPs are essential in appropriately assessing a participant's condition as well as avoiding unnecessary ER visits and inpatient admissions. Staff believes that the updated PACE PCP Incentive Program will support quality care, reduce inpatient utilization and promote appropriate use of healthcare resources. The program will continue to have both UM and QI elements. Please note that the implementation of the incentive plan is subject to regulatory approvals.

Staff would like to extend the program to include all current and future PACE PCPs including community-based physicians. PACE will need additional PCPs to provide both clinic-based and non-clinic based care as the program grows and expands into south county. Staff also proposes to increase the number of QI elements and the funds allocated to these elements to bring them more in line with CalOptima's other lines of business. Staff also proposes to revise the distribution of the UM inpatient cost savings sharing element to support the inpatient avoidance strategies. PCPs must be specifically contracted to participate in the PACE PCP Incentive Program. In order to be eligible to receive the incentive payments, PCPs must be contracted and in good standing at the time of the payout. Any payouts to otherwise eligible PCPs who are contracted for less than the entire fiscal year will be pro-rated accordingly.

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UM Element (Inpatient Cost Savings Sharing)

- The UM inpatient cost savings will be apportioned between CalOptima and the PACE PCPs (reference Attachment A: PACE UM Incentive grid).
    - CalOptima and the PACE PCPs
        - The first 5% in inpatient cost savings will be apportioned to CalOptima as this target should be met with usual and customary care.
        - PCPs will be able to earn up to 40% of the cumulative inpatient cost savings below the first 5% up to the percentages outlined in Attachment A, the PACE UM Incentive grid.
        - For comparison, the One Care and One Care Connect physician performance shares 50% and the Medi-Cal physician performance shares 60%.
    - Clinic-based care and non-clinic based care.
        - Those incentives earned by the PCPs will be apportioned to those PCPs providing clinic-based and those providing non-clinic based care.
        - Clinic-based care
            - Includes all the primary care taking place in an outpatient clinic such as the clinic at the PACE center or in the office of PACE community-based PCP.
            - Staff recognizes the importance of this care has in reducing inappropriate admissions. For example, the better a participant's medical condition, such as Congestive Heart Failure (CHF) or Chronic Obstructive Pulmonary Disease (COPD) is managed, the less likely a participant will need to go to the ER or be admitted to the hospital.
        - Non-clinic based care
            - Includes all of the care occurring outside of an outpatient clinic. This includes evaluations and care delivered in IP, SNF, and ER locations. It also includes evaluations and care which occurs in the participant's home.
            - Any funds allocated to the non-clinic based care will be apportioned based upon the volume of services provided for the above non-clinic based services.
            - The percentage of the UM inpatient cost savings apportioned to the PACE PCPs who are providing non-clinic based care will increase as the savings increases to recognize the additional work being done by these providers who will be performing real-time evaluations in the evenings, on weekends and on holidays to help insure that participants get the care they need in a timely manner.
    - PACE center clinic and community-based physician offices.
        - The UM inpatient cost savings apportioned to those PCPs providing clinic-based care will be further apportioned to the clinic sites (PACE center or offices of the PACE community-based physicians) based on the number of participant member months assigned to the clinic site during the measurement year.
    - PACE center clinic PCPs .

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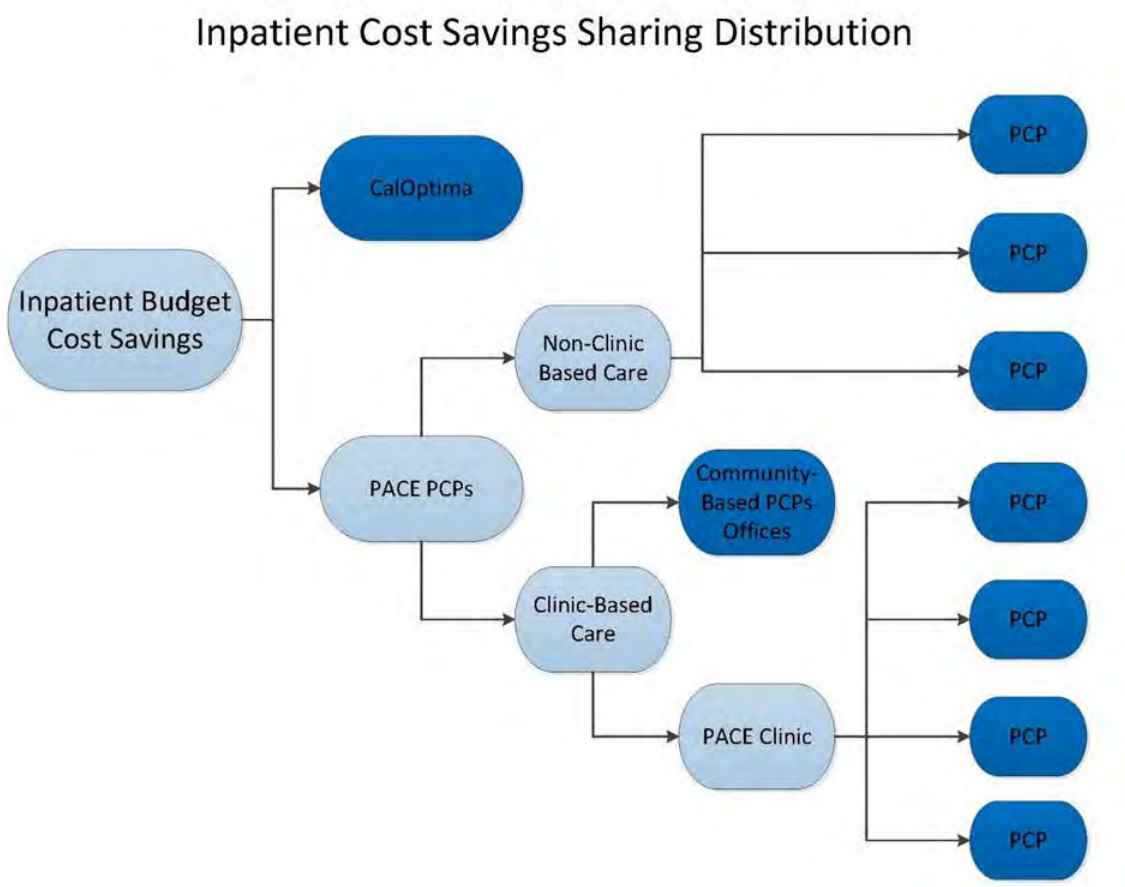
  - The UM cost savings incentive apportioned to the PACE center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
- The targets for the UM inpatient cost sharing incentive is based on the PACE inpatient budget (determined by the current trend). Appropriate performance targets are based on CalPACE and NPA benchmarks.
- The UM elements, metrics, goals, and apportioned amounts will be reviewed and updated and approved annually by the Board.
- In the future, staff will consider developing a draft policy that would incorporate all of the PACE PCP Incentive Programs activities. Prior to implementation, the draft policy would be brought to the Board for approval.

<u>Incentive Program Transition</u>

- The current PACE PCP Incentive Program began on January 1, 2018 and will end on June 30 2018.
- The current PACE PCP Incentive Program performance will be measured and paid according to the timeline in Attachment D: PACE PCP Incentive January to June 2018 Measurement and Payment Timelines.
- The revised PACE PCP Incentive Program will start on July 1, 2018.



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Quality Improvement Elements

- The number of QI elements will increase from three to five.
  - Completion of the physician participant assessments within the regulatory required timeline will be added as a QI element and coding errors will be removed.
  - The participant satisfaction QI elements will be enhanced. Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with medical care and overall satisfaction with the PACE program.
  - Two potentially harmful Drug/Disease Interactions in the Elderly (DDE) elements will be added.
- The potential QI incentives will increase from $3 per member per month (PMPM) to $10 PMPM and are detailed in Attachment B: PACE PCP QI Incentive Grid.
- The QI inpatient cost savings will be apportioned between the PACE PCPs (reference Attachment B: PACE QI Incentive grid).
  - PACE center clinic and community-based physician offices.
    - The QI incentive will be apportioned to the clinic sites (PACE center or offices of the PACE community-based physicians) based on the number of participant member months assigned to the clinic site during the measurement year.
  - PACE center clinic PCPs.
    - The QI incentive apportioned to the PACE center clinic will be further apportioned based on the number of clinical hours the PCPs worked at the center during the measurement year.
- The QI elements, metrics and goals will be reviewed and updated annually.
- The QI element rates and incentive for the community-based PCPs will be calculated based on the number of member months of those participants assigned to them.

As proposed, the contract with UCI would be amended to reflect these changes in the PACE PCP Incentive program and to include the program in all current and future PACE PCP contracts. In addition,, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract will also be included, as necessary

Fiscal Impact

The recommended action to modify the PACE PCP Incentive Program is a budgeted item under the proposed CalOptima Fiscal Year (FY) 2018-19 Operating Budget, with no additional fiscal impact. Specifically, the QI incentive is budgeted at $10.00 PMPM. Based on the projected PACE enrollment, the estimated annual cost for the QI incentive is approximately $37,000 for FY 2018-19. The UM incentive will not incur additional costs beyond the approved budgeted inpatient expense for FY 2018-19. Distributions to participating providers will only occur if actual inpatient expenses are lower than budgeted amounts.

Rationale for Recommendation

Staff recommends revising the PACE PCP incentive program to better align incentives and ensure that PACE participants cost effectively receive necessary care.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. PowerPoint Presentation: Proposed PACE PCP Incentive Program Revisions
2. Board Action dated September 7, 2017, Specific to the CalOptima PACE program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services.
3. PACE PCP Quality Improvement Incentive Grid
4. PACE PCP Utilization Management Incentive Grid
5. PACE PCP Incentive Program January to June 2018 Measurement and Payment Timelines.

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

5/30/2018 — **Date**

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Proposed PACE PCP Incentive Program Revisions

Board of Directors Meeting

June 7, 2018

Miles Masatsugu, M.D.

Medical Director

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Overview of the PACE Program

- To be eligible for PACE, a person must be:
  - 55 years or older
  - Residing in the PACE service area
  - Certified to need nursing facility level care
  - Able to live safely in community

- PACE serves the frailest seniors
  - Average age is older than 80 years
  - Multiple chronic medical conditions
  - High level of functional dependencies (need help bathing, walking, toileting, etc.)

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PACE UCI PCP Incentive Background

- University of California, Irvine (UCI) had been providing all of the PCP clinic-based care at PACE since the program began in October 2013.
- Staff started working on a contract update with UCI in December 2016.
- At that time, PACE did not have a pay-for-value or an inpatient cost savings sharing program.
- Inpatient care is one of the highest costs for PACE.
- Most of the elements and goals had been established by June, 2017.

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Board Actions

- September 7, 2017: Board authorized four actions via two COBARS
  - UCI PACE PCP incentive program with two components
    - Pay-for-value Quality Improvement (QI) component
      - Overall participant satisfaction
      - Participation satisfaction with medical care
      - Coding error rate
    - A savings sharing Utilization Management (UM) component
      - Based on actual inpatient costs
  - Fellows and residents rotations at PACE
  - Contract with non-UCI PCPs
  - Application for the PACE community-based physician waiver (approved in March, 2018)

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Preliminary QI Results: 2017 Annual Participant Satisfaction Survey

Domain	2016 CalOptima PACE	2017 CalOptima PACE	2017 CalPACE Average	2017 National Average
Transportation	98%	**98%**	93%	95.5%
Center Aids	92%	**96%**	93%	91.7%
Home Care	92%	**93%**	87%	87.8%
Medical Care	86%	**92%**	88%	89.5%
Health Care Specialist	85%	**92%**	87%	87.4%
Social Worker	96%	**95%**	94%	95.5%
Meals	71%	**63%**	71%	73.1%
Rehabilitation Therapy and Exercise	98%	**97%**	95%	93.2%
Recreational Therapy	82%	**86%**	84%	82.7%
Other Indicators	92%	**94%**	89%	89.4%
Overall Satisfaction	89%	**90%**	88%	88.4%

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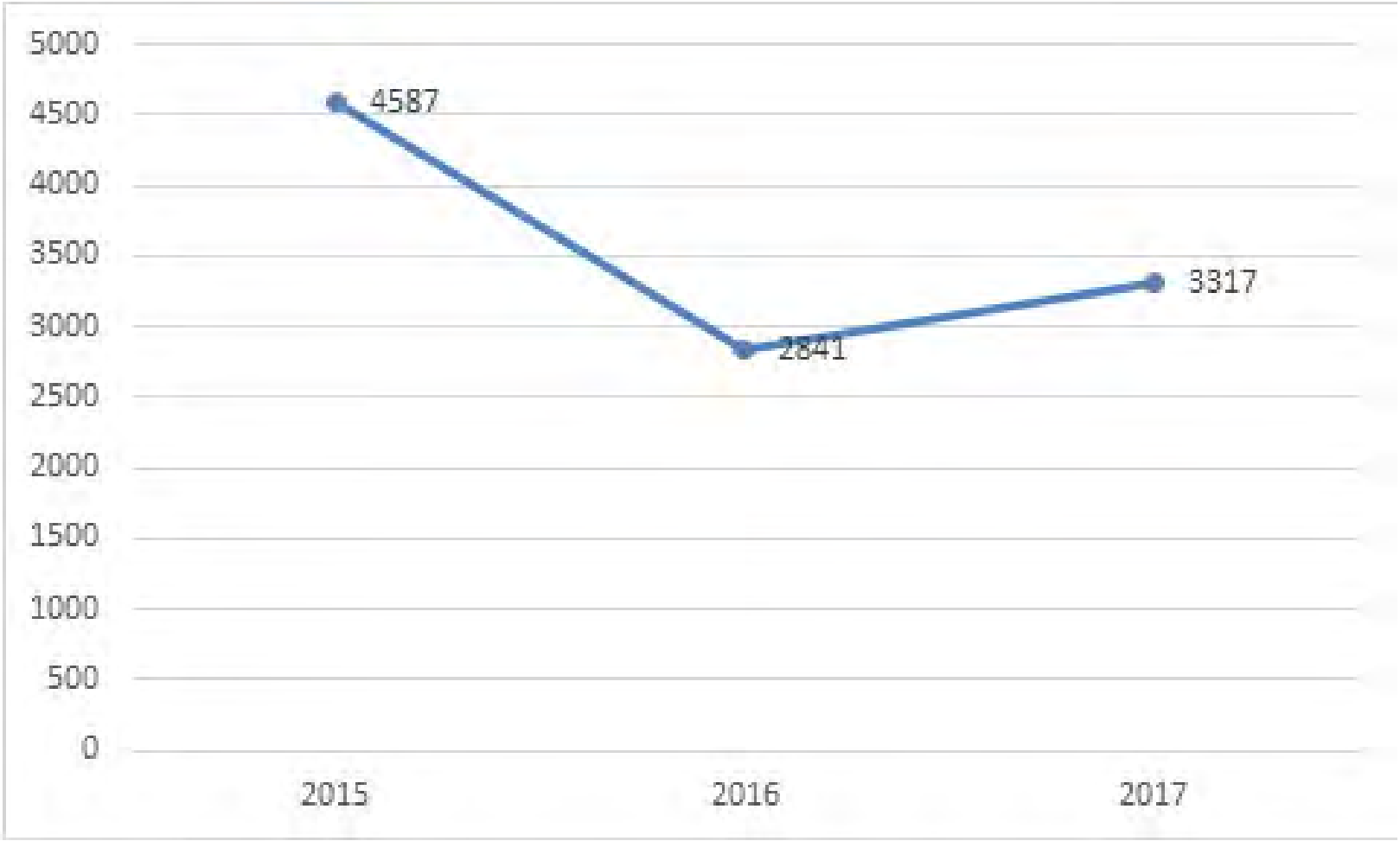
Preliminary Utilization Results: Hospital Bed Days (Goal: 2,100 Bed Days/1,000 Participants/Year)



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Challenges/Opportunities

- Small number of QI elements
- Funding of the QI component is small compared with CalOptima's other comparable lines of business
- Only UC Irvine PACE PCPs can participate in the incentive program
- UCI PCPs are not directly involved in inpatient and nursing home care
- The frail population and unfamiliarity with PACE leads to unnecessary hospitalizations.

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Steps Taken

- September 2017: Board approves 4 actions related to PACE
- October 2017: UCI PACE PCP contract amended
- October 2017: PACE contracts with House Call Medical Associates (HCMA) for PCP services
- November 2017: HCMA assumes most inpatient and Skilled Nursing Facility (SNF) care
- January 2018: UCI PACE PCP incentive begins for remainder of fiscal year (ends 6/30/18)
- May 2018: Presented to CalOptima Board of Directors Quality Assurance Committee

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Proposed Modifications to PACE PCP Incentive Program

- Allow all PACE PCPs to participate in the PACE incentive program, including community-based physicians
- Increase the number of QI elements
- Increase QI incentive from $3 PMPM to $10 PMPM.
- Change distribution of UM component (savings sharing) to support inpatient avoidance strategies
  - After-hours telephonic coordination of care
  - After-hours home visit evaluations
  - Admission directly to SNFs for appropriate cases
  - ER evaluations with observation stays

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Proposed QI Incentive Elements

Elements	Current	Proposed
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	✓	✓
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	✓	✓
Coding Errors	✓	
Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Falls plus tricyclic antidepressants or antipsychotics		✓
Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia plus tricyclic antidepressant or anticholinergic agents		✓
Functional Status Assessment		✓
Total Potential QI Incentive	**$3 PMPM**	**$10 PMPM**

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Proposed UM Incentive (Savings Sharing)

	Budget	Sharing by Tier Level		Cumulative Total Savings		PCP Role (Distribution by Tier)	
	100%	CalOptima	PCP	CalOptima	PCP	Non-clinic based (IP, ER, SNF, Home Visits)	Clinic-based
Tier 1	95%–100%	100%	0%	100%	$0	N/A	N/A
Tier 2	90%–95%	50%	50%	75%	25%	75%	25%
Tier 3	85%–90%	50%	50%	67%	33%	80%	20%
Tier 4	80%–85%	50%	50%	63%	38%	85%	15%
Tier 5 (Incentive Ends)	75%–80%	50%	50%	60%	40%	90%	10%

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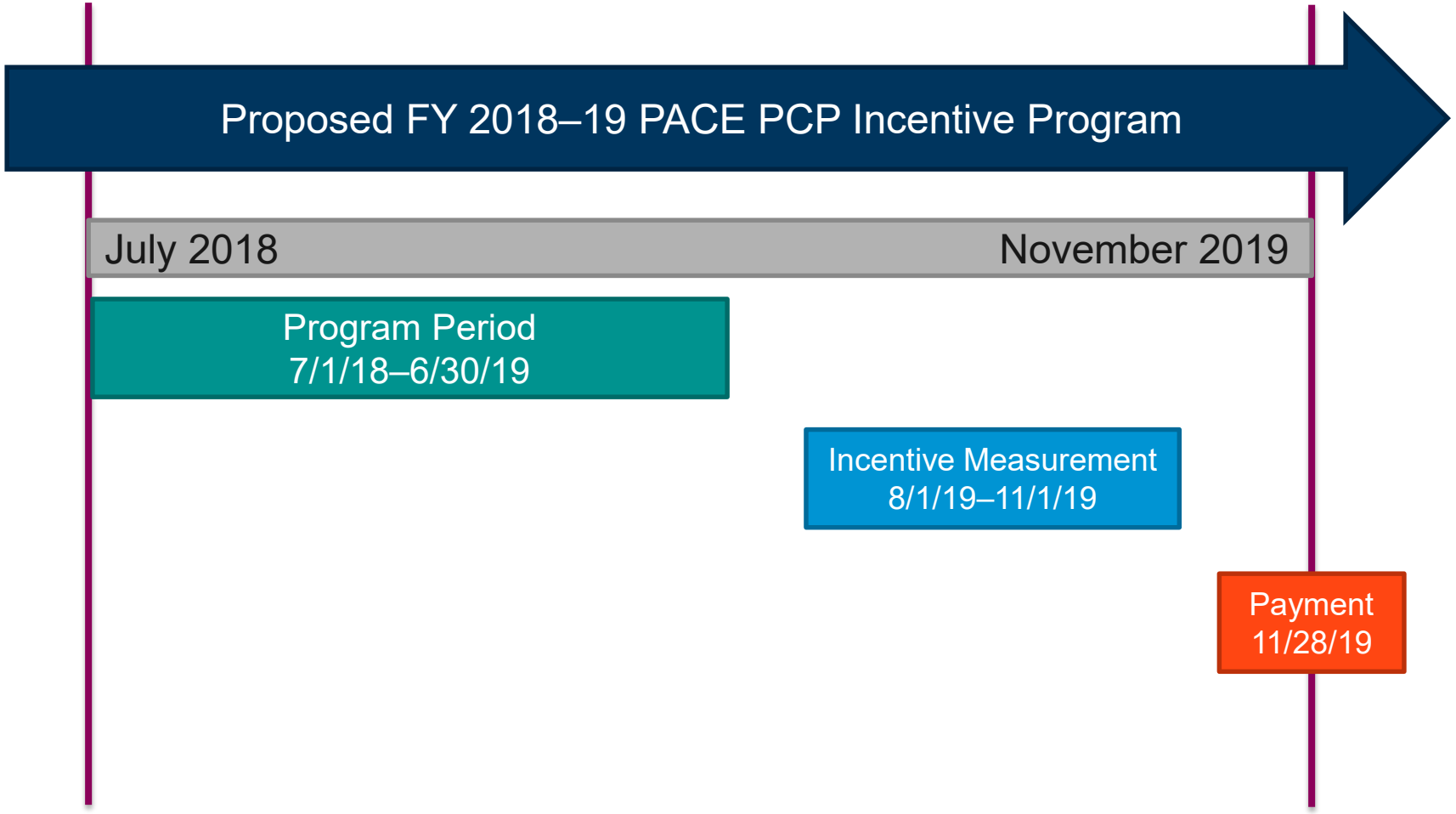
Proposed Timeline



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Recommendation

- Specific to the CalOptima PACE Program, consider authorizing the Chief Executive Officer (CEO), with the assistance of Legal Counsel to:
  - Revise and expand the CalOptima Program of All Inclusive Care (PACE) Primary Care Physician Incentive Program, subject to applicable regulatory approval(s);
  - Amend CalOptima's contract with the Regents of the University of California on behalf of UC-Irvine (UCI) for PACE PCP services to modify the PACE PCP Incentive Program; and
  - Add the PACE PCP Incentive Program to PCP contracts currently in place and include this program in any future PACE PCP contacts, including those of community-based physicians serving CalOptima PACE members.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Specific to the CalOptima PACE Program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to enter into an amendment of the Program of All Inclusive Care (PACE) contract between CalOptima and the Regents of the University of California on behalf of the University of California Irvine, School of Medicine, Geriatric Program (UCI) for physician and non-physician medical practitioner (NPMP) services to amend the scope of work, compensation terms, and to add an incentive program, upon regulatory approval.
2. Establish maximum hourly rates for PACE Physician and Non-physician Providers.
3. Authorize the implementation of an incentive program for UCI PACE PCP services, in accordance with the attached CalOptima PACE PCP Incentive Program Grid, subject to any necessary regulatory agency approval.
4. Authorize contracting with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE.

Background

PACE is a managed care service delivery model for frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent participants from unnecessarily being confined to an institution and to maintain or improve the functional status of the program's participants. CalOptima's program is the first PACE program offered to Orange County residents

The PACE program requires that a number of services are provided at a PACE Center. The Center is a medically-intensive care coordination facility that provides a number of services, including Primary Care, to participants.

At the November 3, 2011 Board of Directors Meeting, Staff received authorization to enter into new provider and vendor contracts as necessary for the operation of PACE. CalOptima subsequently executed a contract with UCI to provide Primary Care services at the PACE center effective March 15, 2013 ("Contract"). Compensation to UCI for this service is on an hourly basis. Subsequently, the Contract was amended in October of 2013 to add on-call services and in December of 2013 to revise

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the hourly rate. In July 2014, the Contract was amended to revise the hourly rate and to add an hourly rate for non-physician medical practitioners (NPMPs).

UCI's Department of Family Medicine Division of Geriatric Medicine and Gerontology has provided Primary Care services to PACE since the opening of the Center. The Department not only provides expertise in geriatric medicine but also a significant amount of staffing depth with currently eleven faculty members. It also provides the opportunity for geriatric fellows and residents to experience care in a PACE setting. This is positive for UCI in attracting fellows, resident and faculty. It is a benefit for Orange County in that physicians often remain in the area where they train. And it is a benefit for CalOptima PACE in that members receive care from practitioners dedicated to this population and who are up to date on current trends in geriatrics. The relationship between the parties has been positive and mutually beneficial. Staff wishes to continue its relationship with UCI.

Discussion

UCI Compensation: At the inception of the Primary Care contract with UCI, Staff negotiated an hourly rate for the provision of services. UCI only receives compensation for services rendered. Although Staff received authorization to complete a contract for Primary Care services at the November 3, 2011 Board meetingThe method of compensation is in the form of an hourly rate for the services of physicians and NPMPs. On-call services are contracted on a per on-call period. On-call periods are based on the non-PACE Center hours during Monday - Friday (4:30 p.m. to 8:00 a.m.) and per day on weekends and holidays (8:00 a.m. to 8:00 a.m.).

UCI has notified CalOptima of a need to increase the hourly rates it receives for the provision of services to the PACE Center. The costs associated with the provision of services by UCI have increased. In addition, staff is recommending contracting with additional providers of primary care services to provide appropriate coverage for the ongoing operation of PACE (see below). It is recommended that the Board establish a maximum hourly rate for PACE physician and non-physician services, and authorize staff to enter into appropriate contracts at rates up to the Board-established maximum. Staff is recommending a maximum rate for physician services of $200.00 per hour, and a maximum rate for non-physician primary care services of $130.00 per hour. The actual rates within the allowable range would be set based on the provider's training, experience, and other resources brought to the provision of the services at the PACE Center (e.g., UCI has requested to provide additional services using Fellows and residents at no cost to CalOptima).

UCI Incentives: Staff requests authorization to add an incentive program for UCI at PACE to focus on increasing patient satisfaction; increasing accuracy of documentation of participant care; and reducing inappropriate inpatient admissions. Please note that the implementation of the incentive plan is subject to regulatory approvals. A detailed grid of the proposed program is attached to this COBAR.

- Staff will use the Annual CalPACE Participant Satisfaction Report to assess patient satisfaction with the medical care provided at the PACE center. Participant medical care and overall

satisfaction with PACE are measured. UCI is eligible to receive an incentive based on a 90% or higher participant satisfaction score.

- Physician documentation of patient care is essential the delivery of quality care and insures appropriate payment from State and federal entities. CalOptima Staff, using audit processes that align with industry standards, will audit physician documentation biannually. UCI will receive additional compensation based on positive results of the audit as reflected on the attached grid.

- As the primary care provider for PACE participants, UCI primary care providers are essential in appropriately assessing a participant's condition and avoiding unnecessary inpatient admissions. Participation in the concurrent review process helps prevent under and over utilization of services. Assisting in the transition of care for a participant from an acute care setting assures the member will continue to receive the care they need and will reduce readmissions. If successful in reducing bed days per thousand per year to the levels identified in the incentive grid attached, UCI will be eligible for a portion of the savings attributed to inpatient costs for PACE. The target bed days per thousand per year are based on CalPACE benchmarks.

Revision to the Scope of Work: Staff requests authority to revise the scope of work to modify responsibilities and qualifications of the physician and NPMP rendering Primary Care services and add responsibilities for UCI to provide clinical Medical Director services. UCI may incorporate care provided by Fellows and residents at the PACE clinic, under the condition that these services are overseen by an onsite contracted UCI physician. The Fellows and residents will be provided at no cost to CalOptima and will enhance the number of providers rendering services at the PACE center.

Updating of Contract Form: In addition to the above changes, staff is also recommending that the Board authorize any additional changes necessary to conform the contract to CalOptima's current standard provider contracts, and to comply with any additional CMS or DHCS requirements relative to PACE that were not included in the original contract also be included.

Additional Authority to Contract: Staff requests authority to contract with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE. Additional providers include, but are not limited to, local Primary Care physicians, Locum Tenens and NPMPs. These providers will be paid at the CalOptima fee schedule.

Fiscal Impact

The recommended action to revise the rate paid to UCI effective September 1, 2017 through June 30, 2018, modify the compensation methodology for on-call services, and implement an incentive payment program is an unbudgeted item. Based on current utilization, funding for the recommended action will increase medical expenses by $80,000, thereby reducing budgeted income for the PACE program to

$131,373 for Fiscal Year 2017-18. Management will include updated PACE medical expenses in future operating budgets.

Rationale for Recommendation

CalOptima staff recommends this action to maintain the contractual relationship with UCI for the provision of Primary Care services to CalOptima PACE and to ensure coverage of Primary Care services for PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated November 3, 2011, Authorize the Chief Executive Office to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE.
2. CalOptima PACE PCP Incentive Program Grid

/s/ Michael Schrader — *9/1/2017*

Authorized Signature — **Date**

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2011
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. B. Authorize the Chief Executive Officer (CEO) to Amend Existing Provider and Vendor Contracts to Include the CalOptima Program of All-inclusive Care for the Elderly (PACE), and to Enter Into New Provider and Vendor Contracts as Necessary for Operation of PACE

Contact

Peerapong Tantameng, Manager, PACE (714) 246-8400

Recommended Action

Authorize the CEO, with the assistance of legal counsel, to amend existing medical provider and administrative support vendor contracts to include PACE, and to enter into new medical provider and administrative support vendor contracts as necessary for operation of PACE within the parameters of the Board-approved operating budget.

Background

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. CalOptima's program will be the first PACE program offered to Orange County residents. Also, CalOptima will be the first County Organized Health System to offer a PACE program to its members.

The hub of a PACE program is the PACE Center, a medically-intensive care coordination facility that provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide a full range of necessary services outside of the PACE Center setting to ensure the proper continuum of care, including, but not limited to:

- Transportation to the PACE center and to medical appointments
- Skilled and personal home care
- Inpatient, outpatient, and specialty care
- Nursing home care, both short and long-term
- Home-delivered meals
- Durable medical equipment

Discussion

On October 7, 2010, the CalOptima Board of Directors authorized the CEO to submit CalOptima's PACE application to the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS). At that time, staff committed to returning to Board to obtain authority to implement operational items for PACE and which are

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required by federal and state regulations, including the execution of contracts with the necessary providers and vendors, many of which are subject to state licensure requirements, to adequately serve CalOptima members who enroll in PACE.

CalOptima staff now seeks authority to amend existing agreements and enter into new agreements with providers and vendors, subject to regulatory approval of CalOptima's PACE program, to offer the necessary medical, social, and community-based services required of a PACE program, including but not limited to the following types of medical providers and administrative support vendors:

- Medical Director;
- PACE Center-based practitioners, including the primary care physician and rehabilitation therapists;
- Medical specialists for the PACE provider network;
- Hospitals;
- Ancillary health services, including dental, audiology, optometry, podiatry, speech therapy, and behavioral health;
- Nursing facilities, for both acute and long-term care;
- Laboratory services;
- Durable medical equipment;
- Home care and home health;
- Transportation;
- Meal service; and
- Electronic Health Record system

Fortunately, many of the provider network needs for PACE can be addressed by amending contracts with providers within the designated PACE service area who are already contracted with CalOptima under its other lines of business. While provider and vendor contracts must include certain regulatory terms that are required by DHCS and CMS, many of these terms are similar to those required for CalOptima's current Medi-Cal and OneCare programs. However, because CalOptima will be a new entrant into the PACE program, staff anticipates that, within the bounds of regulatory and budgetary limitations, there may be a need for variations among agreements based upon the type of provider or vendor, PACE regulatory requirements, and unique institutional requirements that providers or vendors may have in finalizing CalOptima agreements. Staff's proposed strategy is to approach providers and vendors with uniform sets of terms and conditions to minimize the number and scope of variances between contracts. Staff will update the Board of Directors on the progress of the contracting efforts as they move forward.

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Fiscal Impact
It is anticipated that the amendments and new contracts to be negotiated with medical providers and vendors for administrative services will be consistent with the projected expenses reflected in the operational budget for PACE approved by the Board on June 2, 2011.

Rationale for Recommendation
As a new entrant to the PACE market and given the tight timeline for bringing up the PACE program, CalOptima will need to both amend contracts with existing medical providers and administrative support vendors, as well as enter into agreements with new medical providers and administrative support vendors. Through this process, staff plans to put in place the various contractual relationships that are necessary for the proper operation of the CalOptima PACE program.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Richard Chambers — *10/28/11*
Authorized Signature — **Date**

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CalOptima PACE PCP Incentive Program

Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	CY	CY Q4	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	April
					>/= 90%	$1 PMPM	April
Coding Accuracy Rate	Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis.	CY	Biannually	The CalOptima Coding Department will audit charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits.	<75%	$0 PMPM	April
					75-89%	$0.5 PMPM	April
					>/= 90%	$1 PMPM	April
CalOptima PACE Actual Inpatient Performance	Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP.	CY for 1st 6 Months of 2018	Audited CY Performance for the 1st 6 Months of 2018	PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016.	Incentive Begins at BD / K / Y equivalent of 2,300	Total potential: $19.30 PMPM or ~ $30,000***	October, 2018
					Incentive ends at BD / K / Y equivalent of 2,000		
		FY Starting July 1st, 2018	Audited FY Performance	Will be determined by budget and CalPACE updated averages	TBD	TBD	October, 2019
					TBD	TBD	

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.
*** Potential incenitve was estimated based on the projected member months from January, 2018 to June, 2018.

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2018-2019 CalOptima PACE PCP Incentive Program Grid

QI: Potentially Harmful Drug/Disease Interactions in the Elderly (DDE): Dementia + tricyclic antidepressant or anticholinergic agents	PACE participants with a diagnosis of Dementia will be monitored by the PACE QI department who will work with the interdisciplinary and clinical teams as well as the PACE pharmacist to develop strategies for improvement.	FY	August	TruChart Analytics and Pharmacy Utliization Report. 2016 HEDIS Quality Compas 90th percentile is <37.50%.	>/=37.50%	$0 PMPM	January
					<37.50%	$2 PMPM	
QI: Functional Status Assessment	At a minimum, all participants need a complete Functional Status Assessment every 6 months. This ensures that the services and treatment being provided reflect their current needs.	FY	August	The PACE QI Department will pull this data from TruChart Analytics.	<100%	$0 PMPM	January
					100%	$2 PMPM	January
Total Potential QI Incentive						$10	January

PACE Community PCP's will be eligible for the QI Incentive based on the member months of the members assigned to them.
PACE PCP Incentives will be based on the member months of all member's not assinged to PACE Community PCP's.
Individual PACE PCP Incentives will be calculated based on the number of hours worked at the PACE center
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.

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2018-2019 CalOptima PACE PCP Incentive Program Grid: UM Cost Savings Sharing

Measure	Background	Time Period	Source	Metric Detail										Paid
UM; CalOptima PACE Actual Inpatient Performance	Effective clinic and non-clinic PCP care are important factors in avoiding unnecessary inpatient admissions. Non-clinc PCP care including real-time evaluations in the evenings and weeksends at the participant's homes, ER's and SNF's will be important in ensuring particiapnts gets timely, appropriate care. The structure of this program avoids any risk to the PCP.	FY 2019	Audited FY Performance	PCP receives % of the actual inpatient cost savings calculated from the audited FY financial.	Tier	Performance (% below Budget)	Maximum % Savings from Inpatient Budget	% of UM Savings to Cal Optima by Tier	% of UM Savings to PCPs by Tier	% of PCP UM Cost Savings Sharing Incentive to PCPs performing Clinic-Based Services	% of PCP UM Cost Savings Sharing Incentive to PCPs performing Non-Clinic Based Services (IP, ER. SNIF, Home Visits)	Cumulative % of UM Savigs to Cal Optima	Cumulative % of UM Savings to PACE PCP's UM Incentive	Nov-19
					Budget	100%								
					Tier 1	95%-100%	5%	100%	0%	N/A	N/A	**100%**	**0%**	
					Tier 2	90%-95%	10%	50%	50%	25%	75%	**75%**	**25%**	
					Tier 3	85%-90%	15%	50%	50%	20%	80%	**67%**	**33%**	
					Tier 4	80%-85%	20%	50%	50%	15%	85%	**63%**	**38%**	
					Tier 5	75%-80%	25%	50%	50%	10%	90%	**60%**	**40%**	

PACE Community PCP's will be eligible for the QI Incentive based on the member months of the members assigned to them.
PACE PCP Incentives will be based on the member months of all member's not assinged to PACE Community PCP's.
Individual PACE PCP Incentives will be calculated based on the number of hours worked at the PACE center

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Measure	Background	Time Period	Time of Measurement	Metric Detail	Scoring	Amount	Payment
Annual PACE Participant Satisfaction Survey: Patient Satisfaction with Medical Care	PCP's are important component of the medical team which provides care to the participants at the PACE center.	Jan 1, 2018 to June 30th, 2018	Oct-18	Annual CalPACE Participant Satisfaction Report: Participant Satisfaction with Medical Care, Summary Score*	<90%	$0 PMPM	Nov-18
					>/= 90%	$1 PMPM	Nov-18
Annual PACE Participant Satisfaction Survey: Overall PACE Patient Satisfaction	Participants satisfaction of medical care is directly measured. However, PCPs are important members of the IDT and center management team. Overall satisfaction of participants is key to the success of PACE.	Jan 1, 2018 to June 30th, 2018	Oct-18	Annual CalPACE Participant Satisfaction Report: Reporting Period Overall Satisfaction Score**	< 90%	$0 PMPM	Nov-18
					>/= 90%	$1 PMPM	Nov-18
Coding Accuracy Rate	Physician documentation of care is an important component in the delivery of quality care. It also insures appropriate payment and regulatory oversight. CalOptima Coding Initiatives has an audit process that aligns with industry standards. They currently provide auditing to PACE on a quarterly basis.	Jan 1, 2018 to June 30th, 2018	Oct-18	The CalOptima Coding Department will audit 100% of the charts for those active PACE participant who have Medicare every 6 months. The Coding Audit Accuracy Rate will be the average of the two coding audits.	<75%	$0 PMPM	Nov-18
					75-89%	$0.5 PMPM	Nov-18
					>/= 90%	$1 PMPM	Nov-18
CalOptima PACE Actual Inpatient Performance	Effective primary care to address both chronic and acute issues is an important factor in avoiding unnecessary inpatient admissions. In addition, PCP are important in helping to coordinate transitions of care and in the concurrent review review process which will help to prevent under and over utilization. Access to the PCP's is an important component in preventing re-admissions. The target inpatient performance is consistent with PACE CalPACE benchmarks. The structure of this program avoids any risk to the PCP.	Jan 1, 2018 to June 30th, 2018	Audited FY Performance September 2018	PCP receives 20% of the actual cost savings calculated from the audited CY financials which begins at the equivalent of 2,300 Bed Days per thousand per year (BD/K/Y) and ends at the equilavent of 2,000 BD/K/Y). 2,300 BD/K/Y is 10% above the CalPACE average for 2015 and 2016. 2000 BD/K/Y is 5% below CalPACE average for 2015 and 2016.	Incentive Begins at BD / K / Y equivalent of 2,300	Total potential: $20 PMPM or $31,020***	Nov-18
					Incentive ends at BD / K / Y equivalent of 2,000		

Payment will be adjusted by the number of hours provided by UCI practitioners divided by total number of hours provided by all practitioners in the time period.
Goals were determined using CalPACE benchmarks.
*The summary score is a weighted average of the quality indicators within the "Participant Satisfaction with Medical Care".
** Computed as a weighted average of participant satisfaction for ten domains.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
40. Consider Authorizing Selection and Contracting for State Legislative Advocacy Services

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

Recommended Actions
1. Select Edelstein Gilbert Robson & Smith as the recommended state legislative advocacy firm to represent CalOptima for state advocacy services; and
2. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into a contract with the recommended firm, commencing July 1, 2018, for one (1) year, with four (4) one-year extension options, with each extension option exercisable at CalOptima's sole discretion.

Background
CalOptima has historically retained representation in Sacramento to assist with tracking and advocating on legislation, analyzing and developing positions on bills, and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants, as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in March 2018 and two proposals were received. An evaluation committee of CalOptima staff and external subject matter experts reviewed and scored the submitted proposals. Subsequently, the two firms were interviewed by Board Members Ron Diluigi and Dr. Nikan Khatibi as members of the State Lobbyist RFP Ad Hoc committee on May 16, 2018.

Discussion
After reviewing the written proposal scores and participating in interviews with both firms, in which a weighted formula was used at 25 percent for the written evaluation and 75 percent for the interview evaluation, the State Lobbyist RFP Ad Hoc committee is recommending Edelstein Gilbert Robson & Smith as CalOptima's state legislative advocacy firm, due to the firm's substantial knowledge of health care issues important to CalOptima. These issues include, but are not limited to, the transition of the California Children's Services program, the County Organized Health System (COHS) model, Prop. 56 implementation, the Cal MediConnect Medicare-Medicaid Plan (CalOptima's OneCare Connect), the Denti-Cal program, Medi-Cal funding and rate issues as well as the potential impact of any changes to the Affordable Care Act.

As proposed, the recommended action is to contract with Edelstein Gilbert Robson & Smith for a one-year term with four one-year options, each exercisable at CalOptima's sole discretion. As proposed by Edelstein Gilbert Robson & Smith, the contract fee would $100,000 annually, or $8,333.33 per month. The fee includes phone, fax, in-office copying, regular postage, and the cost of legislative bills. Any out of the ordinary expenses, such as airline travel, will be incurred only if authorized in advance by CalOptima.

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Consistent with CalOptima's practice, staff will monitor the performance of Edelstein Gilbert Robson & Smith to ensure that the deliverables and components outlined in the RFP as well as within the contract are being achieved. Deliverables include but are not limited to written and verbal monthly reports, updates and discussions with staff. When appropriate, occasional verbal updates will be provided at the Board of Directors' meetings.

Fiscal Impact
Funding for the recommended actions to contract with the selected firm for state legislative advocacy services is a budgeted item under the proposed CalOptima Fiscal Year 2018–19 Operating Budget pending Board approval.

Rationale for Recommendation
State legislative advocacy efforts continue to be a priority for CalOptima given level of activity on health care in Sacramento and Washington, D.C. CalOptima anticipates that several important issues will require focus, attention, involvement and advocacy.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. State Legislative Advocacy Services RFP 18-039 – Interview Evaluation Summary
2. State Legislative Advocacy Services RFP 18-039 – Firm Proposal Evaluation Summary

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

5/30/2018 — **Date**

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State Legislative Advocacy Services RFP 18-039
Interview Evaluation Summary

(75% weighted)

Wednesday, May 16, 2018

All firms were evaluated on a five point scale, 0-5.

Edelstein

	Firm Presentation (25% of overall score)	Question 1 re: State Budget (25%)	Question 2 re: Admin/Leg (25%)	Question 3 re: COHS (25%)	Total (Out of 5.0)
Average Score of Evaluation Committee	5.0 x 0.25 = 1.25	4.5 x 0.25 = 1.125	4.5 x 0.25 = 1.125	4.5 x 0.25 = 1.125	**4.625**

Townsend Public Affairs

	Firm Presentation (25% of overall score)	Question 1 re: State Budget (25%)	Question 2 re: Admin/Leg (25%)	Question 3 re: COHS (25%)	Total (Out of 5.0)
Average Score of Evaluation Committee	4.5 x 0.25 = 1.125	3.5 x 0.25 = 0.875	3.5 x 0.25 = 0.875	4.0 x 0.25 = 1.00	**3.875**

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State Legislative Advocacy Services RFP 18-039
Firm Proposal Evaluation Summary

(25% weighted)

Thursday, April 26, 2018

All firms were evaluated on a five point scale, 0-5.

Edelstein

	Technical Capabilities (20% of overall score)	Qualifications (25%)	Proposal (10%)	Pricing (20%)	COHS Experience (25%)	Total (Out of 5.0)
Average Score of Evaluation Committee	5.0 x 0.20 = 1.00	5.0 x 0.25 = 1.25	3.25 x 0.10 = 0.33	4.25 x 0.20 = 0.85	5.0 x 0.25 = 1.25	**4.63**

Townsend Public Affairs

	Technical Capabilities (20% of overall score)	Qualifications (25%)	Proposal (10%)	Pricing (20%)	COHS Experience (25%)	Total (Out of 5.0)
Average Score of Evaluation Committee	3.25 x 0.2 = 0.65	3.63 x 0.25 = 0.91	4.38 x 0.1 = 0.44	4.0 x 0.2 = 0.80	0.25 x 0.25 = 0.06	**2.86**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

41. Consider Authorization of Release of Requests for Information (RFIs) for Intergovernmental Transfer (IGT) 5 Categories Identified by the CalOptima Member Health Needs Assessment (MHNA)

Contact

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

Recommended Actions

Authorize the release of Requests for Information (RFI) for the eight board-approved categories identified by the CalOptima Member Health Needs Assessment to develop specific Scopes of Work for full Requests for Proposal (RFP).

Background

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA). The results of the MHNA would be used to drive the development of competitive community grants to award approximate $14.4 million in IGT 5 funds.

CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders.

At the February 1, 2018 Board of Directors meeting, staff presented the results and Executive Summary of the MHNA as well as requested authority to release Requests for Proposal (RFP) for community grants. From the information gathered, the MHNA identified eight board-approved categories as needs in the community. The eight board-approved categories include:

1. Expand Access to Mental Health Services for Adults
2. Expand Access to Mental Health and Socialization Services for Older Adults
3. Expand Access to Mental Health/Developmental Services for Children Ages 0-5
4. Expand Access to Nutrition Education and Fitness Programs for Children and their Families
5. Increase Medi-Cal Benefits Education and Outreach
6. Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health
7. Expand Access to Adult Dental Services
8. Expand Access to Children's Dental Services

Approval to release the RFPs was unanimous by the Board of Directors.

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Discussion
In preparation for the release of the community grant RFPs, staff conducted a review of the descriptions for each of the eight categories identified by the MHNA. Staff recognized a need to narrow and better define a more precise and definitive Scope of Work (SOW) for each category. The specific SOWs for the RFPs will be developed based on the responses received from the RFI process. The RFI responses will be evaluated to select innovative ideas for services and programs to address the needs of CalOptima members. Staff will review the RFI responses and develop full RFPs so that interested community-based organizations, public agencies and other eligible entities can submit a proposal for consideration. More than one idea per category may be selected from the RFI responses and developed into a full RFP.

Staff is requesting authority to release RFIs for the eight board-approved categories that were identified through the MHNA. Staff will return to the Board for approval of the scopes of work developed in conjunction with the RFI and to release the RFPs.

Fiscal Impact
There is no fiscal impact to CalOptima's general operating budget.

Rationale for Recommendation
As part of CalOptima's vision in working Better. Together, CalOptima staff plans to work with our provider and community partners to address gaps in health care services for CalOptima members.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Board Action dated February 1, 2018, Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

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

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

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

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

- Adult Mental Health
- Children's Mental Health
- Childhood Obesity
- Improving Children's Health
- Strengthening the Safety Net

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

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#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

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6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

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.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

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Member Health Needs Assessment

Board of Directors Meeting
February 1, 2018

Cheryl Meronk
Director, Strategic Development

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Member Health Needs Assessment

A better study offering deeper insight, leading to a healthier future.

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A Better Study

- ➔ More Comprehensive
- ➔ More Engaging
- ➔ More Personal

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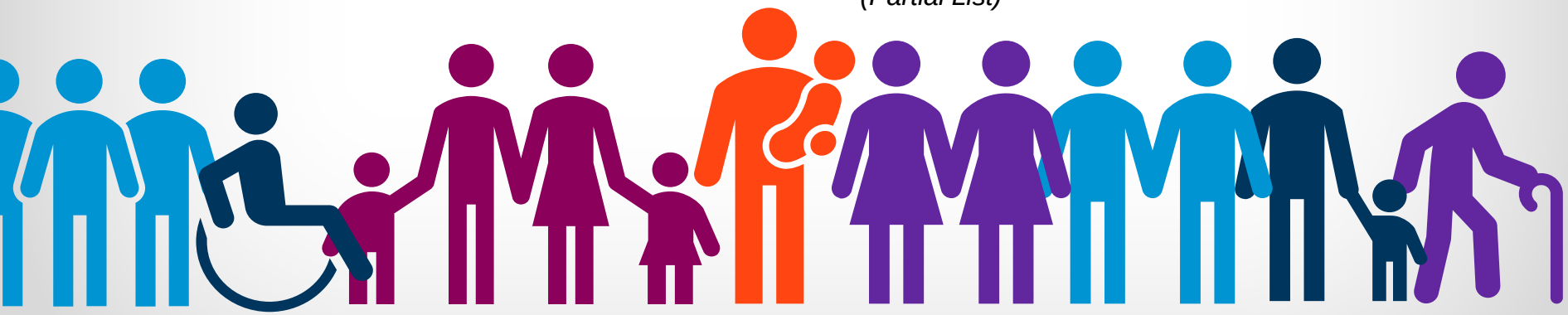
More Comprehensive

- Reached new groups of members whose voices have rarely been heard before
  - Young adults with autism
  - People with disabilities
  - Homeless families with children
  - High school students
  - Working parents
  - New and expectant mothers
  - LGBTQ teens
  - Homeless people in recuperative care
  - Farsi-speaking members of a faith-based group
  - PACE participants
  - Chinese-speaking parents of children with disabilities

(Partial List)



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CalOptima
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More Comprehensive (Cont.)

- Gathered responses from all geographic areas of Orange County

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CalOptima
A Public Agency
Better. Together.

More Comprehensive (Cont.)

- Probed a broader view of members' lives beyond immediate health care needs
  - Hunger
  - Child care
  - Economic stress
  - Housing status
  - Employment status
  - Physical activity
  - Community engagement
  - Family relationships
  - Mental health
  - Personal safety
  - Domestic violence
  - Alcohol and drug consumption

(Partial List)

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CalOptima
A Public Agency
Better. Together.

More Comprehensive (Cont.)

- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In the past 12 months, did you have the need to see a mental health specialist?
  - How open are you with your doctor about your sexual orientation?
  - How sensitive are your health care providers in understanding your disability?

(Partial List)

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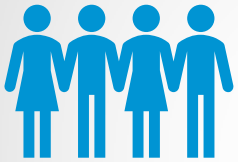
More Engaging: Members



Focus Groups

- 31 face-to-face meetings in the community
- 353 members

Telephone Conversations

- 534 live interviews in members' languages

Mailed Surveys

- Nearly 6,000 surveys returned

Electronic Responses

- More than 250 replied conveniently online

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More Engaging: Member Advocates

- Abrazar Inc.
- Access CA Services
- Alzheimer's OC
- Boys & Girls Club
- The Cambodian Family
- CHOC
- Dayle McIntosh
- La Habra Family Resource Center
- Latino Health Access
- Korean Community Services
- Mercy House
- MOMS Orange County
- OMID
- SeniorServ
- South County Outreach
- State Council on Developmental Disabilities
- Vietnamese Community of OC Inc.

(*Partial List)*

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More Personal

- Met in familiar, comfortable locations at convenient times for our members
  - Apartment complexes
  - Churches
  - Community centers
  - Schools
  - Homeless shelters
  - Recuperative care facilities
  - PACE center
  - Community clinics
  - Restaurant meeting rooms

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More Personal (Cont.)

- We spoke their language
  - English
  - Spanish
  - Vietnamese
  - Korean
  - Farsi
  - Chinese
  - Arabic
  - Cambodian
  - Marshallese
  - American Sign Language

The Voice of the Member

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Offering Deeper Insight

- → Barriers to Care
- → Lack of Awareness About Benefits and Resources
- → Negative Social and Environmental Impacts

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Notable Barriers to Care

- Study revealed that members encounter structural and personal barriers to care
  - Structural
    - It can be challenging to get an appointment to see a doctor
    - It takes too long to get an appointment
    - Doctors do not always speak members' languages
    - Interpreter services are not always readily available
    - Doctors lack understanding of members' cultures
  - Personal
    - Members don't think it is necessary to see the doctor
    - Members have personal beliefs that limit treatment
    - Members are concerned about their immigration status
    - Members are concerned someone would find out they sought mental health care

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Barriers to Care (Cont.)

Examples

52%

Don’t think it is necessary to see the doctor for a checkup

28%

Takes too long to get an appointment

26%

Concerned someone would find out about mental health needs

41%

Didn’t think it is necessary to see a specialist, even when referred

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Notable Lack of Awareness

- Survey revealed a lack of understanding about available benefits and services
  - 25 percent of members who needed to see a mental health specialist did not pursue treatment
  - 38 percent of members had not seen a dentist in more than a year

- Focus group participants commented frequently about having difficulty regarding certain resources
  - Interpreter services
  - Social services needs
  - Transportation

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Lack of Awareness (Cont.)

Examples

40%

Didn't know who to ask for help with mental health needs

41%

Didn't see a dentist because of cost (i.e., didn't know dental care was covered)

25%

Don't have or know of a dentist

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Negative Social and Environmental Impacts

- Survey revealed significant social and environmental difficulties
  - Lack of well paying jobs and employment opportunities
  - Lack of affordable housing
  - Social isolation due to cultural differences, language barriers or fear of violence
  - Economic insecurity and financial stress
  - Lack of walkable neighborhoods and the high cost of gym programs

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Negative Impacts (Cont.)

Examples

32%
Needed help getting food in the past six months

56%
Accessing other public assistance

43%
Needed help to buy basic necessities

29%
Needed help getting transportation

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Negative Impacts (Cont.)

Stakeholder Perspective

> There's a significant issue with improper nutrition. They may not have enough money or the ability to go to the grocery store to buy the right foods. They get what they can, and that's what they eat.
>
> *—Interviewee*

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Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

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Funding

$14.4 Million

Total Available IGT 5 Funds

- **Member Health Needs Assessment results drive funding allocations**

- **Eight Requests for Proposal (RFPs) to expand access to mental health, dental and other care, and outreach/education services**

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RFP 1

Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $5 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category
Adult Mental Health

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RFP 2

Expand Mental Health and Socialization Services for Older Adults

Funding Amount: $500,000

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category
Adult Mental Health

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RFP 3

Expand Access to Mental Health/ Developmental Services for Children 0–5 Years

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Shortage of pediatric mental health professionals
- ✓ Shortage of children's inpatient mental health beds
- ✓ Increase in adolescent depression

Funding Category
Children's Mental Health

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RFP 4

Nutrition Education and Fitness Programs for Children and Their Families

Funding Amount: $1 million

Findings Addressed

- ✓ Healthier food choices can be more expensive, less convenient and less accessible
- ✓ Cultural foods may not be the healthiest options
- ✓ Lack of time and safe places may limit physical activity

Funding Category
Childhood Obesity

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RFP 5

Medi-Cal Benefits Education and Outreach

Funding Amount: $500,000

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits

Funding Category

Supporting the Safety Net

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RFP 6

Expanded Access to Primary Care and Programs Addressing Social Determinants of Health

Funding Amount: $4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Lack of ability to cover basic necessities

Funding Category
Supporting the Safety Net

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RFP 7

Expand Adult Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1.4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Limited dental providers for adults

Funding Category
Supporting the Safety Net

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RFP 8

Expand Access to Children's Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not utilizing covered services
- ✓ Challenging to get an appointment to see a provider

Funding Category
Children's Health

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Moving Forward

- Eight Grant Applications/RFPs
  - Expand access to mental health, dental and other care services
  - Expand access to childhood obesity services regarding nutrition and fitness
  - Support outreach and education regarding social services and covered benefits
- RFPs to be released in March 2018
- Recommended grantees to be presented at June Board meeting

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EXECUTIVE SUMMARY
MEMBER HEALTH NEEDS ASSESSMENT

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In summer and fall 2017, more than 6,000 CalOptima members, service providers and community representatives participated in one of the most extensive and inclusive member health needs assessments (MHNA) undertaken by CalOptima in its 20-plus year history. The MHNA provides data critical to ensuring that CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima participates in numerous efforts to assess the health of Orange County's residents and create community-driven plans for improving the health of the Medi-Cal population. Some examples are detailed below.

- The 2013 Orange County Health Profile, produced by the Orange County Health Care Agency, highlighted key health indicators as well as other social, economic and environmental indicators that impact health conditions in groups of people based on economics, race, ethnicity, gender, age and geography.
- The 2016 Orange County Community Indicators Report tracked and analyzed Orange County's health and prosperity on a myriad of issues.
- The 2017 Conditions of Children in Orange County Report offered a comprehensive and detailed summary of how children in Orange County fair in the areas of health, economic well-being, educational achievement, and safe homes and communities.
- CalOptima's Group Needs Assessment, conducted every five years with annual updates in between, identifies members' needs, available health education, cultural and linguistic programs, and gaps in services.

When combined, these assessments provide a broad picture of important health information in Orange County. However, they do not focus specifically on Medi-Cal beneficiaries or on ethnic and linguistic minorities within this population, whose health needs are at the core of CalOptima's mission. For this reason, CalOptima undertook this comprehensive MHNA, summarized on the following pages.

By the Numbers

5,815
Surveys

31
Focus Groups

24
Stakeholder Interviews

21
Provider Surveys

10
Languages

Birth–101
Years of Age

Back to Agenda

CalOptima's comprehensive MHNA is an innovative collaboration that builds upon existing data-gathering efforts and takes them a step further. The study was designed to be a more comprehensive assessment, using engaging methods that resulted in a much more personal experience for our members and the community. The MHNA captures the unique and specific needs of Medi-Cal beneficiaries from an array of perspectives, including providers, community leaders and, most importantly, the members themselves. As a result, this in-depth study offers actionable recommendations for consideration by the CalOptima Board of Directors and executive leadership.

The MHNA was designed to help CalOptima identify:

1. Unique needs and challenges of specific ethnic communities, including economic, social and environmental stressors, to improve health outcomes

2. Challenges to health care access and how to collaborate with community-based organizations and providers to address these barriers

3. Member awareness of CalOptima services and resources, and effective strategies to increase awareness as well as disseminate information within target populations

4. Ways to leverage outreach efforts by partnering with community-based organizations on strategic programs

Our Partners

To guide the direction of the study, CalOptima established an MHNA Advisory Committee made up of community-based representatives. The committee then engaged CalOptima staff and Harder+Company Community Research (Harder+Company), in partnership with the Social Science Research Center (SSRC) at California State University, Fullerton. A summary of their qualifications to participate in this extensive effort is below.

Harder+Company was founded in 1986 and works with philanthropic, nonprofit and public-sector clients nationwide to reveal new insights about the nature and impact of clients' work. Harder+Company has a deep commitment to lifting the voices of marginalized and underserved communities — and working across sectors to promote lasting change. In addition, Harder+Company offers extensive experience working with health organizations to plan, evaluate and improve services for vulnerable populations, along with deep experience assisting hospitals, health departments and other health agencies on a variety of efforts, including conducting needs assessments, engaging and gathering meaningful input from community members, and using data for program development and implementation.

SSRC was established in 1987 to provide research services to community organizations and research support to university faculty. The center's primary goal is to assist nonprofit and tax-supported agencies and organizations to answer research questions that will lead to improved service delivery and public policy. The SSRC conducts surveys, evaluation research and other applied research activities to meet its clients' information needs. The center conducts multilingual telephone surveys from its 24-station computer-assisted telephone interviewing lab, as well as web-based, mailed and face-to-face surveys. In the past 10 years, SSRC has successfully completed 200 telephone survey projects using a variety of sample designs in diverse areas of focus, such as health care, public safety, education, workforce development and pregnancy prevention.

harder + co | community research

CALIFORNIA STATE UNIVERSITY FULLERTON

Due to strong partnerships with the community, the 2017 MHNA engaged members who may be hard to reach. We are proud that our efforts included:

- Young adults on the autism spectrum
- People with disabilities
- Homeless families and children
- High school students
- Working parents
- New and expectant mothers
- LGBTQ teens
- Farsi-speaking members of faith-based groups
- PACE participants
- Chinese-speaking parents of children with disabilities

More Comprehensive

To represent CalOptima's nearly 800,000 members, an in-depth analysis was performed to uncover their unique needs and challenges. An oversampling was thoughtfully incorporated in the calculation of responses needed to achieve a true statistical representation of the Orange County Medi-Cal population. For the mailed survey, more than 42,000 members were selected within a specific sampling frame that included language, age range and region.

With the oversampling, the aim was to collect 4,000 responses with targets for each subgroup. The final data collection results were far beyond the goal in every subgroup. More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

The assessment gathered responses from all geographic areas of Orange County, across all age groups and 10 languages. Additionally, the assessment reached new groups of members whose voices have rarely been sought out or heard before, such as young adults with autism, people with disabilities and homeless families with children.

Ultimately, the assessment concentrated on the underlying social determinants of health that have been recognized as factors that impact the health of individuals. The MHNA probed a broader view of members' lives beyond immediate health care needs to explore issues related to:

- ☑ Hunger
- ☑ Child care
- ☑ Economic stress
- ☑ Housing status
- ☑ Employment status
- ☑ Physical activity
- ☑ Community engagement
- ☑ Family relationships
- ☑ Mental health
- ☑ Personal safety
- ☑ Domestic violence
- ☑ Alcohol and drug use

More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

More Engaging

The MHNA used a mixed-methods approach to engage members who generally have been underrepresented in previous assessments as well as community stakeholders who work directly with the Medi-Cal population. The data collection effort was extensive, incorporating both qualitative and quantitative methods and going beyond previous processes in Orange County. The mixed-methods approach consisted of the following:

Member Survey

5,815 members completed an in-depth 50-question survey that was available in each of CalOptima's seven threshold languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic. As described further below, three additional languages that are less common in Orange County were also incorporated to ensure the assessment was comprehensive. Most surveys were completed and returned via mail (86 percent), with 9 percent completed via telephone and 5 percent online. Telephone calls were made to reach members who were homeless or more transient and may not have a permanent address. An online survey was offered for members' convenience.

Provider Survey

An online survey of 20 questions was sent to a broad sample of providers in CalOptima's network to seek insight on the challenges that members face. Providers identified what they perceive as the top problems for Medi-Cal members as well as barriers for these members in accessing health care. There were 21 network or physician medical groups that completed the provider survey.

Focus Groups

31 focus groups were conducted with members in partnership with community-based organizations across Orange County. Focus groups allowed for face-to-face conversations with members in comfortable and familiar environments, which helped to foster organic, open-ended discussions where members felt safe to share their thoughts. The discussions were conducted in CalOptima's seven threshold languages, as well as Cambodian, Marshallese and American Sign Language. Focus group conversations covered numerous key topics, including quality of life, community assets, barriers to accessing care, violence, behavioral health, chronic disease, and health practices, such as healthy eating and active living.

Key Stakeholder Interviews

24 leaders from community-based organizations participated in the interviews. Those chosen for the study have direct interactions with Medi-Cal members or serve as advocates for Orange County's vulnerable population. Interviews focused on key health issues facing Medi-Cal members, the provision of culturally competent services, and the social determinants of health, such as economic and environmental factors.

In the spirit of collaboration, individuals and groups in the community came together in a remarkable way to demonstrate their dedication to CalOptima members. Countless hours were spent planning, engaging and meeting with members. For example, in addition to serving as stakeholder interviewees, many of CalOptima's community partners reached out to members to encourage them to respond to the surveys, and they also hosted and recruited members to focus group meetings. Community organizations were invaluable in helping members feel comfortable with the process and in providing another view into members' lives. The engagement of community partners and member advocates was instrumental in the success of the MHNA.

More Personal

The MHNA aimed to give CalOptima members a more personal experience by hosting focus group conversations in familiar locations at convenient times, often evenings and weekends. These settings were intentionally selected based on members' comfort levels. Focus groups were also held at specific times to ensure that members could have their voices heard without having to miss work, school or other obligations. Focus groups were conducted in 10 languages enabling members to respond in their preferred spoken language.

Focus groups were held at:

- Apartment complexes
- Churches
- Community centers
- Schools
- Homeless shelters
- Recuperative care facilities
- PACE center
- Community clinics
- Restaurant meeting rooms

Methods

With a strong focus on engaging a representative sample of CalOptima members, Harder+Company and SSRC developed the sample frame to capture a breadth of perspectives as well as focus on the specific needs of key populations. Although the purpose of the MHNA was to assess the needs of Medi-Cal members in Orange County overall, Harder+Company and SSRC sought to gain a better understanding of the needs of CalOptima's non-English speakers by purposefully oversampling all seven subgroups. The oversampling of members designated as speaking one of the seven threshold languages ensured that CalOptima and community stakeholders can be 95 percent confident that the true population parameters for any particular subgroup will fall between +/- 5 percent of the observed sample estimate.

At more than 5,800 members, the survey response far exceeded the target number of respondents in the sampling frame. The robust response was due to a comprehensive data collection plan that included communication with members and partners in advance of sending the survey, reminder phone calls and multilingual computer-assisted telephone interviewing for members preferring to respond by phone.

Survey data was entered, monitored and quality checked by SSRC before being exported for analysis by Harder+Company. All variables were screened to determine the amount of missing data, and basic frequencies were initially computed for each question by language, region and age. To adjust for the oversampling built into the sampling frame, comprehensive statistical analysis was then completed applying weights calculated by SSRC. Additional analysis included collapsing of questions, construction of scale scores and cross-tabulations.

Exhibit 1: Distribution of Completed Surveys and CalOptima Population by Language, Region and Age

Language	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
English	658	11.3%	55.5%
Spanish	715	12.3%	28.6%
Vietnamese	981	16.9%	10.3%
Korean	940	16.2%	1.4%
Farsi	743	12.8%	1.1%
Arabic	648	11.1%	0.6%
Chinese	731	12.6%	0.5%
Other	399	6.9%	2.0%

Region	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
Central	2,315	39.8%	51.5%
North	1,947	33.5%	32.4%
South	1,538	26.4%	15.1%
Out of County	15	0.3%	1.0%

Age	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
0–18 years old	1,665	28.6%	41.8%
19–64 years old	2,453	42.2%	47.2%
65 or older	1,697	29.2%	10.9%

KEY FINDINGS

Given the scope and depth of the study, the MHNA revealed many key findings, which will all be included in the final, comprehensive report. This Executive Summary shares five **key findings**, including related **bright spots** and **opportunities**. Bright spots are CalOptima and community-based resources that already serve to support health behaviors and outcomes. CalOptima can nurture, leverage and build upon these assets. **Opportunities** are areas that CalOptima and its partners can strengthen to positively impact the health and well-being of members.

KEY FINDING: SOCIAL DETERMINANTS OF HEATLH

Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

Given that Medi-Cal eligibility is income-based, it is not surprising that many CalOptima members struggle with economic insecurity. In fact, 55.7 percent of members receive some form of public benefits (Exhibit 2). Further, in the past six months, more than one-quarter of members indicated they needed help with food (32.4 percent), housing (24 percent), money to buy things they need (43.1 percent) and transportation (28.8 percent) (Exhibit 3). Economic stress and financial insecurity cause members and their families to make tradeoffs, such as living in more dense and overcrowded housing with limited space for play and exercise, buying cheaper but less healthy food, or not going to the doctor despite wanting to.

Exhibit 2: Percent of members who receive public benefits (n=5,117)

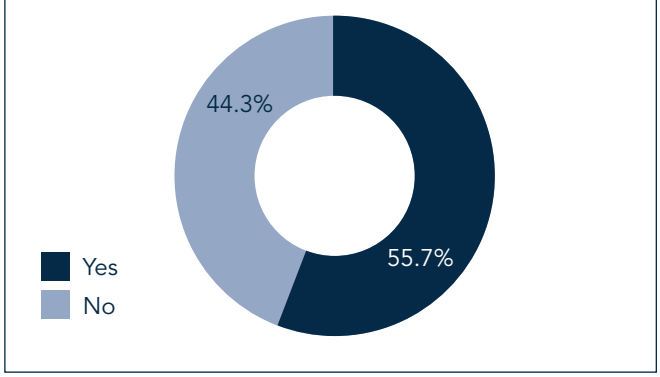
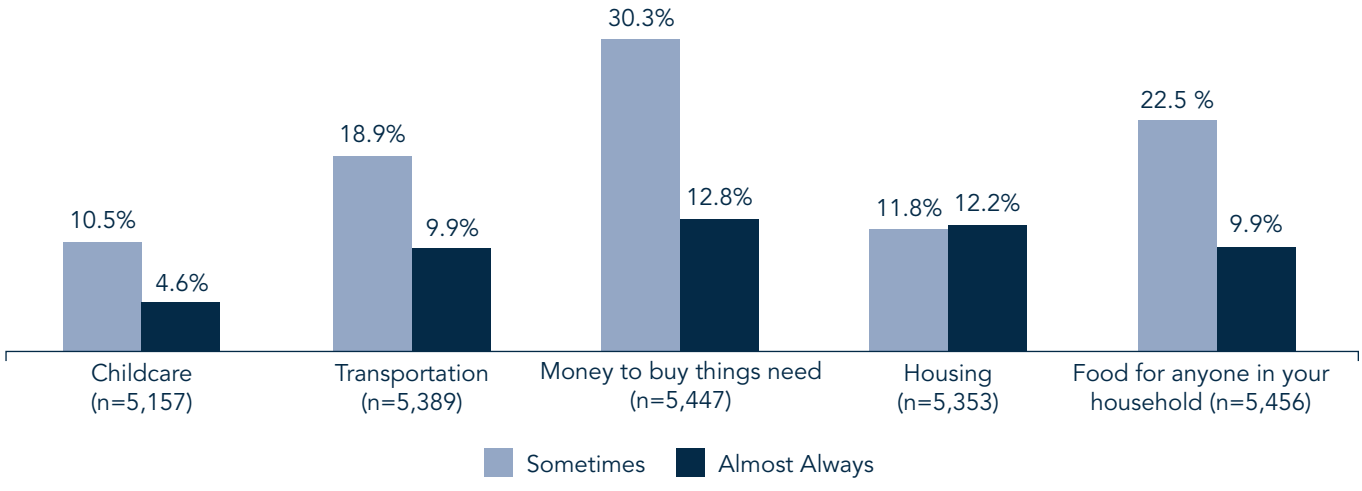


Exhibit 3: Percent of members who needed help with basic needs in the past six months



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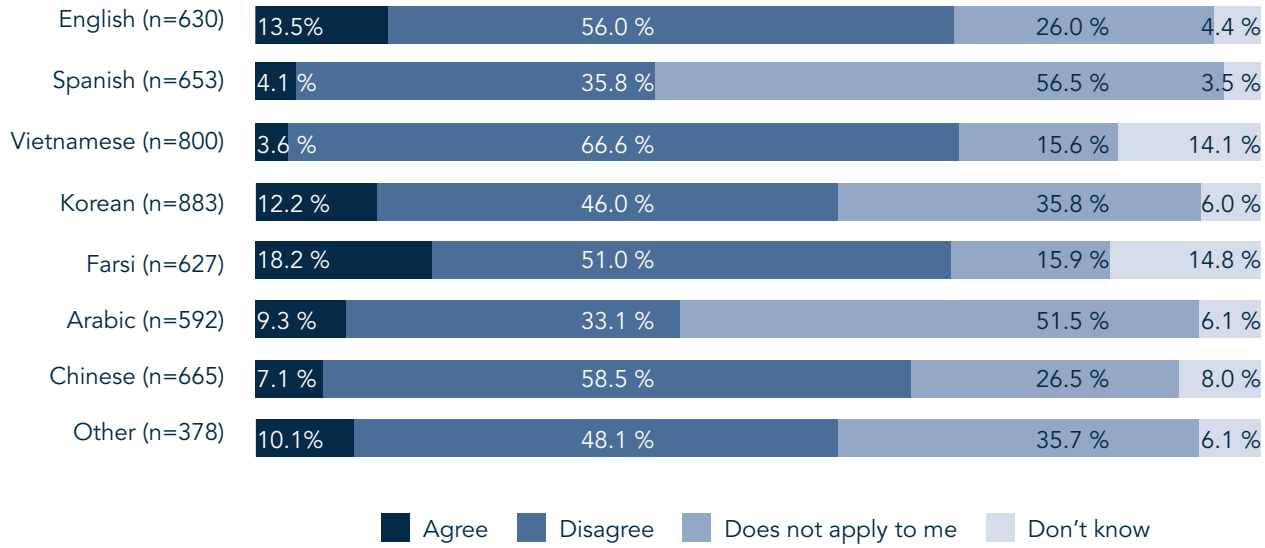
Social isolation negatively impacts the overall health and well-being of some CalOptima member populations. Social isolation is characterized by a lack of social supports and relationships. It occurs for many reasons, including language barriers, immigration status, age, ability and sexual orientation. In focus groups, members described how feelings of being disconnected from the community can lead to depression, lack of follow-up with health care or service providers, and negative health behaviors. In the survey, 10 percent of all respondents indicated that they felt lonely or isolated. Yet there were higher rates among certain populations, with loneliness and isolation affecting more speakers of English (13.5 percent), Korean (12.2 percent) and Farsi (18.2 percent) (Exhibit 4).

Exhibit 4: Percent of those who reported feeling lonely or isolated by language



Environmental factors also contribute to social isolation and other negative health behaviors, such as lack of physical activity. Focus group participants discussed feeling unsafe in their neighborhoods, which caused them to stay inside or to avoid nearby parks and/or other common spaces.

In addition, lack of affordable housing was a major concern to MHNA respondents, and it resulted in living in overcrowded households, neighborhoods with high crime rates, areas with poor indoor and outdoor air quality, and in the most extreme cases, homelessness.

Bright Spot: CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health a priority, not a lack of knowledge or concern.

Opportunity: CalOptima has already taken steps to strengthen the safety net for members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand this work would positively impact health outcomes in the long run. CalOptima can ensure that providers and community partners understand the social and economic issues that members face and how to adapt health care services accordingly.

KEY FINDING: MENTAL HEALTH

Lack of knowledge and fear of stigma are key barriers to using mental health services.

About 14 percent of members reported needing mental health services in the past year (Exhibit 5). However, local and national data suggest that the need for mental health services is likely underreported and underrecognized. Among those reporting a need, nearly 25 percent did not see a mental health specialist (Exhibit 6). Members did not seek mental health services for several reasons (Exhibit 7), including not knowing who to call or how to ask for help making an appointment (39.8 percent), not feeling comfortable talking about personal problems (37.5 percent) or concern that someone would find out they had a problem (26.1 percent). These factors, along with data gathered from key stakeholder interviews and focus groups, reflect a fear of stigma associated with seeking mental health services.

Exhibit 5: Percent of members who indicated they needed to see a mental health specialist (n=5,723)

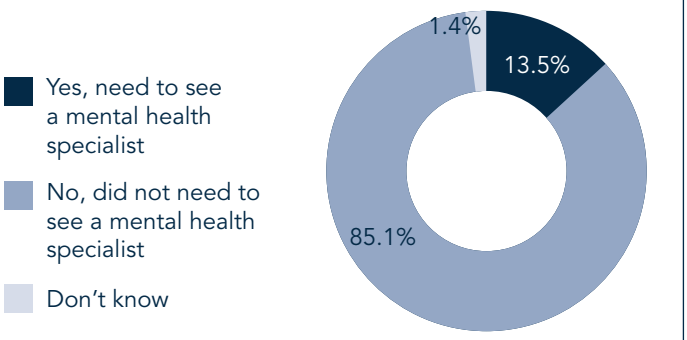
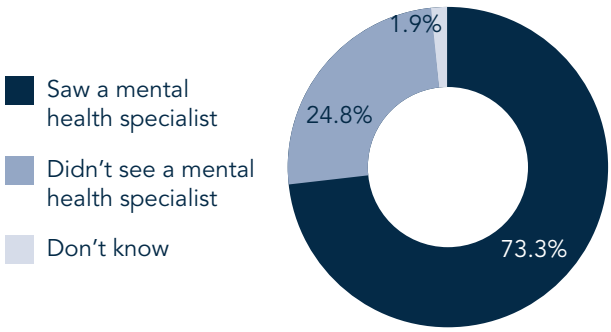
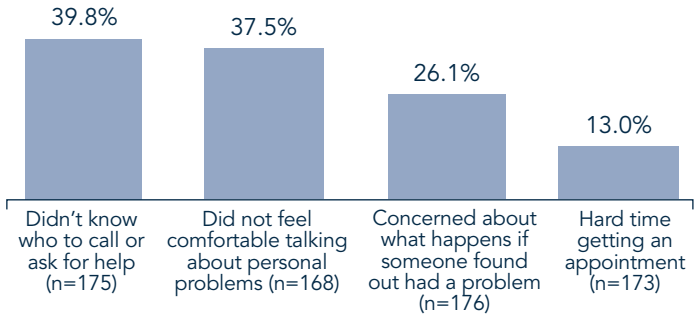


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



Fear of stigma is more prevalent among certain language groups. For example, Chinese-speaking members were more likely to indicate discomfort talking about personal problems and concern about what others might think if they found out about a mental illness than other language groups, followed by Korean-, Vietnamese- and English-speaking members. Conversations with community members and service providers offered cultural context for these findings as many stakeholders described prevalent feelings of shyness, avoidance and shame around discussing mental health issues, let alone seeking care.

Exhibit 7: Reasons why members (who needed to see a mental health specialist but) didn't get services



Bright Spot: CalOptima provides access to mental health services, which meets a clearly established need. Although members needing mental health services do not always connect with providers, many do not do so because of a lack of knowledge, an issue that can be addressed through strengthened connections with existing systems.

Opportunity: Although mental health services are covered by CalOptima, fear of stigma may prevent members from seeking services. This presents an opportunity for CalOptima to continue to provide culturally relevant education around mental health to improve understanding of available services and to address fear of stigma many people face. Community partners with deep knowledge of specific cultural communities are eager to offer support that would increase the use of mental health services.

KEY FINDING: PRIMARY CARE

Most members are connected to primary care, but barriers can make it challenging to receive timely care.

The majority of CalOptima members indicated that they are connected to at least one primary care doctor (82.6 percent), and most go to a doctor's office (69.2 percent) or clinic/health center (18.1 percent) when they need medical attention (Exhibits 8 and 9). However, navigating the health care system can be challenging, and significant barriers make it difficult for people to seek or follow through with care when needed.

Exhibit 8: Percent who report at least one person as their doctor (n=5,749)

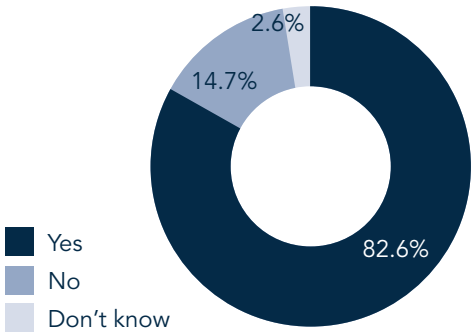
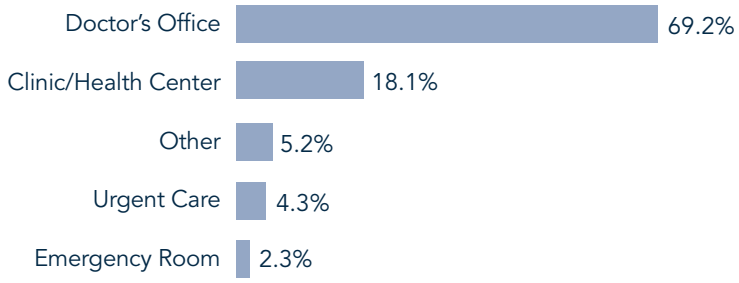


Exhibit 9: Where respondents go to see their doctor (n=5,743)

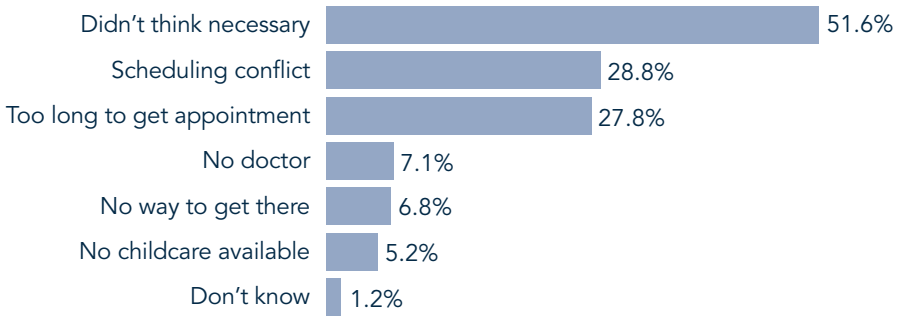


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited hours of operation and inefficiency of public transportation, can make it difficult for people to receive care when needed. When asked why they don't make an appointment to see a doctor, 27.8 percent of CalOptima members indicated that it takes too long to get an appointment while 51.6 percent of members did not think it was necessary to make an appointment (Exhibit 10).

Bright Spot: CalOptima members have access to more than 1,500 primary care providers and 6,200 specialists, as well as 14 different health networks. And staff members are dedicated to continually engaging and educating these providers and networks to ensure they are ready to deliver the care needed by members.

Opportunity: The challenge of maintaining a robust provider network never goes away, and CalOptima must carefully monitor members' access to care. The provider community may be ready to embrace innovations that enhance access, such as extended hours, weekend operations or telemedicine visits, to expand the options for members.

Exhibit 10: Reasons why members don't make an appointment to see doctor (n=4,598)[1]



KEY FINDING: PROVIDER ACCESS

Members are culturally diverse and want providers who both speak their language and understand their culture.

CalOptima members hail from around the globe, reflecting the rich diversity of Orange County's population. In total, 40.3 percent of respondents were born outside of the U.S. and 23.6 percent indicated that they don't speak English well (Exhibits 11 and 12). Among non-English speakers, more than 50 percent were born outside of the United States and many are still acculturating to life in the U.S. This presents challenges when finding a well-paying and fulfilling job, safe and affordable housing, and healthy and familiar food. It also affects the ways members interact with the health care system. In fact, those born outside of the U.S. were significantly less likely to have a doctor and more likely to report feeling lonely or isolated.

Exhibit 11: How well members speak English (n=5,549)

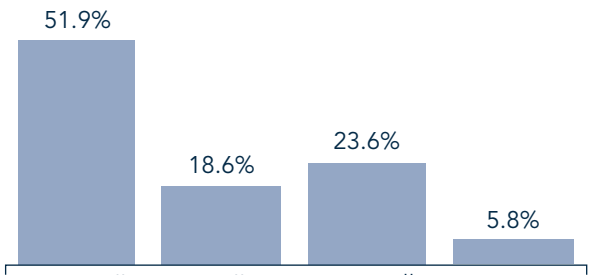
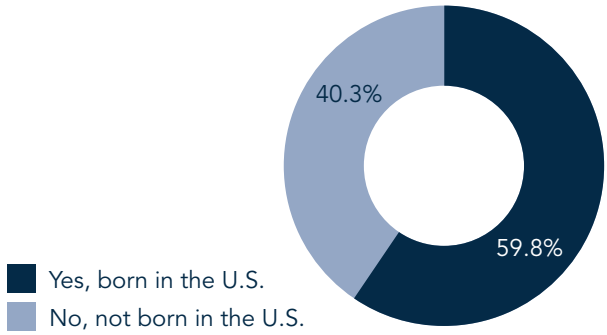


Exhibit 12: Percent of members who were born in the United States (n=5,599)



Further, they report having to adapt to new ways of receiving medical care. Some focus group participants shared that they did not understand why they must wait so long to see a doctor, as it is not this way in their country of origin. Others shared that cultural beliefs and practices made them uncomfortable and often unwilling to see a physician of the opposite gender. In addition, members and key stakeholders indicated that it can be challenging to seek medical care from providers who do not speak members' preferred language, which leads to issues with communication and comfort level. Although many stakeholders highlighted the availability of translation or interpretation services, such services do not always meet members' needs, especially when limited by short appointment times and when sharing sensitive information.

Bright Spot: CalOptima provides services and resources to members in seven languages[2] and can connect members to translation and interpretation services in any language when needed. Members appreciate that CalOptima recognizes the importance of providing care in familiar languages, and they also highly value providers who are sensitive to the cultural norms and practices of their homeland.

Opportunity: CalOptima has an opportunity to build its existing resources and deepen cultural competence of providers and services. CalOptima can engage partners in culturally focused community-based organizations to tailor and implement trainings for providers around specific populations. Trainings can build language and sensitivity skills and increase knowledge in areas such as ethnopharmacology (variations in medication responses in diverse ethnic populations). This can strengthen the workforce and improve member/provider interactions overall.

KEY FINDING: DENTAL CARE

Many members are not accessing dental care and are often unsure about what dental services are covered.

The gap in dental health care is striking and pronounced; 38.2 percent of members indicated they had not seen a dentist within the past 12 months (Exhibit 13). Among those individuals, 41 percent cited cost as the main reason they did not see a dentist (Exhibit 14). Members expressed confusion about dental care benefits available to them via Medi-Cal/Denti-Cal, and they said they would be more likely to seek out a dentist if they knew some of their visits were covered.

Bright Spot: Members in all CalOptima programs are eligible for routine dental care through Denti-Cal, and members in OneCare and OneCare Connect have access to supplemental dental care as well. Better yet, for 2018, California restored additional Denti-Cal benefits, expanding the covered services even further. The challenge is ensuring that members know about these benefits and then actually obtain the services.

Opportunity: To boost the number of members receiving dental care, CalOptima will have to first raise awareness about the availability of services and correct misperceptions that dental care comes at a cost. Further, to remove barriers to care and expand access, the community may embrace the use of alternative providers, such as mobile dental clinics, or the option of co-located dental and medical services.

Exhibit 13: When members last saw a dentist (n=5,685)

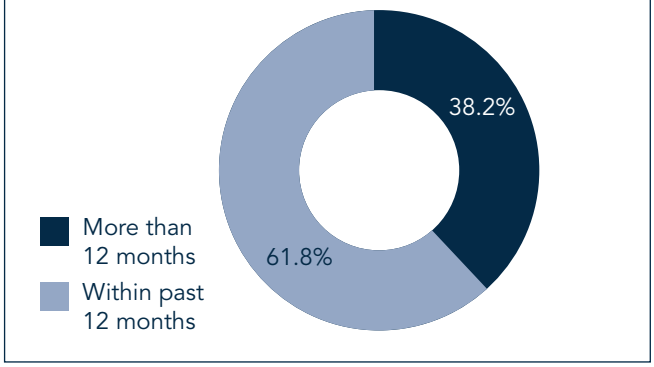
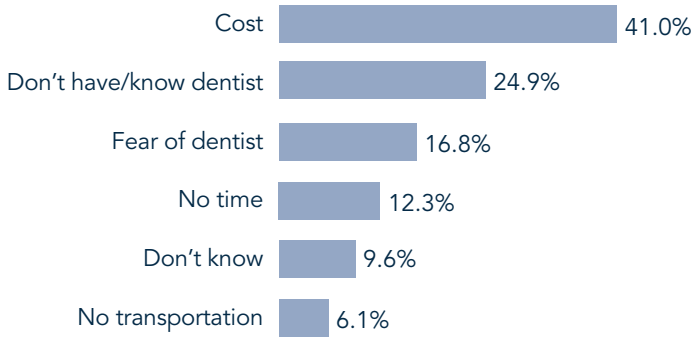


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3] [4]



Endnotes

[1] Members could choose multiple answers; thus, the total does not equal 100 percent.

[2] CalOptima provides bilingual staff, interpreter services, health education and enrollment materials in seven languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.

[3] Members could choose multiple answers; thus, the total does not equal 100 percent.

[4] Only reported those who have not seen a dentist within the past 12 months.

January 2018

CalOptima Member Survey Analysis:

Unweighted Estimates by Language, Region, and Age

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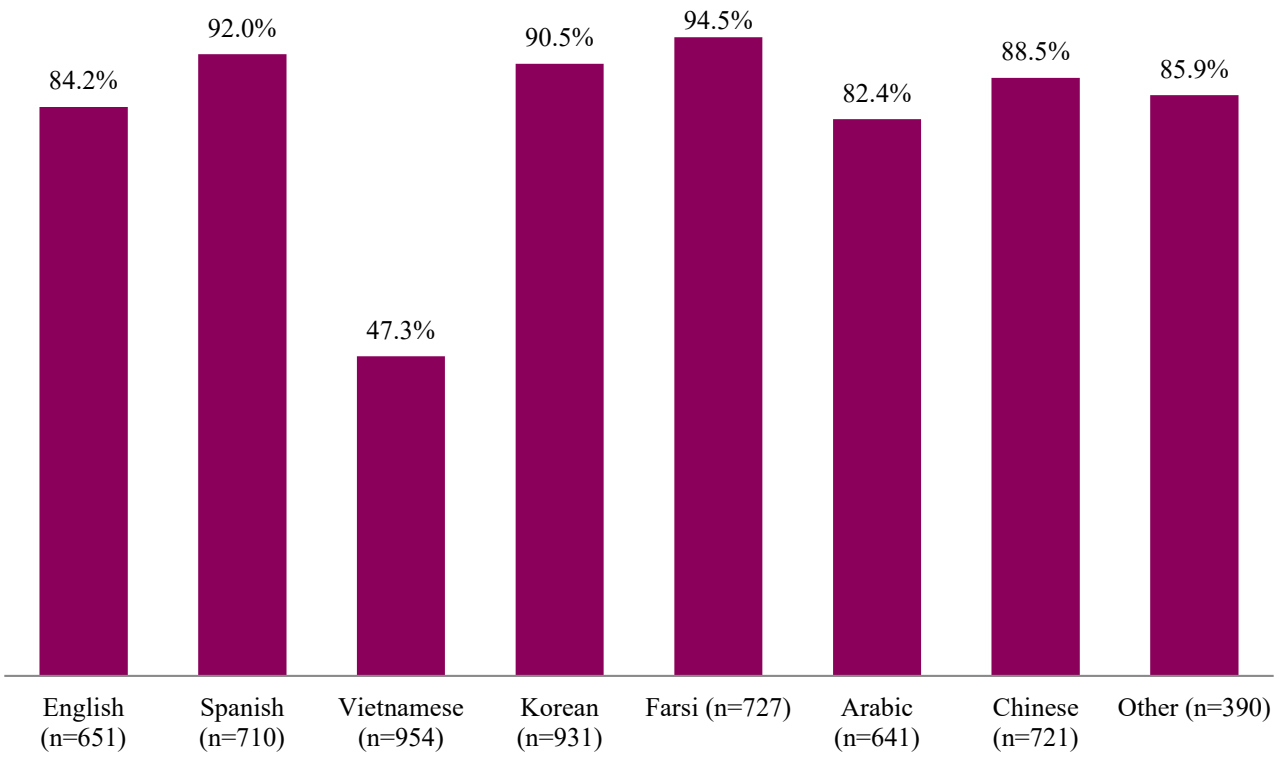
Back to Agenda

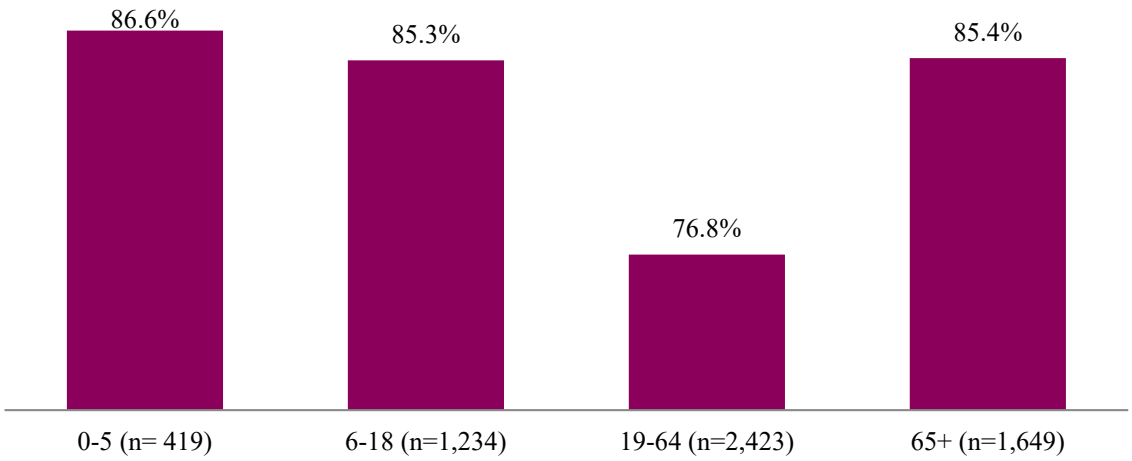
Navigating the Healthcare System

Exhibit 1. Percent who report at least one person as their doctor[1]

CalOptima language:



Age Group:



[1] An issue was identified with the Vietnamese translation of this question. Therefore, results likely misrepresent percentage of Vietnamese members who have a doctor.

Region:

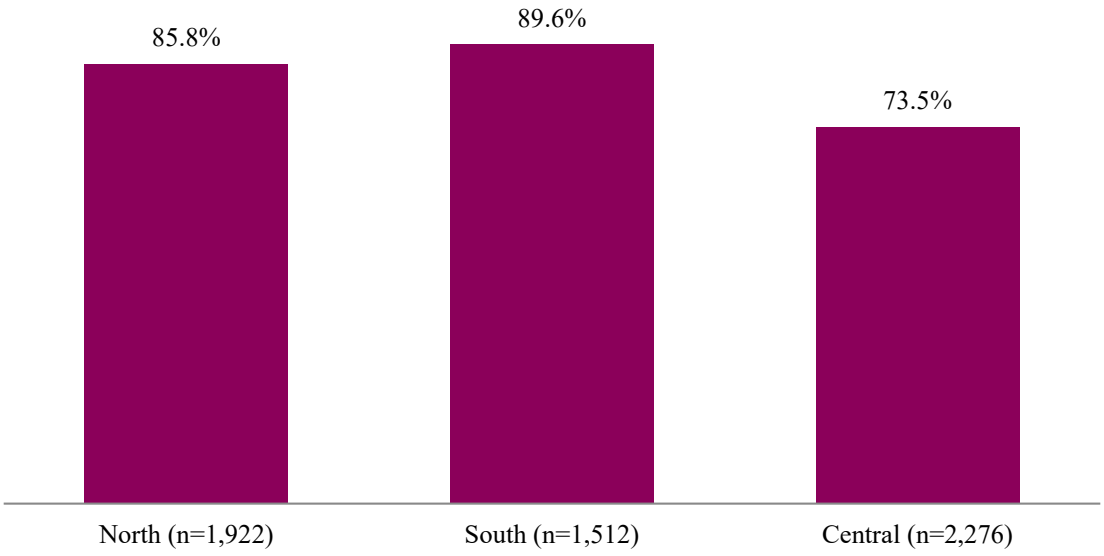


Exhibit 2. Where respondents go to see their doctor

CalOptima language:

CalOptima Language	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
English	71.8%	11.9%	2.0%	6.6%	0.5%	6.4%	0.8%	653
Spanish	59.7%	32.3%	3.4%	1.0%	0.3%	3.1%	0.1%	699
Vietnamese	86.3%	12.0%	0.1%	0.2%	0.0%	1.0%	0.3%	965
Korean	87.8%	4.3%	0.9%	1.1%	0.7%	4.1%	1.2%	938
Farsi	84.0%	6.5%	3.0%	0.8%	0.1%	5.0%	0.5%	737
Arabic	65.3%	15.8%	4.6%	5.4%	0.3%	8.0%	0.5%	625
Chinese	77.2%	11.4%	0.3%	0.8%	0.4%	6.6%	3.3%	727
Other	72.2%	12.6%	1.5%	3.0%	0.0%	9.6%	1.0%	396

Age Category:

CalOptima Age Category	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	68.4%	19.1%	1.9%	2.7%	0.2%	7.2%	0.5%	414
6-18 (Children)	73.0%	16.5%	1.6%	3.0%	0.4%	4.4%	1.0%	1,224
19-64 (Adults/MCE)	73.1%	14.2%	2.6%	2.7%	0.5%	5.5%	1.4%	2,425
65+ (Older Adults)	87.5%	6.8%	0.8%	0.4%	0.1%	4.1%	0.4%	1,677

Region:

CalOptima Region	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
North	74.4%	13.8%	1.7%	3.4%	0.4%	5.4%	1.0%	1,920
South	80.4%	7.9%	2.0%	1.4%	0.5%	6.4%	1.4%	1,521
Central	76.8%	15.5%	1.8%	1.4%	0.2%	3.6%	0.6%	2,284

Exhibit 3. Reasons why members go somewhere other than their doctor when they need medical attention

CalOptima language:

CalOptima Language	I don't have a doctor	It is easier for me to get to the emergency room or urgent care than my doctor's office	It's hard to get an appointment with my doctor	Other	Don't know	n
	%	%	%	%	%	
English	7.4%	26.5%	21.4%	40.7%	4.0%	570
Spanish	7.5%	22.2%	20.1%	37.9%	12.4%	523
Vietnamese	3.1%	31.8%	16.8%	46.2%	2.1%	584
Korean	11.5%	22.7%	27.8%	37.6%	0.4%	687
Farsi	3.1%	15.4%	22.7%	58.8%	0.0%	422
Arabic	5.2%	40.6%	25.5%	28.0%	0.7%	554
Chinese	9.1%	26.8%	14.6%	47.9%	1.6%	549
Other	6.0%	24.9%	16.7%	50.8%	1.6%	317

Age Category:

Age Category	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
0-5 (Children)	4.5%	34.4%	25.4%	29.3%	6.5%	355
6-18 (Children)	5.2%	27.7%	24.0%	36.2%	6.9%	986
19-64 (Adults/MCE)	9.2%	26.0%	23.7%	39.9%	1.3%	1,789
65+ (Older Adults)	4.5%	34.4%	25.4%	29.3%	6.5%	1,076

Region:

Region	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
North	7.4%	27.1%	25.2%	38.4%	1.9%	1,501
South	6.7%	23.1%	20.5%	47.2%	2.5%	1,052
Central	6.3%	28.9%	17.6%	43.2%	4.0%	1,639

Exhibit 4. When do members make an appointment to see doctor[2]

CalOptima Language:

CalOptima Language	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
English	75.8%	77.2%	51.8%	1.1%	4.2%	650
Spanish	77.7%	76.2%	36.9%	0.8%	4.5%	713
Vietnamese	76.0%	74.7%	39.7%	0.1%	1.7%	973
Korean	81.3%	75.2%	47.4%	0.4%	0.6%	938
Farsi	87.4%	80.0%	65.1%	1.8%	3.7%	736
Arabic	82.5%	40.4%	30.9%	0.5%	1.4%	644
Chinese	80.3%	73.6%	48.6%	1.5%	1.2%	727
Other	70.1%	82.0%	51.1%	1.5%	4.6%	395

Age Category:

Age Category	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
0-5 (Children)	86.4%	76.9%	41.9%	0.7%	1.2%	420
6-18 (Children)	81.8%	73.2%	39.9%	0.5%	2.2%	1,236
19-64 (Adults/MCE)	78.0%	67.9%	47.3%	1.1%	2.3%	2,433
65+ (Older Adults)	77.8%	77.4%	50.0%	0.9%	3.4%	1,687

[2] **Members were allowed to choose multiple answers; thus, the total does not equal 100%.**

Region:

Region	When Sick	Check-Up	Specialist Needed	Don't Know	Other	n
	%	%	%	%	%	
North	78.2%	70.5%	43.6%	0.9%	2.3%	1,938
South	83.3%	75.9%	55.9%	1.3%	2.8%	1,527
Central	77.7%	72.0%	41.8%	0.5%	2.5%	2,296

Exhibit 5. Reasons why members don't make an appointment to see doctor[3]

CalOptima language:

CalOptima Language	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
English	7.8%	6.7%	28.0%	27.6%	5.2%	54.0%	1.8%	554
Spanish	6.3%	6.5%	20.8%	27.4%	5.2%	53.2%	0.8%	504
Vietnamese	2.3.%	7.0%	50.9%	24.8%	4.1%	42.8%	0.0%	725
Korean	11.7%	4.1%	48.4%	39.7%	3.8%	31.5%	0.0%	677
Farsi	5.7%	19.5%	24.9%	45.1%	6.9%	33.3%	0.0%	406
Arabic	2.7%	7.0%	28.2%	42.6%	2.1%	37.1%	0.0%	561
Chinese	7.2%	9.6%	29.8%	24.8%	2.2%	51.0%	0.9%	541
Other	4.1%	8.8%	25.0%	29.1%	1.7%	56.8%	0.0%	296

[3] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Age Category:

Age Category	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	4.6%	6.5%	32.8%	35.9%	10.5%	43.7%	0.0%	323
6-18 (Children)	4.8%	4.5%	38.2%	32.8%	3.9%	43.4%	0.1%	990
19-64 (Adults /MCE)	7.8%	7.4%	36.3%	34.5%	4.2%	39.5%	0.8%	1,933
65+ (Older Adults)	4.5%	13.3%	26.1%	26.9%	1.3%	53.2%	0.3%	1,018

Region:

Region	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%			
North	7.6%	7.7%	36.3%	35.0%	3.3%	40.5%	0.3%	1,521
South	6.3%	10.5%	27.5%	35.8%	4.8%	45.7%	0.6%	1,019
Central	4.6%	6.9%	35.9%	28.1%	4.0%	46.1%	0.5%	1,712

Exhibit 6. When do members make an appointment to see a specialist[4]

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
English	76.0%	26.5%	63.5%	638
Spanish	71.9%	30.5%	60.7%	679
Vietnamese	70.3%	24.4%	56.7%	949
Korean	69.1%	27.1%	45.2%	877
Farsi	78.6%	31.4%	55.7%	688
Arabic	68.9%	16.3%	42.5%	631
Chinese	66.0%	35.6%	45.4%	694
Other	79.2%	26.8%	59.9%	384

Age Category:

Age Category	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
0-5 (Children)	71.1%	28.4%	53.8%	394
6-18 (Children)	67.7%	25.7%	52.6%	1,172
19-64 (Adults/MCE)	71.5%	25.2%	54.5%	2,328
65+ (Older Adults)	75.7%	31.3%	51.7%	1,646

[4] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

Region:

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
North	69.3%	27.7%	50.6%	1,857
South	74.3%	28.3%	52.9%	1,453
Central	72.6%	26.6%	55.5%	2,216

Exhibit 7. Reasons why members don't make an appointment to see specialist[5]

CalOptima Language:

CalOptima Language	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
English	19.5%	8.0%	20.4%	27.0%	41.1%	548
Spanish	7.9%	5.5%	12.0%	20.2%	46.4%	560
Vietnamese	11.3%	9.3%	37.8%	30.7%	33.4%	724
Korean	14.2%	12.5%	32.6%	41.5%	27.6%	696
Farsi	13.9%	14.3%	15.2%	37.6%	24.5%	474
Arabic	9.9%	6.9%	21.5%	47.1%	25.6%	577
Chinese	11.9%	14.6%	17.6%	25.4%	42.6%	556
Other	15.6%	12.6%	16.5%	27.2%	39.2%	334

Age Category:

Age Category	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
0-5 (Children)	10.8%	8.1%	22.8%	33.5%	41.0%	334
6-18 (Children)	12.1%	7.9%	27.2%	32.1%	35.9%	1,019
19-64 (Adults/MCE)	13.7%	9.8%	24.9%	35.5%	31.6%	1,953
65+ (Older Adults)	12.6%	13.8%	16.3%	27.6%	37.0%	1,163

[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

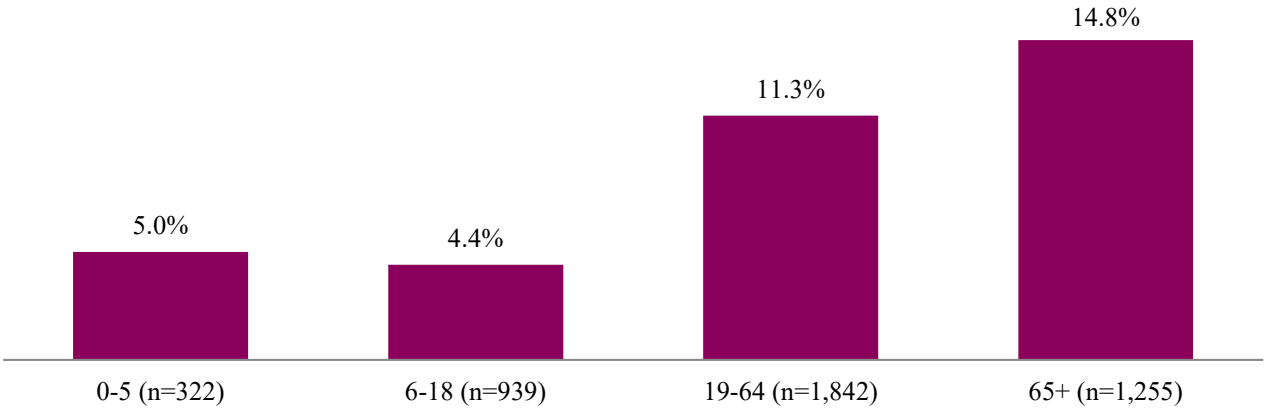
Region:

Region	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
North	14.0%	11.3%	24.8%	35.9%	31.1%	1,567
South	13..6%	11.3%	17.5%	33.6%	35.9%	1,097
Central	11.4%	8.8%	24.9%	28.9%	37.2%	1,792

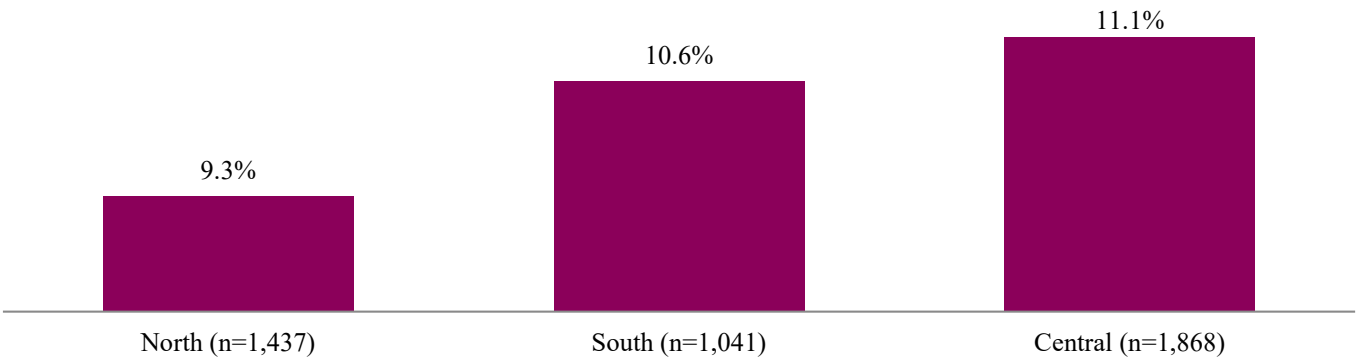
Exhibit 8. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor

CalOptima language:

Age Category:



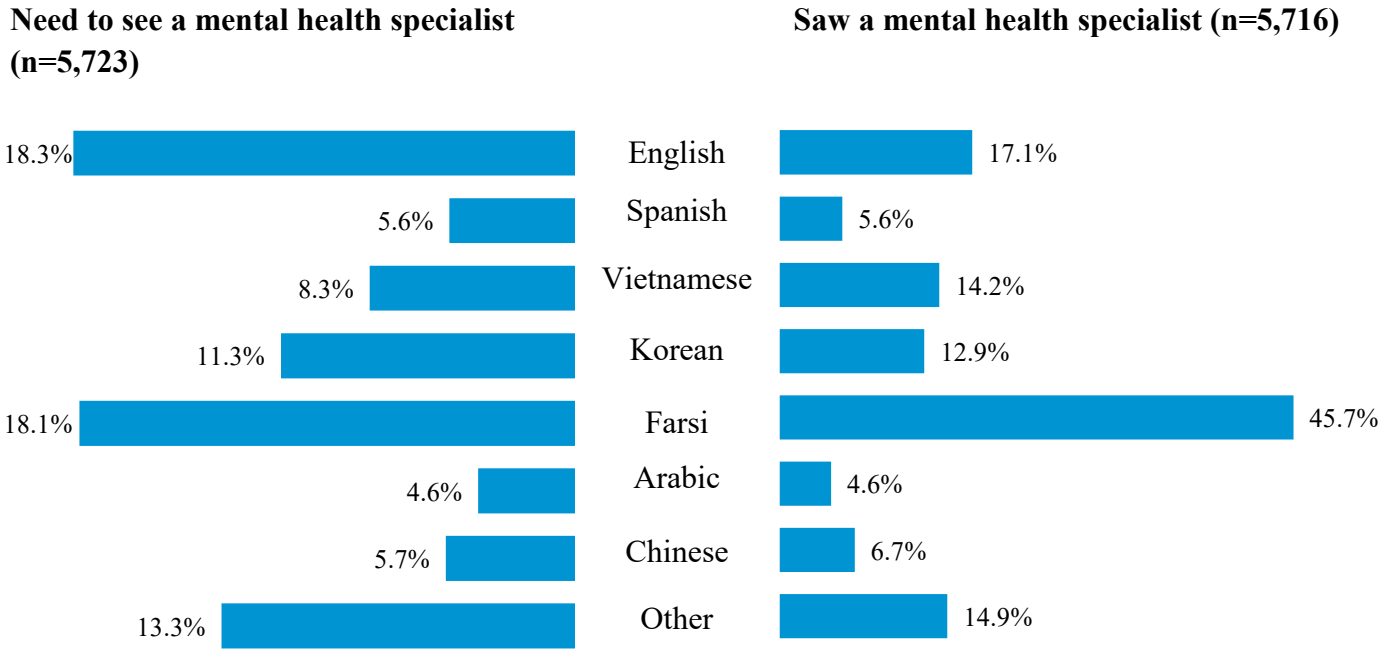
Region:



Social and Emotional Well-Being

Exhibit 9. Members who needed to see compared to those who saw a mental health specialist in the last 12 months[6]

CalOptima Language:

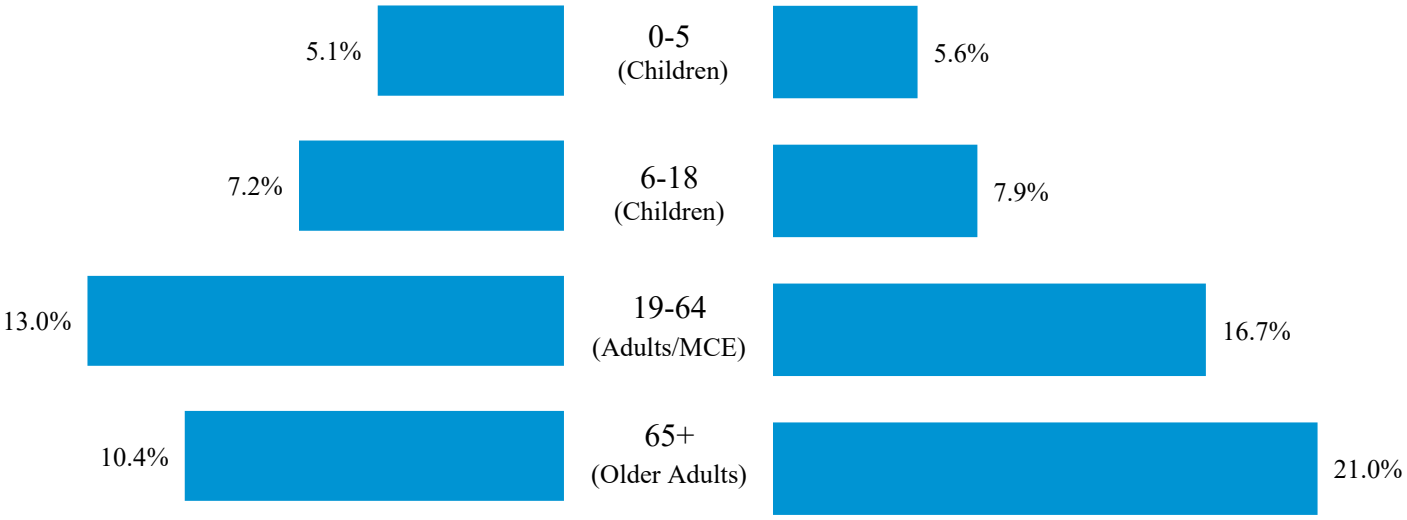


[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

Age Category:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)



Region:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)

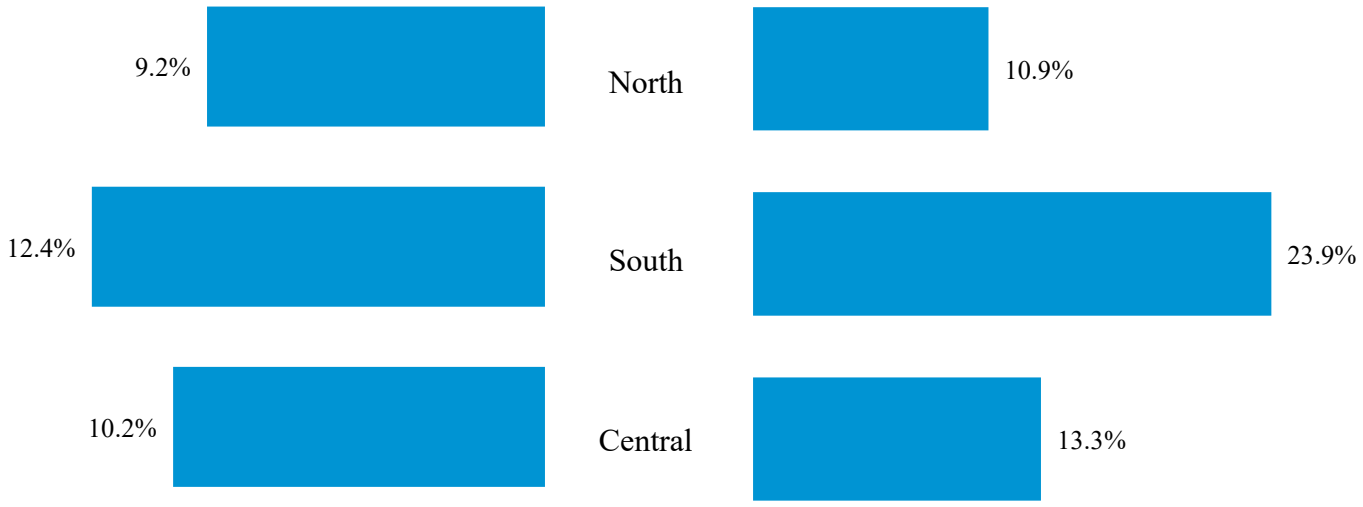
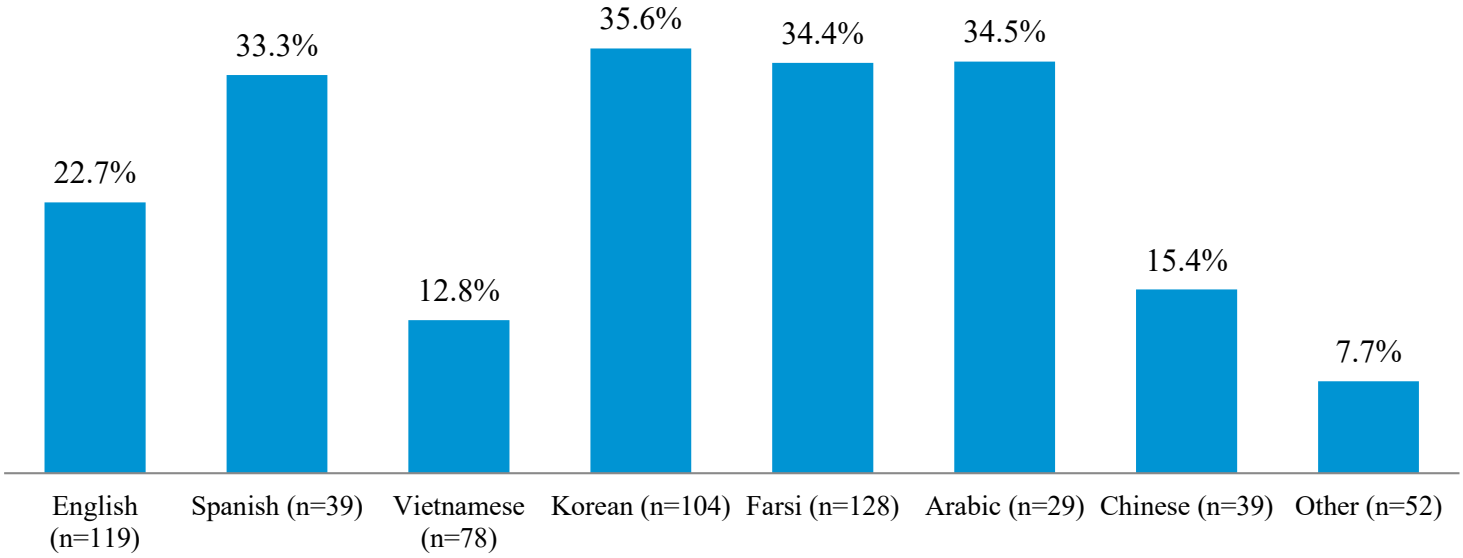
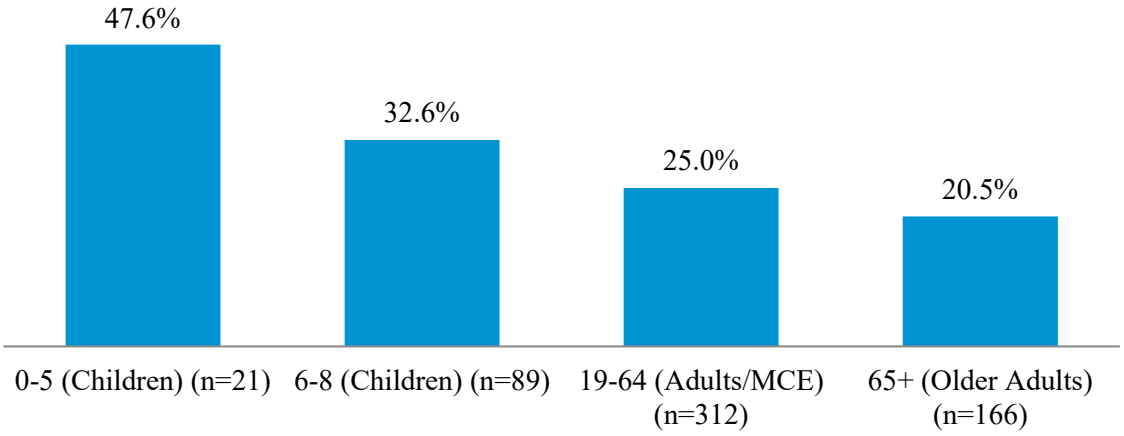


Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist

CalOptima Language:



Age Category:



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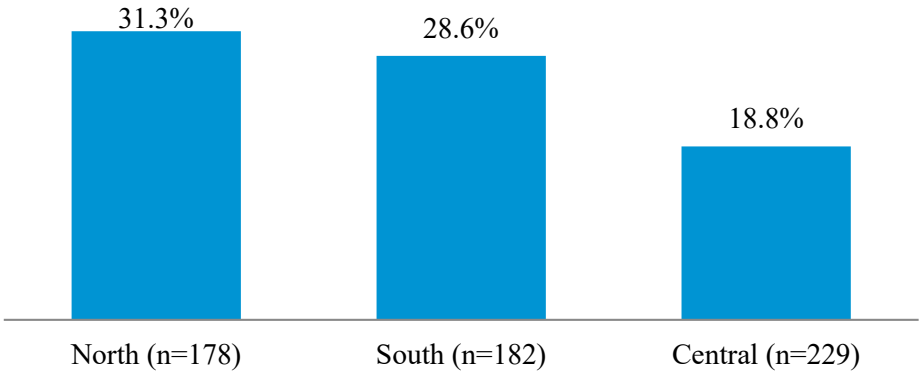
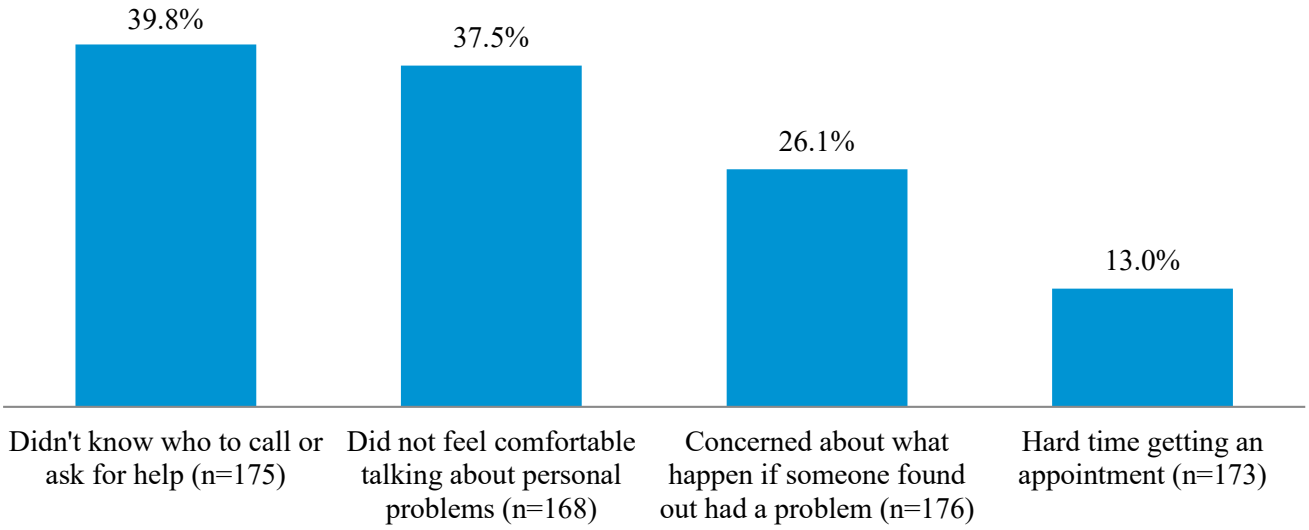


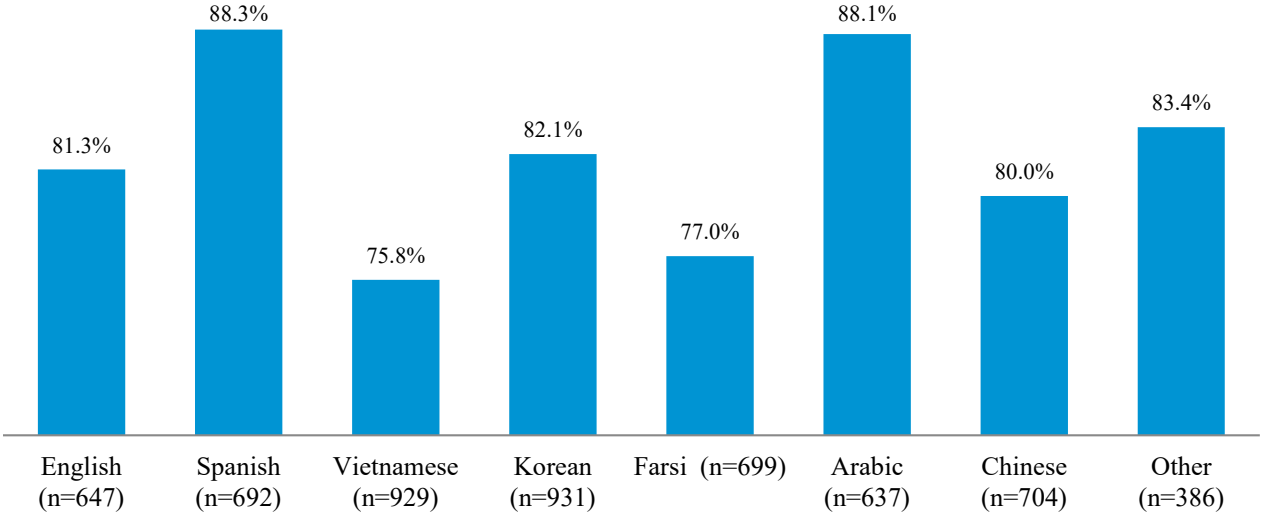
Exhibit 11. Reasons why members didn't see mental health specialist[7]



[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

Exhibit 12. Percent of members who can share their worries with family members

CalOptima language:



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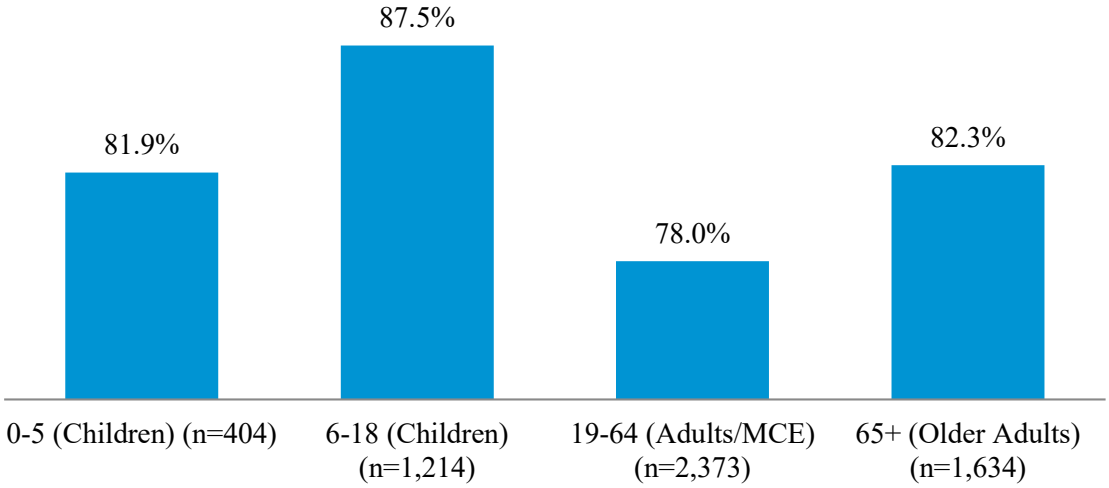

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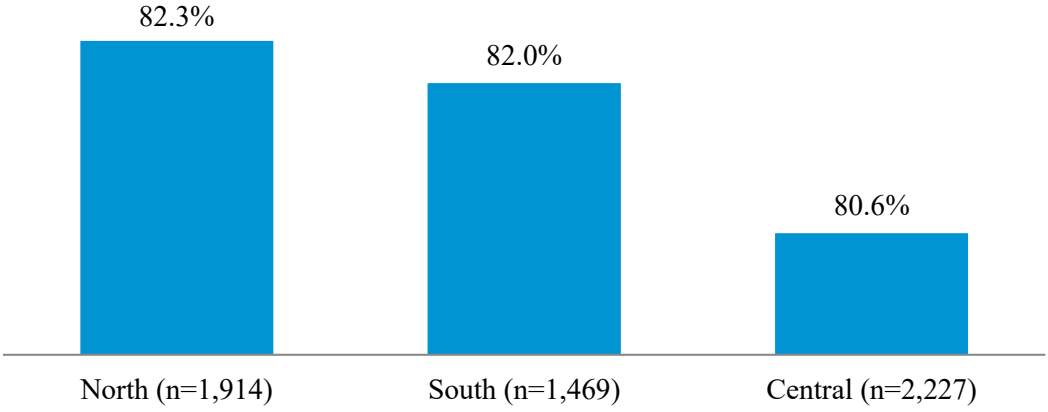
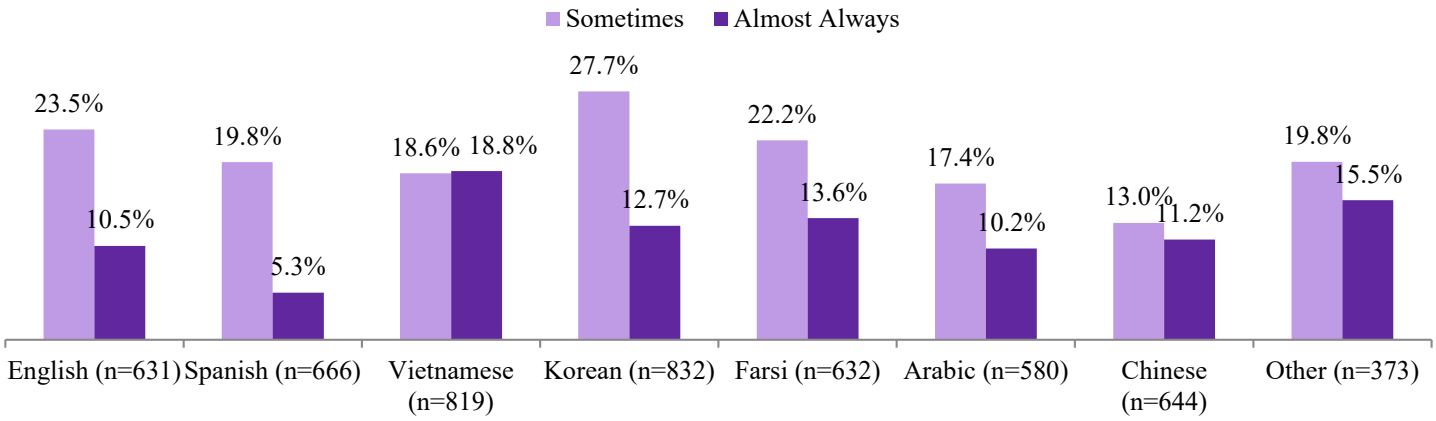


Social Determinants of Health

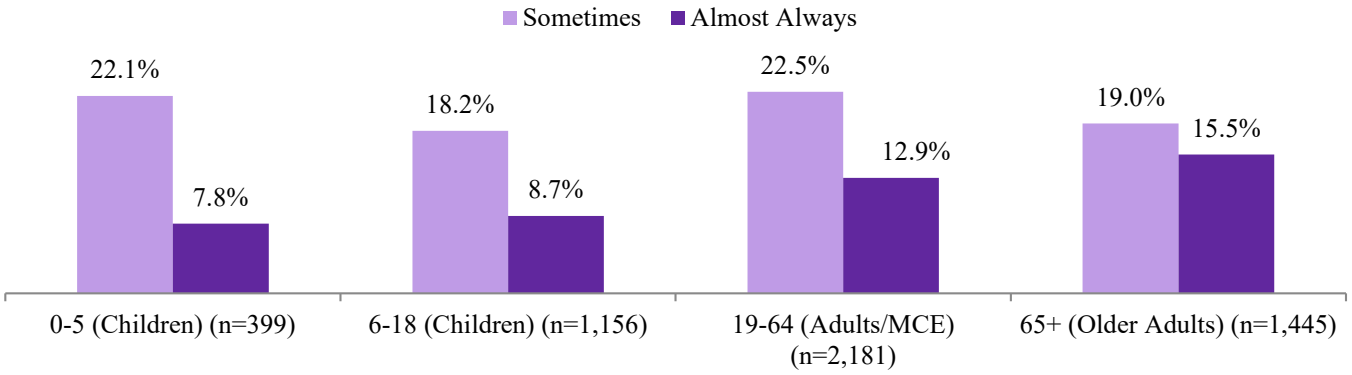
Exhibit 13. Needed help with the following in the past 6 months:

Food for anyone in your household:

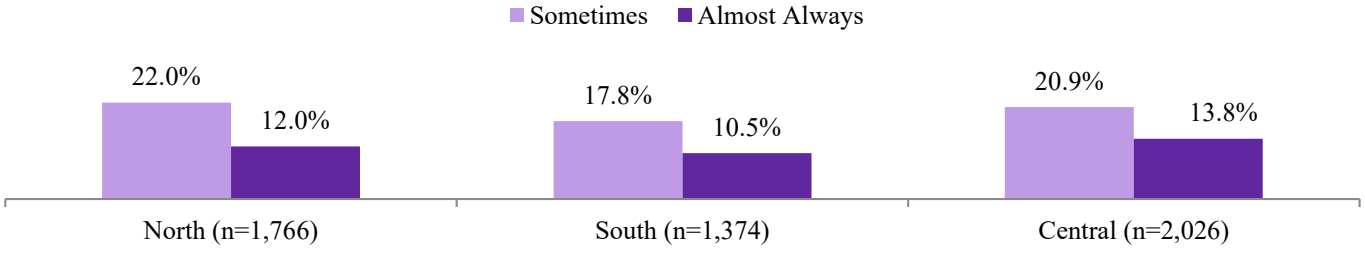
CalOptima language:



Age Category:

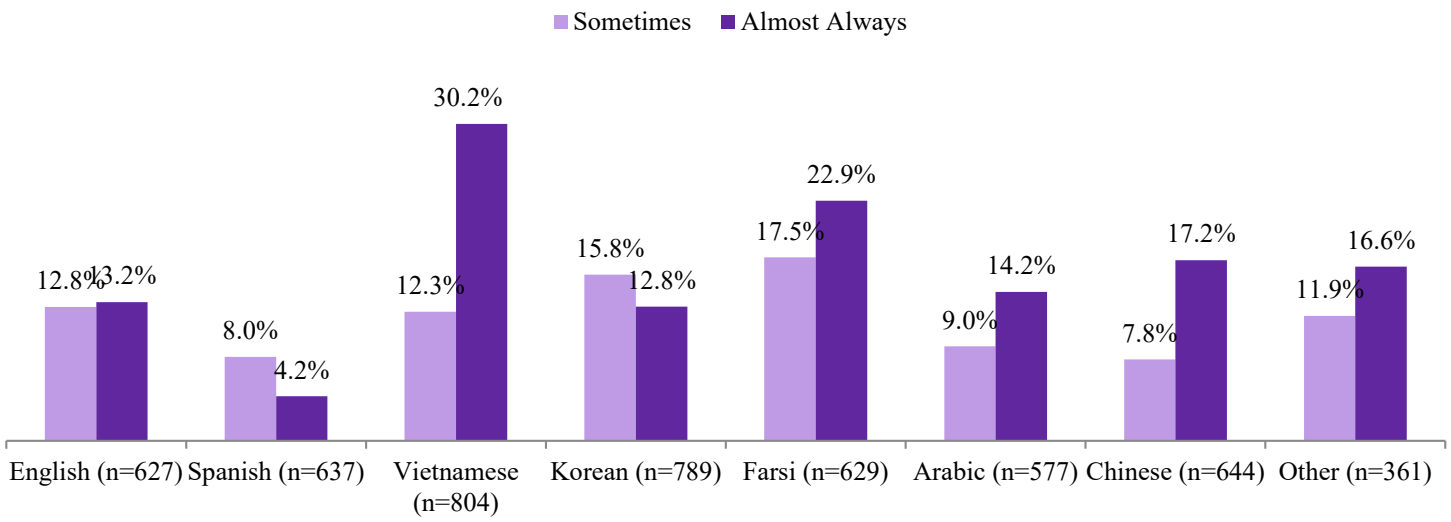


Region:

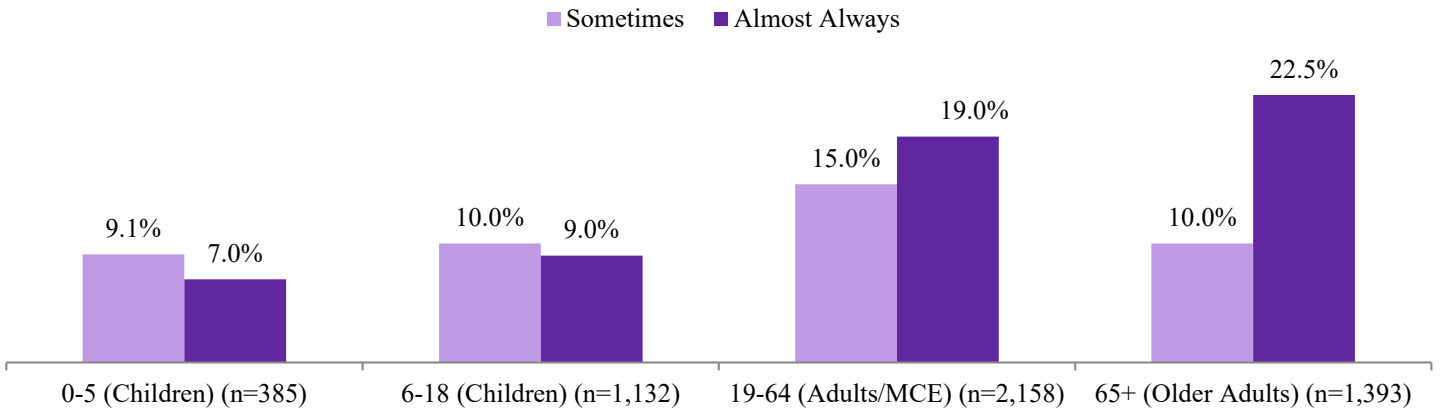


Housing:

CalOptima language:



Age Category:



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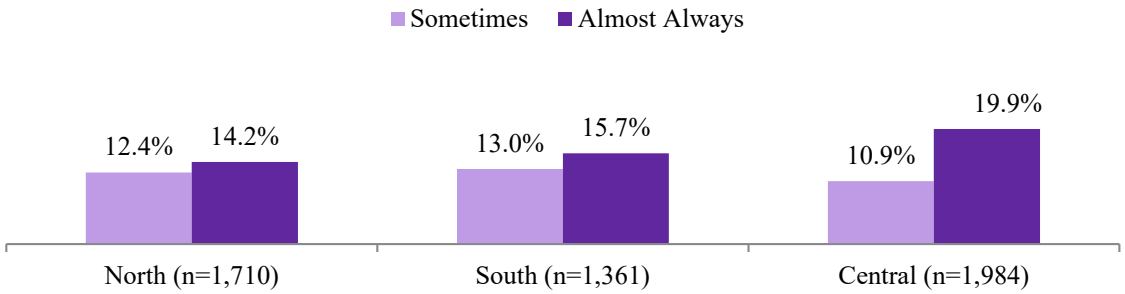
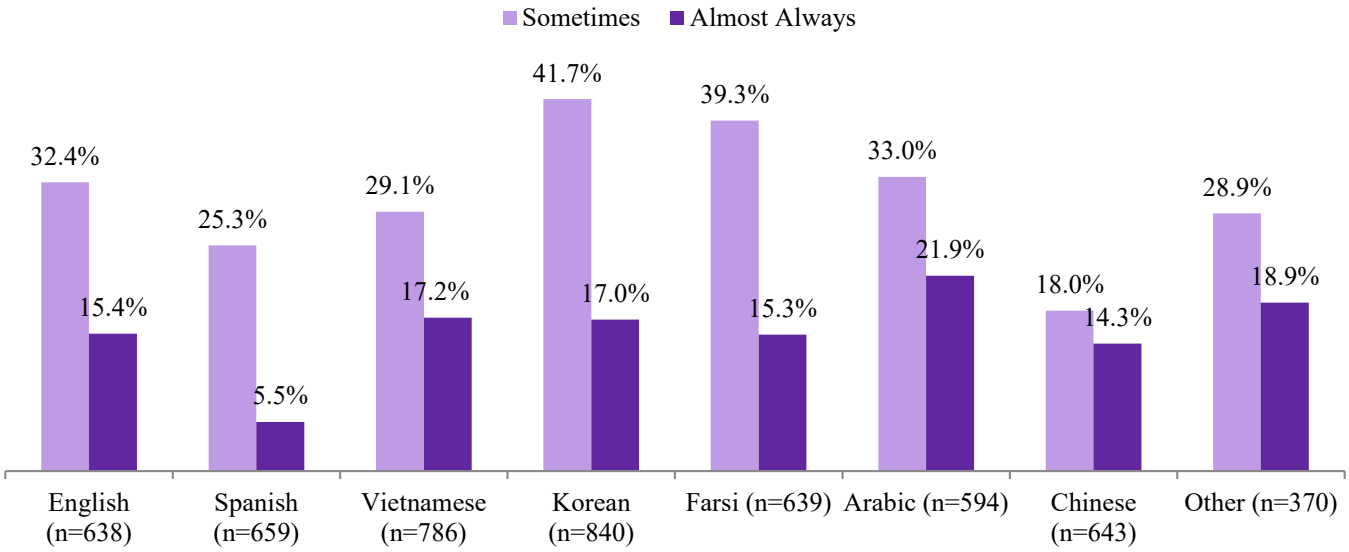
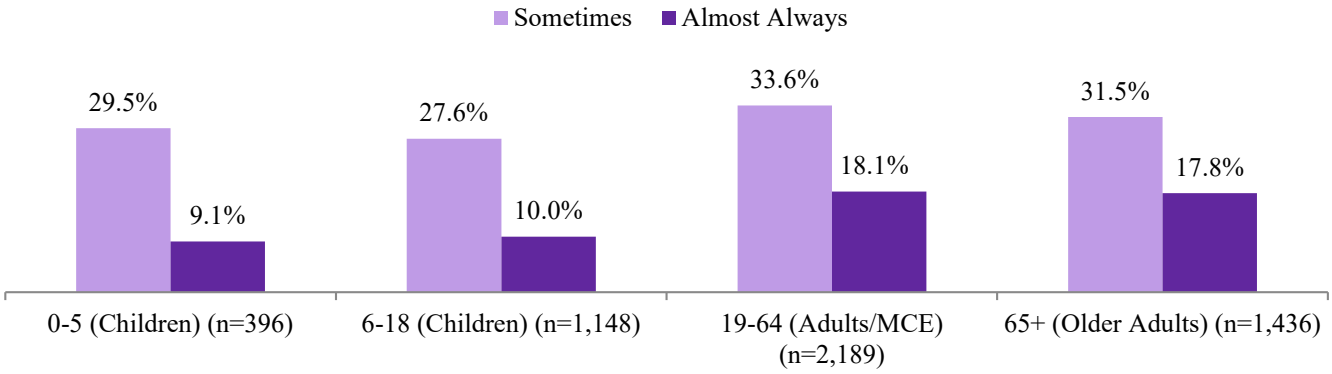


Money to buy things need:

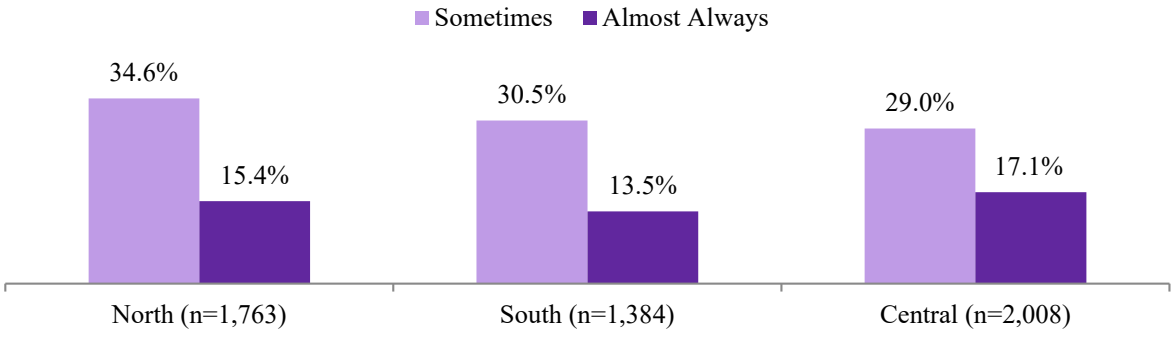
CalOptima language:



Age Category:

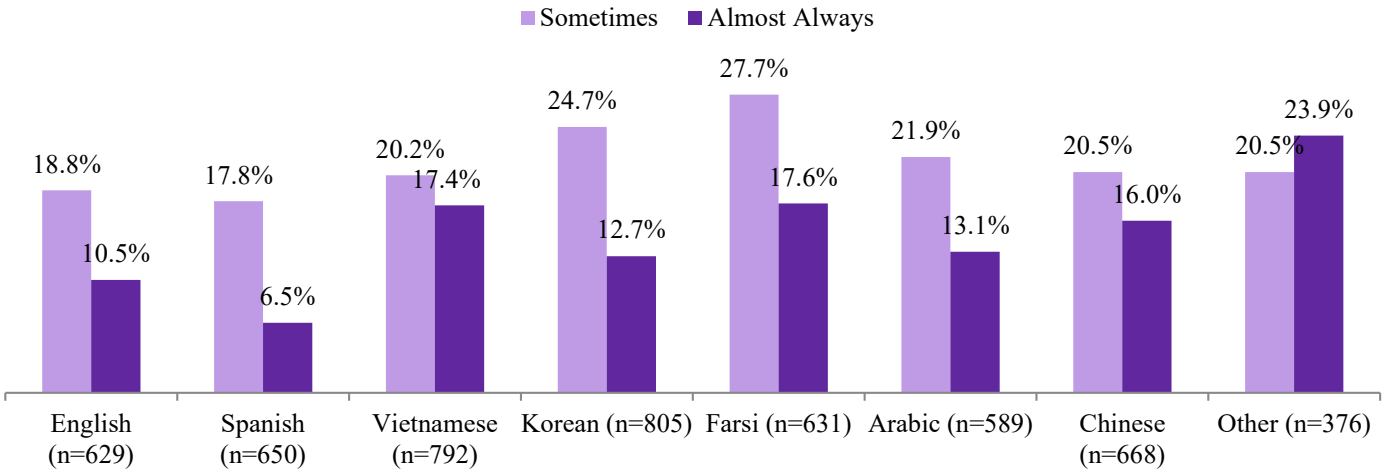


Region:

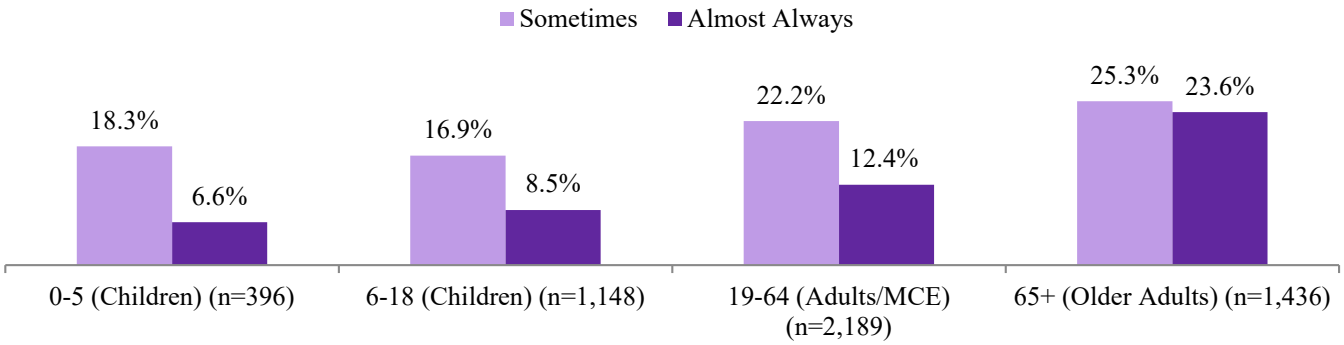


Transportation:

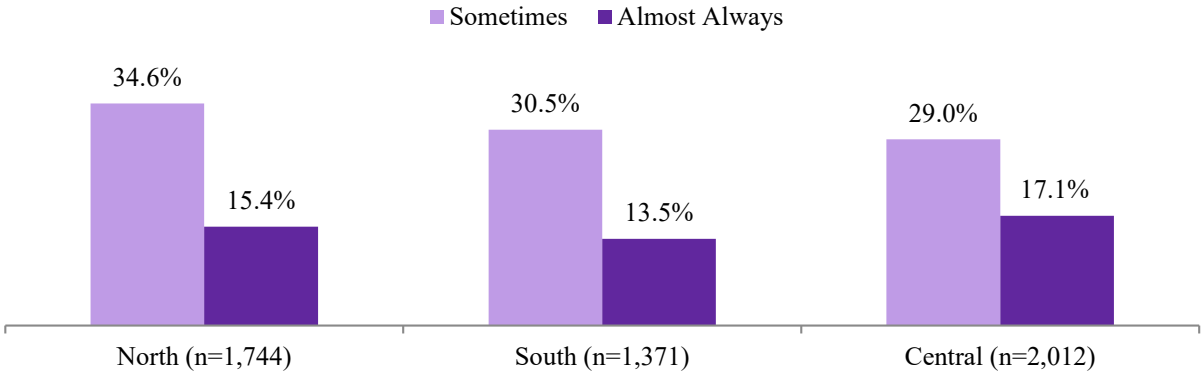
CalOptima language:



Age Category:

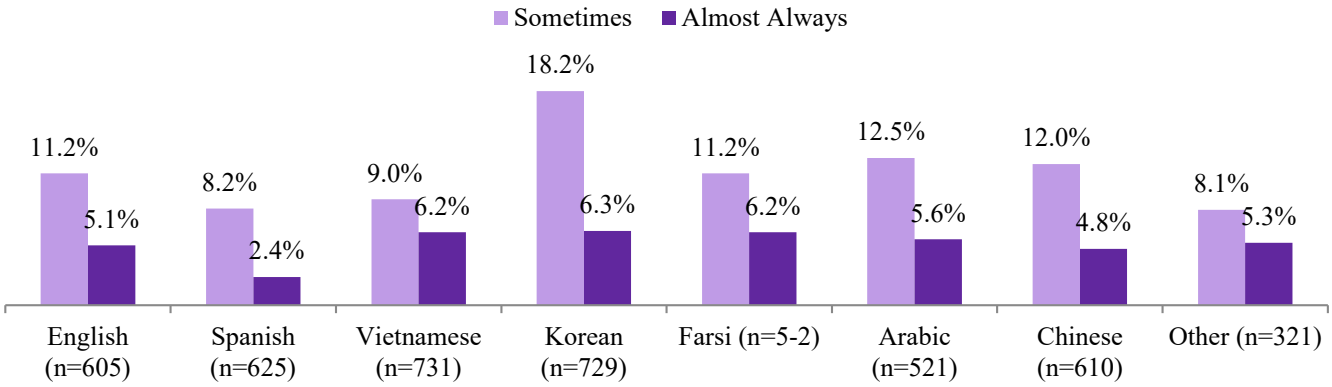


Region:

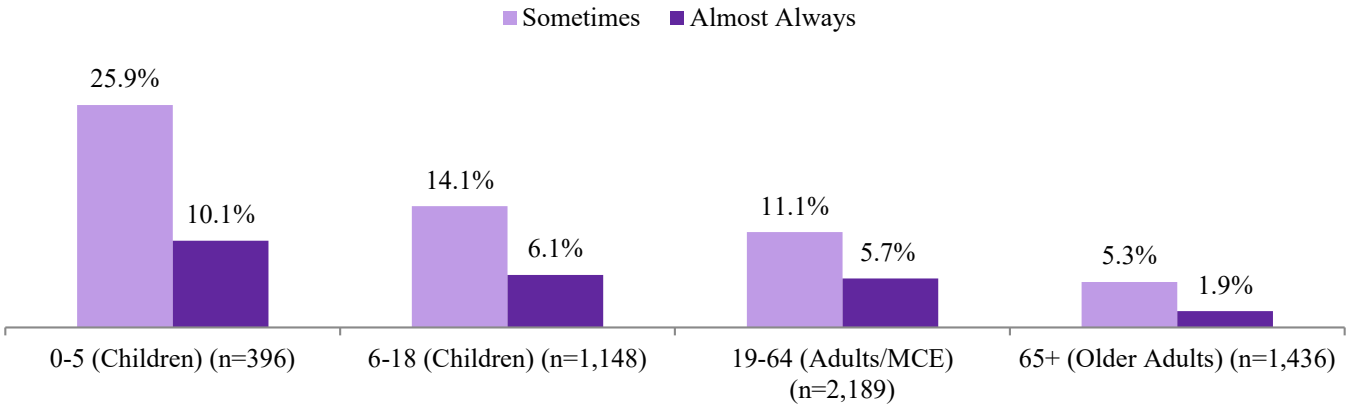


Child care:

CalOptima language:



Age Category:



Region:

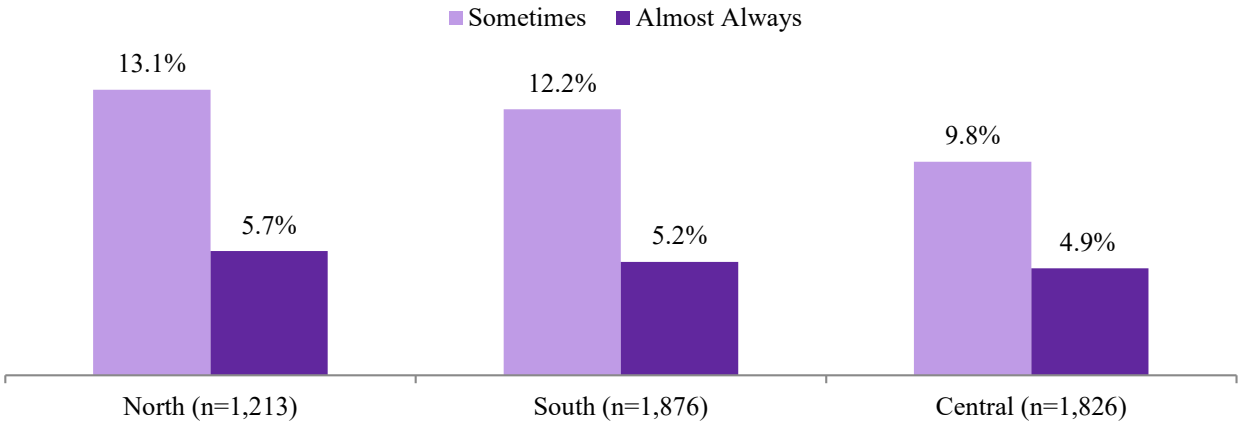
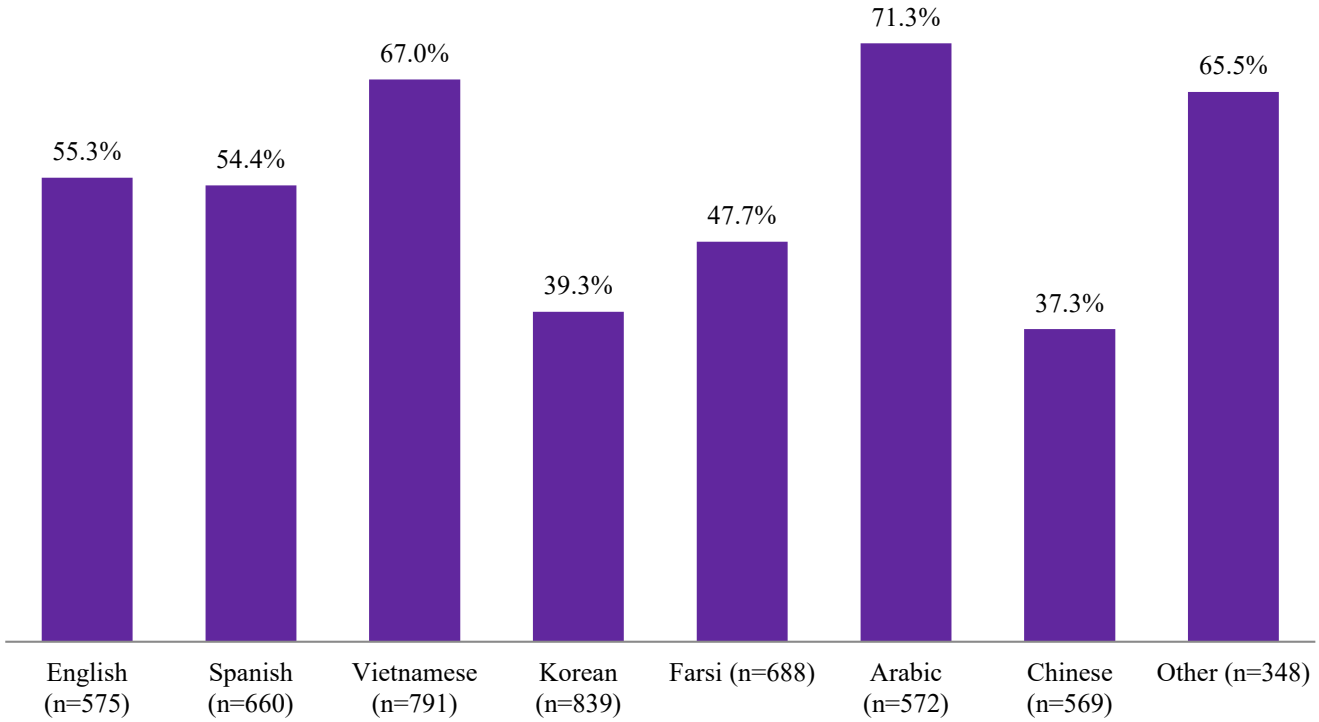


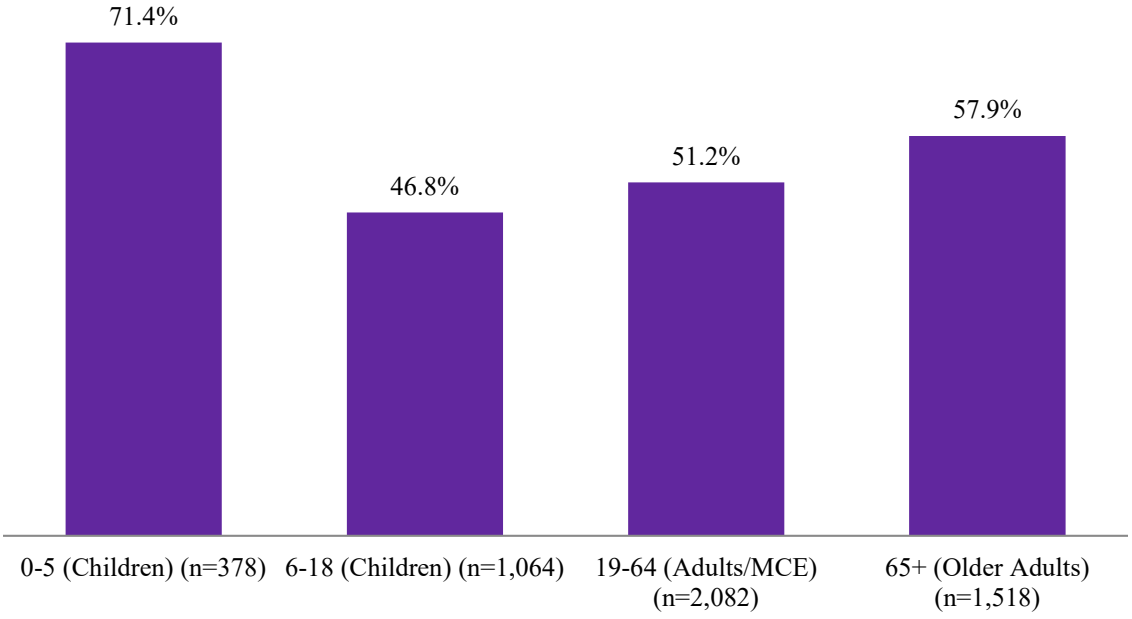
Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

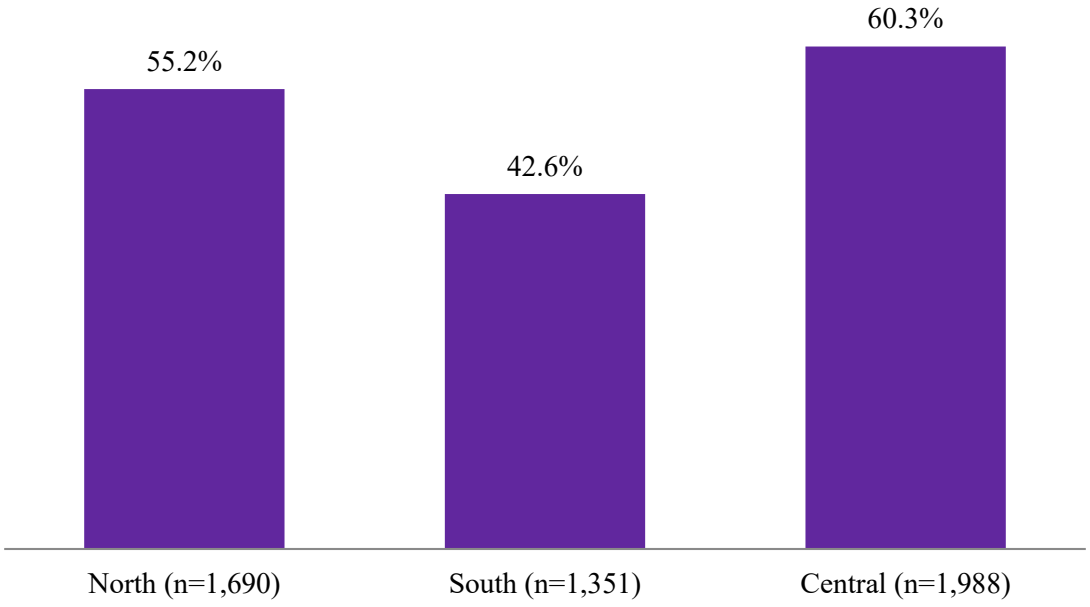
CalOptima language:



Age Category:



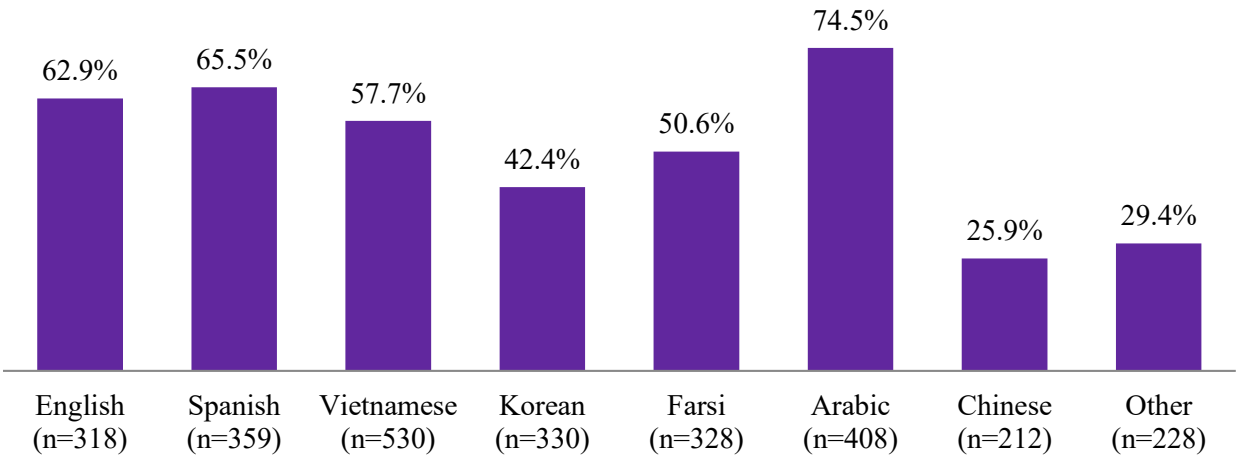
Region:



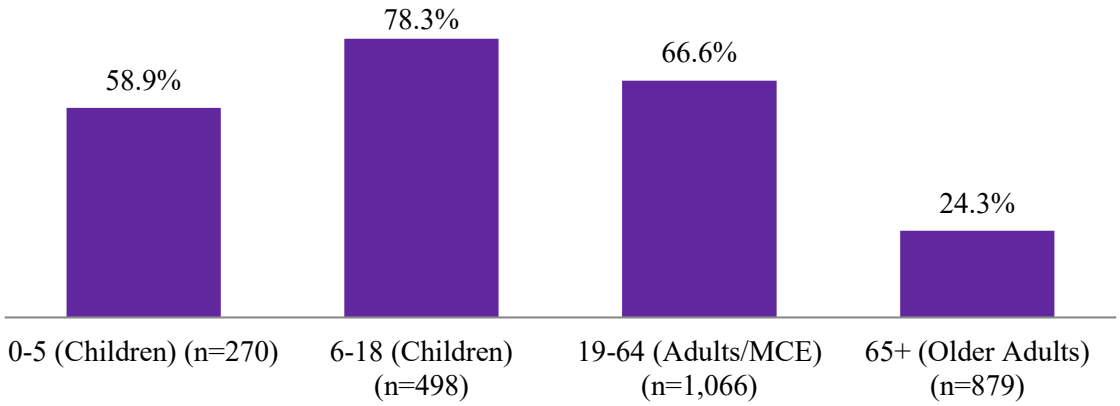
Type of public benefits that members receive[8]:

Receive CalFresh as a public benefit:

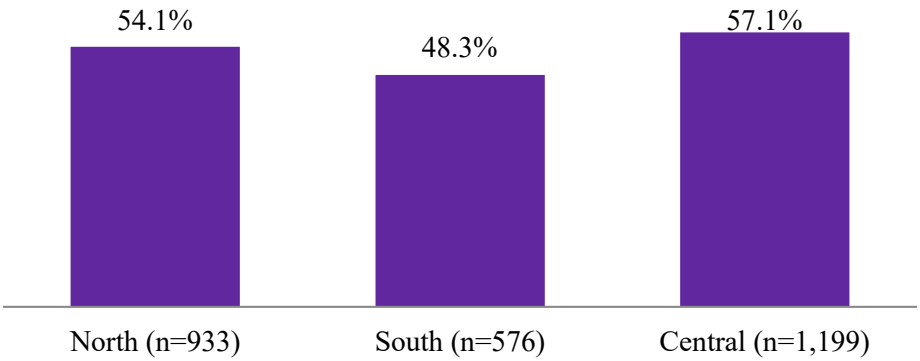
CalOptima language:



Age Category:



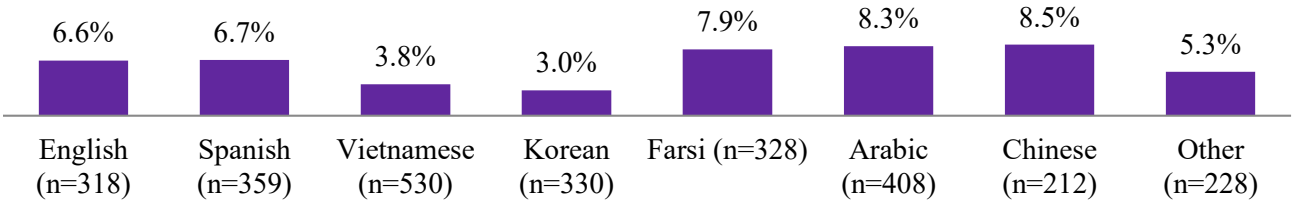
Region:



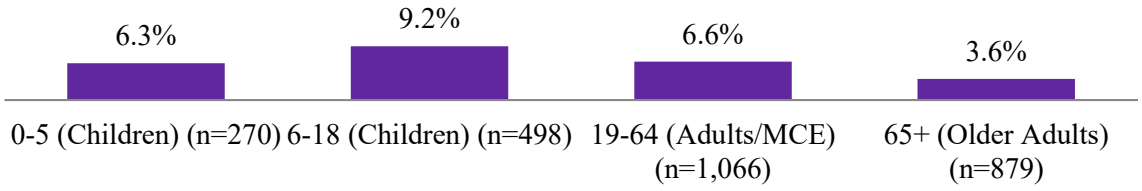
[8] Only reporting those who reported that they received at least one public benefit.

Receive TANF or CalWorks as a public benefit:

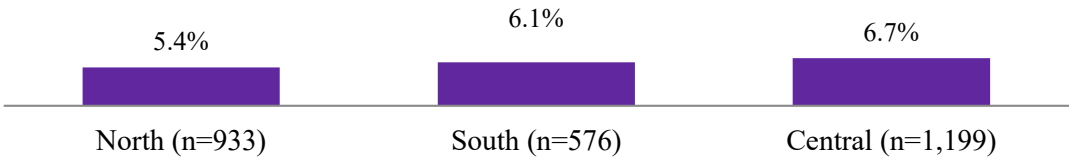
CalOptima language:



Age Category:

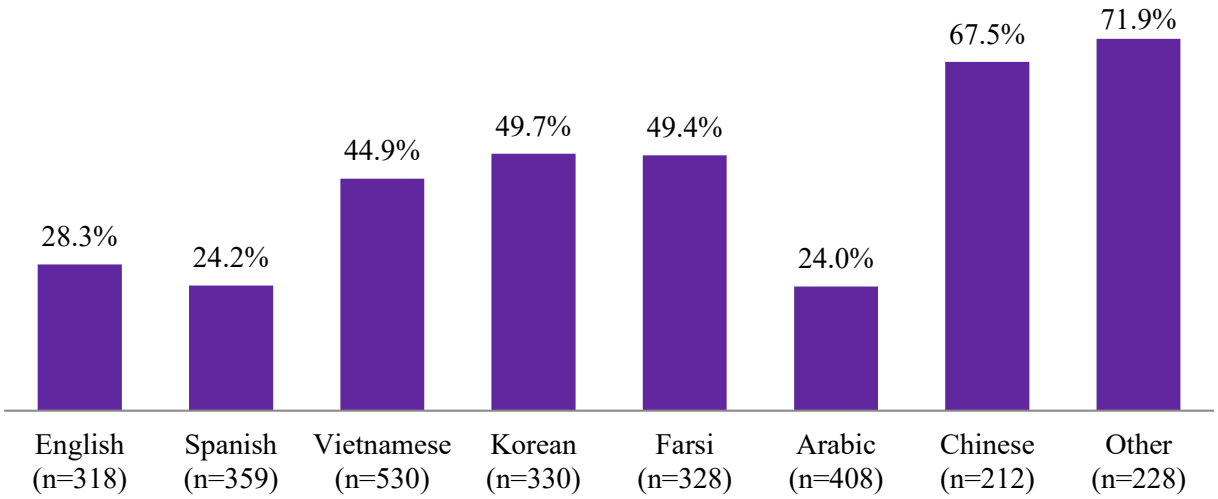


Region:

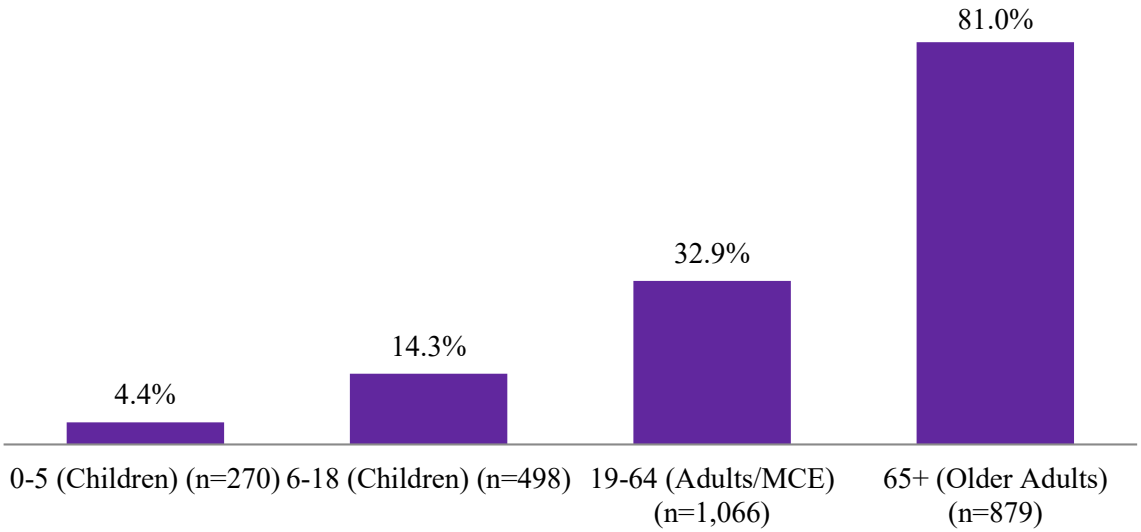


Receive SSI or SSDI as a public benefit:

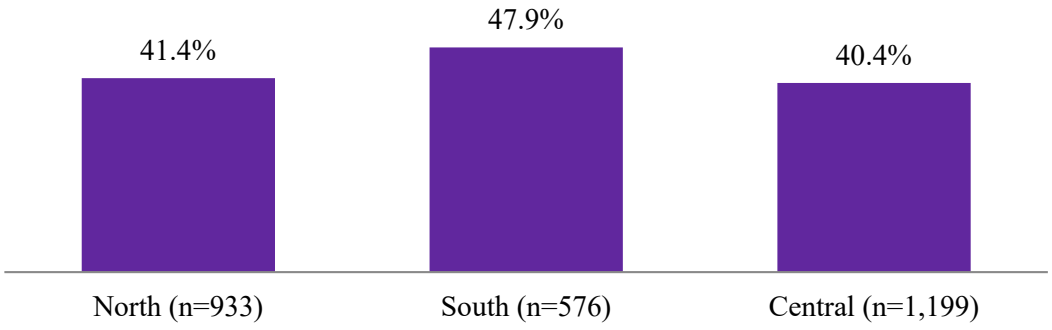
CalOptima language:



Age Category:

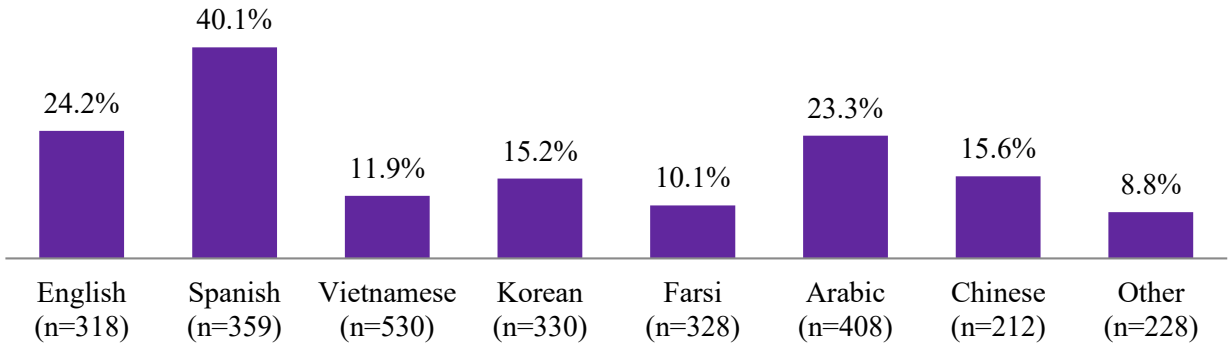


Region:

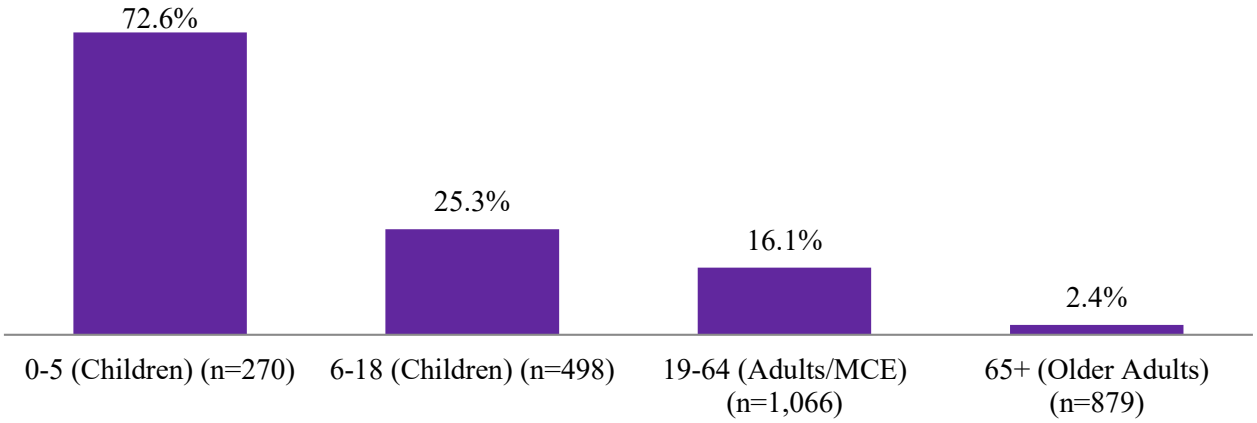


Receive WIC as a public benefit:

CalOptima language:



Age Category:



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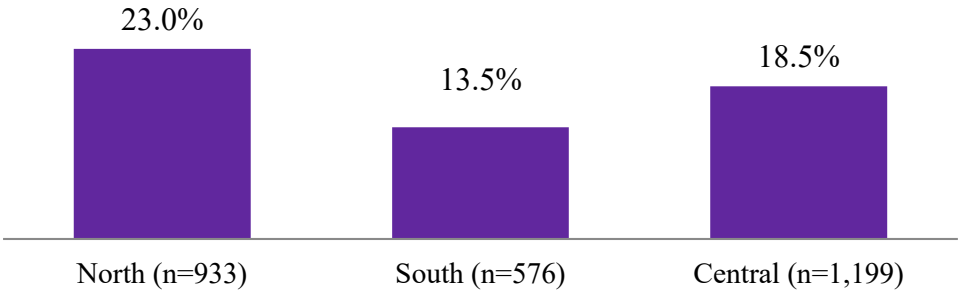


Exhibit 15. Personal activities participation:

CalOptima language:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	41.2%	6.4%	6.4%	45.9%	621
Spanish	19.1%	4.3%	3.1%	73.5%	607
Vietnamese	53.5%	3.3%	4.3%	38.9%	766
Korean	35.4%	6.3%	2.3%	56.0%	809
Farsi	28.5%	3.2%	3.4%	65.0%	537
Arabic	47.2%	5.9%	1.9%	45.0%	540
Chinese	16.8%	3.8%	3.1%	76.3%	583
Other	32.3%	4.0%	5.1%	58.6%	350
Do fun activities with others	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
English	63.3%	18.3%	7.4%	11.0%	635
Spanish	61.8%	13.0%	4.0%	21.2%	647
Vietnamese	49.6%	19.5%	9.3%	21.7%	789
Korean	51.9%	22.7%	7.3%	18.0%	859
Farsi	39.5%	25.0%	10.2%	**25.3%**	608
Arabic	54.8%	20.6%	6.7%	17.9%	586
Chinese	45.4%	12.1%	5.8%	**36.7%**	619
Other	46.3%	21.6%	11.6%	20.5%	361

Volunteer or charity	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	16.2%	15.8%	19.4%	48.6%	628
Spanish	15.9%	10.0%	9.9%	64.2%	628
Vietnamese	15.8%	19.1%	26.7%	38.3%	752
Korean	21.0%	13.2%	15.6%	50.2%	825
Farsi	15.4%	13.8%	19.9%	50.9%	578
Arabic	23.5%	18.1%	14.3%	44.2%	575
Chinese	16.5%	11.9%	14.0%	57.7%	607
Other	9.9%	7.0%	12.1%	71.0%	355

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	68.7%	11.5%	6.0%	13.7%	633
Spanish	66.0%	8.7%	2.8%	22.5%	644
Vietnamese	69.6%	6.6%	4.0%	19.8%	807
Korean	75.1%	10.1%	3.7%	11.2%	874
Farsi	68.9%	7.7%	5.6%	17.9%	627
Arabic	59.1%	11.8%	4.4%	24.7%	587
Chinese	71.9%	7.3%	3.8%	17.1%	661
Other	57.6%	10.2%	4.7%	27.5%	363

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	83.3%	6.0%	1.0%	9.6%	612
Spanish	85.1%	5.3%	1.0%	8.6%	590
Vietnamese	78.0%	5.1%	1.5%	15.4%	740
Korean	88.2%	6.3%	1.0%	4.5%	842
Farsi	84.3%	4.8%	1.9%	8.9%	516
Arabic	83.2%	5.5%	1.5%	9.8%	531
Chinese	86.9%	5.2%	1.1%	6.7%	610
Other	80.3%	6.7%	3.5%	9.5%	315

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	76.7%	12.2%	2.9%	8.2%	621
Spanish	80.1%	7.7%	2.9%	9.3%	613
Vietnamese	78.2%	7.7%	1.9%	12.1%	725
Korean	73.6%	13.8%	4.6%	8.0%	864
Farsi	78.4%	9.9%	3.7%	8.0%	538
Arabic	74.5%	11.4%	2.7%	11.4%	553
Chinese	85.9%	5.3%	2.4%	6.3%	618
Other	82.9%	9.2%	3.5%	4.4%	315

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	0.8%	1.1%	6.2%	91.9%	632
Spanish	0.2%	0.3%	2.5%	97.1%	651
Vietnamese	2.6%	0.6%	3.1%	93.7%	772
Korean	0.8%	0.8%	6.5%	91.8%	846
Farsi	1.3%	1.0%	2.9%	94.8%	594
Arabic	5.0%	2.4%	1.0%	91.6%	582
Chinese	7.5%	2.3%	3.3%	86.8%	598
Other	2.2%	2.0%	8.1%	87.7%	358

Age Category:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	32.2%	3.4%	2.0%	62.4%	348
6-18 (Children)	33.0%	3.9%	2.5%	60.6%	1,077
19-64 (Adults/MCE)	43.2%	5.6%	4.2%	47.0%	2,093
65+ (Older Adults)	24.3%	4.3%	4.2%	67.2%	1,295
Do fun activities with others	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
0-5 (Children)	75.0%	9.8%	2.9%	12.2%	376
6-18 (Children)	72.5%	12.3%	4.7%	10.6%	1,137
19-64 (Adults/MCE)	43.6%	24.2%	9.3%	23.0%	2,190
65+ (Older Adults)	41.9%	19.2%	8.6%	30.3%	1,401
Volunteer or charity	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
0-5 (Children)	14.5%	10.4%	11.0%	64.1%	365
6-18 (Children)	22.7%	18.3%	17.2%	41.8%	1,117
19-64 (Adults/MCE)	18.0%	14.9%	20.8%	46.3%	2,142
65+ (Older Adults)	12.1%	10.1%	12.2%	65.6%	1,324

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	69.2%	7.0%	1.9%	21.9%	370
6-18 (Children)	77.9%	8.4%	3.2%	10.5%	1,148
19-64 (Adults/MCE)	62.2%	12.6%	5.7%	19.5%	2,211
65+ (Older Adults)	69.3%	4.9%	3.6%	22.2%	1,467
Get enough sleep	**Once a week**	**Once a month**	**Once in the last 6 months**	**Never**	**n**
	%	%	%	%	
0-5 (Children)	89.8%	3.6%	0.6%	6.1%	362
6-18 (Children)	90.2%	4.5%	0.9%	4.3%	1,084
19-64 (Adults/MCE)	80.5%	6.7%	1.7%	11.0%	2,061
65+ (Older Adults)	82.4%	5.2%	1.6%	10.8%	1,249
Have enough time for self	**Once a week**	**Once a month**	**Once in the last 6 months**	**Never**	**n**
	%	%	%	%	
0-5 (Children)	79.0%	6.4%	3.6%	11.0%	362
6-18 (Children)	83.2%	7.7%	2.4%	6.7%	1,110
19-64 (Adults/MCE)	70.7%	14.3%	4.3%	10.8%	2,105
65+ (Older Adults)	86.5%	5.3%	1.7%	6.5%	1,270

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	3.0%	0.5%	1.6%	94.8%	368
6-18 (Children)	2.3%	0.6%	1.8%	95.3%	1,134
19-64 (Adults/MCE)	1.9%	1.0%	5.4%	91.7%	2,171
65+ (Older Adults)	3.2%	2.3%	4.6%	89.9%	1,360

Region:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	35.3%	5.4%	3.7%	55.6%	1,639
South	28.8%	4.2%	4.0%	62.9%	1,252
Central	38.8%	4.4%	3.4%	53.4%	1,910

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	51.8%	20.1%	8.0%	20.0%	1,757
South	47.7%	21.1%	8.0%	23.2%	1,345
Central	55.0%	16.6%	6.9%	21.5%	1,989

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	17.7%	13.8%	16.0%	52.5%	1,702
South	16.8%	13.2%	16.8%	53.3%	1,307
Central	17.1%	14.9%	17.9%	50.1%	1,927

Physical fitness	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	67.4%	10.2%	4.9%	17.5%	1,780
South	69.4%	8.8%	4.4%	17.4%	1,387
Central	67.9%	8.3%	3.7%	20.1%	2,017

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	86.8%	4.7%	0.8%	7.7%	1,668
South	86.0%	5.3%	1.8%	6.9%	1,230
Central	79.9%	6.6%	1.7%	11.8%	1,848

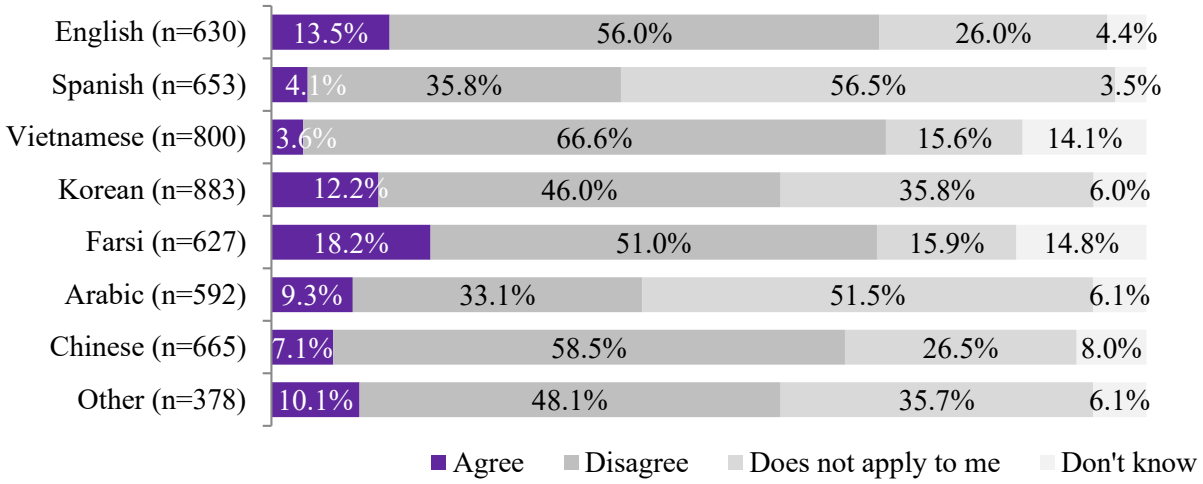
Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	76.2%	10.9%	3.8%	9.1%	1,694
South	81.0%	9.2%	3.3%	6.5%	1,263
Central	78.5%	9.2%	2.3%	9.9%	1,880

Visit a casino or gamble on the internet	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	1.5%	0.9%	4.5%	93.2%	1,726
South	4.0%	1.1%	3.7%	91.3%	1,327
Central	2.2%	1.7%	4.0%	92.1%	1,969

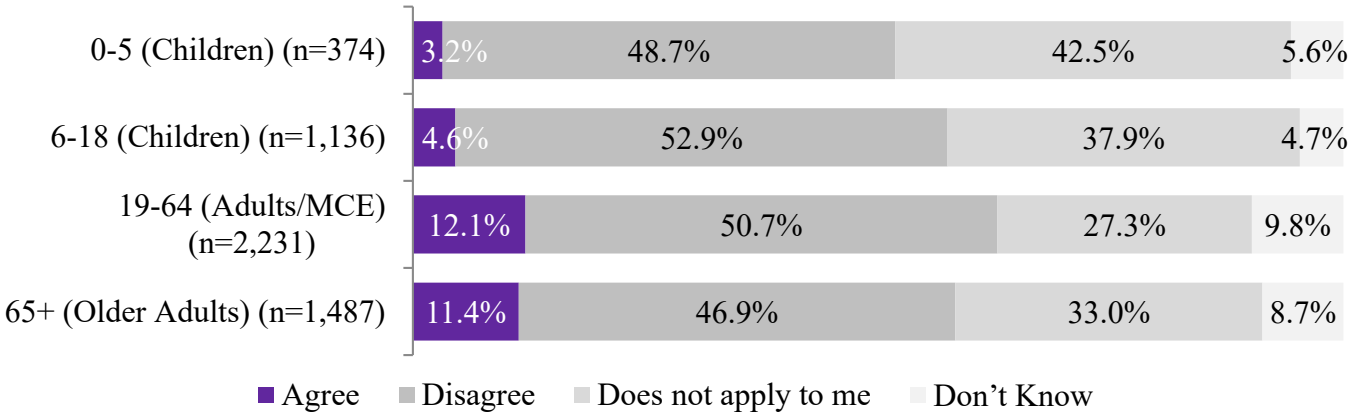
Exhibit 16. Feelings towards community and home enviroment:

Feeling lonely and isolated:

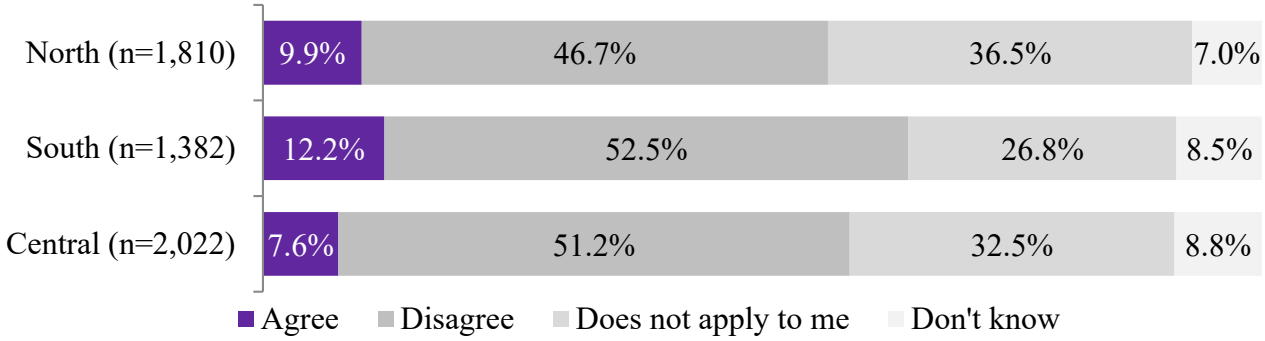
CalOptima language:



Age Category:

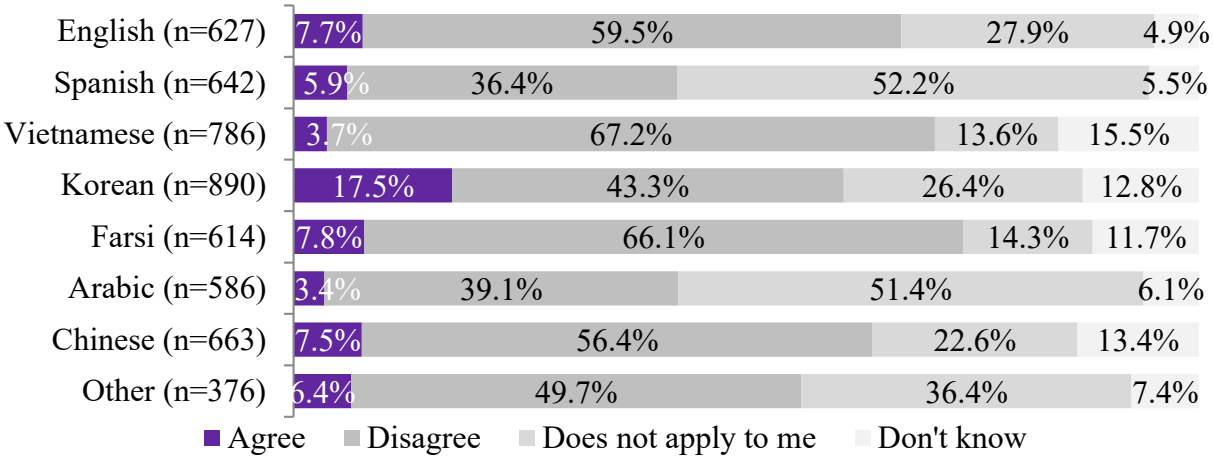


Region:

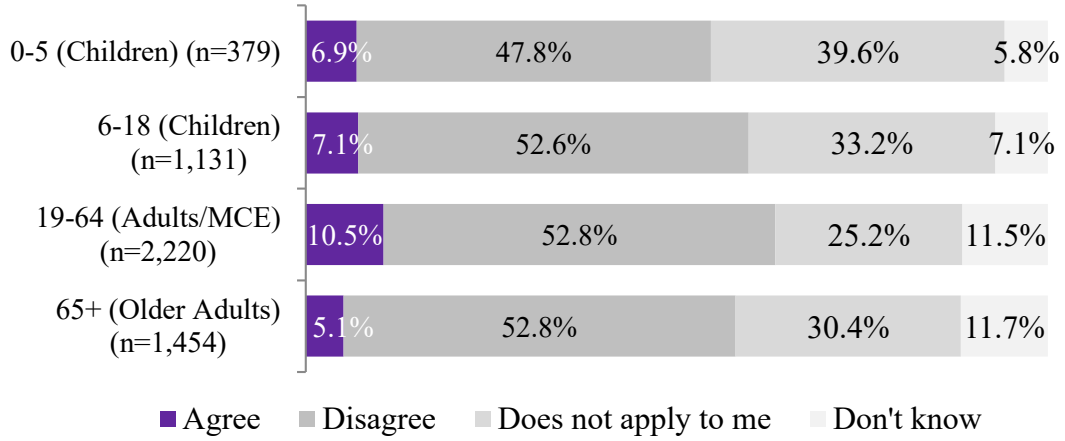


Feel not treated equally because of ethnic and culutral backgrounds:

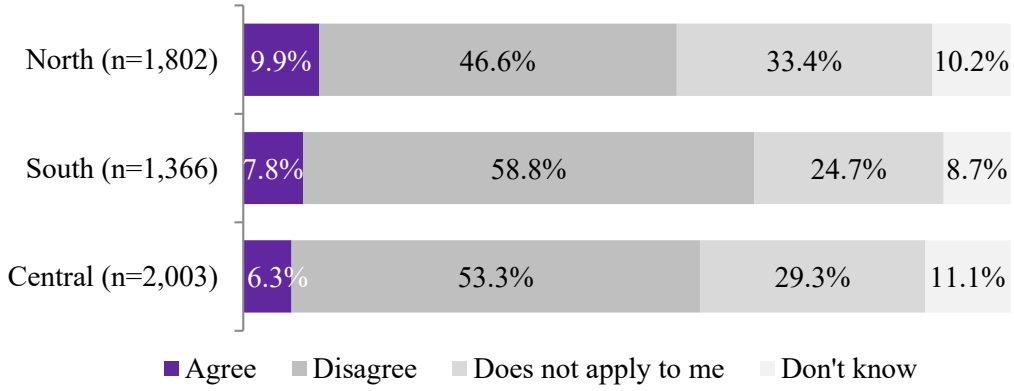
CalOptima language:



Age Category:

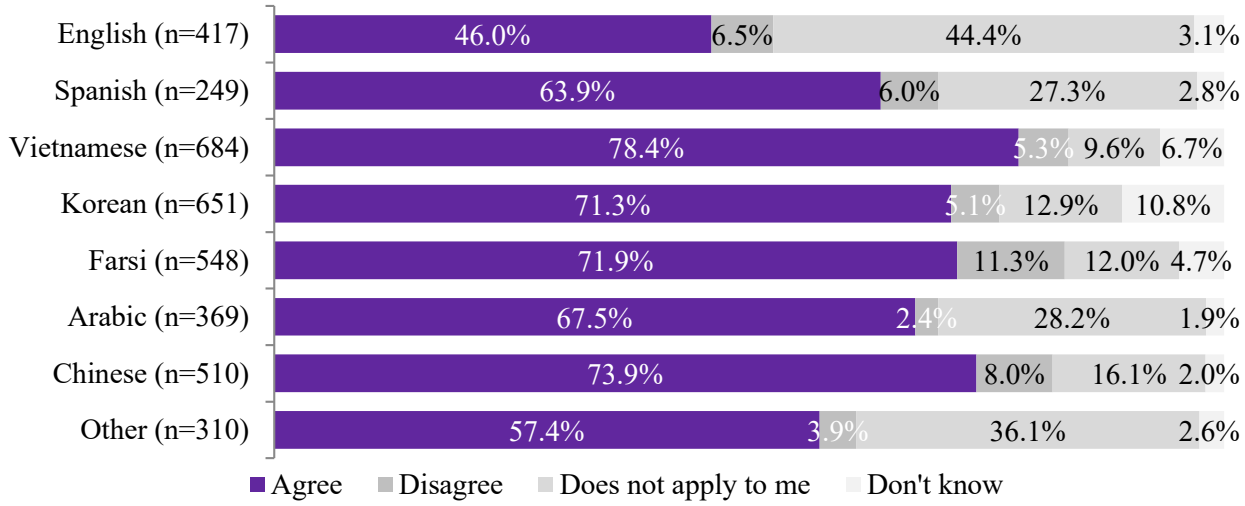


Region:



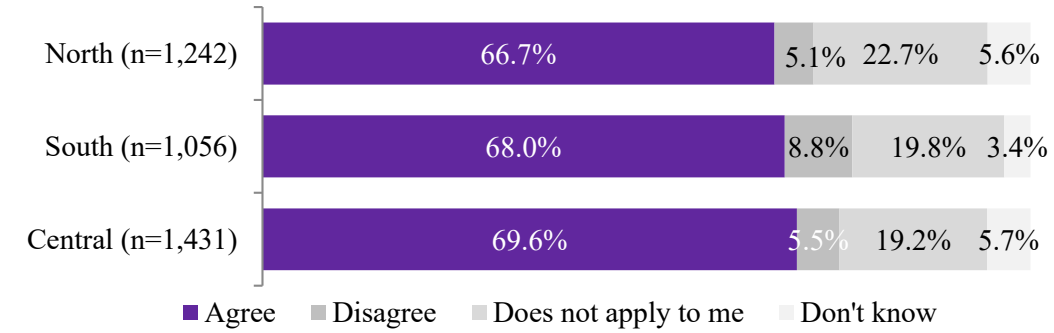
Feel child respects them as a parent[9]:

CalOptima language:



Age Category:

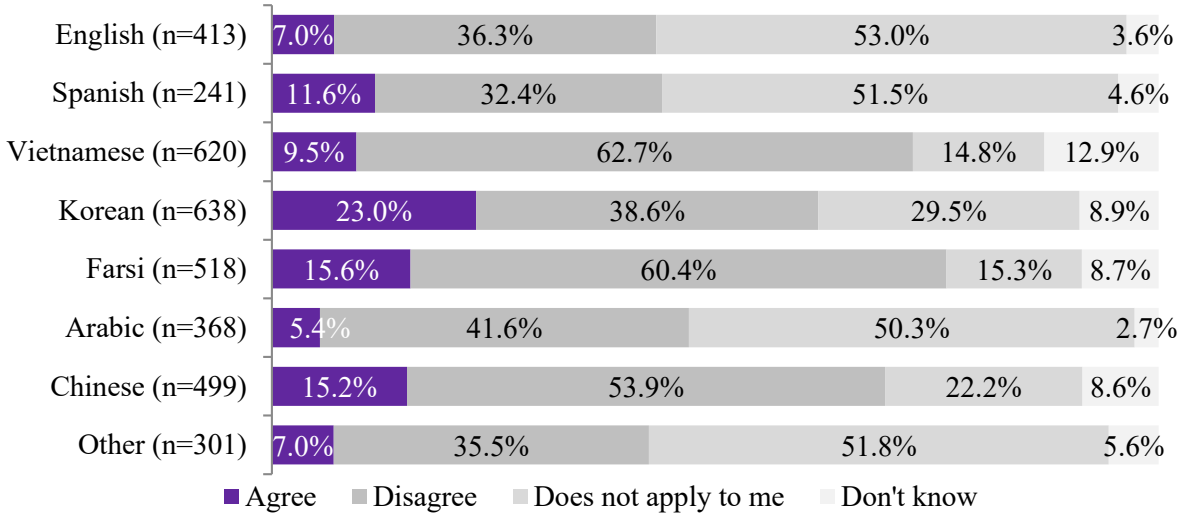
Region:



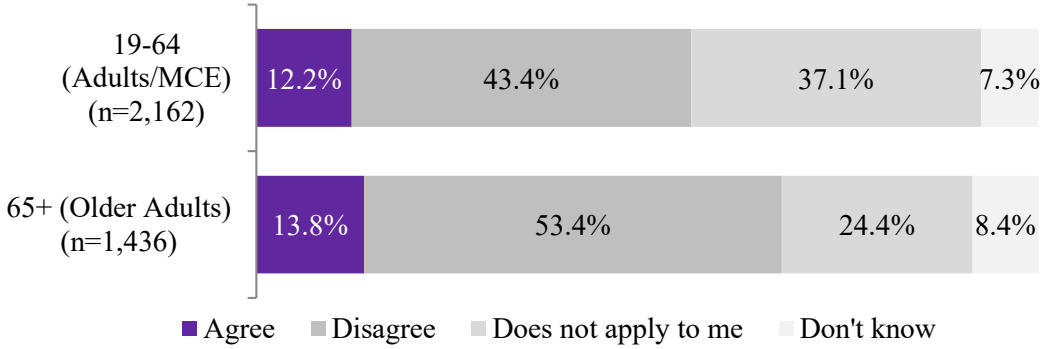
[9] Only reported those who are over 18 years old.

Feel child's attitudes and behavior conflict with cultural values[10]:

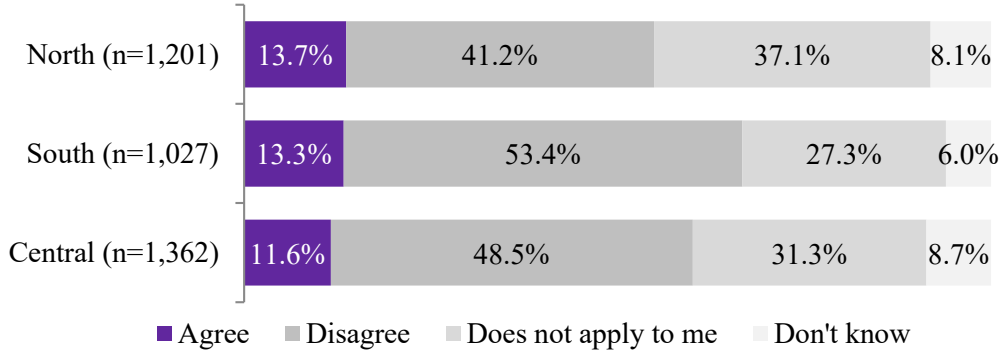
CalOptima language:



Age Category:



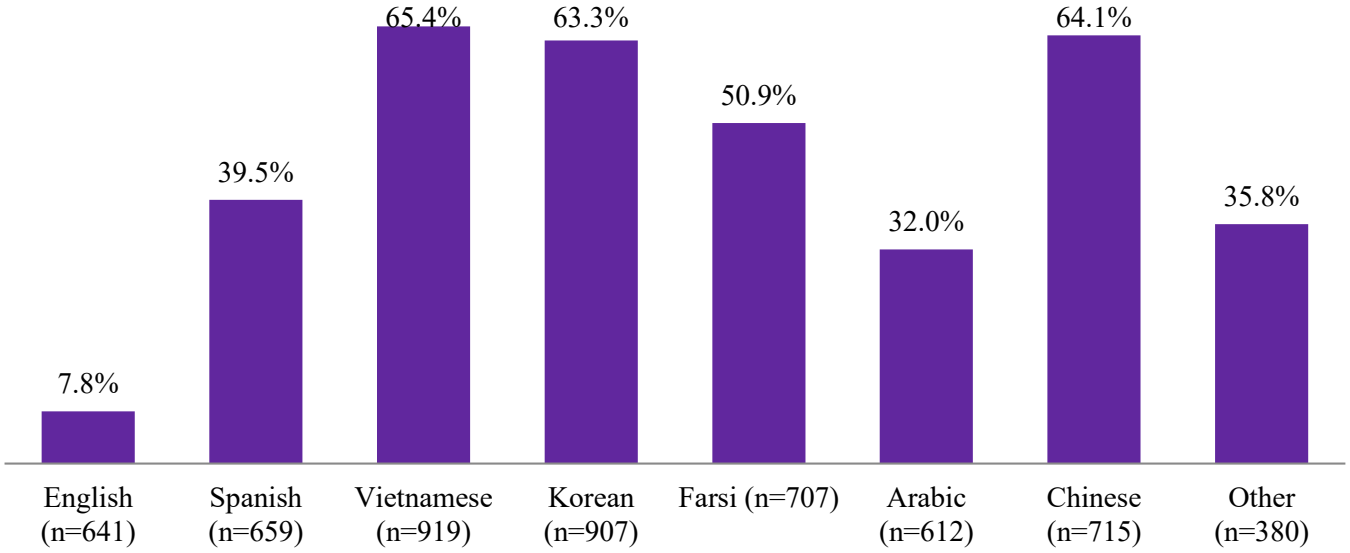
Region:



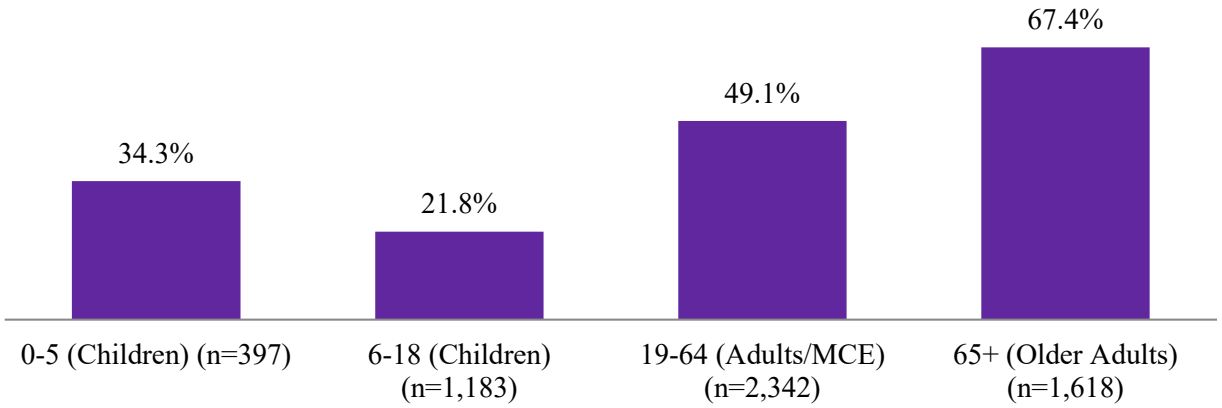
[10] Only reported those who are over 18 years old.

Exhibit 17. Members who reported that they speak English "not well":

CalOptima language:



Age Category:



Region:

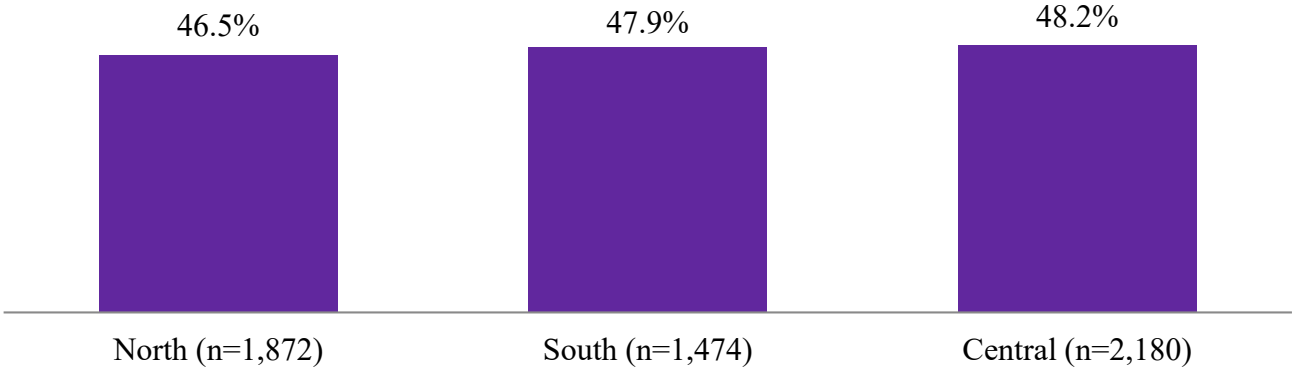


Exhibit 18. Employment status[11,12]

CalOptima language:

CalOptima language	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
English	36.7%	9.8%	7.2%	9.4%	13.4%	15.8%	20.4%	417
Spanish	21.7%	7.8%	11.6%	4.7%	21.3%	17.1%	28.3%	258
Vietnamese	32.1%	1.8%	12.1%	6.6%	24.4%	17.0%	20.0%	761
Korean	18.2%	11.6%	21.3%	6.9%	24.5%	10.0%	16.5%	638
Farsi	18.0%	4.4%	15.3%	7.6%	19.5%	26.5%	29.9%	616
Arabic	25.5%	4.2%	21.1%	9.4%	15.7%	11.9%	22.0%	427
Chinese	14.0%	3.8%	14.2%	4.9%	45.0%	6.8%	19.5%	529
Other	15.7%	3.4%	8.9%	3.7%	37.5%	10.2%	30.8%	325

Age Category:

Age Category	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
19-64 (Adults/MCE)	35.8%	8.3%	17.5%	10.9%	5.9%	17.6%	15.3%	2,370
65+ (Older Adults)	4.1%	1.7%	10.1%	0.7%	53.7%	10.5%	33.3%	1,601

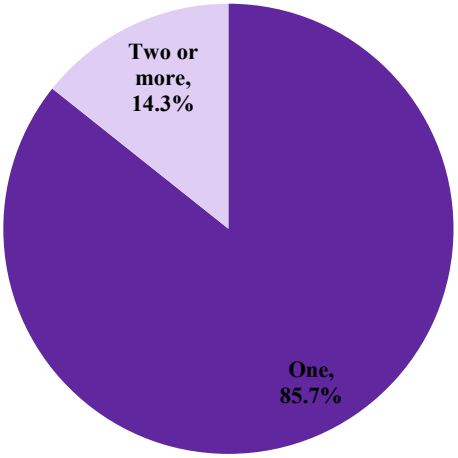
Region:

Region	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
North	24.0%	6.7%	15.9%	6.7%	23.6%	12.7%	22.5%	1,269
South	17.3%	6.6%	16.7%	7.3%	26.6%	17.3%	22.1%	1,129
Central	26.1%	4.0%	11.7%	6.5%	25.6%	14.7%	23.2%	1,561

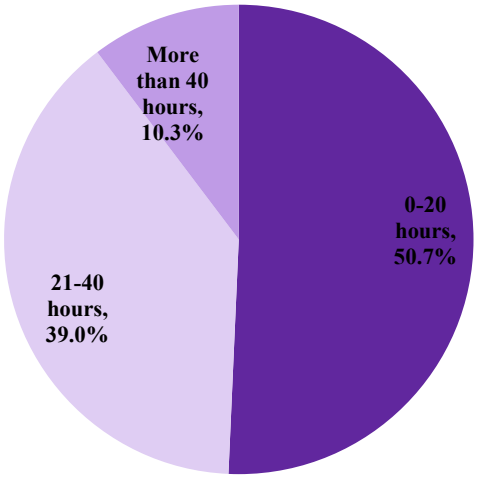
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]

Number of jobs members have

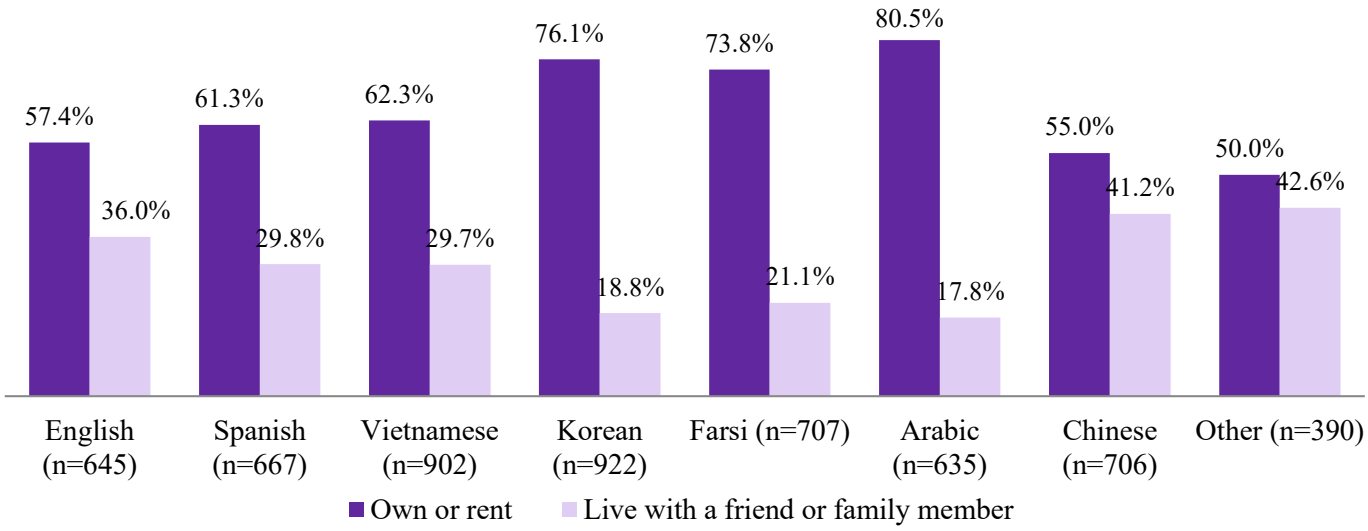


Number of hours that members work each week

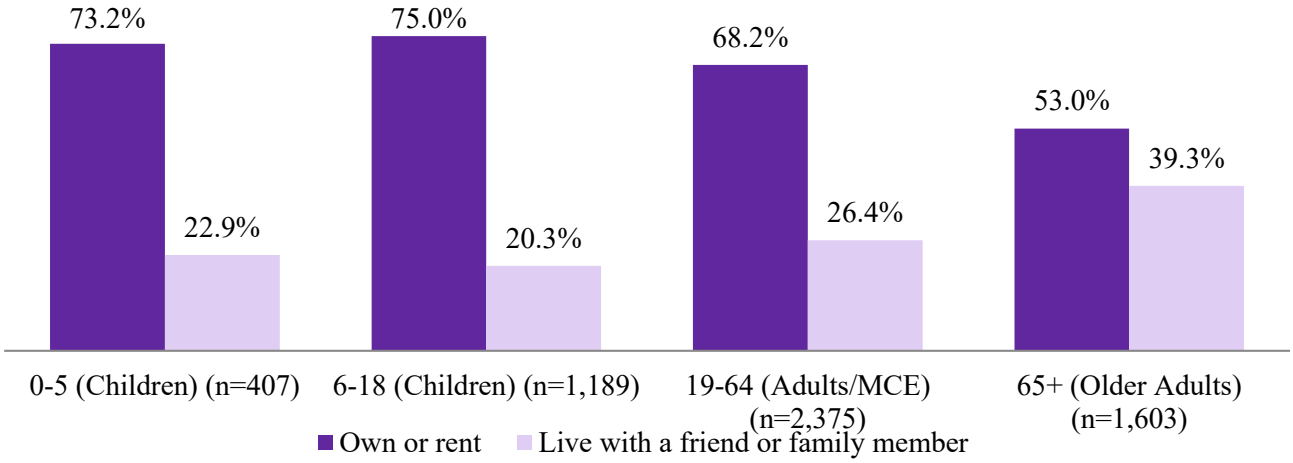


[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

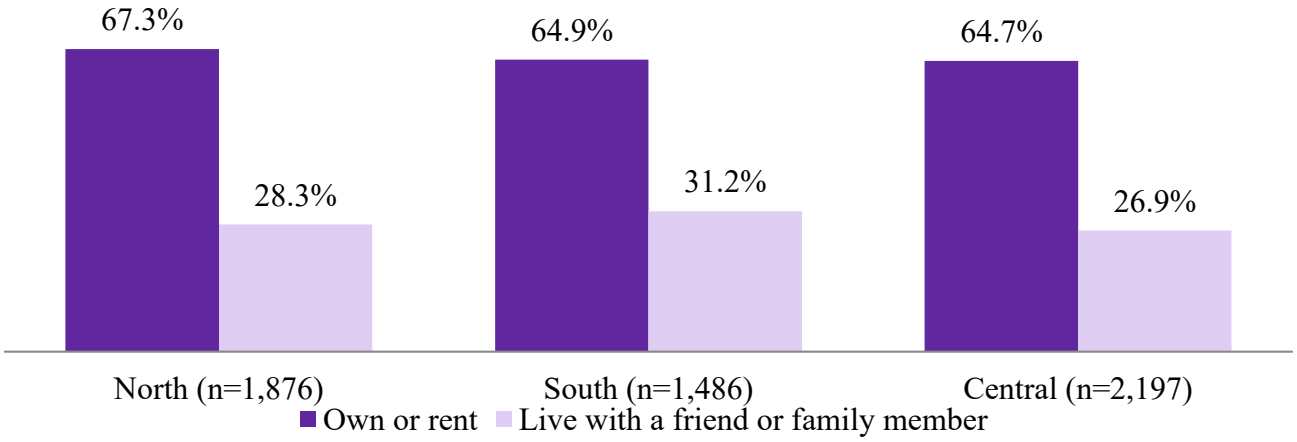
Exhibit 20. Members' living situation[14]



Age Category:



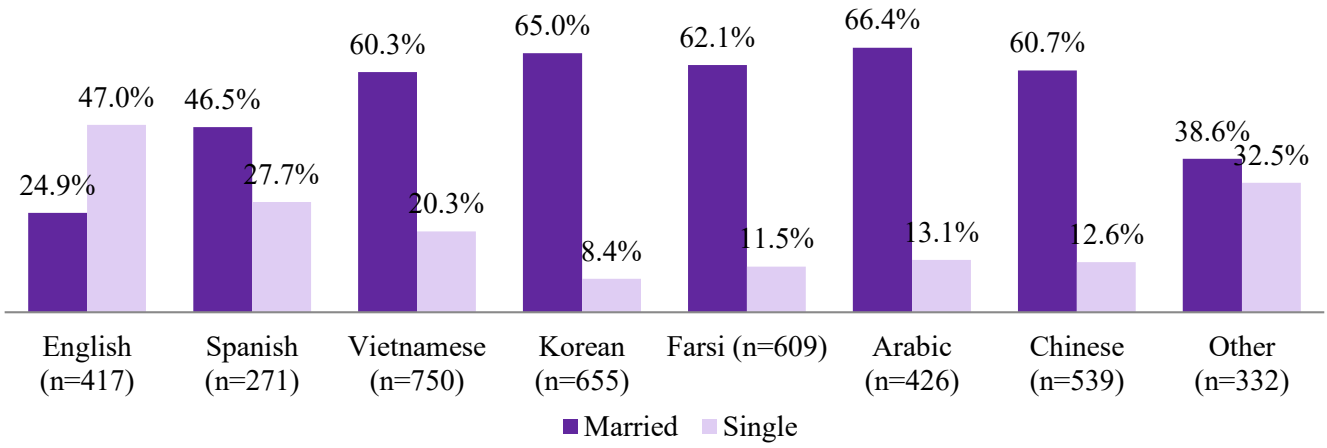
Region:



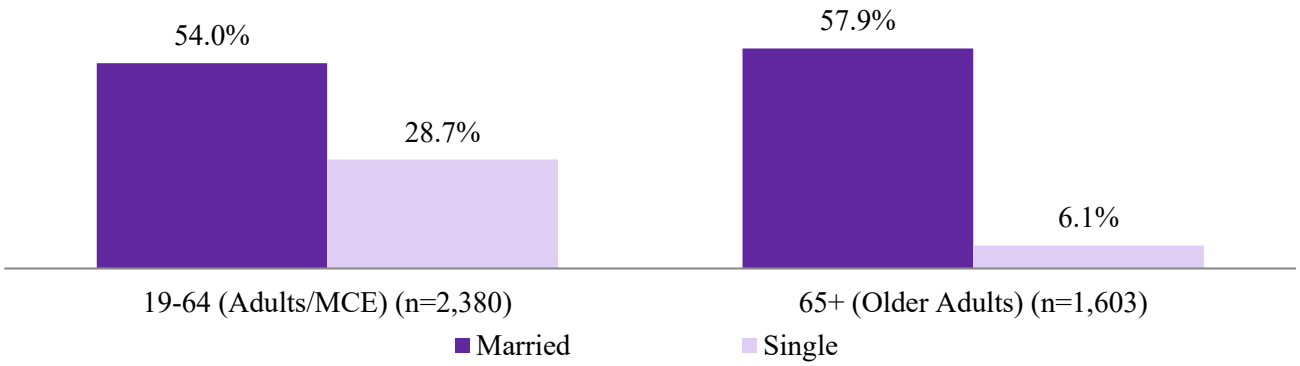
[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

Exhibit 21. Marital status of members[15],[16]

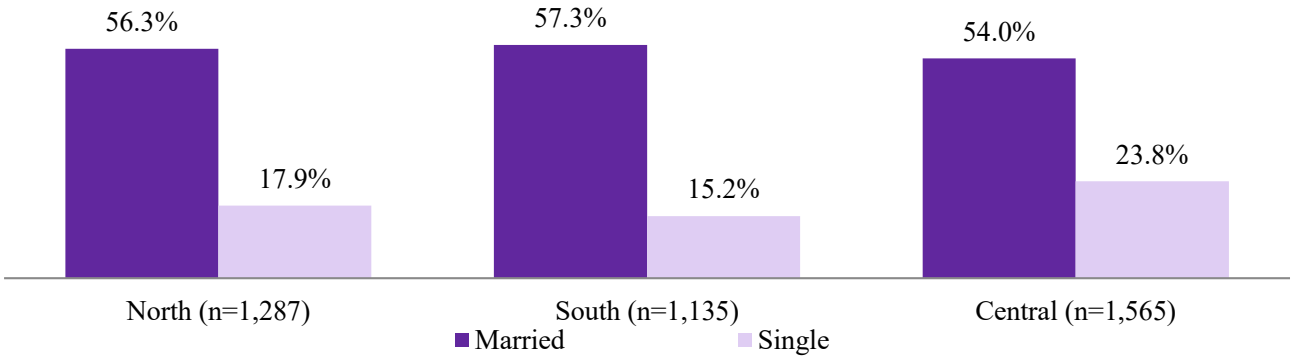
CalOptima language:



Age Category:



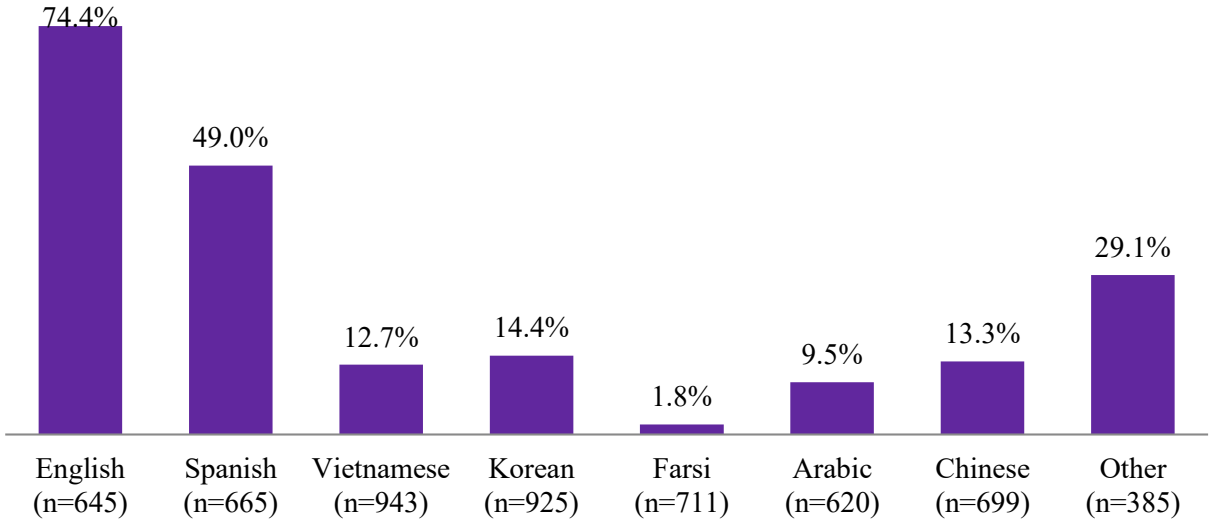
Region:



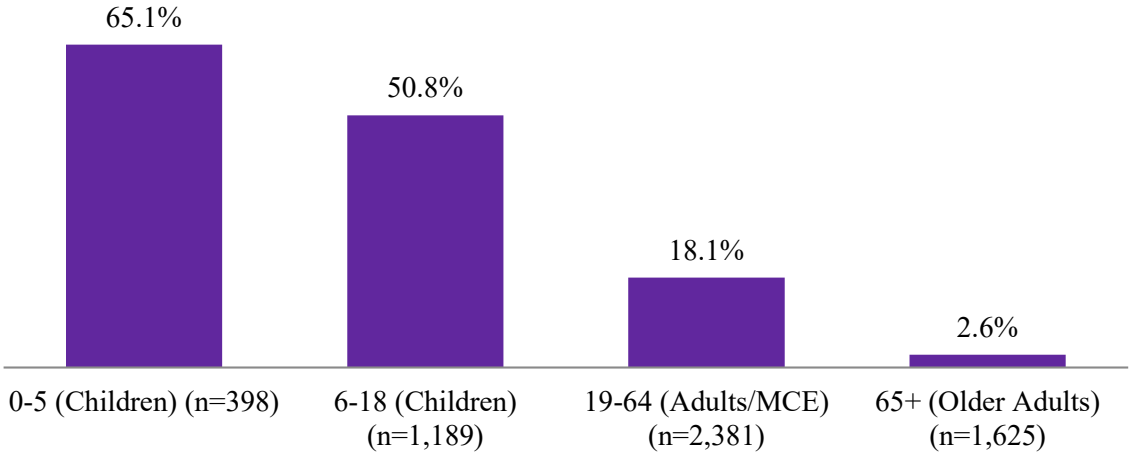
[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

Exhibit 22. Percent of members who were born in the United States:

CalOptima language:



Age Category:



Region:

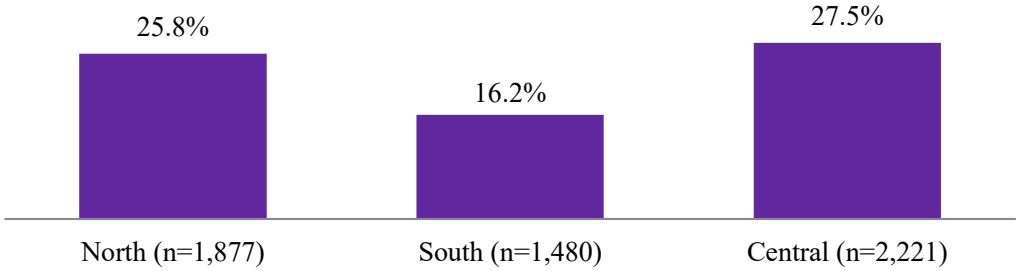
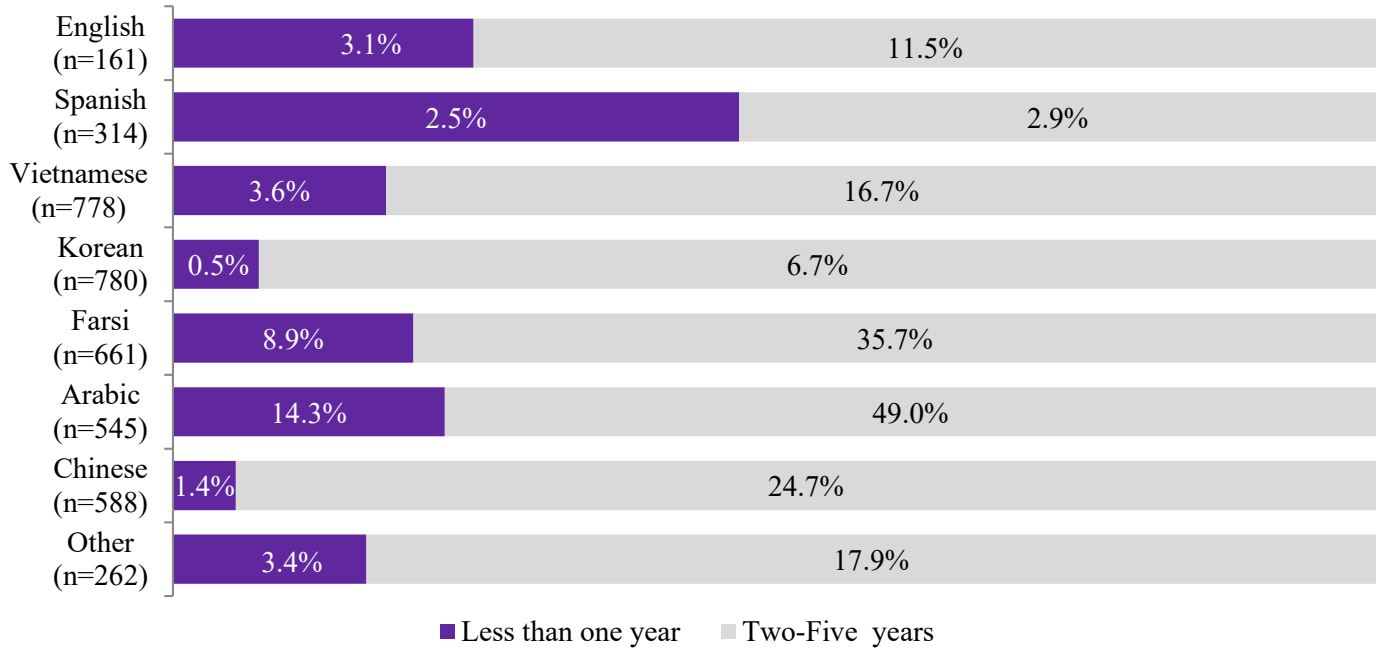
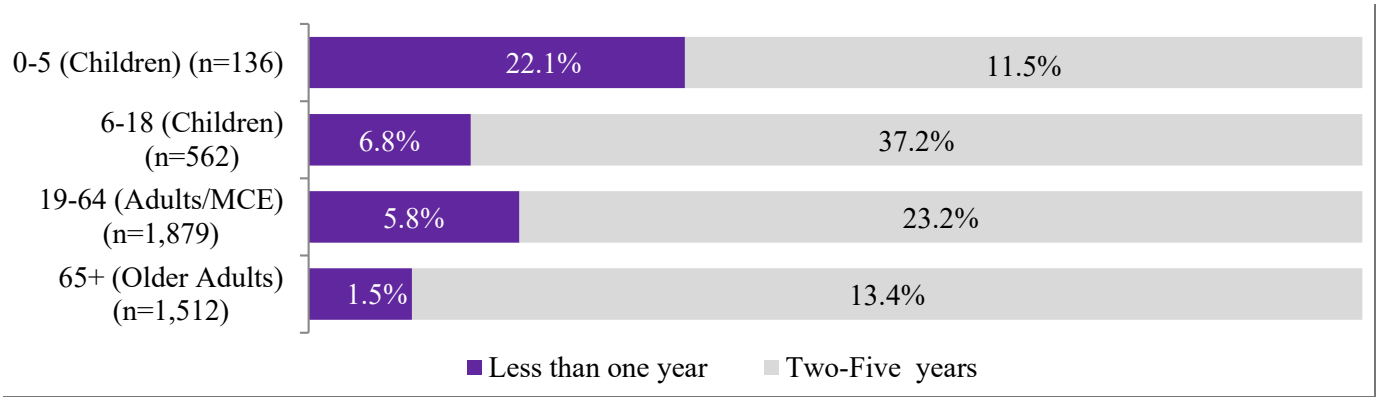


Exhibit 23. Length of time lived in the United States of those not born in the United States

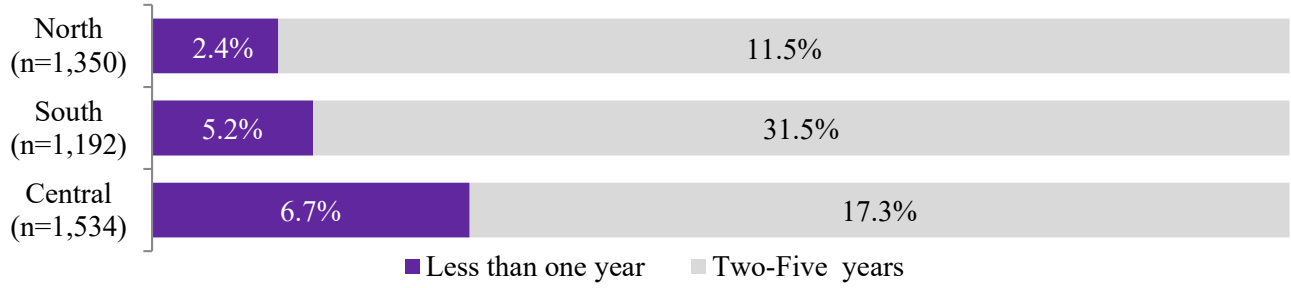
CalOptima language:



Age Category:



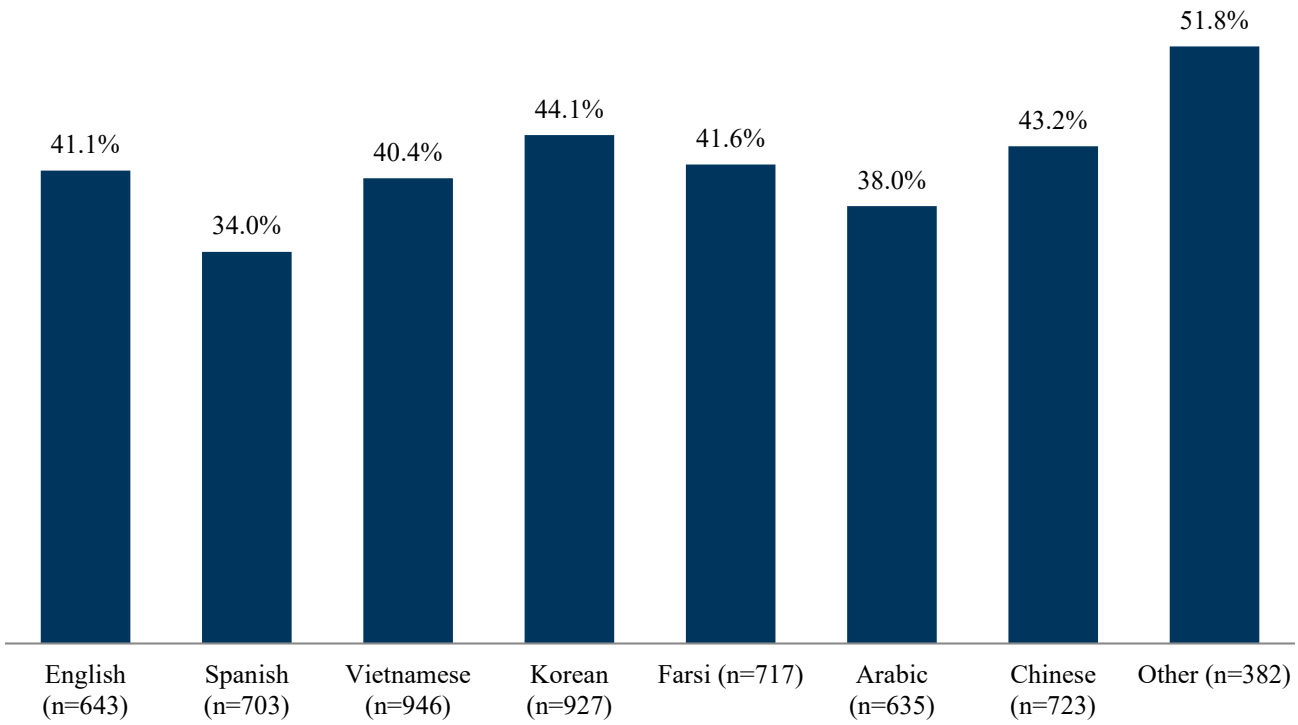
Region:



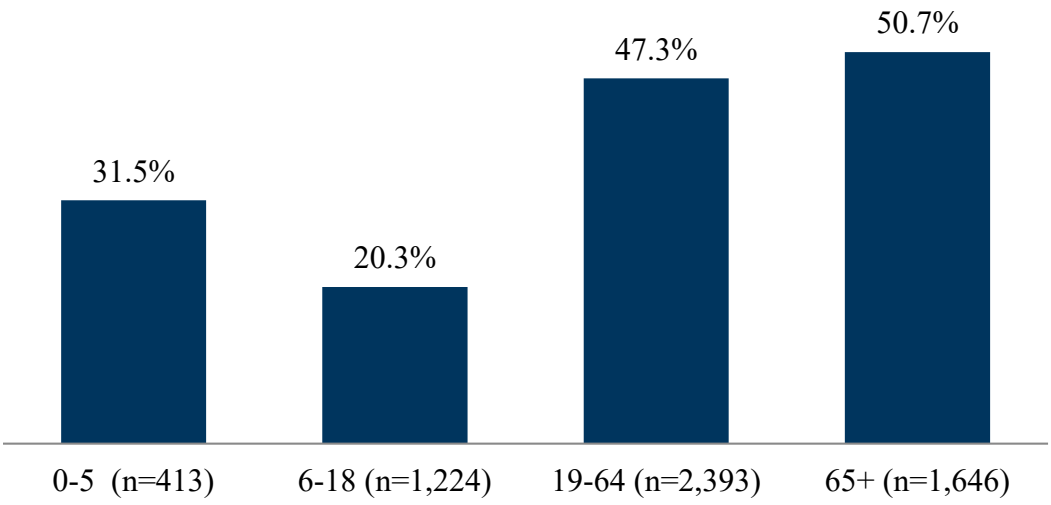
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:



Age Category:



Region:

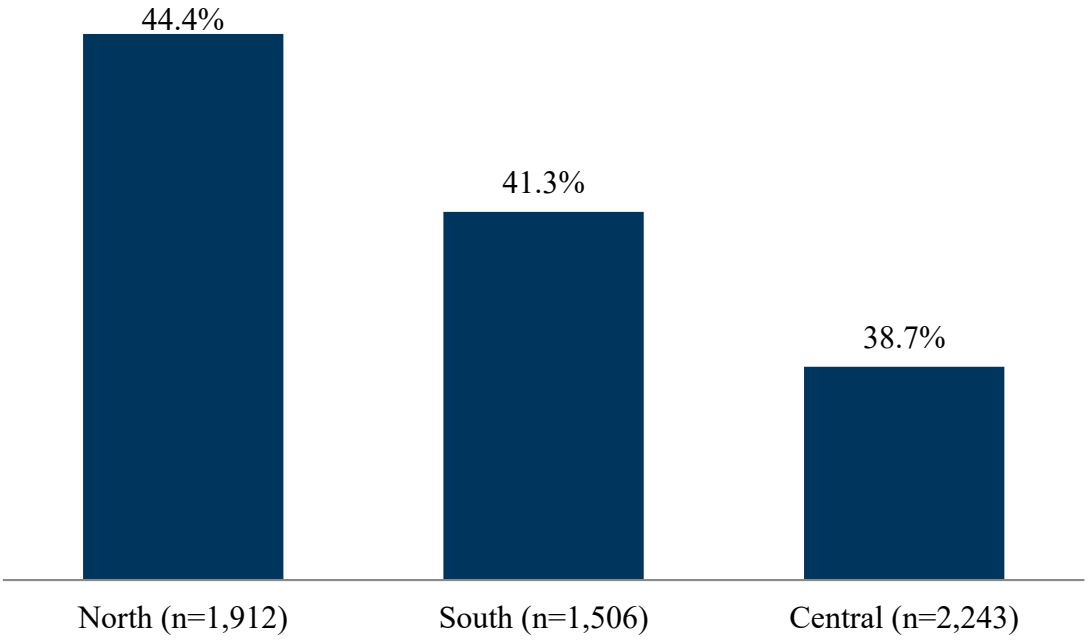


Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]

CalOptima Language:

CalOptima Language	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
English	43.8%	28.3%	6.6%	8.1%	258
Spanish	39.5%	17.6%	4.9%	12.2%	205
Vietnamese	26.6%	15.7%	5.0%	13.0%	338
Korean	64.2%	35.3%	4.1%	5.1%	391
Farsi	53.1%	23.8%	5.1%	8.1%	273
Arabic	62.9%	16.3%	1.8%	11.8%	221
Chinese	40.6%	21.1%	7.7%	14.1%	298
Other	33.1%	23.2%	5.5%	12.7%	181

Age Category:

CalOptima Age Category	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
0-5 (Children)	19.5%	23.7%	3.4%	14.4%	118
6-18 (Children)	34.7%	25.6%	1.8%	15.1%	219
19-64 (Adults/MCE)	52.7%	27.3%	4.1%	9.0%	1,062
65+ (Older Adults)	19.5%	23.7%	3.4%	14.4%	766

[17] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

[18] Only reported those who have not seen a dentist within the past 12 months.

Region:

CalOptima Region	Cost	Don't have/know dentist	No transportation	Don't know	n
	%	%	%	%	
North	48.9%	22.3%	5.5%	9.9%	798
South	51.6%	28.2%	4.6%	9.4%	585
Central	39.2%	20.9%	5.2%	11.3%	776

Exhibit 26. Days per week member had at least one drink of alcoholic beverage during the past 30 days [19]

CalOptima language:

CalOptima Language	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
English	71.7%	19.6%	4.0%	2.0%	2.7%	403
Spanish	83.5%	10.4%	1.3%	0.9%	3.9%	230
Vietnamese	81.3%	10.7%	1.9%	1.8%	4.3%	738
Korean	77.1%	15.5%	3.0%	1.5%	2.9%	593
Farsi	74.8%	19.3%	1.2%	0.2%	4.4%	497
Arabic	87.6%	4.5%	0.6%	0.8%	6.5%	355
Chinese	84.9%	8.0%	1.2%	0.6%	5.4%	503
Other	83.7%	7.7%	1.6%	1.3%	5.8%	312

Age Category:

CalOptima Age Category	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
19-64 (Adults/MCE)	78.7%	13.0%	2.3%	1.0%	4.9%	2,163
65+ (Older Adults)	82.2%	11.4%	1.4%	1.4%	3.5%	1,468

[19] Only reported those who are 18 years or older.

Region:

CalOptima Region	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
North	81.1%	11.9%	1.2%	1.5%	4.3%	1,156
South	79.5%	14.5%	1.8%	0.7%	3.5%	1,000
Central	79.7%	11.4%	2.5%	1.3%	5.1%	1,465

January 2018

CalOptima Member Survey Data Book:

Weighted Population Estimates

harder + co | community research

CalOptima A Public Agency Better. Together.

Navigating the Healthcare System

Exhibit 27. Percent who report at least one person as their doctor (n=5,749)

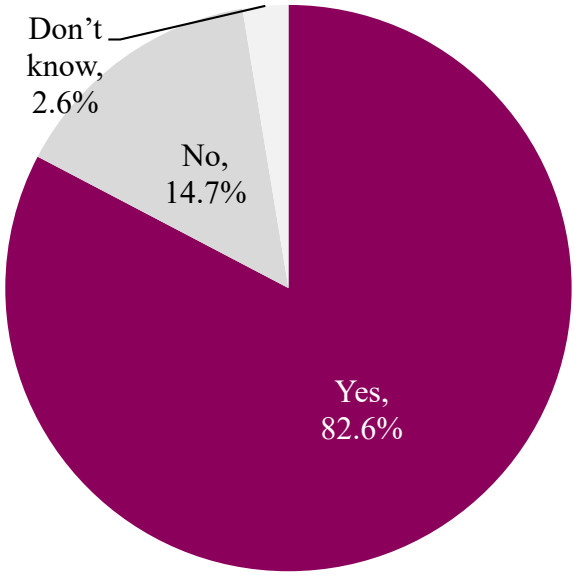


Exhibit 28. Where respondents go to see their doctor (n=5,743)

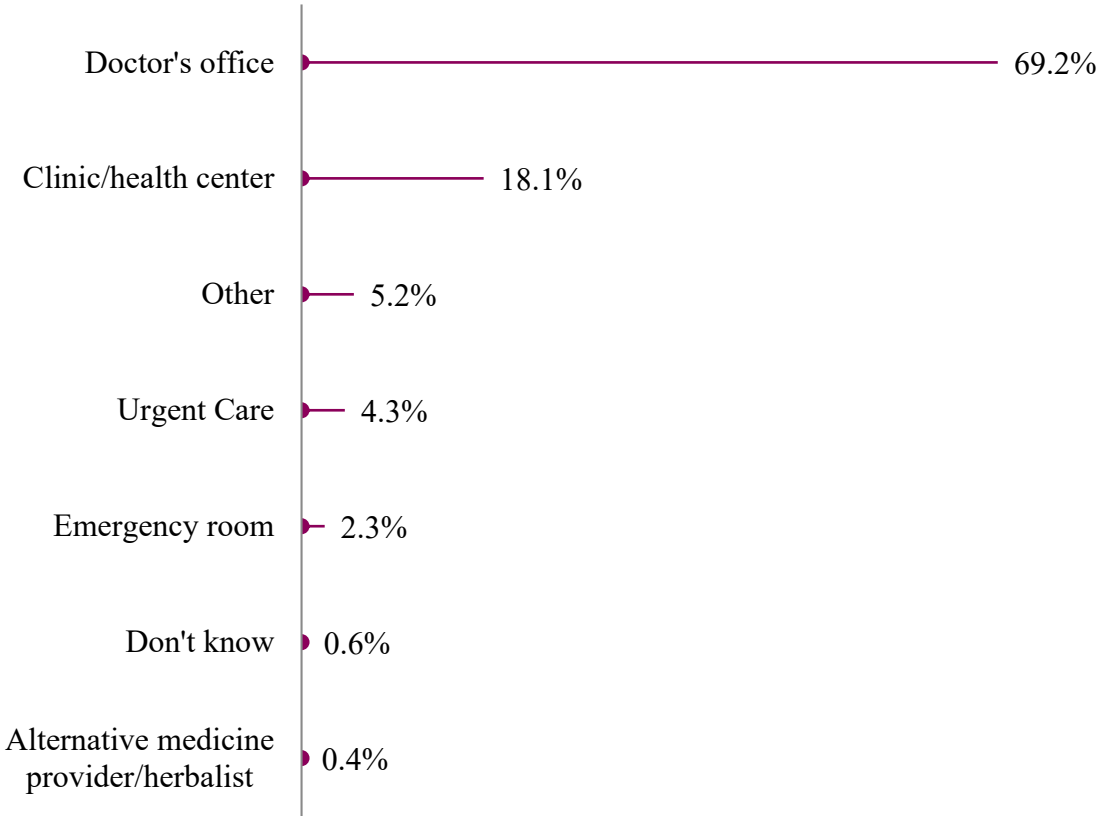


Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

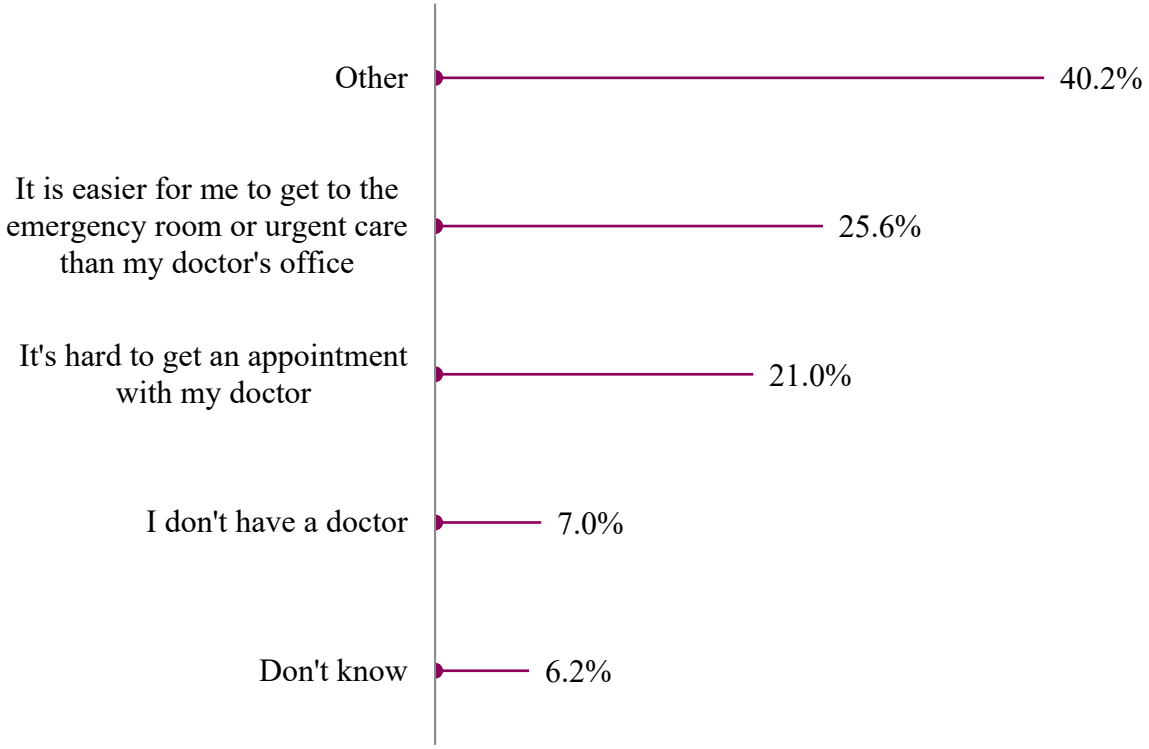


Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]

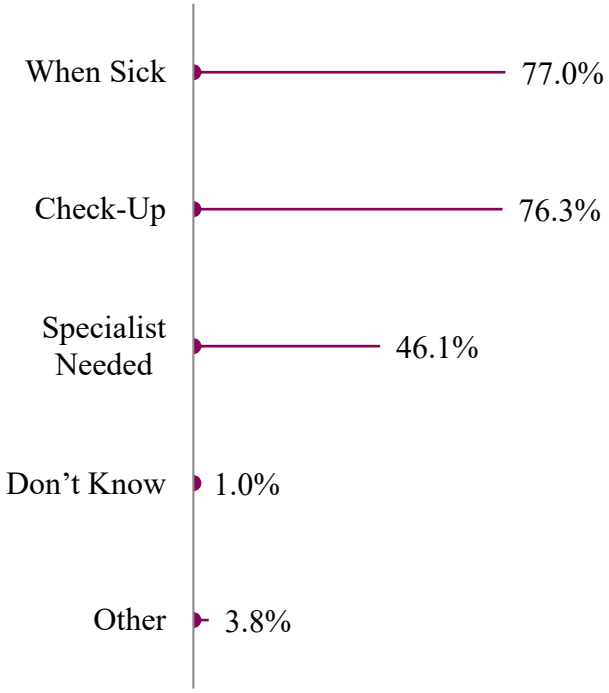
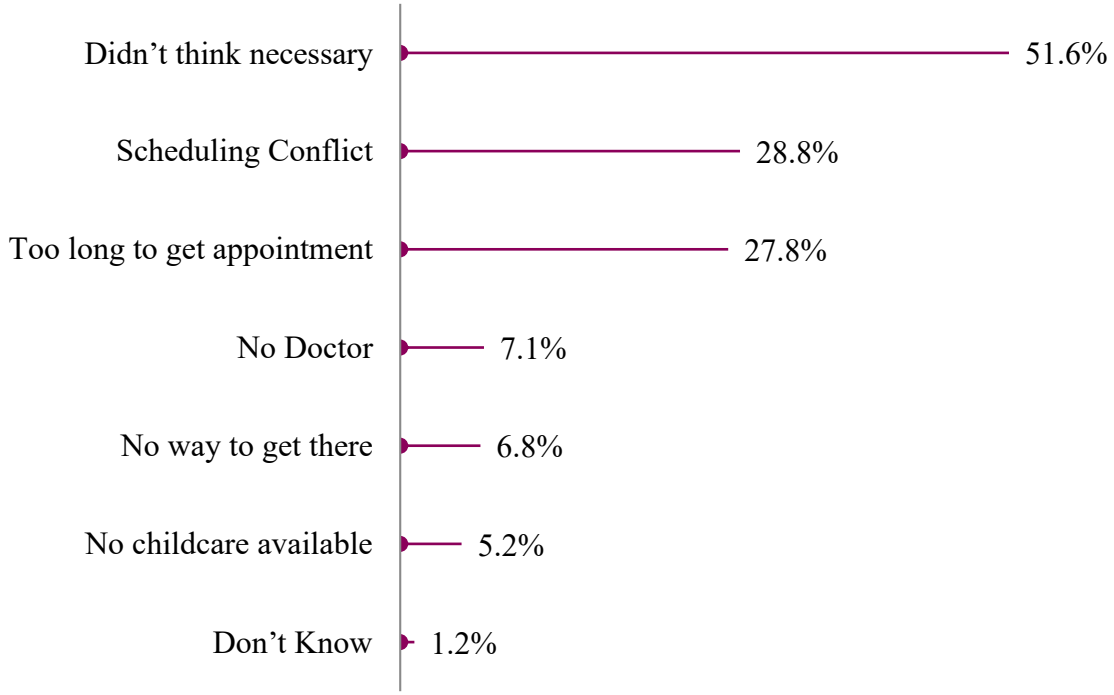


Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]



[20] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[21] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 32. When do members make an appointment to see a specialist (n=5,590)[22]

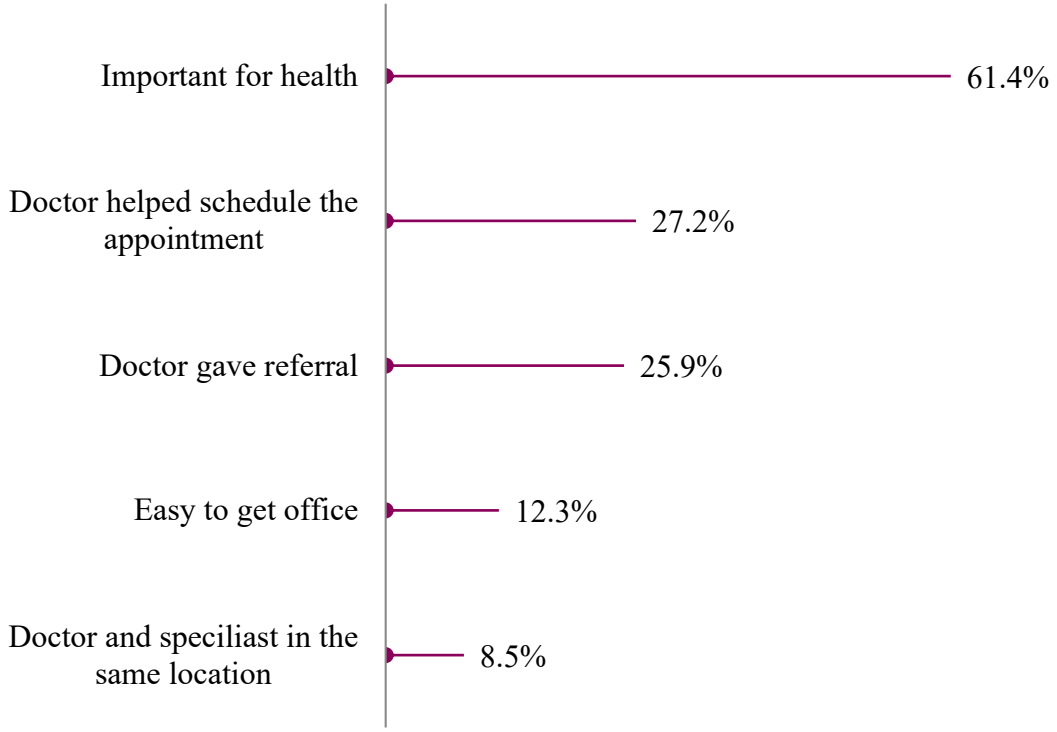
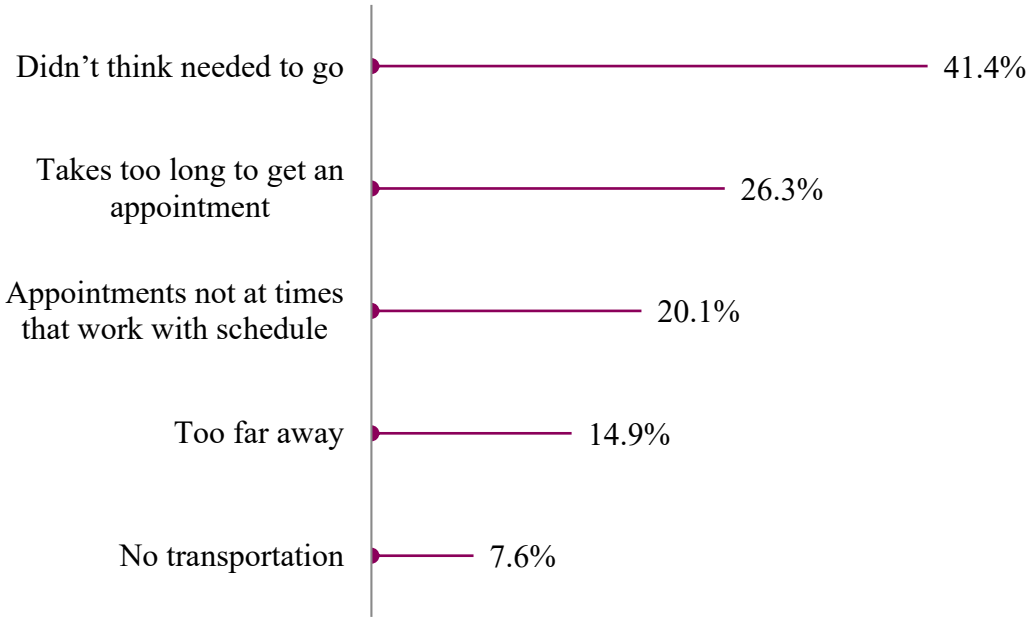
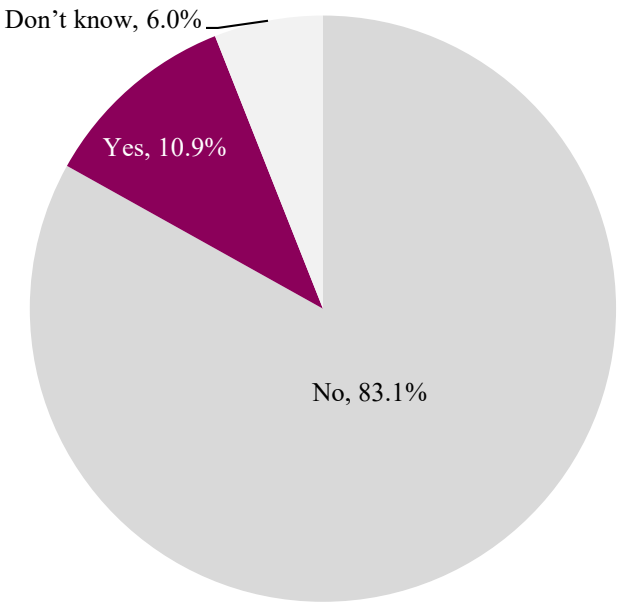


Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]



[22] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[23] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 34. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor (n=4,955)



Social and Emotional Well-Being

Exhibit 35. Percent of members who indicated they needed to see a mental health specialist (n=5,723)

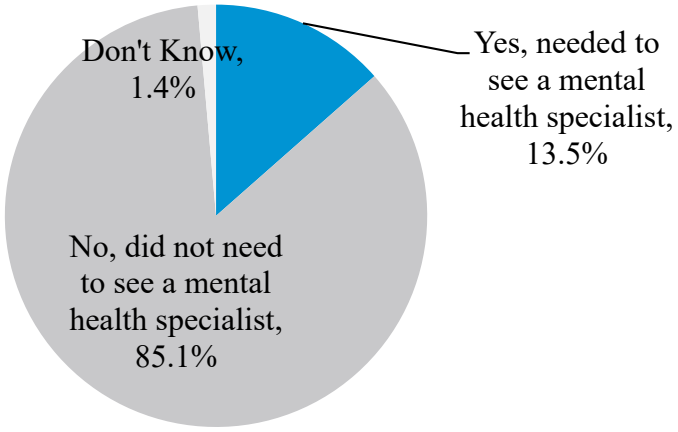


Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)

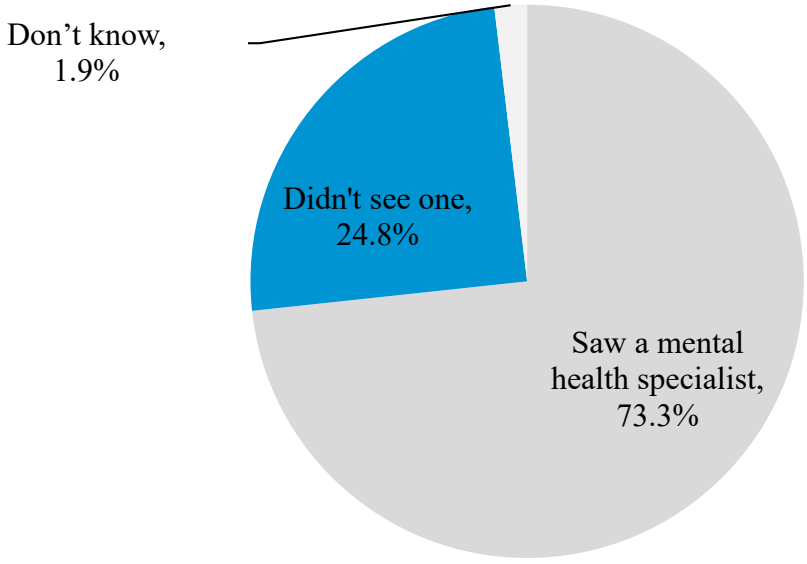


Exhibit 37. Reasons why members didn't see mental health specialist[24]

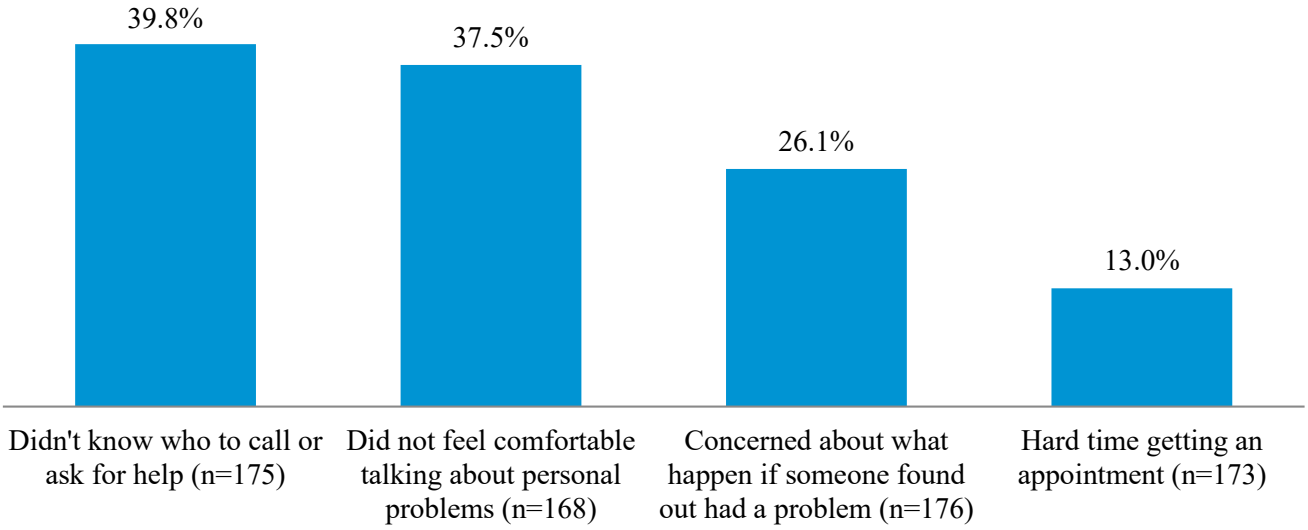
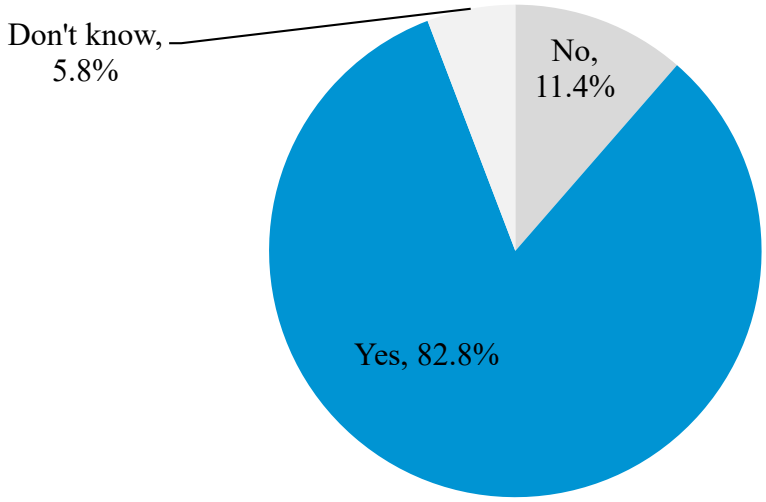


Exhibit 38. Percent of members who can share their worries with family members (n=5,670)



[24] Among those who indicated that they needed to see a mental health specialist but did not see one.

Social Determinants of Health

Exhibit 39. Percent of members who needed help with basic needs in the past 6 months:

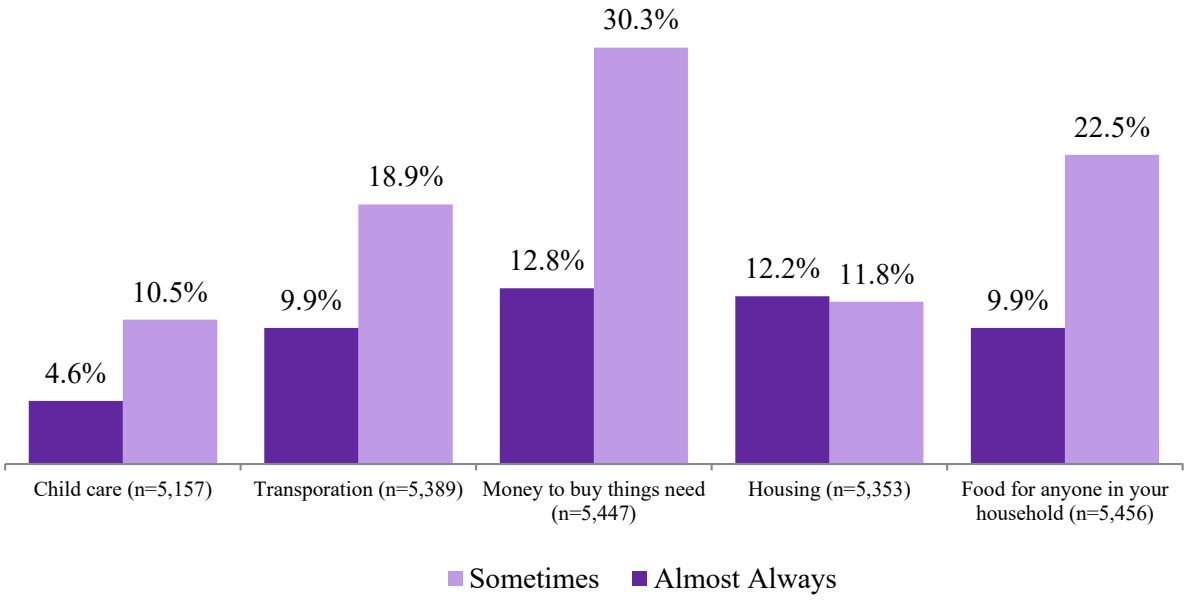


Exhibit 41. Percent of members who receive public benefits (n=5,117):

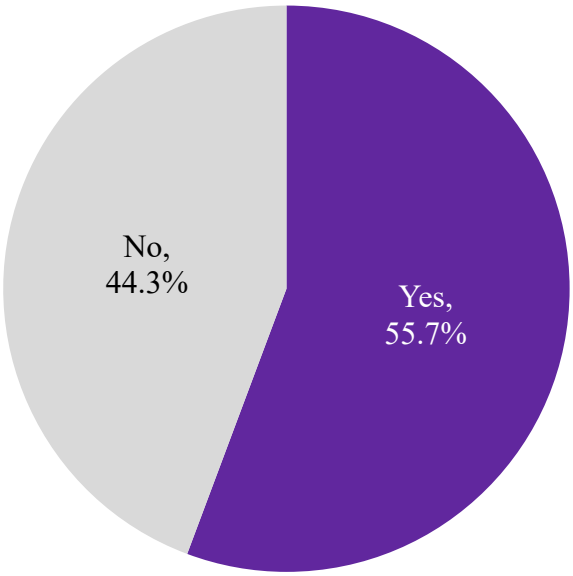
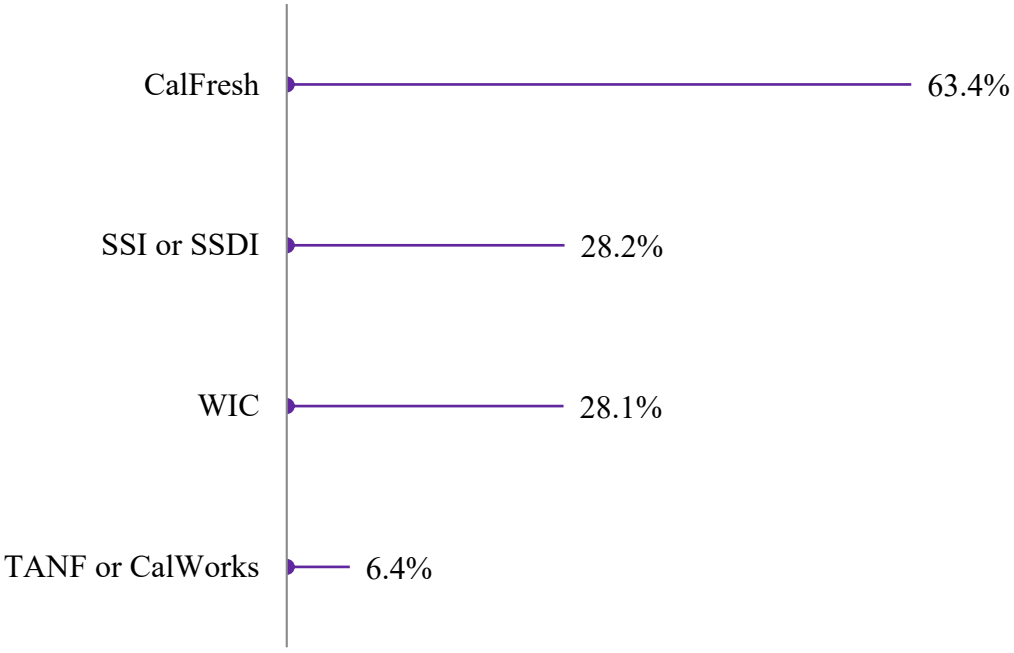


Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:

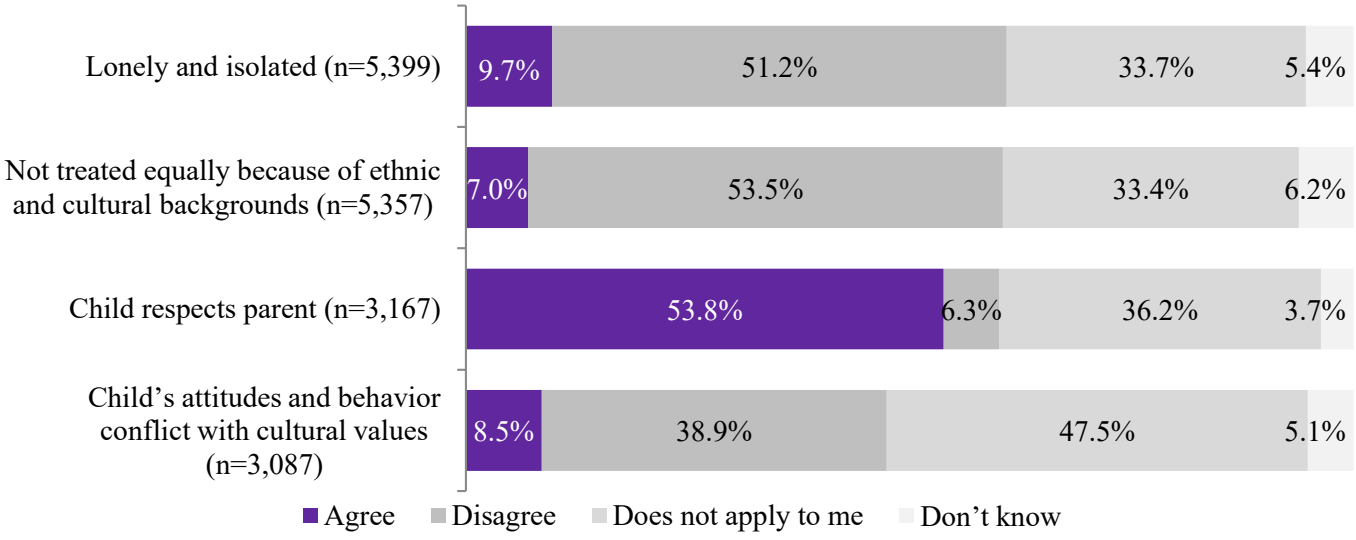


[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

Exhibit 43. Personal activities members participant in:

	Once a week	Once a month	Once in the last 6 months	Never	n
Care for a family member	36.2%	5.6%	5.1%	53.1%	5,209
Fun with others	61.9%	17.0%	6.6%	14.6%	5,396
Volunteer or Charity	16.4%	14.2%	17.3%	52.1%	5,288
Physical fitness	68.4%	10.2%	4.8%	16.7%	5,393
Attend religious centers	48.7%	11.1%	10.8%	29.4%	5,470
Get enough sleep	83.5%	5.8%	1.1%	9.6%	5,119
Enough time for self	77.4%	10.6%	3.1%	8.8%	5,209
Enough time for family	81.5%	8.5%	3.1%	6.9%	5,274
Gambling activities	0.9%	0.8%	4.8%	93.5%	5,378

Exhibit 44. Feelings towards community and home enviroment[26]:



[26] Only reported for those over 18 years old for "Child respects parent" and "Child's attitudes and behavior conflict with cultural values."

Exhibit 45. How well members speak English (n=5,549)

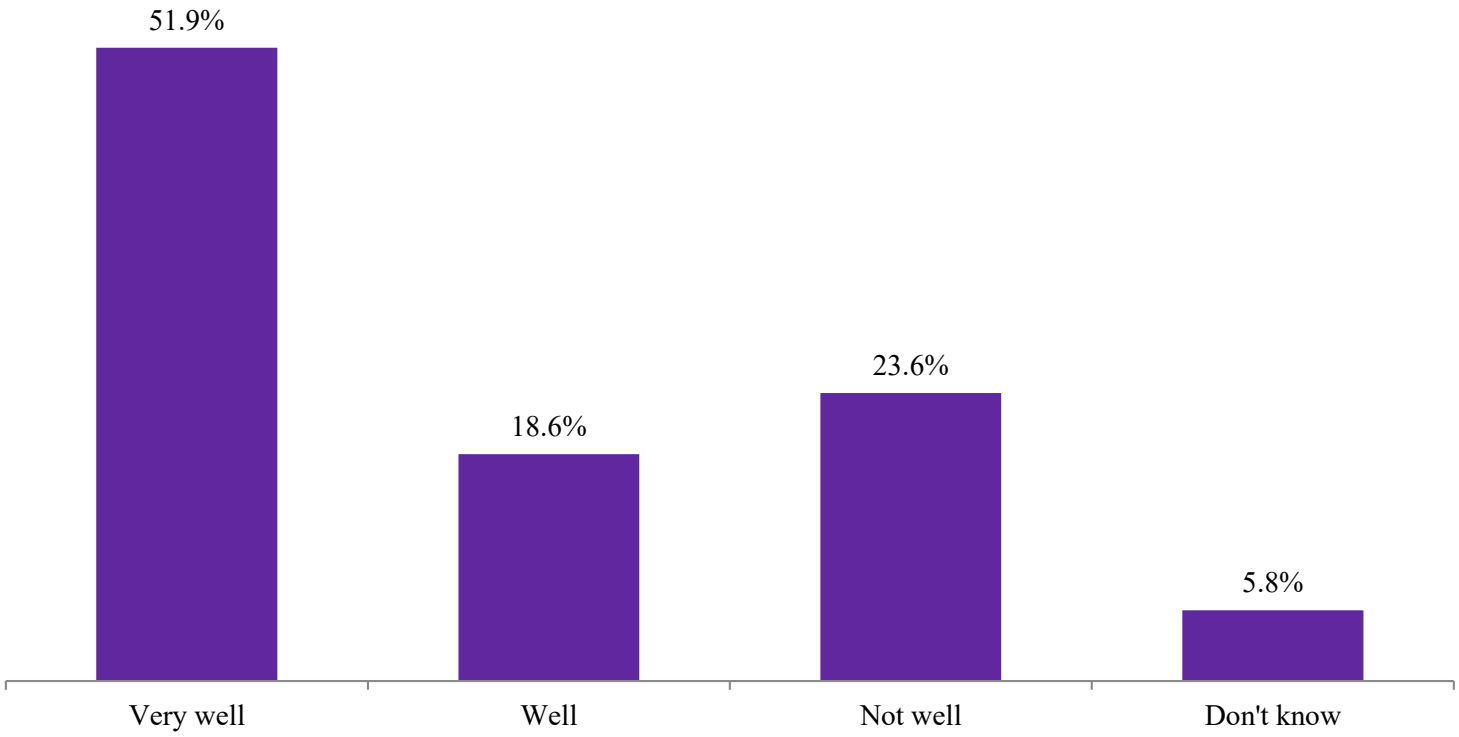


Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]

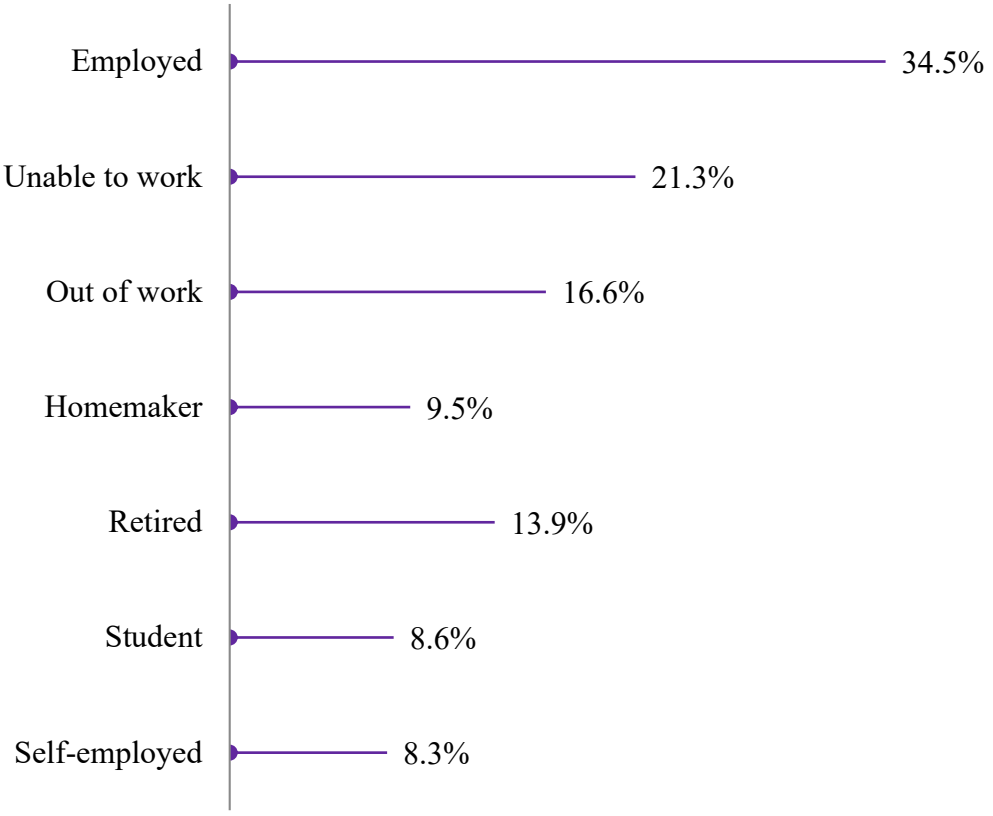
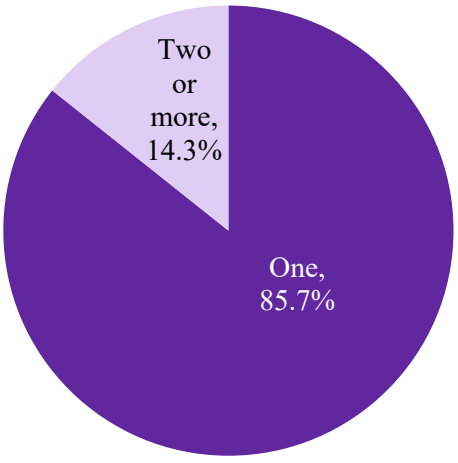
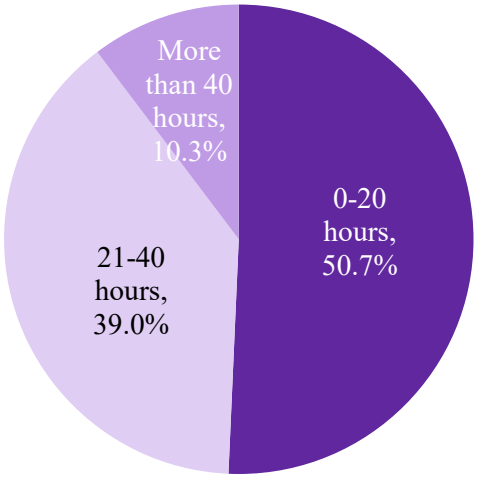


Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]

Number of jobs members have



Number of hours that members work each week



[27] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[28] Only reported the members who are over 18 years old.
[29] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

Exhibit 48. Members' living situation (n=5,590)

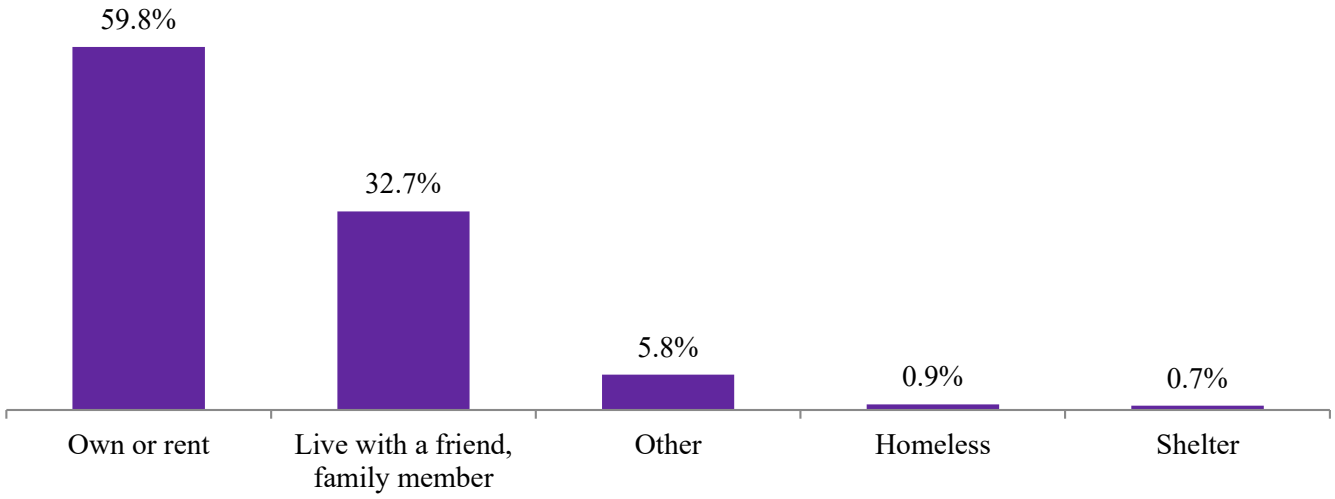
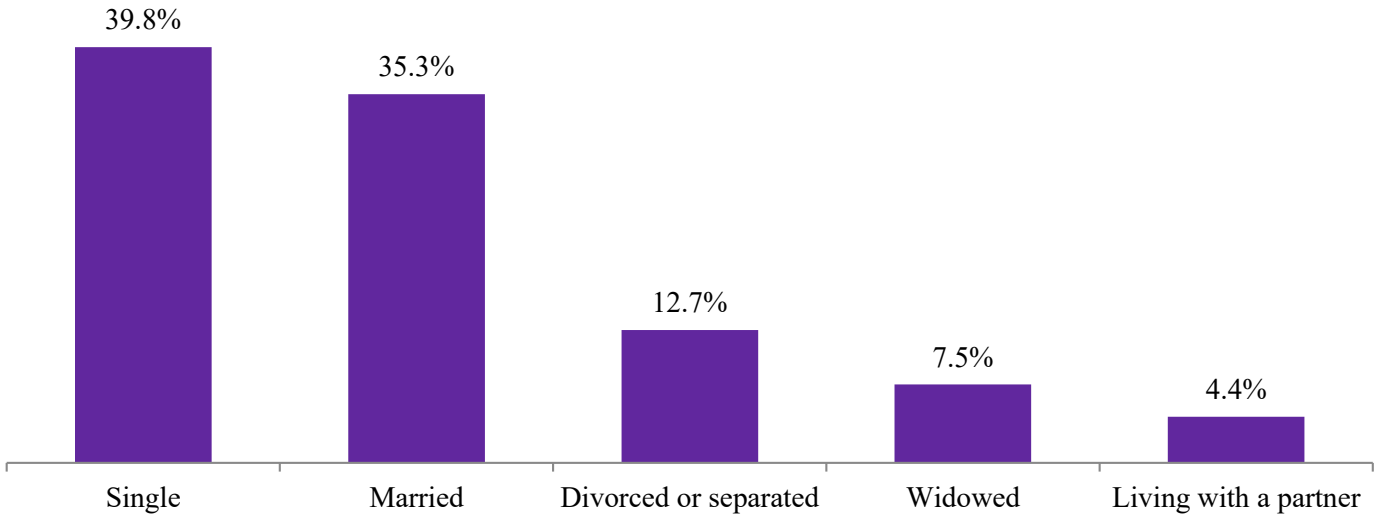


Exhibit 49. Marital status of members (n=3,271)[30]



[30] Only reported those who are over 18 years old.

Exhibit 50. Percent of members who were born in the United States (n=5,599)

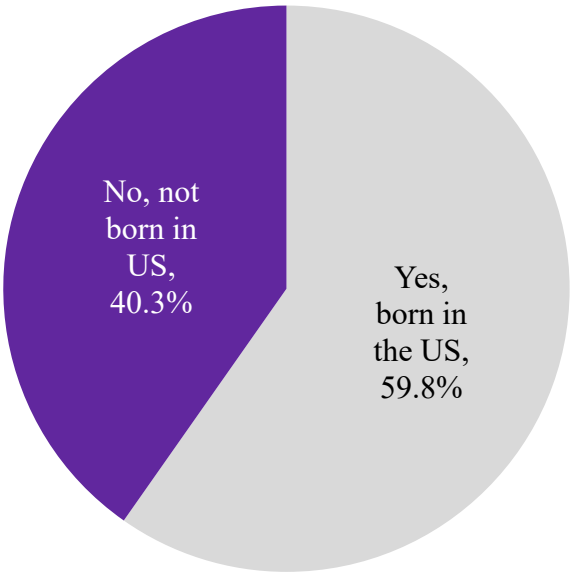
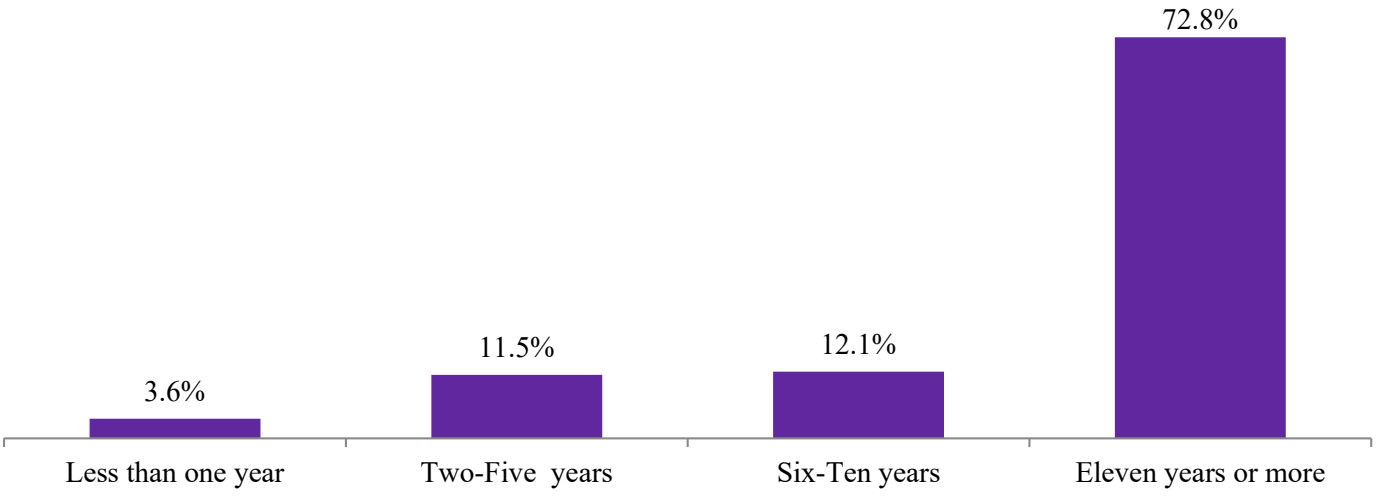


Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]



[31] Of those who were born outside of the U.S.

Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

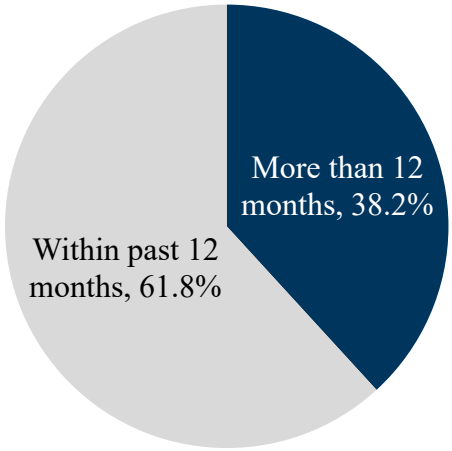
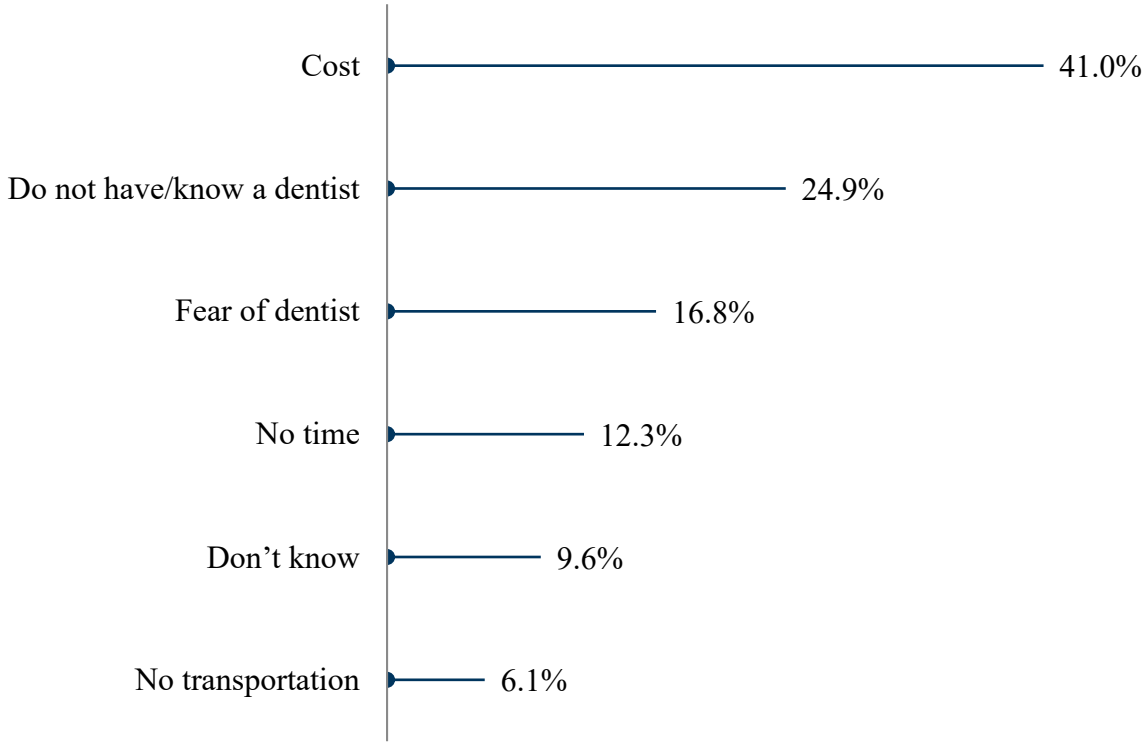
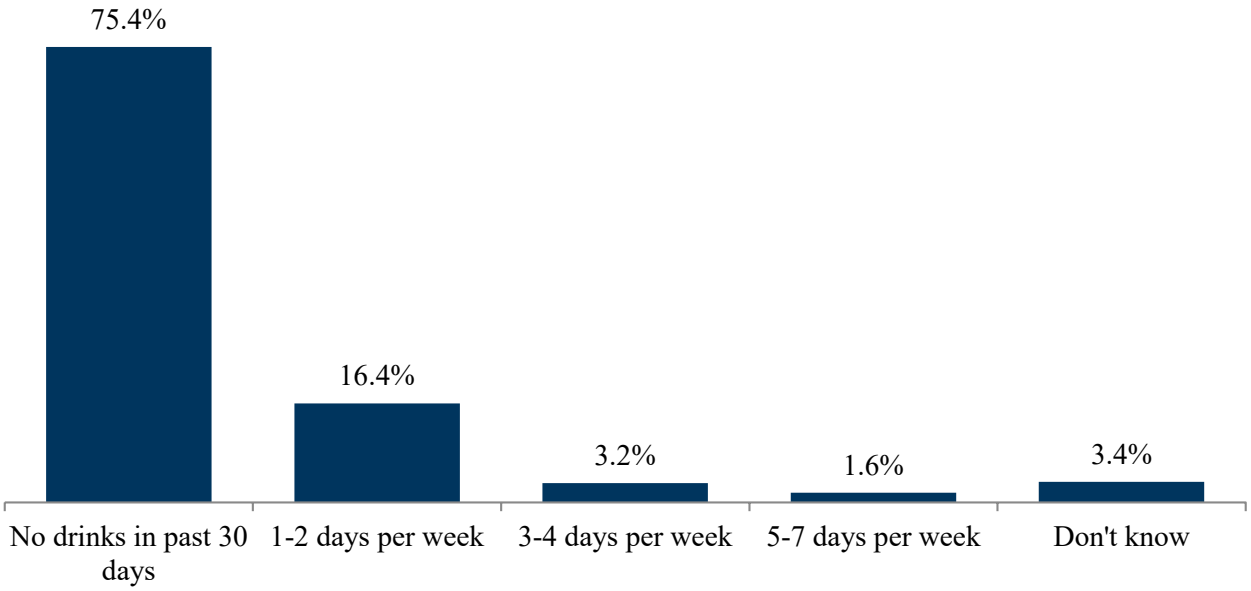


Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]



[32] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[33] Only reported those who have not seen a dentist within the past 12 months.

Exhibit 54. Days per week member had at least one drink of alcoholic beverage during the past 30 days (n=3,083)[34]



[34] Only reported those who are 18 years or older.

Continued to a Future Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
42. Consider Approving Grant Allocation(s) of Intergovernmental Transfer (IGT) 6 and 7 Funds

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

Recommended Actions
1. Approve a grant allocation of $10 million to the Orange County Health Care Agency (OCHCA) from the Department of Health Care Services (DHCS)-approved and Board-approved Intergovernmental Transfer (IGT) 6 and 7 Homeless Health priority area; and
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Care Agency (OCHCA) for use of the above allocated funds for recuperative care services under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members.

Background
Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. IGT funds are to be used to provide enhanced/additional benefits for Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program, thus funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

At the August 3, 2017 Board of Directors meeting, IGT 6 and 7 funds totaling approximately $22 million were approved to support community-based organizations through one-time competitive grants at the recommendation of the IGT Ad Hoc committee to address the following priority areas:

- Children's Mental Health
- Homeless Health
- Opioid and Other Substance Use Disorders
- Community Grants to support program areas beyond those funded by IGT 5

On October 19, 2017 CalOptima released a notice for Requests for Information/Letters of Interest (RFI/LOI) from organizations seeking funding to address community needs in one or more of the board approved priority areas. The RFI/LOIs helped staff determine funding allocation amounts for the board-approved priority areas. CalOptima received a total of 117 RFI/LOIs from community-based organizations, hospitals, county agencies and other community interests. The 117 RFI/LOIs are broken down as follows:

Priority Area	**# of LOIs**
Children's Mental Health	57
Homeless Health	36
Opioid and Other Substance Use Disorders	22
Other/Multiple Categories	2
Total	**117**

Back to Agenda

Staff performed a thorough examination of all the responses and evaluated them based on the following criteria:

- Statement of need describing the specific issue and/or problem and proposed program and/or solution, including new and innovative and/or collaborative efforts and expansion of services and personnel;
- Information on the impact to CalOptima members; and
- Demonstration of efficient and effective use of the potential grant funds for the proposed program and/or solutions.

Discussion

The IGT Ad Hoc committee comprised of Supervisor Do and Directors Nguyen and Schoeffel met on April 17 to further discuss the results of the RFI/LOI responses specifically in the Homeless Health priority area and to review the staff-recommended IGT 6 and 7 expenditure plan with suggested allocation of funds per priority area.

Separate from the RFI/LOI process, the County of Orange over the past several months has been engaged in addressing the very sensitive and highly visible homeless issue and is currently a defendant in litigation brought in federal court by advocates for the homeless. Public agencies and non-profit organizations across Orange County, have been working diligently to address this challenging matter, with CalOptima partnering to ensure that any homeless CalOptima members have access to needed medical care. A lot has been accomplished, yet much more needs to be addressed.

Before releasing the limited grant dollars, the Ad Hoc committee met to carefully review the staff-recommended IGT 6 and 7 expenditure plan while also considering the pressing homeless issue.

In response to this on-going and challenging environment, and through the recommendation of the Ad Hoc committee, staff is recommending an allocation of approximately $10 million outside of the RFP process to the OCHCA from IGT 6 and 7 to address the health needs of CalOptima's homeless members. The amount includes the entire $8.6 million allocation recommended by staff for the Homeless Health priority area. In addition, the Ad Hoc committee is also recommending moving an additional $1.4 million from staff-recommended allocation for Opioid and other Substance Use Disorder to the Homeless Health priority area, which will result in a total of $10 million allocated to the Homeless Health priority area to the OCHCA.

This will result in a remaining balance of approximately $12 million for the IGT 6 and 7 community grants which will be distributed through a competitive Request for Proposal (RFP) process. The expenditure plans for this remaining approximate $12 million under IGT 6 and 7 funds will be addressed by the Ad Hoc committee in June.

In addition, staff is seeking authority to enter into a grant agreement with the County to direct the funds to provide access to health care and recuperative care services for homeless CalOptima members, consistent with the current recuperative care/WPC Pilot agreement with the OCHCA.

Back to Agenda

The WPC recuperative care program serves and is available for homeless CalOptima members, with CalOptima reimbursing OCHCA for up to $150/day for up to 15 days of recuperative care when medically indicated for CalOptima members who are discharged from hospitals and skilled nursing facilities, as well as those referred from clinics and OCHCA public health nurses.

Fiscal Impact
The recommended action to approve the allocation of $10 million from IGT 6 and 7 funds to OCHCA has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

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

Attachment
Board Action dated August 3, 2017, Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

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

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. The IGT funds are to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program. Consequently, these funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

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Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

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 benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal plan for Orange County is committed to continuing to work with our provider and community partners to address gaps and work to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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IGT Update & Proposed Funding Categories for IGT 6 & 7

Board of Directors Meeting
August 3, 2017

Cheryl Meronk
Director, Strategic Development

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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

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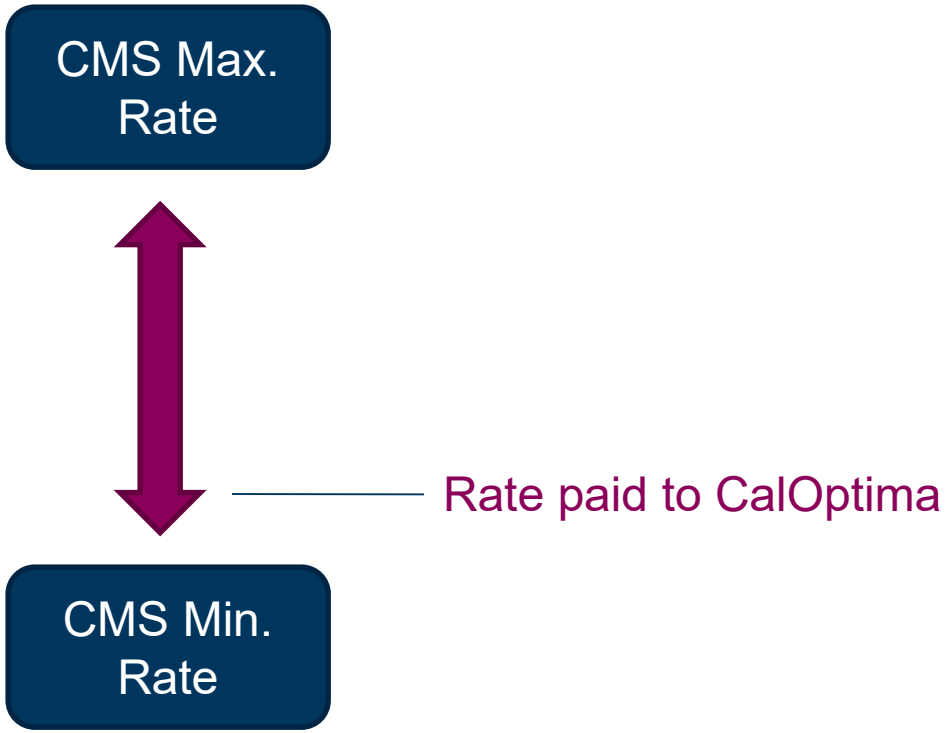
Low Medi-Cal Managed Care Rates

- CMS approves a rate range for Medi-Cal managed care
- California pays near the bottom of the range



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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

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CalOptima Share Totals To-Date

IGTs	CalOptima Share
IGT 1	$12.52 M
IGT 2	$8.60 M
IGT 3	$4.88 M
IGT 4	$6.97 M
IGT 5	$14.42 M
Total	**$47.39 M**

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IGT 1 Status

Project	Budget	Balance	Notes
Personal Care Coordinators	$3,850,000	$0	Completed
Case Management System	$2,099,000	$0	Completed
Strategies to Reduce Readmissions	$533,585	($77,836)	Completed
Program for High-Risk Children	$500,000	$481,440	*Complete by 12/31/2018*
Case Management System Consulting	$866,415	$16,320	*Complete by 12/31/2017*
OCC PCC Program	$3,550,000	$0	Completed
Reallocated	*$1.1 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Total	**$11.4 M**	**$0.5 M**	

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IGT 2 Status

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	$1,756,620	$0	Completed
Security Audit Remediation	$98,000	$0	Completed
Continuation of COREC	$970,000	$186,745	*Complete by 10/31/2018*
OCC PCC Program	$2,400,000	$2,400,000	*Complete by 3/31/2018*
Children's Health/ Safety Net Services	$1,300,000	$25,875	*Complete by 9/30/2017*
Wraparound Services	$1,400,000	$448,400	*Complete by 6/30/2018*
Recuperative Care	$500,000	$146,300	*Complete by 12/31/2018*
Program Administration	$100,000	$0	Completed
PACE EHR System	$80,000	$0	Completed
Total	**$8.6 M**	**$3.2 M**	

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IGT 3 Status

Project	Budget	Balance	Notes
Recuperative Care (Phase 2)	$500,000	$500,000	*Complete by 12/31/2018*
Program Administration	$165,000	$70,885	*Complete by 12/31/2017*
Reallocated	*$4.2 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Remaining Total	**$0.7 M**	**$0.6 M**	

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IGT 4 Status

Project	Budget	Balance	Notes
Data Warehouse Expansion	$750,000	$553,588	*Complete by 3/31/2018*
Depression Screenings	$1,000,000	$1,000,000	*Complete by 3/31/2019*
Member Health Homes	$250,000	$250,000	*Complete by 12/31/2017*
Member Health Needs Assessment	$500,000	$479,805	*Complete by 12/31/2017*
Personal Care Coordinators	$7,000,000	$6,982,240	*Complete by 6/30/2018*
Provider Portal Communications & Interconnectivity	$1,500,000	$1,472,480	*Complete by 12/31/2018*
UCI Observation Stay Payment Pilot	$750,000	$750,000	TBD
Program Administration	$529,608	$510,428	*Complete by 12/31/2018*
Reallocated	*$0*	*$5.3 M*	*Dollars reallocated from IGTs 1 & 3 (included in IGT 4 total)*
Total	**$12.3 M**	**$12.0 M**	

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IGT 5

- $14.4M allocated for competitive community grants
- Community grant initiatives to be developed, pending results from CalOptima's Member Health Needs Assessment

- Funding Categories:
  - Adult Mental Health
  - Children's Mental Health
  - Strengthening the Safety Net
  - Childhood Obesity
  - Improving Children's Health

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Member Health Needs Assessment (IGT 5)

- Builds upon previous surveys and assessments, e.g.
  - CalOptima Group Needs Assessment
  - OC Health Care Agency – OC Health Profile
  - Hospital Community Needs Assessments
- Deeper focus on needs of diverse, underserved Medi-Cal membership, including:
  - 7 threshold languages + others never previously represented
  - Homeless
  - Mentally ill
  - Older adults
  - Persons with disabilities

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Member Health Needs Assessment (IGT 5)

- Comprehensive assessment to identify gaps in and barriers to service
  - Access to PCPs, specialists & hospitals
  - Pharmacy and lab
  - Oral health services
  - Mental health services
- Insights into social determinants of health
  - Economic stability/employment status
  - Housing status
  - Education/literacy level
  - Social isolation
  - Transportation issues
  - Cultural differences
  - Communication barriers

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Estimated IGT 6 and 7 Totals

IGT	CalOptima Share
IGT 6	≈ $9.95 M (Anticipated December 2017)
IGT 7	≈ $12.16 M (Anticipated May 2018)
Total	**≈ $22.11 M**

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Proposed IGT Funding Categories - IGT 6 and 7

- Funds to be used to deliver enhanced services for the Medi-Cal population

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Opioid/Other Substances Overuse

- Nationwide, 78 opioid overdose deaths per day
  - 45% of Rx drug overdose deaths are Medicaid beneficiaries
- In OC, 286 opioid-related drug overdose deaths in 2016
  - Opioid dependence second leading cause of substance-related hospitalizations in OC after alcohol dependence syndrome

- Potential solutions to be funded:
  - Expand access to pain management, addiction treatment and recovery services
  - Outreach and education
  - Technical assistance to community groups working to reduce opioid and other substance overuse

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Children's Mental Health

- Estimated 52,500 OC youth living with a mental health condition
- Hospitalization rate for major depression among children and youth continues to rise
- Only 32 psychiatric acute care beds in OC for adolescents, and zero for children under 12
  - New CHOC facility will add 18 beds, for ages 3-18

- Potential solutions to be funded:
  - Expand inpatient and outpatient psychiatric services capacity for children 3-18

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Homeless Health

- Homelessness in OC on the rise
  - 2017 Point-in-Time count identified 4,792 homeless individuals
  - 2015 Point-in-Time count was 4,452
  - As of 2015, estimated 15,291 homeless individuals in OC
    - Approximately 11,000+ of these are CalOptima members
- Economic impact of homelessness ≈ $300M over 12-month period between 2014-15
  - Includes $121M for health care costs
- Potential solutions to be funded:
  - Expand recuperative care services
  - Increase/expand mobile health clinics

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Competitive Community Grants

- Funding to fill gaps and address barriers to service beyond IGT 5 funding categories:
  - Examples of possible additional priority areas:
    - Older Adult Health
    - Dental Health
    - Persons with Disabilities
    - Maternal/perinatal Health

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CalOptima Projects and Program Admin

- Approx. 10% of total IGT 6 & 7 set aside for internal priorities and program administration, e.g.:
  - Expansion of provider electronic records capabilities
  - IGT program administration
  - Grant development and administration

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Next Steps

- Gather stakeholder input
  - PAC
  - MAC
  - OCC MAC
  - Community organizations
- Develop expenditure plans for Board approval

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

43. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Event

Contact

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

Recommended Actions

1. Authorize expenditures for CalOptima's participation in the following community event:
   a. Up to $1,500 and staff participation in the 2018 Collaboration to Assist Motel Families' Back to School Outreach Event on Saturday, July 28, 2018 at the Downtown Community Center in Anaheim;
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 event and expenditures.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners and key stakeholders.

Requests for participation are considered based on several factors, including: the number of current and potential CalOptima members and others the activity/event will reach, the marketing benefits accrued to CalOptima, the strength of the partnership or level of involvement with the requesting entity in serving CalOptima members, past participation, staff availability, and available budget.

Discussion

Staff recommends the authorization of expenditures for participation in this community event to provide information and support to CalOptima's children and families in the homeless population. Staff will have an opportunity to provide outreach and education to this under-served and hard to reach community, potentially increasing enrollment and increasing access to health care services.
The Collaboration to Assist Motel Families helps meet the needs of motel families by providing services and supports to achieve self-sufficiency. The Back to School Outreach Event serves children in the McKinney-Vento programs throughout Orange County and families residing in motels; the event provides medical, educational and community resources to support these children's academic success. Children will be provided haircuts, school supplies, hygiene kits and consultations for education, medical, financial and housing services at no-cost. This event is free to the public and is designed to

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meet the needs of children who have been identified through the McKinney-Vento program and their families.

a. For the Back to School Outreach Event, a $1,500 financial commitment includes recognition at the event, one exhibit table, and CalOptima's logo displayed on the all printed materials to promote the event. Employee time will be used to participate in this event. Employees will have an opportunity to interact with current and potential CalOptima members and share information about CalOptima's programs and services. Nearly 500 guests are expected to attend the event. Participation in this event will provide CalOptima an opportunity to establish and build a relationship with under-served and hard to reach members who are homeless.

CalOptima staff has reviewed each request and determined that they each meet the considerations for participation including the following:

1. The number of current and potential CalOptima members and others the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity in serving CalOptima members;
4. Past participation;
5. Staff availability; and
6. Available budget.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended action of up to $1,500 is included as part of the Community Events budget under the CalOptima Fiscal Year 2017-18 Operating Budget approved by the CalOptima Board of Directors on June 1, 2017.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, or promote health and wellness to seniors in the Iranian community and serving our threshold languages of Farsi and Arabic.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Sponsorship Request Letter

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

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ANAHEIM UNION HIGH SCHOOL DISTRICT

Learning With Purpose: College and Career Ready

May 2, 2018

Lisa Nguyen
CalOptima
505 City Parkway West
Orange, CA 92868

Dear Lisa Nguyen,

This letter is concerning a sponsorship opportunity with the **2018 Collaboration to Assist Motel Families' Back to School Outreach Event** on *Saturday, July 28th 2018*. We understand thatt Cal Optima has a mission and desire to give back to the local community and educate residents about healthy living and provide assistance to access medical care; which is why we think this is a wonderful opportunity to connect with an overlooked population. The Collaboration to Assist Motel Families (CAMF) works on addressing gaps of those families living in motels. Every year we work with local school districts and agencies to provide a back to school event for these families. Here they are connected to services such as medical, educational and community resources and much more. We believe you would be a great addition to our agency list and would greatly appreciate your support this year.

In 2017, the CAMF's Back to School Outreach event hosted over 400 homeless children with their families. More than 100 volunteers and community stakeholders were also in attendance. Your sponsorship would provide homeless children with **carnival game activities** to assist in distributing school supplies to ensure family engagement in the resource fair. Additionally, we will provide food for the volunteers throughout the event.

Sponsorship opportunity

- **$1,500**- *Premier sponsor*: Banner with Cal Optima's name/logo and resource table.
- Adding services like free haircuts, free consultations (Education, Medical, Financial, Housing), free health screenings, free books and school supplies.
- The Anaehim Union High School District is able to serve as the fiscal manager of the sponsorship and provide documentation at your request.

We are excitedly looking forward to even greater success at this year's event. Thank you for your time and consideration.

501(c) # _____

Sincerely,

Adela Cruz, LCSW, PPSC
Program Administrator, Mental Health Services
McKinney-Vento & Foster Youth
cruz_ad@auhsd.us
714-999-7734 / Cell#: 714-404-9062

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
44. Consider Authorization of Expenditures Related to Board Membership in the National Association of Corporate Directors

Contact
Michael Schrader, Chief Executive Officer, (714) 246-8400
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions
1. Authorize expenditures of $8,500 for board membership in the National Association of Corporate Directors (NACD) for Fiscal Year 2018-19; and
2. Authorize up to $20,300 for additional seminars and related travel expenses.

Background
For more than thirty-five (35) years, NACD has worked with corporate directors to advance exemplary board leadership. It is a recognized authority on leading boardroom practices and currently helps more than 17,000 corporate directors nationwide. NACD enables corporate directors to anticipate risks and opportunities and equip them to make sound decisions based on leading practices and insights from recognized experts. Beginning in July 2015, the CalOptima Board of Directors signed up for membership in NACD, with some board members participating in NACD events.

Discussion
NACD recommends that members of the board of directors, members of executive management, and corporate secretaries participate in NACD activities. CalOptima's annual membership renewal fee of $8,500 includes membership for the full Board for the FY 2018-19 fiscal year. The additional proposed expenses of $20,300 are based on prior year CalOptima expenditures for Board member seminar fees, and related travel, lodging, and meals.

Fiscal Impact
The recommended action is a budgeted item under the proposed CalOptima Fiscal Year 2018-19 Operating Budget.

Rationale for Recommendation
CalOptima's continued membership with NACD will assist Board members in remaining current on best practices in board leadership and governance.

Concurrence
Gary Crockett, Chief Counsel

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Attachments
None

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

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
45. Consider Actions Related to CalOptima's Whole-Child Model Program

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions
1. Authorize CalOptima staff to develop an implementation plan to integrate California Children's Services into its Medi-Cal program in accordance with the Whole Child Model (WCM), and return to the Board for approval after developing draft policies, and completing additional analysis and modeling prior to implementation;
2. Authorize and direct the Chief Executive Officer (CEO), with assistance of Legal Counsel, to execute a Memorandum of Understanding (MOU) with Orange County Health Care Agency (OC HCA for coordination of care, information sharing and other actions to support WCM activities; and
3. In connection with development of the Whole Child Model Family Advisory Committee:
    a. Direct the CEO to adopt new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee; and,
    b. Appoint the following ~~eleven~~ individuals to the Whole-Child Model Family Advisory Committee (WCM FAC) for one or two-year terms as indicated or until a successor is appointed, beginning July 1, 2018:

Rev. 6/7/2018

        i. Family Member Representatives:
            a) Maura Byron for a two-year term ending June 30, 2020;
            b) Melissa Hardaway for a one-year term ending June 30, 2019;
            c) Grace Leroy-Loge for a two-year term ending June 30, 2020;
            d) Pam Patterson for a one-year term ending June 30, 2019;
            e) Kristin Rogers for a two-year term ending June 30, 2020; and
            f) Malissa Watson for a one-year term ending June 30, 2019.
        ~~ii. Community Representatives:~~
            ~~a) Michael Arnot for a two-year term ending June 30, 2020;~~
            ~~b) Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
            ~~c) Gabriela Huerta for a two-year term ending June 30, 2020; and~~
            ~~d) Diane Key for a one-year term ending June 30, 2019.~~

6/7/2018: Continued to future Board meeting.

Background
The California Children's Services (CCS) Program is a statewide program providing medical care, case management, physical/occupational therapy, and financial assistance for children (to age 21) meeting financial and health condition eligibility criteria. On September 25, 2016, Governor Brown signed Senate Bill 586 into law, which authorizes DHCS to incorporate CCS services into Medi-Cal managed care plan (MCP) contracts for county organized health systems (COHS). This transition is referred to as the Whole-Child Model (WCM). WCM's goals include improving coordination and

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integration of services to meet the needs of the whole child; retaining CCS program standards; supporting active family participation; and, maintaining member-provider relationships, where possible.

DHCS is implementing WCM on a phased basis; Orange County's implementation will be no sooner than January 1, 2019. Based on this schedule, CalOptima will assume financial responsibility for authorization and payment of CCS-eligible medical services including service authorization activities, claims (with some exceptions), case management, and quality oversight. DHCS will retain responsibility for program oversight, CCS provider paneling, and claims payment for CCS eligible Neonatal Intensive Care Unit (NICU) services. OC HCA will remain responsible for CCS eligibility determination for all children and for CCS services for non-Medi-Cal members (e.g., those who exceed the Medi-Cal income thresholds and undocumented children who transition out of MCP when they turn 18). OC HCA will also remain responsible for Medical Therapy Program (MTP) services and the Pediatric Palliative Care Waiver.

WCM will incorporate requirements from SB 586 and CCS into the Medi-Cal managed care plans. New requirements under WCM will include, but not be limited to:

- Using CCS paneled providers and facilities to treat children and youth for their CCS condition, including network adequacy certification;
- Offering continuity of care (e.g., durable medical equipment, CCS paneled providers) to transitioning members;
- Paying CCS or Medi-Cal rates, whichever is higher, unless provider has agreed to a different contractual arrangement;
- Offering CCS services including out-of-network, out-of-area, and out-of-state, including Maintenance & Transportation (travel, food and lodging) to access CCS services;
- Executing Memorandum of Understanding with OC HCA to support coordination of services;
- Permitting selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP);
- Establishing Pediatric Health Risk Assessment (P-HRA), associated risk stratification, and individual care planning process;
- Establishing WCM clinical and member/family advisory committees; and,
- Reporting in accordance with WCM specific requirements.

For the requirements, CalOptima will rely on SB 586 and DHCS guidance provided through All Plan Letters (APL) and current and future CCS requirements published in the CCS Numbered Letters. Additional information will be provided in DHCS contact amendments, readiness requirements, and other regulatory releases.

On November 2, 2017, the CalOptima Board of Directors authorized establishment of the WCM FAC. The WCM FAC is comprised of eleven (11) voting seats.

1. Seven (7) to nine (9) seats shall be seats for family representatives, with a priority to family representatives (i.e., if qualifying family candidates are available, all nine (9) seats will be filled by family members). Family representatives will be in the following categories:
   a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   b. CalOptima members age 18 - 21 who are current recipients of CCS services; or

   c. Current CalOptima members age of 21 and over who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS including
   a. Community-based organizations; or
   b. Consumer advocates.

While two (2) of the WCM-FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill the family seats.

Except for the initial appointments, WCM FAC members will serve two-year terms, with no limits on the number of terms a representative may serve, provided they meet applicable criteria. The initial appointment will be divided between one- and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee members seats will be appointed for two-year terms.

Discussion

Throughout the years, CalOptima staff has monitored regulatory and industry discussions on the possible transition of CCS services to the managed care plans, including participation in DHCS CCS stakeholder meetings. In 2013, the Health Plan of San Mateo, in partnership with the San Mateo County Health System, became the first CCS demonstration project under California's 1115 "Bridge to Reform" Waiver. In 2014, DHCS formally launched its stakeholder process for *CCS Redesign*, which later became known as the *Whole Child Model*.

CalOptima began meeting with OC HCA in early 2016 to learn about CCS and, more broadly, to share information about CalOptima programs supporting our mutual members. CalOptima conducted its first broad-based stakeholder meeting in March 2016 and launched its WCM stakeholder webpage in 2016. Since that time, CalOptima has shared WCM information and vetted its WCM implementation strategy with stakeholders at events and meetings hosted by CalOptima and others. In January 2018, CalOptima hosted a WCM event for local stakeholders that included presentations by DHCS and CalOptima leadership. Six (6) family-focused stakeholder meetings were held throughout the county in February 2018. CalOptima health networks and providers have also been engaged through Provider Advisory Committee meetings, Provider Associations, Health Network Joint Operations Meetings, and Health Network Forum Meetings. CalOptima has scheduled WCM-specific meetings with health networks to support the implementation and provide a venue for them to raise questions and concerns.

Implementation Plan Elements

Delivery Model

As CCS has been carved-out of CalOptima's Medi-Cal managed care plan contract with DHCS, it has similarly been carved-out of CalOptima's health network contracts. CalOptima considered several options for WCM service delivery including: 1) requiring all CCS participants to be enrolled in CalOptima's direct network (rather than a delegated health network); 2) retaining the current health network carve-out for CCS services, while allowing members to remain enrolled in a delegated health network; or, 3) carving CCS services into the health network division of financial responsibility (DOFR) consistent with their current contract model.

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Requiring enrollment in CalOptima Direct could potentially break relationships with existing health network contracted providers and disrupt services for non-CCS conditions. Carving CCS services out of health network responsibility, while allowing members to remain assigned to a health network, would continue the siloed service delivery CCS children currently receive and, therefore, not maximize achievement of the "whole-child" goal. Carving the CCS services into the health networks according to the current health network contract models is most consistent with the WCM goals and existing delivery model structure. For purposes of this action, the CalOptima Community Network (CCN) would be considered a health network.

Health Network Financial Model
CalOptima has worked closely with the DHCS to ensure adequate Medi-Cal revenue to support the WCM and actuarially sound provider and health network rates. For the WCM, DHCS will establish capitation that will include CCS and non-CCS services. However, only limited historical CCS claims payment detail is available. In order to mitigate health network financial risk due to potentially costly outliers, CalOptima staff is considering, with the exception of Kaiser, to:

- Expand current policy that transitions clinical management and financial risk of CalOptima medical members diagnosed with hemophilia, in treatment for end stage renal disease (ESRD), or receiving an organ transplant from the health network to CCN to include Medi-Cal members under 21;
- Establish an estimated capitation rate, similar to the DHCS methodology, that includes CCS and non-CCS services and develop a medical loss ratio (MLR) risk corridor; and
- Modify existing or establish new policies related to payment of services for members enrolled in a shared risk group, reinsurance, health-based risk adjusted capitation payment, shared risk pool, and special payments for high-cost exclusions and out-of-state CCS services.

The estimated capitation rate for the health networks, excluding Kaiser, will be established based on known methodologies and data provided by DHCS. Capitation will include services based on the current health network structure and division of responsibility. Also built into the rates will be the requirement that at a minimum, the Medi-Cal or CCS fee-for-service rate, whichever is higher, will be utilized, unless an alternate payment methodology or rate is mutually agreed to by the CCS provider and the health network. CalOptima staff will review the capitation rate structure with the health networks once final rates are received from DHCS and analyzed by CalOptima staff. In the interim, CalOptima staff will develop, with input from the health networks, the upper and lower limits of the MLR risk corridor and reconciliation process. Current policy regarding high-cost medical exclusions will also be discussed. Separate discussions will occur with Kaiser, as its capitation rate structure is different than the other health networks. CalOptima staff will return to the Board with future recommendations, as required.

Clinical Operations
CalOptima will be responsible for providing CCS-specific case management, care coordination, provider referral, and service authorization to children with a CCS condition. CalOptima will conduct risk stratification, health risk assessment and care planning. For transitioning members, CalOptima will also be responsible for ensuring continuity of services, for example, CCS professional services, durable medical equipment and pharmacy.

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While many services currently provided to children enrolled in CCS are covered by CalOptima for non-CCS conditions, the transition to WCM will incorporate new responsibilities to CalOptima including authorizing High-Risk Infant Follow-Up (HRIF), and NICU, and new benefits such as Cochlear implants Maintenance and Transportation services when applicable, to the child and/or family. Maintenance and Transportation services include meals, lodging, transportation, and other necessary costs (i.e. parking, tolls, etc.).

CalOptima will also be responsible for facilitating the transition of care between the County and CalOptima case management and following State requirements issued to the County, in the form of Numbered Letters, in regard to CCS administration and implementation. An example of this would be implementing the County's process for transitioning out of the program children currently enrolled in CCS but who will not be eligible once they turn twenty-one (21).

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, CCS comprehensive case management, risk stratification, health risk assessment, continuity of care, authorization for durable medical equipment (including wheelchairs) and pharmacy. CalOptima staff will return to the Board with future recommendations as required.

Provider Impact and Network Adequacy
The State requires plans, and their delegates, to have an adequate network of CCS-paneled and approved providers to serve to children enrolled in CCS. During the timeframe given for readiness and as an ongoing process, CalOptima will attempt to contract with as many CCS providers on the State-provided list and located in Orange County as possible. CalOptima is attempting to contract with all CCS providers in Orange County and specialized providers outside Orange County currently providing services to CalOptima members. Historically, CalOptima has paid, and expects to continue to pay, contracted CCS specialists an augmented rate to support participation and coordination of CalOptima and CCS services. This process is based on previous Board Action and reflected in Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct or a Member Enrolled in a Shared Risk Group.

CalOptima may modify existing or establish new policies to implement WCM. These may include policies related to, for example, access and availability standards, credentialing, primary care provider assignment, CalOptima staff will return to the Board with future recommendations as required.

<u>Memorandum of Understanding (MOU)</u>
Leveraging the DHCS WCM MOU template, CalOptima and OC HCA staff have worked in partnership to develop a new WCM MOU to reflect shared needs and to serve as the primary vehicle for ensuring collaboration between CalOptima and OC HCA in serving our joint CCS members. The MOU identifies each party's responsibilities and obligations based on their respective scope of responsibilities as they relate to CCS eligibility and enrollment, case management, continuity of care, advisory committees, data sharing, dispute management, NICU and quality assurance.

<u>Whole Child Model Family Advisory Committee (WCM FAC)</u>
In connection with the November 2, 2017 Board Action described above, CalOptima staff developed new Medi-Cal policy AA.1271: Whole Child Model Family Advisory Committee to establish policies and procedures related to development and on-going operations of the WCM FAC, Staff recommends Board approval of AA.1271: Whole Child Model Family Advisory Committee.

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To identify nominees for the WCM FAC for Board consideration, CalOptima conducted recruitment to ensure that there would be a diverse applicant pool from which to choose candidates. The recruitment included several notification methods, sending outreach flyers to community-based organizations (CBOs) and OC HCA CCS staff for distribution to CCS members and their families, targeting outreach at six (6) CalOptima hosted WCM family events and at community meetings, and posting information on the WCM Stakeholder Information and WCM Family Advisory Committee pages on CalOptima's website. A total of sixteen (16) applications (eight (8) in each category) were received from fifteen (15) individuals (one (1) individual applied for a seat in both categories).

As the WCM FAC is in development, CalOptima requested members of CalOptima's Member Advisory Committee (MAC) to serve as the Nomination Ad Hoc Subcommittee (Subcommittee). Prior to the MAC Nominations Ad Hoc meeting on April 19, 2018, Subcommittee members evaluated each application. The Subcommittee, including Connie Gonzalez, Jaime Munoz and Christine Tolbert, selected a candidate for each of the seats. All eligible applicants for a Family Representative seat were recommended. (One (1) of the eight (8) applicants was not eligible as she did not have family or personal experience in CCS.) At the May 10, 2018 meeting, the MAC considered and accepted the recommended slate of candidates, as proposed by the Subcommittee.

Candidates for the open positions are as follows:
Family Representatives

1. Maura Byron for a two-year term ending June 30, 2020;
2. Melissa Hardaway for a one-year term ending June 30, 2019;
3. Grace Leroy-Loge for a two-year term ending June 30, 2020;
4. Pam Patterson for a one-year term ending June 30, 2019;
5. Kristin Rogers for a two-year term ending June 30, 2020; and
6. Malissa Watson for a one-year term ending June 30, 2019.

Maureen Byron is the mother of a young adult who is a current CCS client. Ms. Byron became involved in the CCS Parent Advisory Committee resulting in her being hired by Family Support Network (FSN). At FSN, she is a parent mentor assisting families of children with complex health care needs to maneuver in the system and secure services. In addition, she responds to families' questions and provides peer and emotional support.

Melissa Hardaway is the mother of a special needs child who receives CCS services. Ms. Hardaway is familiar with the health care industry as a health care professional and a broker. She believes her understanding of managed care and her advocacy experience for her child will benefit her to assist families of children in CCS.

Grace Leroy-Loge is the mother of an adolescent receiving CCS services. Ms. Leroy-Loge works as the Family Support Liaison at CHOC Children's Hospital NICU where she assists families of children with medically complex needs to advocate for their children. She has served in the community on several committees, such as the parent council of CCS, Make-a-Wish Medical Advisory Committee and Orange County Children's Collaborative.

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Pam Patterson is the mother of a special needs adolescent receiving CCS. Ms. Patterson is a special needs attorney and a constitutional law attorney. She has many years of experience advocating for her child with CCS and the Regional Center of Orange County. Ms. Patterson is also very active in the community.

Kristin Rogers is the mother of a young teenager who receives CCS services. Ms. Rogers explained that because she encountered difficulties obtaining the correct health care coverage for her child, she wants to educate others with similar situations on how to obtain appropriate coverage. Ms. Rogers is an active volunteer at CHOC.

Malissa Watson is the mother of a child that receives CCS services. Ms. Watson's desire is to help families navigate CCS and CalOptima. Ms. Watson is active in the community, serving on the CHOC Hospital Parent Advisory Committee and mentoring other parents.

~~*CBO/Advocate Representatives*~~

~~1. Michael Arnot for a two-year term ending June 30, 2020;~~
~~2. Sandra Cortez-Schultz for a one-year term ending June 30, 2019;~~
~~3. Gabriela Huerta for a two-year term ending June 30, 2020; and~~
~~4. Diane Key for a one-year term ending June 30, 2019.~~

~~Michael Arnot is the Executive Director for Children's Cause Orange County, an organization that provides evidence-based therapeutic intervention for children with traumatic stress, such as trauma from medical procedures from co-occurring health conditions covered under CCS. Mr. Arnot has extensive experience working with children in varying capacities.~~

~~Sandra Cortez-Schultz is the Customer Service Manager at CHOC Children's Hospital. Ms. Cortez-Schultz is responsible for ensuring that the families of medically complex children receive the appropriate care and treatment they require. She is also the Chair of CHOC's Family Advisory Council. Ms. Cortez-Schultz has over 25 years of experience working directly and indirectly at varying levels with the CCS program.~~

~~Gabriela Huerta is a Lead Case Manager, California Children's Services/Regional Center for Molina Healthcare, Inc. Ms. Huerta is responsible for health care management and coordination of services for CCS members, including assessments, intervention, planning and development of member centric plans and coordination of care. She has expertise in CCS as a carve-out benefit as well as a managed care benefit.~~

~~Diane Key is the Director of Women's and Children's Services for UCI Medical Center. Ms. Key has over 30 years of experience working in women and children's services in clinical nursing and leadership oversight positions. She has knowledge of CCS standards, eligibility criteria and facility requirements. In addition, she understands the physical, psycho-social and developmental needs of CCS children.~~

6/7/2018: Continued to future Board meeting.

Staff recommends Board approval of the proposed nominees for the WCM FAC.

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Fiscal Impact

The recommended action to approve the implementation plan for the WCM program carries significant financial risks. Based on draft capitation rates received from DHCS on April 27, 2018, staff estimates the total annual program costs for WCM at $274 million. Management has included projected revenues and expenses associated with the WCM program in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval. However, given the high acuity and medical utilization associated with a relatively small CCS population, costs for the program are difficult to predict and likely to be volatile. CalOptima will continue to work closely with DHCS to ensure that Medi-Cal revenue will be sufficient to support the WCM program.

Rationale for Recommendation

The recommended actions will enable CalOptima to operationally prepare for the anticipated January 1, 2019, transition of California Children's Services to Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. PowerPoint Presentation: Whole-Child Model Implementation Plan
2. Board Action dated November 2, 2017, Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program
3. Policy AA.1271: Whole Child Model Family Advisory Committee (redline and clean copies)

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

5/30/2018 — **Date**

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Whole-Child Model (WCM) Implementation Plan

Board of Directors Meeting

June 7, 2018

Candice Gomez, Executive Director

Program Implementation

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Background

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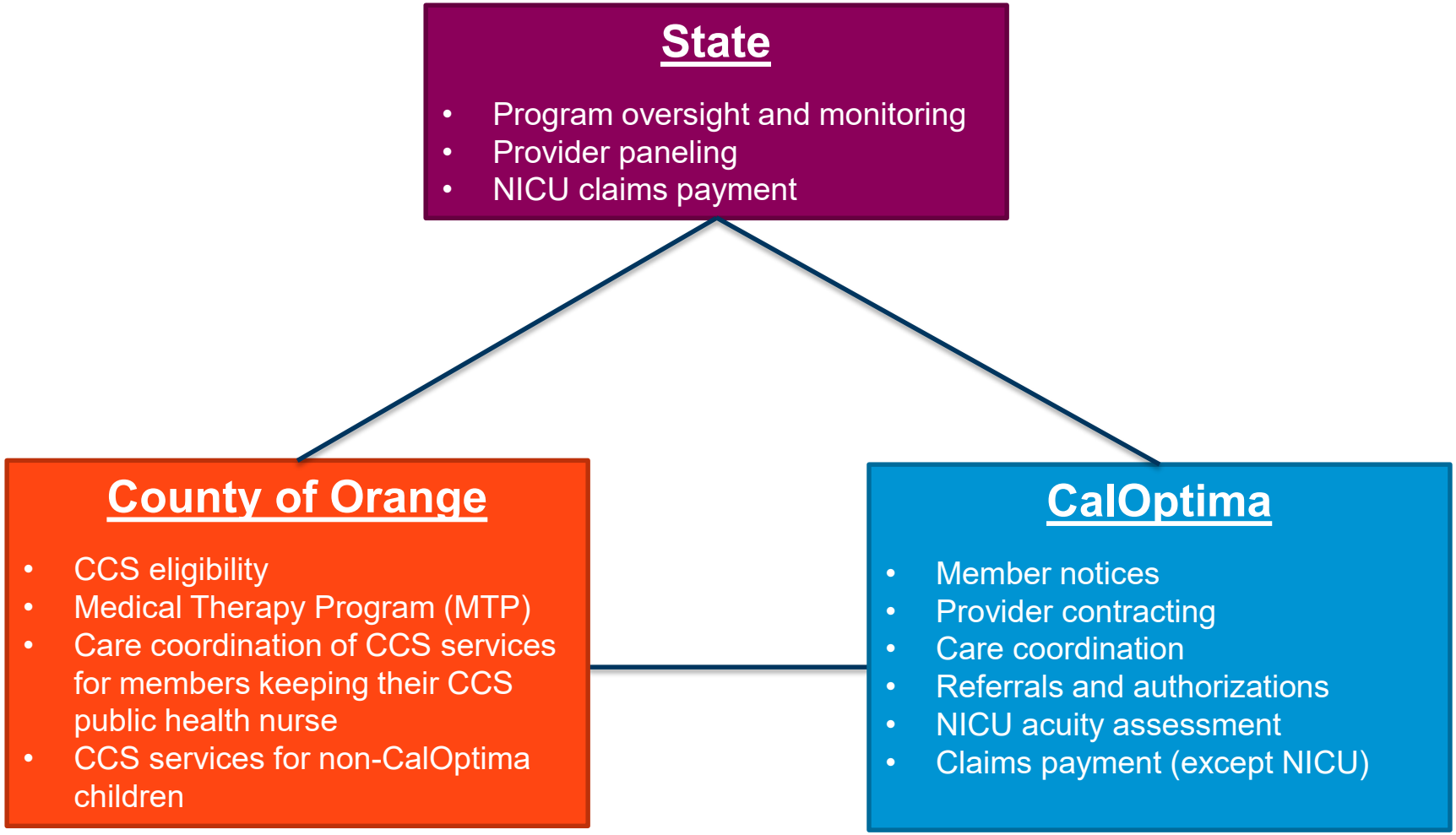
Whole-Child Model (WCM) Overview

- California Children's Services (CCS) is a statewide program providing medical care and case management for children under 21 with certain medical conditions
  - Locally administered by Orange County Health Care Agency
- The Department of Health Care Services (DHCS) is implementing WCM to integrate the CCS services into select Medi-Cal plans
  - CalOptima will implement WCM effective January 1, 2019

Division of WCM Responsibilities



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WCM Transition Goals

- Improve coordination and integration of services to meet the needs of the whole child
- Retain CCS program standards
- Support active family participation
- Establish specialized programs to manage and coordinate care
- Ensure care is provided in the most appropriate, least restrictive setting
- Maintain existing patient-provider relationships when possible

CCS Demographics

- About 13,000 Orange County children are receiving CCS services
  - ➢ 90 percent are CalOptima members

Languages	City of Residence (Top 5)
• Spanish = 48 percent • English = 44 percent • Vietnamese = 4 percent • Other/unknown = 4 percent	• Santa Ana = 23 percent • Anaheim = 18 percent • Garden Grove = 8 percent • Orange = 6 percent • Fullerton = 4 percent

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WCM Requirements

- Required use of CCS paneled providers and facilities, including network adequacy certification
- Memorandum of Understanding with OC HCA to support coordination of services
- Maintenance & Transportation (travel, food and lodging) to access CCS services
- WCM specific reporting requirements
- Permit selection of a CCS paneled specialist to serve as a CCS member's Primary Care Provider (PCP)
- Establish WCM clinical and member/family advisory committees

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2018 Stakeholder Engagement to Date

- January 25– General stakeholder event (93 attendees)
- February 26 -28 – Six family events (87 attendees)
- Provider focused presentations and meetings:
  - Hospital Association of Southern California
  - Safety Net Summit - Coalition of Orange County Community Health Centers
  - Pediatrician focused events hosted by Orange County Medical Association Pediatric Committee and Health Care Partners
  - Health Network convenings including Health Network Forum, Joint Operations Meetings and on-going workgroups
- Speakers Bureau and community meetings

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Implementation Plan Elements

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Proposed Delivery Model

- Leverage existing delivery model using health networks, subject to Board approval
  - Reflects the spirit of the law to bring together CCS services and non-CCS services into a single delivery system

- Using existing model creates several advantages
  - Maintains relationships between CCS-eligible children, their chosen health network and primary care provider
  - Improves clinical outcomes and health care experience for members and their families
  - Decreases inappropriate medical and administrative costs
  - Reduces administrative burden for providers

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Financial Approach

- DHCS will establish a single capitation rate that includes CCS and non-CCS services
- Limited historical CCS claims payment detail available
- CalOptima Direct and CalOptima Community Network
  - Follow current fee-for-service methodology and policy
  - CCS paneled physicians are reimbursed at 140% Medi-Cal
- Health Network
  - Keep health network risk and payment structure similar to current methodologies in place
  - Develop risk corridors to mitigate risk

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Clinical Operations

- Providing CCS-specific case management, care coordination, provider referral and authorizations

- Supporting new services such as High-Risk Infant Follow-Up authorization, Maintenance and Transportation (lodging, meals and other travel related services)

- Facilitating transitions of care
  - Risk stratification, health risk assessment and care planning for children and youth transitioning to WCM
  - Between CalOptima, OC HCA and other counties
  - Age-out planning for members who will become ineligible for CCS when they turn 21 years of age

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Provider Impact and Network Adequacy

- CalOptima and delegated networks must have adequate network of CCS paneled and approved providers
  - CCS panel status will be part of credentialing process
  - CCS members will be able to select their CCS specialists as primary care provider
  - CalOptima is in process of contracting with CCS providers in Orange County and specialized providers outside of county providing services to existing members
  - Documentation of network adequacy will be submitted to DHCS by September 28, 2018

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Memorandum of Understanding (MOU)

- DHCS requires CalOptima and Orange County Health Care Agency to develop WCM MOU to support collaboration and information sharing
  - Leverage DHCS template
  - Outlines responsibilities related:
    - CCS eligibility and enrollment
    - Case management
    - Continuity of care
    - Advisory committees
    - Data sharing
    - Dispute management
    - NICU
    - Quality assurance

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WCM Family Advisory Committee

- CalOptima must establish a WCM Family Advisory Committee per Welfare & Institutions Code § 14094.17
- November 2, 2017 Board authorized development of committee
  - Eleven voting seats
    - Seven to nine family representative seats
    - Two to four community-based organizations or consumer advocates
    - Priority to family representatives
  - Two-year terms, with no term limits
    - Staggered terms
    - In first year, five seats for one-year term and six seats for two-year term
  - Approval requested for AA.1271: Whole Child Model Family Advisory Committee

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WCM Family Advisory Committee (cont.)

- Sixteen applications (eight in each category)
- April 19, 2018 Member Advisory Committee (MAC) Nominations ad hoc committee selected candidates
  - All eligible applicants in family category were selected
    - One applicant was ineligible as she has no prior CCS experience
  - Four applicants in community category were selected
- May 10, 2018 MAC considered and accepted MAC Ad Hoc's recommended nominations for Board consideration

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Recommended Nominees

Family Seats	Community Seats
Maura Byron	**Michael Arnot** Executive Director Children's Cause Orange County
Melissa Hardaway	
Grace Leroy-Loge	**Sandra Cortez – Schultz** Customer Service Manager CHOC Children's Hospital
Pam Patterson	
Kristin Rogers	**Gabriela Huerta** Lead Case Manager, California Children's Services/Regional Center Molina Healthcare, Inc.
Malissa Watson	
	Diane Key Director of Women's and Children's Services UCI Medical Center

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Next Steps

- Review WCM capitation and risk corridor approach with Health Networks

- Planned stakeholder engagement
  - Community-based organization focus groups in June
  - General event in July
  - Family events in Fall

- Future Board actions
  - Update policies and procedures
  - Health network contracts

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

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- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
    i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
    ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
    iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
    i. Community-based organizations; or
    ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

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Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

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The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

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Fiscal Impact

The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation

SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Resolution No. 17-1102-01

Rev.
11/2/17

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

10/23/2017 — **Date**

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RESOLUTION NUMBER 17-1102-01

**RESOLUTION OF THE BOARD OF DIRECTORS
ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA
ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD
MODEL MEMBER ADVISORY COMMITTEE**

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

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If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

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The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

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

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Policy #:	AA.1271PP
Title:	**Whole Child Model Family Advisory Committee**
Department:	General Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	06/07/18
Last Review Date:	Not Applicable
Last Revised Date:	Not Applicable

I. PURPOSE

This policy describes the composition and role of the Family Advisory Committee for Whole Child Model (WCM) and establishes a process for recruiting, evaluating, and selecting prospective candidates to the Whole Child Model Family Advisory Committee (WCM FAC).

II. POLICY

A. As directed by CalOptima's Board of Directors (Board), the WCM FAC shall report to the CalOptima Board and shall provide advice and recommendations to the CalOptima Board and CalOptima staff in regards to California Children's Services (CCS) provided by CalOptima Medi-Cal's implementation of the WCM.

B. CalOptima's Board encourages Member and community involvement in CalOptima programs.

C. WCM FAC members shall recuse themselves from voting or from decisions where a conflict of interest may exist and shall abide by CalOptima's conflict of interest code and, in accordance with CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments.

D. CalOptima shall provide timely reporting of information pertaining to the WCM FAC as requested by the Department of Health Care Services (DHCS).

E. The composition of the WCM FAC shall reflect the cultural diversity and special needs of the health care consumers within the Whole-Child Model population. WCM FAC members shall have direct or indirect contact with CalOptima Members.

F. In accordance with CalOptima Board Resolution No. 17-1102-01, the WCM FAC shall be comprised of eleven (11) voting members representing CCS family members, as well as consumer advocates representing CCS families. Except as noted below, each voting member shall serve a two (2) year term with no limits on the number of terms a representative may serve. The initial appointments of WCM FAC members will be divided between one (1) and two (2)-year terms to stagger reappointments. In the first year, five (5) committee member seats shall be appointed for a one (1)-year term and six (6) committee member seats shall be appointed for a two (2)-year term. The WCM FAC members serving a one (1) year term in the first year shall, if reappointed, serve two (2) year terms thereafter.

1. Seven (7) to nine (9) of the seats shall be family representatives in one (1) of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):

    a. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima Member who is a current recipient of CCS services;

    b. CalOptima Members eighteen (18)-twenty-one (21) years of age who are current recipients of CCS services; or

    c. Current CalOptima members over the age of twenty-one (21) who transitioned from CCS services.

2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:

    a. Community-based organizations; or

    b. Consumer advocates.

3. While two (2) of the WCM FAC's eleven (11) seats are designated for community-based organizations or consumer advocates, an additional two (2) WCM FAC candidates representing these groups may be considered for these seats in the event that there are not sufficient family representative candidates to fill the family member seats.

4. Interpretive services shall be provided at committee meetings upon request from a WCM FAC member or family member representative.

5. A family representative, in accordance with Section II.G.1 of this Policy, may be invited to serve on a statewide stakeholder advisory group.

G. Stipends

1. Subject to approval by the CalOptima Board, CalOptima may provide a reasonable per diem payment to a member or family representative serving on the WCM FAC. CalOptima shall maintain a log of each payment provided to the member or family representative, including type and value, and shall provide such log to DHCS upon request.

    a. Representatives of community-based organizations and consumer advocates are not eligible for stipends.

H. The WCM FAC shall conduct a nomination process to recruit potential candidates for expiring seats, in accordance with this Policy.

I. WCM FAC Vacancies

1. If a seat is vacated within two (2) months from the start of the nomination process, the vacated seat shall be filled during the annual recruitment and nomination process.

2. If a seat is vacated after the annual nomination process is complete, the WCM FAC nomination ad hoc subcommittee shall review the applicants from the recent recruitment to see if there is a viable candidate.

    a. If there is no viable candidate among the applicants, CalOptima shall conduct recruitment, per section III.B.2.

3. A new WCM FAC member appointed to fill a mid-term vacancy, shall serve the remainder of the resigning member's term, which may be less than a full two (2) year term.

J. On an annual basis, WCM FAC shall select a chair and vice chair from its membership to coincide with the annual recruitment and nomination process. Candidate recruitment and selection of the chair and vice chair shall be conducted in accordance with Sections III.B-D of this Policy.

1. The WCM FAC chair and vice chair may serve two (2) consecutive one (1) year terms.

2. The WCM FAC chair and/or vice chair may be removed by a majority vote of CalOptima's Board.

K. The WCM FAC chair, or vice chair, shall ask for three (3) to four (4) members from the WCM FAC to serve on a nomination ad hoc subcommittee. WCM FAC members who are being considered for reappointment cannot participate in the nomination ad hoc subcommittee.

1. The WCM FAC nomination ad hoc subcommittee shall:

    a. Review, evaluate and select a prospective chair, vice chair and a candidate for each of the open seats, in accordance with Section III.C-D of this Policy; and

    b. Forward the prospective chair, vice chair, and slate of candidate(s) to the WCM FAC for review and approval.

2. Following approval from the WCM FAC, the recommended chair, vice chair, and slate of candidate(s) shall be forwarded to CalOptima's Board for review and approval.

L. CalOptima's Board shall approve all appointments, reappointments, and chair and vice chair appointments to the WCM FAC.

M. Upon appointment to WCM FAC and annually thereafter, WCM FAC members shall be required to complete all mandatory annual Compliance Training by the given deadline to maintain eligibility standing on the WCM FAC.

N. WCM FAC members shall attend all regularly scheduled meetings, unless they have an excused absence. An absence shall be considered excused if a WCM FAC member provides notification of an absence to CalOptima staff prior to the meeting. CalOptima staff shall maintain an attendance log of the WCM FAC members' attendance at WCM FAC meetings. As the attendance log is a public record, any request from a member of the public, the WCM FAC chair, the vice chair, the Chief Executive Officer, or the CalOptima Board, CalOptima staff shall provide a copy of the attendance log to the requester. In addition, the WCM FAC chair, or vice chair, shall contact any committee member who has three (3) consecutive unexcused absences.

1. WCM FAC members' attendance shall be considered as a criterion upon reapplication.

III. PROCEDURE

A. WCM FAC meeting frequency

1. WCM FAC shall meet at least quarterly.

2. WCM FAC shall adopt a yearly meeting schedule at the first regularly scheduled meeting in or after January of each year.

3. Attendance by a simple majority of appointed members shall constitute a quorum, and a quorum must be present for any votes to be valid.

B. WCM FAC recruitment process

1. CalOptima shall begin recruitment of potential candidates in March of each year. In the recruitment of potential candidates, the ethnic and cultural diversity and special needs of children and/or families of children in CCS which are or are expected to transition to CalOptima's Whole-Child Model population shall be considered. Nominations and input from interest groups and agencies shall be given due consideration.

2. CalOptima shall recruit for potential candidates using one or more notification methods, which may include, but are not limited to, the following:

   a. Outreach to family representatives and community advocates that represent children receiving CCS;

   b. Placement of vacancy notices on the CalOptima website; and/or

   c. Advertisement of vacancies in local newspapers in Threshold Languages.

3. Prospective candidates must submit a WCM Family Advisory Committee application, including resume and signed consent forms. Candidates shall be notified at the time of recruitment regarding the deadline to submit their application to CalOptima.

4. Except for the initial recruitment, the WCM FAC chair or vice chair shall inquire of its membership whether there are interested candidates who wish to be considered as a chair or vice chair for the upcoming fiscal year.

   a. CalOptima shall inquire at the first WCM FAC meeting whether there are interested candidates who wish to be considered as a chair for the first year.

C. WCM FAC nomination evaluation process

1. The WCM FAC chair or vice chair shall request three (3) to four (4) members, who are not being considered for reappointment, to serve on the nominations ad hoc subcommittee. For the first nomination process, Member Advisory Committee (MAC) members shall serve on the nominations ad hoc subcommittee to review candidates for WCM FAC.

a. At the discretion of the nomination ad hoc subcommittee, a subject matter expert (SME), may be included on the subcommittee to provide consultation and advice.

2. Prior to WCM FAC nomination ad hoc subcommittee meeting (including the initial WCM FAC nomination ad hoc subcommittee).

a. Ad hoc subcommittee members shall individually evaluate and score the application for each of the prospective candidates using the applicant evaluation tool.

b. Ad hoc subcommittee members shall individually evaluate and select a chair and vice chair from among the interested candidates.

c. At the discretion of the ad hoc subcommittee, subcommittee members may contact a prospective candidate's references for additional information and background validation.

3. The ad hoc subcommittee shall convene to discuss and select a chair, vice chair and a candidate for each of the expiring seats by using the findings from the applicant evaluation tool, the attendance record if relevant and the prospective candidate's references.

D. WCM FAC selection and approval process for prospective chair, vice chair, and WCM FAC candidates:

1. The nomination ad hoc subcommittee shall forward its recommendation for a chair, vice chair, and a slate of candidates to WCM FAC (or in the first year, the MAC) for review and approval. Following WCM FAC's approval (or in the first year, the MAC), the proposed chair, vice chair and slate of candidates shall be submitted to CalOptima's Board for approval.

2. The WCM FAC members' terms shall be effective upon approval by the CalOptima Board.

a. In the case of a selected candidate filling a seat that was vacated mid-term, the new candidate shall attend the immediately following WCM FAC meeting.

3. WCM FAC members shall attend a new advisory committee member orientation.

IV. ATTACHMENTS

A. Whole-Child Model Member Advisory Committee Application
B. Whole-Child Model Member Advisory Committee Applicant Evaluation Tool
C. Whole-Child Model Community Advisory Committee Application
D. Whole-Child Model Community Advisory Committee Applicant Evaluation Tool

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Board Resolution 17-1102-01
C. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
D. Welfare and Institutions Code §14094.17(b)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/07/2018	AA.1271PP	Whole Child Model Family Advisory Committee	Medi-Cal

IX. GLOSSARY

Term	Definition
California Children's Services Program	The public health program that assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of twenty-one (2l) years who have CCS-Eligible Conditions, as defined in Title 22, California Code of Regulations (CCR), Sections 41515.2 through 41518.9.
Member	For purposes of this policy, an enrollee-beneficiary of the CalOptima Medi-Cal Program receiving California Children's Services through the Whole Child Model program.
Member Advisory Committee (MAC)	A committee comprised of community advocates and Members, each of whom represents a constituency served by CalOptima, which was established by CalOptima to advise its Board of Directors on issues impacting Members.
Threshold Languages	Those languages identified based upon State requirements and/or findings of the Group Needs Assessment (GNA).
Whole Child Model	An organized delivery system that will ensure comprehensive, coordinated services through enhanced partnerships among Medi-Cal managed care plans, children's hospitals and specialty care providers.

Whole-Child Model Family Advisory Committee (WCM FAC) Member Application

Instructions: Please type or print clearly. This application is for current California Children's Services (CCS) members and their family members. Please attach a résumé or bio outlining your qualifications and include signed authorization forms. For questions, please call **1-714-246-8635**.

Name: _____ Primary Phone: _____

Address: _____ Secondary Phone: _____

City, State, ZIP: _____ Fax: _____

Date: _____ Email: _____

Please see the eligibility criteria below:*

Seven (7) to nine (9) seats shall be family representatives in one of the following categories. Please indicate:

- ☐ Authorized representatives, which includes parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
- ☐ CalOptima members age 18–21 who are current recipients of CCS services; or
- ☐ Current CalOptima members over the age of 21 who transitioned from CCS services

Four (4) seats will be appointed for a one-year term and five (5) seats will be appointed for a two-year term.

CalOptima Medi-Cal/CCS status (e.g., member, family member, foster parent, caregiver, etc.):

_____

If you are a family member/foster parent/caregiver, please tell us who the member is and what your relationship is to the member:

Member Name: _____ Relationship: _____

Please tell us whether you have been a CalOptima member (i.e., Medi-Cal) or have any consumer advocacy experience: _____

_____

_____

_____

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Please explain why you would be a good representative for diverse cultural and/or special needs of children and/or the families of children in CCS. Include any relevant experience working with these populations: _____

_____

_____

Please provide a brief description of your knowledge or experience with California Children's Services:_____

_____

_____

Please explain why you wish to serve on the WCM FAC:_____

_____

_____

_____

Describe why you would be a qualified representative for service on the WCM FAC:_____

_____

_____

_____

Other than English, do you speak or read any of CalOptima's threshold languages for the Whole-Child Model (i.e. Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic)? If so, which one(s)?

_____

If selected, are you able to commit to attending quarterly (at least) WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

Please supply two references (professional, community or personal):

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

Name: _____
Relationship: _____
Address: _____
City, State, ZIP: _____
Phone: _____
Email: _____

* Interested candidates for the WCM FAC member or family member seats must reside in Orange County and maintain enrollment in CalOptima Medi-Cal and/or California Children Services/Whole-Child Model or must be a family member of an enrolled CalOptima Medi-Cal and California Children Services/Whole-Child Model member.

This information is available for free in other languages. Please call our Customer Service Department toll-free at **1-888-587-8808**. TDD/TTY users can call toll-free at **1-800-735-2929**.

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Please sign the **Public Records Act Notice** below and **Limited Privacy Waiver** on the next page. You also need to sign the attached **Authorization for Use or Disclosure of Protected Health Information** form to enable CalOptima to verify current member status.

PUBLIC RECORDS ACT NOTICE

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature: _____ **Date:** _____

Print Name: _____

LIMITED PRIVACY WAIVER

Under state and federal law, the fact that a person is eligible for Medi-Cal and California Children's Services (CCS) is a private matter that may only be disclosed by CalOptima as necessary to administer the Medi-Cal and CCS program, unless other disclosures are authorized by the eligible member. Because the position of Member Representative on Whole Child Model Family Advisory Committee (WCM FAC) requires that the person appointed must be a member or a family member of a member receiving CCS, the member's Medi-Cal and CCS eligibility will be disclosed to the general public. The member or their representative (e.g. parent, foster parent, guardian, etc.) should check the appropriate box below and sign this waiver to allow his or her, or his or her family member or caregiver's name to be nominated for the advisory committee.

☐ **MEMBER APPLICANT — I understand that by signing below and applying to serve on the WCM FAC, I am disclosing my eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

☐ **FAMILY MEMBER APPLICANT — I understand that by applying to serve on the WCM FAC, my status as a family member of a person eligible for Medi-Cal and CCS benefits is likely to become public. I authorize the disclosing of my family member's (insert name of member: _____) eligibility for the Medi-Cal and CCS program, the fact of which is otherwise protected under state or federal law. I am not agreeing to disclose any other information protected by state or federal law.**

Medi-Cal/CCS Member (Printed Name): _____

Applicant Printed Name: _____

Applicant Signature: _____ **Date:** _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The federal HIPAA Privacy Regulations requires that you complete this form to authorize CalOptima to use or disclose your Protected Health Information (PHI) to another person or organization. Please complete, sign, and return the form to CalOptima.

Date of Request: _____ Telephone Number: _____

Member Name: _____ Member CIN: _____

AUTHORIZATION:

I, _____, hereby authorize CalOptima, to use or disclose my health information as described below.

Describe the health information that will be used or disclosed under this authorization (please be specific): Information related to the identity, program administrative activities and/or services provided to {me} {my child} which is disclosed in response to my own disclosures and/or questions related to same.

Person or organization authorized to receive the health information: **General public**

Describe each purpose of the requested use or disclosure (please be specific): **To allow** CalOptima staff to respond to questions or issues raised by me that may require reference to my health information that is protected from disclosure by law during public meetings of **the CalOptima Whole-Child Model Family Advisory Committee**

EXPIRATION DATE:

This authorization shall become effective immediately and shall expire on: **The end of the term of the position applied for**

Right to Revoke: I understand that I have the right to revoke this authorization in writing at any time. To revoke this authorization, I understand that I must make my request in writing and clearly state that I am revoking this specific authorization. In addition, I must sign my request and then mail or deliver my request to:

CalOptima
Customer Service Department
505 City Parkway West
Orange, CA 92868

I understand that a revocation will not affect the ability of CalOptima or any health care provider to use or disclose the health information to the extent that it has acted in reliance on this authorization.

RESTRICTIONS:

I understand that anything that occurs in the context of a public meeting, including the meetings of the Whole Child Model Family Advisory Committee, is a matter of public record that is required to be disclosed upon request under the California Public Records Act. Information related to, or relevant to, information disclosed pursuant to this authorization that is not disclosed at the public meeting remains protected from disclosure under the Health Insurance Portability and Accountability Act (HIPAA), and will not be disclosed by CalOptima without separate authorization, unless disclosure is permitted by HIPAA without authorization, or is required by law.

MEMBER RIGHTS:

- I understand that I must receive a copy of this authorization.
- I understand that I may receive additional copies of the authorization.
- I understand that I may refuse to sign this authorization.
- I understand that I may withdraw this authorization at any time.
- I understand that neither treatment nor payment will be dependent upon my refusing or agreeing to sign this authorization.

ADDITIONAL COPIES:

Did you receive additional copies? ☐ Yes ☐ No

SIGNATURE:

By signing below, I acknowledge receiving a copy of this authorization.

Member Signature: _____ Date: _____

Signature of Parent or Legal Guardian: _____ Date: _____

If Authorized Representative:

Name of Personal Representative: _____

Legal Relationship to Member: _____

Signature of Personal Representative: _____ Date: _____

Basis for legal authority to sign this Authorization by a Personal Representative

(If a personal representative has signed this form on behalf of the member, a copy of the Health Care Power of Attorney, a court order (such as appointment as a conservator, or as the executor or

administrator of a deceased member's estate), or other legal documentation demonstrating the authority of the personal representative to act on the individual's behalf must be attached to this form.)

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Consumer advocacy experience or Medi-Cal member experience	1–5	
2. Good representative for diverse cultural and/or special needs of children and/or families of children in CCS	1–5	
Include relevant experience with these populations	1–5	
3. Knowledge or experience with California Children's Services	1–5	
4. Explanation why applicant wishes to serve on the WCM FAC	1–5	
5. Explanation why applicant is a qualified representative for WCM FAC	1–5	
6. Ability to speak one of the threshold languages (other than English)	Yes/No	
7. Availability and willingness to attend meetings	Yes/No	
8. Supportive references	Yes/No	
	Total Possible Points	30
	Total Points Awarded	

_____
Name of Evaluator

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Whole-Child Model Family Advisory Committee (WCM FAC) Community Application

Instructions: Please answer all questions. You may handwrite or type your answers. Attach an additional page if needed.
If you have any questions regarding the application, call 1-714-246-8635.

Name:_____ Work Phone:_____

Address:_____ Mobile Phone:_____

City, State ZIP:_____ Fax Number:_____

Date:_____ Email:_____

Please see the eligibility criteria below:

Two (2) to four (4) seats will represent the interests of children receiving California Children's Services (CCS), including:

☐ Community-based organizations

☐ Consumer advocates

Except for two designated seats appointed for the initial year of the Committee, all appointments are for a two-year period, subject to continued eligibility to hold a Community representative seat.

Current position and/or relation to a community-based organization or consumer advocate(s) (e.g., organization title, student, volunteer, etc.):

_____

1. Please provide a brief description of your direct or indirect experience working with the CalOptima population receiving CCS services and/or the constituency you wish to represent on the WCM FAC. Include any relevant community experience:

_____

_____

_____

_____

2. What is your understanding of and familiarity with the diverse cultural and/or special needs of children receiving CCS services in Orange County and/or their families? Include any relevant experience working with such populations:

_____

_____

_____

_____

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3. What is your understanding of and experience with California Children's Services, managed care systems and/or CalOptima?

_____

_____

_____

_____

4. Please explain why you wish to serve on the WCM FAC:

_____

_____

_____

_____

5. Describe why you would be a qualified representative for service on the WCM FAC:

_____

_____

_____

_____

6. Other than English, do you speak or read any of CalOptima's threshold languages, such as Spanish, Vietnamese, Korean, Farsi, Chinese or Arabic? If so, which one(s)?

_____

7. If selected, are you able to commit to attending WCM FAC meetings, as well as serving on at least one subcommittee? ☐ Yes ☐ No

8. Please supply two references (professional, community or personal):

Name:_____	Name:_____
Relationship:_____	Relationship:_____
Address:_____	Address:_____
City, State ZIP:_____	City, State ZIP:_____
Phone:_____	Phone:_____
Email:_____	Email:_____

Submit with a **biography or résumé** to:

CalOptima, 505 City Parkway West, Orange, CA 92868
Attn: Becki Melli
Email: bmelli@caloptima.org
For questions, call **1-714-246-8635**

Applications must be received by March 30, 2018.

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Public Records Act Notice

Under California law, this form, the information it contains, and any further information submitted with it, such as biographical summaries and résumés, are public records, with the exception of your address, email address, and telephone numbers, and the same information of any references provided. These documents may be presented to the Board of Directors for their consideration at a public meeting, at which time they will be published, with the contact information removed, as part of the Board Materials that are available on CalOptima's website, and even if not presented to the Board, will be available on request to members of the public.

Signature **Date**

Print Name

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CalOptima
A Public Agency
Better. Together.

Applicant Name: _____

WCM Family Advisory Committee Applicant Evaluation Tool (use one per applicant)

WCM FAC Seat: _____

Please rate questions 1 through 5 below based on how well the applicant satisfies the following statements where
5 is Excellent 4 is Very good 3 is Average 2 is Fair 1 is Poor

Criteria for Nomination Consideration and Point Scale	Possible Points	Awarded Points
1. Direct or indirect experience working with members the applicant wishes to represent	1–5	_____
Include relevant community involvement	1–5	_____
2. Understanding of and familiarity with the diverse cultural and/or special needs populations in Orange County	1–5	_____
Include relevant experience with diverse populations	1–5	_____
3. Knowledge of managed care systems and/or CalOptima programs	1–5	_____
4. Expressed desire to serve on the WCM FAC	1–5	_____
5. Explanation why applicant is a qualified representative	1–5	_____
6. Ability to speak one of the threshold languages (other than English)	Yes/No	_____
7. Availability and willingness to attend meetings	Yes/No	_____
8. Supportive references	Yes/No	_____
	Total Possible Points	35
	Total Points Awarded	_____

_____
Name of Evaluator

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June, 7 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

46. Consider Modifications to CalOptima Policy and Procedures Related to the Delivery of Child Health and Disability Prevention Services for Medi-Cal Members Effective July 1, 2018

Contact

Candice Gomez, Executive Director, Program Implementation; (714) 246-8400

Recommended Actions

Authorize the Chief Executive Officer (CEO) to modify the following policy and procedures related to the delivery of Child Health and Disability Prevention Services for Medi-Cal members, effective for dates of service on and after July 1, 2018:

1. FF.1002: CalOptima Medi-Cal Fee Schedule;
2. FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group; and
3. FF.2003: Coordination of Benefits.

Background

Child Health and Disability Prevention (CHDP) Services are preventive health services for children up to age 21 that include health screenings and immunizations. Since 1998, CalOptima has provided these services on a fee-for-service basis for all members, including those enrolled in the Health Networks; CHDP services have not been included in the Health Network capitation. CHDP services are payable to any qualifying provider, including non-contracted providers. Services are typically billed using CHDP-specific local codes on the Confidential Screening/Billing Report Form PM 160 INF (PM 160 form). California's Department of Health Care Services (DHCS) has established a fee schedule, separate from Medi-Cal, based on the CHDP local codes. Use of the forms allows CalOptima to effectively distinguish between CHDP services payable by CalOptima and non-CHDP services payable by Health Networks.

In 2014, DHCS began planning to transition from use of California-specific CHDP local codes and forms to use of standardized procedure codes and claim forms compliant with the Health Insurance Portability and Accountability Act (HIPAA). Throughout 2017, DHCS implemented this transition for Medi-Cal fee-for-service providers. In November 2017, DHCS announced that beginning January 1, 2018, the requirement to use the PM 160 form would end and the form would no longer be produced for Managed Care Plans (MCPs). DHCS also advised that required encounter reporting of PM 160 data would also be eliminated. However, DHCS will continue to require MCPs to distinguish between CHDP and non-CHDP services encounter in their submitted data. Additionally, DHCS has advised that the State's CHDP fee schedule will sunset and transition to the standard Medi-Cal fee schedule. CalOptima's transition from California-specific CHDP local codes and forms to HIPAA complaint procedure codes and claim forms is effective for services provided on and after July 1, 2018. CalOptima staff has discussed the changes to the CHDP program with its health networks during the monthly health network forum meetings, joint operations meeting, and requested ad hoc discussions.

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Additionally, CHDP has been discussed during the Provider Advisory Committee meetings and the February 2018 Board of Directors' Finance and Audit Committee Meeting.

Discussion

In order to transition from CHDP specific forms and local codes to HIPAA complaint claim forms and codes, operational policy and procedures require modification. Additionally, in separate actions to the CalOptima Board of Directors (Board), CalOptima staff recommend including the responsibility for CHDP services into the Health Networks' Division of Financial Responsibility (DOFR) in accordance with their contract models. Health networks will be required to modify their claims process to include CHDP services and modify their capitated and fee-for-service contracts, as needed. Policy and procedure changes are required contingent upon Board approval of including CHDP services within the scope of health network responsibilities. The following policy and procedures are affected and include other required regulatory updates:

Policy No./Name		Summary of Change(s)	Reason for Change
1.	FF.1002: CalOptima Medi-Cal Fee Schedule	• Change references regarding CHDP rates from the Medi-Cal Provider Manual to the Medi-Cal FFS Fee Schedule • Effective for date of service on or after July 1, 2018 rates for CHDP will be included in the CalOptima Medi-Cal Fee Schedule	• CalOptima will transition CHDP specific codes and rates to HIPAA compliant codes and CalOptima Medi-Cal Fee Schedule effective for services provided on and after July 1, 2018
2.	FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group	• Clarification regarding use of PM 160 form • Changed reference to timeframe for recovering overpayment. Period changed from 365 days to 6 years. • Changed the timeframe for provider to return overpayment from 30 days to 60 days • Clarified ER interest of $15.00 or 15% per annum does not apply	• CalOptima will transition CHDP specific codes and rates to HIPAA compliant codes and CalOptima Medi-Cal Fee Schedule effective for services provided on and after July 1, 2018 • Required changes due to MegaRule final rule • Modified language to clarify interest requirements

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Policy No./Name		Summary of Change(s)	Reason for Change
		to family planning services • Added reference to identified overpayments of $25,000,000 in a single instance, must be reported to DHCS within 60 days	
3.	FF.2003: Coordination of Benefits	• Procedure for Claim forms billing parameters for PM160. Adding billing date of service through June 30,2018. • Added statement "If CalOptima identifies OHC unknown to the Department of Health Care Services (DHCS), the Customer Service Department shall report this information to the DHCS Third Party Liability Branch, Other Coverage Unit, within ten (10) calendar days of discovery in an automated format as prescribed by DHCS" • Added reporting language as detailed in our DHCS contract (Exhibit E, Attachment2, Provision 23.F.1).	• CalOptima will transition CHDP specific codes and rates to HIPAA compliant codes and CalOptima Medi-Cal Fee Schedule effective for services provided on and after July 1, 2018 • Updated based on recommendations to further describe the requirements

Subsequent to Board approval, these policies will be submitted to DHCS for further review. Based on guidance from DHCS, the policies may require further revision.

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Fiscal Impact

The recommended action to authorize CalOptima to include responsibility for CHDP into the Health Networks' DOFR is expected to increase CalOptima's CHDP costs by $4.1 million annually. Trended historical CHDP costs for delegated members are projected to be $20.7 million annually if CalOptima were to retain risk. If delegated, capitated CHDP expenses are projected to be $24.8 million. The increased costs are primarily due to two factors: (1) the application of the contracted CalOptima Direct/CalOptima Community Network Medi-Cal fee schedule for primary care physician services and (2) the application of an administration load to reimburse health networks for increased claims adjudication and management costs. CalOptima will incorporate funding for CHDP services that are currently paid on a FFS basis into an equivalent capitation rate to delegated Health Networks. Management has included expenses associated with the recommended CHDP actions in the proposed CalOptima FY 2018-19 Operating Budget pending Board approval.

Rationale for Recommendation

The recommended actions will enable CalOptima to transition away from use of California-specific CHDP local codes and forms to use of standardized HIPAA compliant procedure codes and claim forms.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. FF.1002: CalOptima Medi-Cal Fee Schedule (redlined and clean copies)
2. FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct- Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group (redlined and clean copies)
3. FF.2003: Coordination of Benefits (redlined and clean copies)

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

5/30/2018 — **Date**

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Policy #: FF.1002
Title: **CalOptima Medi-Cal Fee Schedule**
Department: Coding Initiatives
Section: ~~N/A~~Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 10/01/06
Last Review Date: 06/~~01/17~~07/18
Last Revised Date: 06/~~01/17~~07/18

I. PURPOSE

This policy defines the process by which CalOptima shall establish and maintain the CalOptima Medi-Cal Fee Schedule.

II. POLICY

A. CalOptima shall maintain a Medi-Cal Fee Schedule to determine payments to Providers and Practitioners, as applicable.

III. PROCEDURE

A. The Department of Health Care Services (DHCS) provides a complete file of the Medi-Cal Fee-for-Service (FFS) Fee Schedule to the public on a monthly basis.

B. Effective April 1, 2011, CalOptima shall update the CalOptima Medi-Cal Fee Schedule on a monthly basis based on the monthly file released by DHCS used to update the Medi-Cal Fee-for-Service Schedule.

1. Monthly updates to the CalOptima Medi-Cal Fee Schedule shall be effective the first of the month following.

C. DHCS provides rates for Child Health and Disability Prevention (CHDP) services and medical and incontinence supplies to the public through the Medi-Cal Provider Manuals. DHCS updates the manuals based on subsequent rate changes. For dates of service on or after July 1, 2018, rates for CHDP will be included in the Medi-Cal FFS Fee Schedule rather than in the Provider Manuals.

D. The CalOptima Medi-Cal Fee Schedule is based on the following:

1. DHCS FFS reimbursement rates as included in the Medi-Cal FFS Fee Schedule;

2. DHCS FFS reimbursement rates as referenced in the Medi-Cal Provider Manual for ~~CHDP services,~~ medical and incontinence supplies; and

3. DHCS FFS reimbursement rates based on prospective and retroactive rate revisions issued by DHCS through Operating Instruction Letters (OILs). CalOptima shall implement FFS reimbursement rates received via OILs to the extent the FFS reimbursement rate is not reflected in the Medi-Cal Fee Schedule, unless such OIL is related to a State Plan Amendment (SPA) not approved by the Centers for Medicare & Medicaid Services (CMS).

E. CalOptima shall reimburse Providers and Practitioners for Covered Services provided to CalOptima Direct Members based on the CalOptima Medi-Cal Fee Schedule in effect on the date the claim is

processed for date(s) of service submitted, unless otherwise required by law or contract in accordance with CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

1. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a non-contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable. A non-contracted Provider or Practitioner shall have the right to file a complaint in accordance with CalOptima Policies FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group, and HH.1101: CalOptima Provider Complaint.

2. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable, as required by law or contract.

F. CalOptima may, in its sole discretion, update the CalOptima Medi-Cal Fee Schedule between the regularly scheduled updates.

G. A Provider and Practitioner shall submit claims for Covered Services rendered to a CalOptima Direct Member in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

H. The Medi-Cal FFS Fee Schedule and Provider Manuals are available by accessing the Medi-Cal website.

IV. ATACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Medi-Cal Fee-For-Service Rates: http://files.medi-cal.ca.gov/pubsdoco/Rates/RatesHome.asp .
G. Medi-Cal Provider Manual: Publications; Provider Manual: http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

VI. REGULATORY AGENCY APROVALS

A. 03/14/11: Department of Health Care Services

VII. BOARD ACTIONS

~~None to Date~~

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/01/2006	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	04/01/2011	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	04/01/2016	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	06/01/2017	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	06/07/2018	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal

IX. GLOSSARY

Term	Definition
CalOptima Direct	A direct health care program operated by CalOptima that includes both COD- Administrative (COD-A) and CalOptima Community Network (CCN) and provides services to Members who meet certain eligibility criteria as described in Policy DD.2006: Enrollment in/Eligibility with CalOptima Direct.
CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Covered Service	For purposes of this policy, those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Fee-For-Service Amounts	Amounts adopted by CalOptima for reimbursement to hospitals, physicians and other providers for medical services rendered (other than on a capitated payment basis) to Medi-Cal beneficiaries for which CalOptima is responsible.
Medi-Cal Provider Manual	A provider manual created and updated by the Department of Health Care Services as a reference for providers enrolled in the Medi-Cal Fee-for-Service program to include information on Medi-Cal services, programs, claim reimbursement, complete information about recipient eligibility and provider participation, program policies, code lists, claim form and follow-up instructions pertaining to specific provider communities and specialty programs.
Operating Instruction Letter	A letter issued by the Department of Health Care Service to its Fiscal Intermediary for purposes of administering the Medi-Cal Fee-For-Service program.
Overpayment	For the purposes of this policy, any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.

Term	Definition
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

Policy #: FF.1002
Title: **CalOptima Medi-Cal Fee Schedule**
Department: Coding Initiatives
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 10/01/06
Last Review Date: 06/07/18
Last Revised Date: 06/07/18

I. PURPOSE

This policy defines the process by which CalOptima shall establish and maintain the CalOptima Medi-Cal Fee Schedule.

II. POLICY

A. CalOptima shall maintain a Medi-Cal Fee Schedule to determine payments to Providers and Practitioners, as applicable.

III. PROCEDURE

A. The Department of Health Care Services (DHCS) provides a complete file of the Medi-Cal Fee-for-Service (FFS) Fee Schedule to the public on a monthly basis.

B. Effective April 1, 2011, CalOptima shall update the CalOptima Medi-Cal Fee Schedule on a monthly basis based on the monthly file released by DHCS used to update the Medi-Cal Fee-for-Service Schedule.

1. Monthly updates to the CalOptima Medi-Cal Fee Schedule shall be effective the first of the month following.

C. DHCS provides rates for Child Health and Disability Prevention (CHDP) services and medical and incontinence supplies to the public through the Medi-Cal Provider Manuals. DHCS updates the manuals based on subsequent rate changes. For dates of service on or after July 1, 2018, rates for CHDP will be included in the Medi-Cal FFS Fee Schedule rather than in the Provider Manuals.

D. The CalOptima Medi-Cal Fee Schedule is based on the following:

1. DHCS FFS reimbursement rates as included in the Medi-Cal FFS Fee Schedule;

2. DHCS FFS reimbursement rates as referenced in the Medi-Cal Provider Manual for medical and incontinence supplies; and

3. DHCS FFS reimbursement rates based on prospective and retroactive rate revisions issued by DHCS through Operating Instruction Letters (OILs). CalOptima shall implement FFS reimbursement rates received via OILs to the extent the FFS reimbursement rate is not reflected in the Medi-Cal Fee Schedule, unless such OIL is related to a State Plan Amendment (SPA) not approved by the Centers for Medicare & Medicaid Services (CMS).

E. CalOptima shall reimburse Providers and Practitioners for Covered Services provided to CalOptima Direct Members based on the CalOptima Medi-Cal Fee Schedule in effect on the date the claim is

processed for date(s) of service submitted, unless otherwise required by law or contract in accordance with CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group.

1. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a non-contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable. A non-contracted Provider or Practitioner shall have the right to file a complaint in accordance with CalOptima Policies FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group, and HH.1101: CalOptima Provider Complaint.

2. In the event DHCS issues a retroactive adjustment to a previously published, mandated rate, CalOptima shall reprocess a contracted Provider's or Practitioner's claim and recoup Overpayments, to the extent possible, and refund underpayments, as applicable, as required by law or contract.

F. CalOptima may, in its sole discretion, update the CalOptima Medi-Cal Fee Schedule between the regularly scheduled updates.

G. A Provider and Practitioner shall submit claims for Covered Services rendered to a CalOptima Direct Member in accordance with CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group.

H. The Medi-Cal FFS Fee Schedule and Provider Manuals are available by accessing the Medi-Cal website.

IV. ATACHMENTS

Not Applicable

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. CalOptima Contract for Health Care Services
C. CalOptima Policy FF.1003: Payments for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group
D. CalOptima Policy FF.2001: Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group
E. CalOptima Policy HH.1101: CalOptima Provider Complaint
F. Medi-Cal Fee-For-Service Rates: http://files.medi-cal.ca.gov/pubsdoco/Rates/RatesHome.asp .
G. Medi-Cal Provider Manual: Publications; Provider Manual: http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp

VI. REGULATORY AGENCY APROVALS

A. 03/14/11: Department of Health Care Services

VII. BOARD ACTIONS

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	10/01/2006	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	04/01/2011	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	04/01/2016	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	06/01/2017	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal
Revised	06/07/2018	FF.1002	CalOptima Medi-Cal Fee Schedule	Medi-Cal

IX. GLOSSARY

Term	Definition
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CalOptima Medi-Cal Fee Schedule	Fee schedule adopted by CalOptima for reimbursement of Covered Services rendered to Medi-Cal Members for which CalOptima is responsible.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for children eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Covered Service	For purposes of this policy, those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), or other services as authorized by the CalOptima Board of Directors, which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Fee-For-Service Amounts	Amounts adopted by CalOptima for reimbursement to hospitals, physicians and other providers for medical services rendered (other than on a capitated payment basis) to Medi-Cal beneficiaries for which CalOptima is responsible.
Medi-Cal Provider Manual	A provider manual created and updated by the Department of Health Care Services as a reference for providers enrolled in the Medi-Cal Fee-for-Service program to include information on Medi-Cal services, programs, claim reimbursement, complete information about recipient eligibility and provider participation, program policies, code lists, claim form and follow-up instructions pertaining to specific provider communities and specialty programs.
Operating Instruction Letter	A letter issued by the Department of Health Care Service to its Fiscal Intermediary for purposes of administering the Medi-Cal Fee-For-Service program.
Overpayment	For the purposes of this policy, any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.

Term	Definition
Practitioner	A licensed independent practitioner including, but not limited to, a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatric Medicine (DPM), Doctor of Chiropractic Medicine (DC), Doctor of Dental Surgery (DDS), Doctor of Psychology (PhD or PsyD), Licensed Clinical Social Worker (LCSW), Marriage and Family Therapist (MFT or MFCC), Nurse Practitioner (NP), Nurse Midwife, Physician Assistant (PA), Optometrist (OD), Registered Physical Therapist (RPT), Occupational Therapist (OT), or Speech and Language Therapist, furnishing Covered Services.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

1

Policy #:	FF.2001
Title:	**Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/07
Last Review Date:	06/07/~~01/17~~18
Last Revised Date:	06/07/~~01/17~~18

I. PURPOSE

This policy describes the process by which CalOptima ensures timely and accurate processing of claims for Covered Services provided to a CalOptima Direct-Administrative (COD-A) Member, CalOptima Community Network (CCN) Member, or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process claims in compliance with Title 42, United States Code, Section1396a(a)(37), and Health and Safety Code Sections 1371 through 1371.39.

B. CalOptima shall establish and maintain administrative processes, or contract with a claims processing organization, to accept and adjudicate claims for health care services provided to Members, in accordance with the provisions of this policy and the California Code of Regulations.

C. CalOptima shall ensure timely compliance with claims payment obligations and claims settlement practices.

D. CalOptima shall not impose a deadline for the receipt of a claim that is less than ninety (90) days for a participating Provider or one hundred and eighty (180) days for a non-participating Provider, after the date of service, except as required by state or federal law or regulation.

E. CalOptima shall identify and acknowledge the receipt of each claim, whether or not it is a Complete Claim, and disclose the recorded date of receipt. CalOptima may provide an electronic method of notification, by which the Provider may readily confirm CalOptima's receipt of the claim and the recorded date of receipt within fifteen (15) business days of receipt of the claim.

F. CalOptima may review a claim for National Correct Coding Initiative (NCCI) edits~~,~~ and may contest or deny a claim based on improper coding. CalOptima may subcontract with a third~~-~~party vendor to review claims for NCCI edits and improper billing practices.

G. Claims Processing Timelines

1. CalOptima shall process and adjudicate ninety percent (90%) of Clean Claims for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group, within thirty (30) calendar days after CalOptima's receipt of such Clean Claims.

2. CalOptima shall process and adjudicate ninety-nine (99%) of Claims for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group within ninety (90) calendar days after CalOptima's receipt of such claim.

3. CalOptima shall notify a Provider of an Unclean Claim for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group, within forty-five (45) business days after receipt of such claim. If CalOptima fails to notify the Provider of the Unclean Claim, CalOptima shall consider the claim a Clean Claim, and shall pay, in accordance with the timelines for Clean Claims as set forth in this policy.

H. CalOptima shall reimburse a Provider claim for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group, in accordance with CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group. Covered services shall include payment for Emergency and Family Planning services which do not require authorization.

I. CalOptima shall not request reimbursement for the overpayment of a claim, including requests made pursuant to Health and Safety Code, Section1371.1, unless CalOptima sends a written request for reimbursement to the Provider within ~~three hundred sixty-five (365) calendar days after the date of payment on the overpaid claim. The three hundred sixty-five (365) calendar day time limit shall not apply if the overpayment was caused, in whole or in part, by fraud or misrepresentation on the part of the Provider.~~six (6) years from the date the overpayment was made.

J. CalOptima shall have a process to recoup Overpayments made to Providers, and suppliers when claims payments exceed the allowed amount.

1. CalOptima may recoup Overpayments for a look-back period not to exceed six (6) years from current calendar year.

2. The six (6) year time limit shall not apply if the Overpayment was caused in whole, or in part, by Fraud, or misrepresentation, on the part of the Provider.

~~J.~~K. CalOptima shall pay interest and applicable penalties on all uncontested claims not paid within forty-five (45) business days, in accordance with Section III.G of this policy. The interest is determined by Health and Safety Code, Section1371.

~~K.~~L. CalOptima shall not improperly deny, adjust, or contest a claim, and shall provide a clear and accurate written explanation of the specific reasons for the action taken.

~~L.~~M. CalOptima may contest or deny a claim, or portion thereof, by notifying the Provider, in writing, that the claim is contested or denied, within forty-five (45) business days after the date of receipt of the claim by CalOptima.

~~M.~~N. CalOptima shall establish and maintain a fair, fast, and cost-effective Provider dispute resolution mechanism to process and resolve provider disputes. CalOptima shall make available to the Department of Health Care Services (DHCS) all records, notes, and documents regarding its provider dispute resolution mechanism(s) and the resolution of its provider disputes.

~~N.~~O. CalOptima shall not engage in any practices, policies, or procedures that may constitute a basis for a finding of a demonstrable and unjust payment pattern or unfair payment pattern that results in repeated delays in the adjudication and correct reimbursement of a Provider claim.

~~O.~~P. CalOptima shall submit all required reports and documents regarding claims payment practices and claims settlement practices to DHCS.

~~P.~~Q. CalOptima shall identify and process Overpayments and recoveries in accordance with DHCS All Plan Letter 17-003: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers, or subsequent updates, CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination, and Section III.I of this Policy.

~~1.~~3. ~~CalOptima shall submit documentation including retention policies, process, timeframes, and documentation required for reporting the recovery of all overpayments, upon request by DHCS.~~

III. PROCEDURE

A. A Provider shall verify a Member's eligibility to receive Covered Services through CalOptima Direct, in accordance with CalOptima Policy DD.2003: Member Identification and Eligibility Verification.

B. A Provider shall obtain authorization for Covered Services, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, and GG.1508: Authorization and Processing of Referrals.

C. Members with Other Health Coverage or Medicare

1. If a Member has Other Health Coverage or Medicare, a Provider shall submit a claim for Covered Services provided to the Member to the Other Health Coverage or Medicare prior to submitting the claim to CalOptima, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

2. CalOptima processes Crossover Claims for Members with secondary benefits under Medi-Cal. A Provider may submit Crossover Claims to CalOptima, in accordance with the Medi-Cal Provider Manual guidelines for Crossover Claims.

D. Claims Submission

1. A Provider shall utilize the following standard forms for submitting claims for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group:

a. A Provider shall use the CMS-1500 when submitting a claim for professional services and supplies;

b. A Provider shall use the UB-04 Form when submitting a claim for hospital inpatient or outpatient services;

c. An Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF) shall use the LTC-25-1 Claim Form when submitting a claim for long-term care services; and

d. ~~A Provider may use the PM160 INF Form for the~~ Child Health and Disability Prevention Program (CHDP)

i. For CHDP services provided on or before June 30, 2018, a Provider shall use the PM 160 INF Form and associated codes when submitting a claim for Pediatric Preventive Services to CalOptima.

~~d.~~ii. For CHDP services provided on or after July 1, 2018, a Provider shall use the appropriate CMS-1500 or UB-04 claim form and standard CPT and HCPCS codes when submitting a claim for Pediatric Preventive Services. Claims for COD-A or CCN Members shall continue to be submitted to CalOptima, while claims for Shared Risk Groups Members shall be submitted to the appropriate Shared Risk Group.

2. A Provider shall submit a claim on the appropriate form with supporting documentation, including required prior authorizations and proof of Medicare or Other Health Coverage payment or denial.

3. A Provider may submit electronic or paper claims to CalOptima for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group.

a. A Provider may elect to submit electronic claims to CalOptima utilizing the process outlined in Section H3: Electronic Claim Submissions, in the CalOptima Provider Manual, https://www.caloptima.org/en/Providers/ManualsPoliciesAndResources/CalOptimaProviderManual.aspx.

b. A Provider who submits a paper claim shall submit the original claim form~~,~~ and retain a copy for the Provider's files. CalOptima shall not accept carbon copies, photocopies, computer generated copies, or facsimiles of paper claims.

c. A Provider may submit paper claims to CalOptima by mail, or in person, at the following addresses:

i. By mail:
Attention: Claims Department
CalOptima
Post Office Box 11037
Orange, CA 92856

ii. In person:
Attention: Claims Department
CalOptima
505 City Parkway West
Orange, CA 92868

E. Claim Filing Deadlines

1. A Provider shall submit a claim for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group within three hundred sixty-five (365) calendar days after the month of the date of service.

2. If CalOptima denies a claim because it was filed beyond the claim filing deadline, CalOptima shall, upon a Provider's submission of a provider dispute pursuant to Tile 28, California Code of Regulations, Section 1300.71.38, and the demonstration of good cause for the delay, accept and adjudicate the claim, in accordance with Health and Safety Code, Sections 1371 or 1371.35, whichever is applicable.

3. If CalOptima is not the primary payer under coordination of benefits, CalOptima shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payer that is less than ninety (90) days from the date of payment or date of contest, date of denial, or notice from the primary payer.

F. Misdirected Claims

1. For a Provider claim involving Emergency Services or Family Planning Services that is incorrectly sent to CalOptima, CalOptima shall forward the claim to the appropriate Health Network within ten (10) business days after receipt of the claim.

2. For a Provider Claim that does not involve Emergency Services or Family Planning Services that is incorrectly sent to CalOptima, and the Provider that filed the claim is a participating Provider, CalOptima shall either:

a. Send the Provider a notice of denial via a remittance advice, within forty-five (45) business days, with instructions to bill the Health Network; or

b. Forward the claim to the appropriate Health Network, within ten (10) business days of the receipt of the claim, in a format specified by CalOptima.

3. In all other cases, for claims incorrectly sent to CalOptima, CalOptima shall forward the claim to the appropriate Health Network within ten (10) business days of the receipt of the claim.

G. Interest on Late Claims

1. Interest shall begin to accrue on the forty-sixth (46th) business day~~,~~ and is calculated based on calendar days.

2. CalOptima shall automatically include~~,~~ for late payment on a Complete Claim for emergency services ~~and care or Family Planning Services,~~ the greater of fifteen dollars ($15) for each twelve (12) month period or portion thereof, on a non-prorated basis, or interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

3. CalOptima shall automatically include~~,~~ for late payments on all other claims other than Complete Claims for emergency services ~~and care or Family Planning Services~~, interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

4. If the interest due on an individual claim is less than two dollars ($2), CalOptima may wait until the close of the calendar month~~,~~ and make a lump interest payment for all late claim payments during that time period. CalOptima shall make lump interest payments within ten (10) calendar days of the calendar month's end.

5. If CalOptima fails to automatically include the interest due on a late claim payment, CalOptima shall pay the Provider ~~a~~ ten dollars ($10) penalty for that late claim, in addition to any interest amount due.

H. Denying, Adjusting, or Contesting a Claim

1. In the event that CalOptima requests reasonably relevant information from a Provider; in addition to information that the Provider submits with a claim, CalOptima shall provide a clear, accurate, and written explanation of the necessity for the request.

2. If CalOptima fails to provide the Provider with written notice that a claim has been contested or denied pursuant to Section III.K of this policy within the allowable time period, or requests information from the Provider that is not reasonably relevant information, or requests information from a third party that is in excess of the information necessary to determine payer liability, but ultimately pays the claim in whole or in part, CalOptima shall compute the interest or impose a penalty, pursuant to Section III.G of this policy,

3. A request for information necessary to determine payer liability from a third party shall not extend the time for reimbursement or the time for contesting or denying claims. CalOptima shall either contest or deny, in writing and within the timeframes set forth in Section III.G, incomplete claims and claims for which information necessary to determine payer liability that has been requested, which are held or pended awaiting receipt of additional information. CalOptima shall identify in the denied or contested claim, the individual or entity that was requested to submit information, the specific documents requested, and the reason(s) why the information is necessary to determine payer liability.

4. If CalOptima subsequently denies the claim based on the Provider's failure to provide the requested Medical Records or other information, any dispute arising from the denial of such claim shall be handled as a Provider dispute, in accordance with Title 28, California Code of Regulations, Section 1300.71.38.

I. Reimbursement for the Overpayment of Claims

1. Overpayments Identified by Providers

a. A Provider shall report to CalOptima when it has identified an Overpayment and return such Overpayment to CalOptima within sixty (60) calendar days after the date on which the overpayment was identified~~,~~. The Provider shall notify the CalOptima Claims Department, in writing, of the reason for the overpayment and the Claims Department shall coordinate with the Provider on the process to return the Overpayment to CalOptima.

2. Overpayments Identified by CalOptima

a. If CalOptima determines that it has overpaid a claim, it shall notify the Provider, in writing, through a separate notice clearly identifying the claim, the name of the patient, the date of service and include a clear explanation of the basis upon which CalOptima believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

b. If the Provider contests CalOptima's notice of reimbursement of the Overpayment of a claim, the Provider, within thirty (30) business days of the receipt of the notice of overpayment of a claim, shall send written notice to CalOptima stating the basis upon which the Provider believes that ~~the claim~~CalOptima's notice was ~~not overpaid~~in error. CalOptima shall receive and process the contested notice of overpayment of a claim as a provider dispute, pursuant to Title 28, California Code of Regulations, Section 1300.71.38 and CalOptima Policy HH.1101: CalOptima Provider Complaint.

c. If the Provider does not contest CalOptima's notice of reimbursement of the Overpayment of a claim, the Provider shall reimburse CalOptima within thirty (30) business days of the receipt, by the provider, of the notice of overpayment of a claim.

d. If the Provider does not reimburse CalOptima for the Overpayment of a claim within thirty (30) business days after receipt of CalOptima's notice, interest shall accrue at the rate of ten percent (10%) per annum, beginning with the first (1st) calendar day after the thirty (30) business day period.

e. CalOptima may only offset an uncontested notice of reimbursement of the overpayment of a claim against a Provider's current claim submission when:

i. The Provider fails to reimburse CalOptima within the timeframe in set forth in Section III.I.2 of this policy; and

ii. The Provider has entered into a written contract specifically authorizing CalOptima to offset an uncontested notice of overpayment of a claim from the current claim submissions. In the event that an overpayment of a claim or claims is offset against a Provider's current claim or claims pursuant to this section, CalOptima shall provide the Provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

~~2.~~3. CalOptima shall investigate any identified Overpayments that are suspected to be the result of inappropriate and/or inaccurate billing activity~~,~~ and shall promptly refer such identified

suspected Overpayments to CalOptima's Special Investigations Unit (SIU) and/or DHCS as outlined in CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination.

~~3.~~4. Retention and Reporting of Overpayments

a. CalOptima shall retain all Overpayments less than twenty-five million dollars ($25,000,000).

b. CalOptima shall document all Overpayments retained by CalOptima and review such reports on a quarterly basis.

i. On a monthly basis, the Claims Department shall submit a report to the Accounting Department documenting the Overpayment recovery activities for the prior month.

c. On an annual basis, CalOptima shall submit a report to DHCS on the recoveries of Overpayments, including those made to a Provider that was otherwise excluded from participation the Medicaid program, and those made to a Provider due to Fraud, Waste or Abuse. CalOptima shall submit the report through the rate setting process and in a manner specified by DHCS.

d. Upon identification of an Overpayment to a Provider of twenty-five million dollars ($25,000,000) or more in a single instance, CalOptima shall share the recovery amount with DHCS equally.

i. CalOptima shall report such Overpayment to the DHCS Contract Manager within sixty (60) calendar days after that the Overpayment was identified.

ii. CalOptima shall submit the Overpayment amount that was recovered, the Provider's information, and steps taken to correct future occurrences to the DHCS Contract Manager.

5. CalOptima shall submit documentation including retention policies, process, timeframes, and documentation required for reporting the recovery of all overpayments, upon request by DHCS.

J. Provider Claims Dispute Resolution

1. A Provider may request reconsideration of a claim that has been denied, adjusted, or contested. A Provider may request, in writing, a Provider Dispute Resolution (PDR) within three hundred sixty-five (365) calendar days after the date of the original Remittance Advice Detail (RAD) containing the adjudicated claim to CalOptima's Claims Department. The Provider shall submit a PDR form including, at minimum, the following information:

a. Provider's name;

b. Provider's identification number;

c. Provider's contact information; and

d. A clear identification of the disputed item, including:

i. Member's identification;

ii. Date of service;

iii. Original claim identification number;

iv. A clear explanation of the dispute; and

v. Any relevant material to support the dispute.

2. A Provider shall submit a PDR form, and any required attachments, to the address provided in Section III.D.3.c of this policy.

3. A Provider may obtain a copy of the PDR form on the CalOptima Website at www.caloptima.org.

4. CalOptima shall respond to each PDR individually.

5. Acknowledgement of Provider claims dispute resolution:

a. CalOptima's Claims Department shall send the Provider a PDR Acknowledgement Letter within fifteen (15) business days after receipt of a complete PDR, indicating receipt of the PDR, and identifying a Claims staff member whom the Provider may contact regarding the provider claims dispute.

b. If the PDR is lacking information that is not readily accessible to CalOptima, CalOptima's Claims Department shall return the PDR to the Provider, and clearly identify the missing information necessary to resolve the PDR. A Provider may submit an amended PDR within thirty (30) business days after receipt of a returned PDR setting forth the missing information.

6. PDR processing

a. Upon receipt of a complete PDR from a Provider, CalOptima's Claims Department shall:

i. Review the initial claims decision, and all documents related to the determination of the original adjudicated claim; and

ii. Prepare the case file for review by CalOptima's Claims PDR Unit.

b. CalOptima shall utilize specialist consultants, as appropriate.

7. PDR resolution

a. CalOptima's Claims PDR Unit shall resolve each Provider dispute, or amended Provider dispute, within applicable state and federal laws, regulations, and statutes within forty-five (45) business days after receipt of the PDR request.

i. The Claims PDR unit shall send a written PDR Determination Letter to the Provider, as appropriate. Such written notice shall include information regarding a Provider's right to file a Provider Complaint, in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

ii. If the Claims PDR Unit upholds the original claims adjudication, the Claims PDR Unit shall clearly specify the provisions for such determination.

iii. If the Claims PDR Unit overturns, in whole or in part, the original claims adjudication, the Claims PDR Unit shall pay any outstanding monies determined to be due, and all interest and penalties, if applicable, within five (5) business days of sending a PDR Determination Letter.

8. CalOptima shall retain copies of Provider disputes and determinations for at least ten (10) years, including all notes, documents and any other pertinent information upon which CalOptima PDR unit relied to resolve the Provider dispute.

K. CalOptima shall retain claims information data for a period of at least ten (10) years after the termination of its contract with the Department of Health Care Services (DHCS~~),~~) and shall not remove or transfer such records and data from its offices, except in accordance with applicable laws.

IV. ATTACHMENTS

A. CMS-1500
B. UB-04 Form
C. PM160 INF Form
D. LTC-25-1 Claim Form
E. Provider Claims Dispute Resolution Request Form

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Care Services
C. CalOptima Provider Manual
D. CalOptima Policy DD.2003: Member Identification and Eligibility Verification
E. CalOptima Policy FF.1003: Payment for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared Risk Group
F. CalOptima Policy FF.2003: Coordination of Benefits
G. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. CalOptima Policy HH.1101: CalOptima Provider Complaint
J. CalOptima Policy HH.~~2022~~2022Δ: Record Retention and Access
K. CalOptima Policy HH.~~5000~~5000Δ: Provider Overpayment Investigation and Determination

L. DHCS All Plan Letter 17-003: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers
M. Health and Safety Code, §§1371 through 1371.39
N. Medi-Cal Provider Manual
O. Title 22, California Code of Regulations, ~~Sections~~§§ 53220 and 53222
P. Title 28, California Code of Regulations, ~~Sections~~§§ 1300.71 and 1300.71.38
Q. Title 42, United States Code, ~~Section~~§ 1396a(a)(37)

VI. REGULATORY AGENCY APPROVALS

A. 06/09/17: Department of Health Care Services

VII. BOARD ACTIONS

A. Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/2006	CC.1202	CalOptima Direct Claims Processing	Medi-Cal
Revised	01/01/2007	FF.2001	CalOptima Direct Claims Processing	Medi-Cal
Revised	08/01/2008	FF.2001	CalOptima Direct Claims Processing	Medi-Cal
Revised	01/01/2009	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	03/01/2012	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	01/01/2013	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	12/01/2014	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	03/01/2015	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal
Revised	01/01/2017	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal
Revised	07/01/2017	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal
Revised	06/07/2018	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal

IX. GLOSSARY

Term	Definition
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
CalOptima Direct Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to Members as described in CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for persons eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Clean Claim	A claim that can be processed without obtaining additional information from the provider of the service or from a third party.
Complete Claim	A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: reasonably relevant information and information necessary to determine payer liability as defined in Title 28, California Code of Regulations section 1300.71 (a)(10) and (a)(11).
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Crossover Claims	A claim submitted for payment for a Medi-Medi Member for which Medicare has primary responsibility and Medi-Cal is the secondary payer.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.

Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures.
Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.
Pediatric Preventive Services (PPS)	Regular preventive health assessments, as recommended by the American Academy of Pediatrics or the Child Health and Disability Prevention (CHDP) Program. These include, but are not limited to, health and developmental history, physical examination, nutritional assessment, immunizations, vision testing, hearing testing, selected laboratory tests, health education, and anticipatory guidance.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act~~, or any payment to CalOptima by DHCS to which CalOptima is not entitled to under Title XIX of the Social Security Act.~~

Term	Definition
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.
Unclean Claim	A claim from a Provider that does not have all the required data elements, documentation, or information necessary to process the claim or make a final disposition. Unclean claim shall have the same meaning as incomplete claim submission.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1 MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

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1	2	3a PAT CNTL #	
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30

31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		35 OCCURRENCE SPAN CODE FROM THROUGH		36 OCCURRENCE SPAN CODE FROM THROUGH		37

38		39 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT	
	a				
	b				
	c				
	d				

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
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23		PAGE ____ OF ____	CREATION DATE					

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56 NPI	
A							
B						57 OTHER PRV ID	
C							

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A				
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX										68

69 ADMIT DX		70 PATIENT REASON DX				71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE DATE		b. OTHER PROCEDURE CODE DATE		75	76 ATTENDING	NPI	QUAL	
					LAST		FIRST	
d. OTHER PROCEDURE CODE DATE					77 OPERATING	NPI	QUAL	
					LAST		FIRST	

80 REMARKS	81CC			78 OTHER	NPI	QUAL	
	a			LAST		FIRST	
	b			79 OTHER	NPI	QUAL	
	c			LAST		FIRST	
	d						

UB-04 CMS-1450 APPROVED OMB NO.

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DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

STAPLE HERE

PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (INITIAL) | MEDICAL RECORD NO. | LA Code

BIRTHDATE Mo. Day Year | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Mo. Day Year

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE #) (CITY) (ZIP)

Ethnic Code: 1 American Indian, 2 Asian, 3 Black, 4 Filipino, 5 Mex. Amer./Hispanic, 6 White, 7 Other, 8 Pacific Islander

CHDP ASSESSMENT

Indicate outcome for each screening procedure

	NO PROBLEM SUSPECTED ✓A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column: NEW C	KNOWN D	DATE OF SERVICE Mo. Day Year / FEES
01 HISTORY and PHYSICAL EXAM					01
02 DENTAL ASSESSMENT/REFERRAL					
03 NUTRITIONAL ASSESSMENT					
04 ANTICIPATORY GUIDANCE/HEALTH EDUCATION					
05 DEVELOPMENTAL ASSESSMENT					
06 SNELLEN OR EQUIVALENT					06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT					08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					12

FOLLOW UP CODES
1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED

REFERRED TO: | TELEPHONE NUMBER

REFERRED TO: | TELEPHONE NUMBER

COMMENTS/PROBLEMS

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

CODE	OTHER TESTS	PLEASE REFER TO THE CHDP LIST OF TEST CODES	CODE	OTHER TESTS

HEIGHT IN INCHES 0 4 | WEIGHT LBS OZS | BODY MASS INDEX (BMI) PERCENTILE | BLOOD PRESSURE /

HEMOGLOBIN . | HEMATOCRIT .0% | % | BIRTH WEIGHT LBS OZS

INFORMATION ONLY REPORTING

ROUTINE REFERRAL(S) (✓) ☐ BLOOD LEAD ☐ DENTAL

PATIENT IS A FOSTER CHILD (✓) ☐

DIAGNOSIS CODES 1 2

IMMUNIZATIONS PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES	GIVEN TODAY: NOW UP TO DATE FOR AGE A	GIVEN TODAY: STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	NOT GIVEN TODAY: REFUSED OR CONTRA-INDICATED D

THE QUESTIONS BELOW MUST BE ANSWERED

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ☐
2. Tobacco Used by Patient Yes ☐ No ☐
3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes ☐ No ☐

PATIENT VISIT (✓) 1 New Patient or Extended Visit ☐ 2 Routine Visit ☐

TYPE OF SCREEN (✓) 1 Initial ☐ 2 Periodic ☐

TOTAL FEES

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)

HEALTH PLAN CODE / PROVIDER NUMBER

PLACE OF SERVICE

1 Enrolled in WIC ☐ 2 Referred to WIC ☐

NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

1 PARTIAL SCREEN ☐ 2 SCREENING PROCEDURE RECHECK ☐

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY | COUNTY | AID | IDENTIFICATION NUMBER

RENDERING PROVIDER (PRINT NAME):

SIGNATURE OF PROVIDER | DATE

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

PM 160 INFORMATION ONLY (03/07)

CONFIDENTIAL SCREENING/BILLING REPORT

MAY WORD POSITION

COPY 2 - COMMUNITY CHDP PROGRAM

PLEASE PRESS HARD OR TYPE WHEN FILLING OUT THIS FORM

8610036218

FACE 2; SCREEN 10%, 15% & 25%

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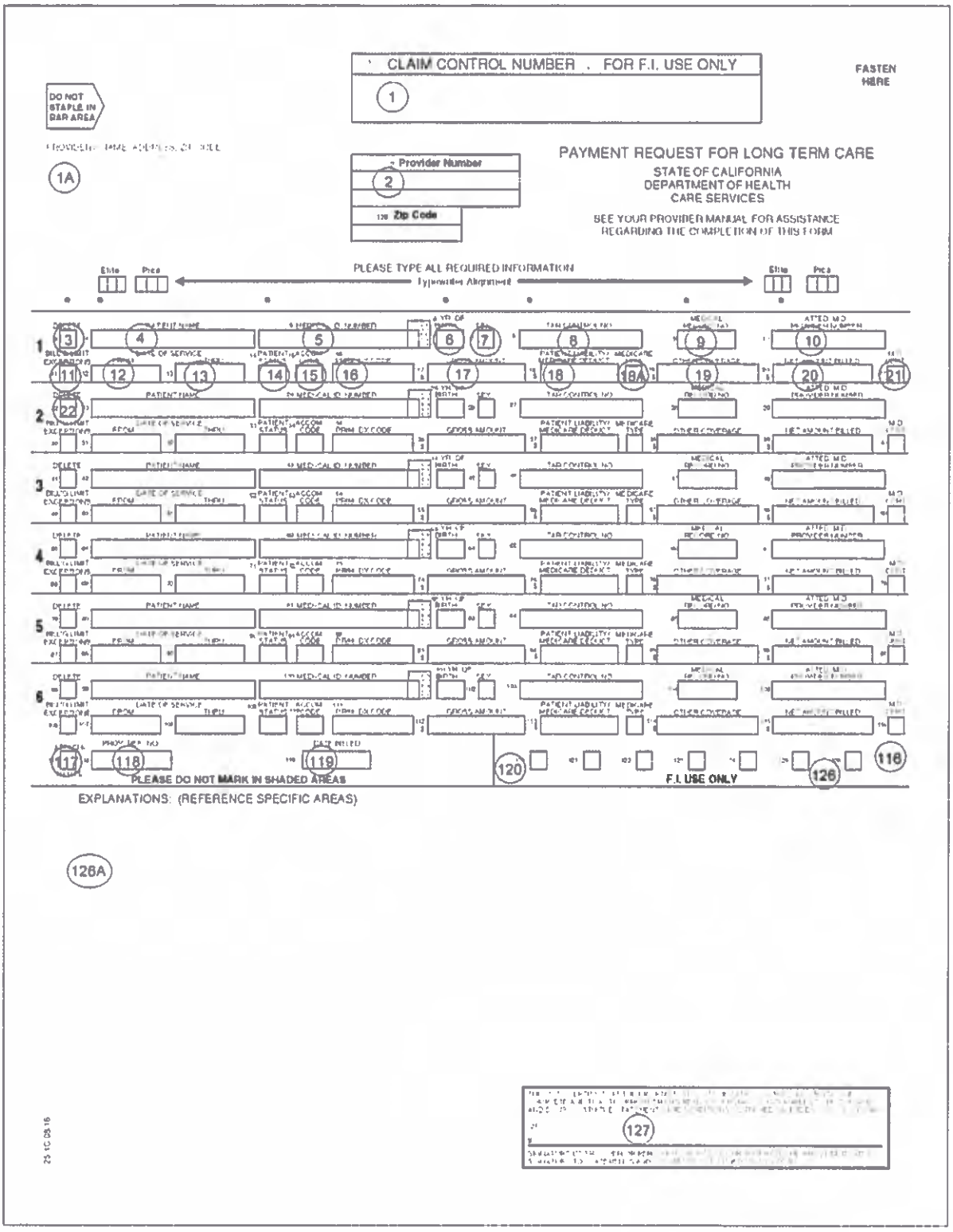

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PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.
- For routine follow-up regarding claims status, please contact the CalOptima Claims Provider Line: 714-246-8885
- Mail the completed form to: CalOptima Claims Provider Dispute
  P.O. Box 11037
  Orange, CA 92856

PRODUCT TYPE: ☐ MEDI-CAL ☐ MEDICARE ☐ COMMERCIAL

*PROVIDER NPI:	*PROVIDER TAX ID # / Medicare ID #:
*PROVIDER NAME:	CONTRACTED: ☑ YES ☐ NO
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC
☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

CLAIM INFORMATION ☐ Single ☐ Multiple "LIKE" Claims (complete attached spreadsheet) *Number of claims:* _____

* Patient Name:		Date of Birth:
* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Disputing Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	Title	( ) Phone Number
Signature	Date	( ) Fax Number

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**
(Please do not staple)

For Health Plan Use Only

TRACKING NUMBER _____ PROV ID# _____
CONTRACTED _____ NON-CONTRACTED _____

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PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

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☐ CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)

Policy #:	FF.2001
Title:	**Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members, or Members Enrolled in a Shared Risk Group**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/07
Last Review Date:	06/07/18
Last Revised Date:	06/07/18

I. PURPOSE

This policy describes the process by which CalOptima ensures timely and accurate processing of claims for Covered Services provided to a CalOptima Direct-Administrative (COD-A) Member, CalOptima Community Network (CCN) Member, or a Member enrolled in a Shared Risk Group. For those Members enrolled in a Shared Risk Group, this policy shall only apply to Covered Services for which CalOptima is financially responsible, in accordance with the Division of Financial Responsibility (DOFR).

II. POLICY

A. CalOptima shall process claims in compliance with Title 42, United States Code, Section1396a(a)(37), and Health and Safety Code Sections 1371 through 1371.39.

B. CalOptima shall establish and maintain administrative processes, or contract with a claims processing organization, to accept and adjudicate claims for health care services provided to Members, in accordance with the provisions of this policy and the California Code of Regulations.

C. CalOptima shall ensure timely compliance with claims payment obligations and claims settlement practices.

D. CalOptima shall not impose a deadline for the receipt of a claim that is less than ninety (90) days for a participating Provider or one hundred and eighty (180) days for a non-participating Provider, after the date of service, except as required by state or federal law or regulation.

E. CalOptima shall identify and acknowledge the receipt of each claim, whether or not it is a Complete Claim, and disclose the recorded date of receipt. CalOptima may provide an electronic method of notification, by which the Provider may readily confirm CalOptima's receipt of the claim and the recorded date of receipt within fifteen (15) business days of receipt of the claim.

F. CalOptima may review a claim for National Correct Coding Initiative (NCCI) edits and may contest or deny a claim based on improper coding. CalOptima may subcontract with a third-party vendor to review claims for NCCI edits and improper billing practices.

G. Claims Processing Timelines

1. CalOptima shall process and adjudicate ninety percent (90%) of Clean Claims for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group, within thirty (30) calendar days after CalOptima's receipt of such Clean Claims.

2. CalOptima shall process and adjudicate ninety-nine (99%) of Claims for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group within ninety (90) calendar days after CalOptima's receipt of such claim.

3. CalOptima shall notify a Provider of an Unclean Claim for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group, within forty-five (45) business days after receipt of such claim. If CalOptima fails to notify the Provider of the Unclean Claim, CalOptima shall consider the claim a Clean Claim, and shall pay, in accordance with the timelines for Clean Claims as set forth in this policy.

H. CalOptima shall reimburse a Provider claim for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group, in accordance with CalOptima Policy FF.1003: Payment for Covered Services Rendered to a Member of CalOptima Direct, or a Member Enrolled in a Shared Risk Group. Covered services shall include payment for Emergency and Family Planning services which do not require authorization.

I. CalOptima shall not request reimbursement for the overpayment of a claim, including requests made pursuant to Health and Safety Code, Section1371.1, unless CalOptima sends a written request for reimbursement to the Provider within six (6) years from the date the overpayment was made.

J. CalOptima shall have a process to recoup Overpayments made to Providers, and suppliers when claims payments exceed the allowed amount.

1. CalOptima may recoup Overpayments for a look-back period not to exceed six (6) years from current calendar year.

2. The six (6) year time limit shall not apply if the Overpayment was caused in whole, or in part, by Fraud, or misrepresentation, on the part of the Provider.

K. CalOptima shall pay interest and applicable penalties on all uncontested claims not paid within forty-five (45) business days, in accordance with Section III.G of this policy. The interest is determined by Health and Safety Code, Section1371.

L. CalOptima shall not improperly deny, adjust, or contest a claim, and shall provide a clear and accurate written explanation of the specific reasons for the action taken.

M. CalOptima may contest or deny a claim, or portion thereof, by notifying the Provider, in writing, that the claim is contested or denied, within forty-five (45) business days after the date of receipt of the claim by CalOptima.

N. CalOptima shall establish and maintain a fair, fast, and cost-effective Provider dispute resolution mechanism to process and resolve provider disputes. CalOptima shall make available to the Department of Health Care Services (DHCS) all records, notes, and documents regarding its provider dispute resolution mechanism(s) and the resolution of its provider disputes.

O. CalOptima shall not engage in any practices, policies, or procedures that may constitute a basis for a finding of a demonstrable and unjust payment pattern or unfair payment pattern that results in repeated delays in the adjudication and correct reimbursement of a Provider claim.

P. CalOptima shall submit all required reports and documents regarding claims payment practices and claims settlement practices to DHCS.

Q. CalOptima shall identify and process Overpayments and recoveries in accordance with DHCS All Plan Letter 17-003: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers, or subsequent updates, CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination, and Section III.I of this Policy.

III. PROCEDURE

A. A Provider shall verify a Member's eligibility to receive Covered Services through CalOptima Direct, in accordance with CalOptima Policy DD.2003: Member Identification and Eligibility Verification.

B. A Provider shall obtain authorization for Covered Services, in accordance with CalOptima Policies GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers, and GG.1508: Authorization and Processing of Referrals.

C. Members with Other Health Coverage or Medicare

1. If a Member has Other Health Coverage or Medicare, a Provider shall submit a claim for Covered Services provided to the Member to the Other Health Coverage or Medicare prior to submitting the claim to CalOptima, in accordance with CalOptima Policy FF.2003: Coordination of Benefits.

2. CalOptima processes Crossover Claims for Members with secondary benefits under Medi-Cal. A Provider may submit Crossover Claims to CalOptima, in accordance with the Medi-Cal Provider Manual guidelines for Crossover Claims.

D. Claims Submission

1. A Provider shall utilize the following standard forms for submitting claims for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group:

a. A Provider shall use the CMS-1500 when submitting a claim for professional services and supplies;

b. A Provider shall use the UB-04 Form when submitting a claim for hospital inpatient or outpatient services;

c. An Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF) shall use the LTC-25-1 Claim Form when submitting a claim for long-term care services; and

d. Child Health and Disability Prevention Program (CHDP)

i. For CHDP services provided on or before June 30, 2018, a Provider shall use the PM 160 INF Form and associated codes when submitting a claim for Pediatric Preventive Services to CalOptima.

ii. For CHDP services provided on or after July 1, 2018, a Provider shall use the appropriate CMS-1500 or UB-04 claim form and standard CPT and HCPCS codes when submitting a claim for Pediatric Preventive Services. Claims for COD-A or CCN Members shall continue to be submitted to CalOptima, while claims for Shared Risk Groups Members shall be submitted to the appropriate Shared Risk Group.

2. A Provider shall submit a claim on the appropriate form with supporting documentation, including required prior authorizations and proof of Medicare or Other Health Coverage payment or denial.

3. A Provider may submit electronic or paper claims to CalOptima for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group.

a. A Provider may elect to submit electronic claims to CalOptima utilizing the process outlined in Section H3: Electronic Claim Submissions, in the CalOptima Provider Manual, https://www.caloptima.org/en/Providers/ManualsPoliciesAndResources/CalOptimaProviderManual.aspx.

b. A Provider who submits a paper claim shall submit the original claim form and retain a copy for the Provider's files. CalOptima shall not accept carbon copies, photocopies, computer generated copies, or facsimiles of paper claims.

c. A Provider may submit paper claims to CalOptima by mail, or in person, at the following addresses:

i. By mail:
Attention: Claims Department
CalOptima
Post Office Box 11037
Orange, CA 92856

ii. In person:
Attention: Claims Department
CalOptima
505 City Parkway West
Orange, CA 92868

E. Claim Filing Deadlines

1. A Provider shall submit a claim for Covered Services provided to a COD-A Member, CCN Member, or a Member enrolled in a Shared Risk Group within three hundred sixty-five (365) calendar days after the month of the date of service.

2. If CalOptima denies a claim because it was filed beyond the claim filing deadline, CalOptima shall, upon a Provider's submission of a provider dispute pursuant to Tile 28, California Code of Regulations, Section 1300.71.38, and the demonstration of good cause for the delay, accept and adjudicate the claim, in accordance with Health and Safety Code, Sections 1371 or 1371.35, whichever is applicable.

3. If CalOptima is not the primary payer under coordination of benefits, CalOptima shall not impose a deadline for submitting supplemental or coordination of benefits claims to any secondary payer that is less than ninety (90) days from the date of payment or date of contest, date of denial, or notice from the primary payer.

F. Misdirected Claims

1. For a Provider claim involving Emergency Services or Family Planning Services that is incorrectly sent to CalOptima, CalOptima shall forward the claim to the appropriate Health Network within ten (10) business days after receipt of the claim.

2. For a Provider Claim that does not involve Emergency Services or Family Planning Services that is incorrectly sent to CalOptima, and the Provider that filed the claim is a participating Provider, CalOptima shall either:

   a. Send the Provider a notice of denial via a remittance advice, within forty-five (45) business days, with instructions to bill the Health Network; or

   b. Forward the claim to the appropriate Health Network, within ten (10) business days of the receipt of the claim, in a format specified by CalOptima.

3. In all other cases, for claims incorrectly sent to CalOptima, CalOptima shall forward the claim to the appropriate Health Network within ten (10) business days of the receipt of the claim.

G. Interest on Late Claims

1. Interest shall begin to accrue on the forty-sixth (46^{th}) business day and is calculated based on calendar days.

2. CalOptima shall automatically include for late payment on a Complete Claim for emergency services the greater of fifteen dollars ($15) for each twelve (12) month period or portion thereof, on a non-prorated basis, or interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

3. CalOptima shall automatically include for late payments on all other claims other than Complete Claims for emergency services, interest at the rate of fifteen percent (15%) per annum for the period of time that the payment is late.

4. If the interest due on an individual claim is less than two dollars ($2), CalOptima may wait until the close of the calendar month and make a lump interest payment for all late claim payments during that time period. CalOptima shall make lump interest payments within ten (10) calendar days of the calendar month's end.

5. If CalOptima fails to automatically include the interest due on a late claim payment, CalOptima shall pay the Provider ten dollars ($10) penalty for that late claim, in addition to any interest amount due.

H. Denying, Adjusting, or Contesting a Claim

1. In the event that CalOptima requests reasonably relevant information from a Provider; in addition to information that the Provider submits with a claim, CalOptima shall provide a clear, accurate, and written explanation of the necessity for the request.

2. If CalOptima fails to provide the Provider with written notice that a claim has been contested or denied pursuant to Section III.K of this policy within the allowable time period, or requests information from the Provider that is not reasonably relevant information, or requests information from a third party that is in excess of the information necessary to determine payer liability, but ultimately pays the claim in whole or in part, CalOptima shall compute the interest or impose a penalty, pursuant to Section III.G of this policy,

3. A request for information necessary to determine payer liability from a third party shall not extend the time for reimbursement or the time for contesting or denying claims. CalOptima shall either contest or deny, in writing and within the timeframes set forth in Section III.G, incomplete claims and claims for which information necessary to determine payer liability that has been requested, which are held or pended awaiting receipt of additional information. CalOptima shall identify in the denied or contested claim, the individual or entity that was requested to submit information, the specific documents requested, and the reason(s) why the information is necessary to determine payer liability.

4. If CalOptima subsequently denies the claim based on the Provider's failure to provide the requested Medical Records or other information, any dispute arising from the denial of such claim shall be handled as a Provider dispute, in accordance with Title 28, California Code of Regulations, Section 1300.71.38.

I. Reimbursement for the Overpayment of Claims

1. Overpayments Identified by Providers

a. A Provider shall report to CalOptima when it has identified an Overpayment and return such Overpayment to CalOptima within sixty (60) calendar days after the date on which the overpayment was identified. The Provider shall notify the CalOptima Claims Department, in writing, of the reason for the overpayment and the Claims Department shall coordinate with the Provider on the process to return the Overpayment to CalOptima.

2. Overpayments Identified by CalOptima

a. If CalOptima determines that it has overpaid a claim, it shall notify the Provider, in writing, through a separate notice clearly identifying the claim, the name of the patient, the date of service and include a clear explanation of the basis upon which CalOptima believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.

b. If the Provider contests CalOptima's notice of reimbursement of the Overpayment of a claim, the Provider, within thirty (30) business days of the receipt of the notice of overpayment of a claim, shall send written notice to CalOptima stating the basis upon which the Provider believes that CalOptima's notice was in error. CalOptima shall receive and process the contested notice of overpayment of a claim as a provider dispute, pursuant to Title 28, California Code of Regulations, Section 1300.71.38 and CalOptima Policy HH.1101: CalOptima Provider Complaint.

c. If the Provider does not contest CalOptima's notice of reimbursement of the Overpayment of a claim, the Provider shall reimburse CalOptima within thirty (30) business days of the receipt, by the provider, of the notice of overpayment of a claim.

d. If the Provider does not reimburse CalOptima for the Overpayment of a claim within thirty (30) business days after receipt of CalOptima's notice, interest shall accrue at the rate of ten percent (10%) per annum, beginning with the first (1st) calendar day after the thirty (30) business day period.

e. CalOptima may only offset an uncontested notice of reimbursement of the overpayment of a claim against a Provider's current claim submission when:

i. The Provider fails to reimburse CalOptima within the timeframe in set forth in Section III.I.2 of this policy; and

ii. The Provider has entered into a written contract specifically authorizing CalOptima to offset an uncontested notice of overpayment of a claim from the current claim submissions. In the event that an overpayment of a claim or claims is offset against a Provider's current claim or claims pursuant to this section, CalOptima shall provide the Provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims.

3. CalOptima shall investigate any identified Overpayments that are suspected to be the result of inappropriate and/or inaccurate billing activity and shall promptly refer such identified suspected Overpayments to CalOptima's Special Investigations Unit (SIU) and/or DHCS as outlined in CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination.

4. Retention and Reporting of Overpayments

a. CalOptima shall retain all Overpayments less than twenty-five million dollars ($25,000,000).

b. CalOptima shall document all Overpayments retained by CalOptima and review such

reports on a quarterly basis.

i. On a monthly basis, the Claims Department shall submit a report to the Accounting Department documenting the Overpayment recovery activities for the prior month.

c. On an annual basis, CalOptima shall submit a report to DHCS on the recoveries of Overpayments, including those made to a Provider that was otherwise excluded from participation the Medicaid program, and those made to a Provider due to Fraud, Waste or Abuse. CalOptima shall submit the report through the rate setting process and in a manner specified by DHCS.

d. Upon identification of an Overpayment to a Provider of twenty-five million dollars ($25,000,000) or more in a single instance, CalOptima shall share the recovery amount with DHCS equally.

i. CalOptima shall report such Overpayment to the DHCS Contract Manager within sixty (60) calendar days after that the Overpayment was identified.

ii. CalOptima shall submit the Overpayment amount that was recovered, the Provider's information, and steps taken to correct future occurrences to the DHCS Contract Manager.

5. CalOptima shall submit documentation including retention policies, process, timeframes, and documentation required for reporting the recovery of all overpayments, upon request by DHCS.

J. Provider Claims Dispute Resolution

1. A Provider may request reconsideration of a claim that has been denied, adjusted, or contested. A Provider may request, in writing, a Provider Dispute Resolution (PDR) within three hundred sixty-five (365) calendar days after the date of the original Remittance Advice Detail (RAD) containing the adjudicated claim to CalOptima's Claims Department. The Provider shall submit a PDR form including, at minimum, the following information:

a. Provider's name;

b. Provider's identification number;

c. Provider's contact information; and

d. A clear identification of the disputed item, including:

i. Member's identification;

ii. Date of service;

iii. Original claim identification number;

iv. A clear explanation of the dispute; and

v. Any relevant material to support the dispute.

2. A Provider shall submit a PDR form, and any required attachments, to the address provided in Section III.D.3.c of this policy.

3. A Provider may obtain a copy of the PDR form on the CalOptima Website at www.caloptima.org.

4. CalOptima shall respond to each PDR individually.

5. Acknowledgement of Provider claims dispute resolution:

   a. CalOptima's Claims Department shall send the Provider a PDR Acknowledgement Letter within fifteen (15) business days after receipt of a complete PDR, indicating receipt of the PDR, and identifying a Claims staff member whom the Provider may contact regarding the provider claims dispute.

   b. If the PDR is lacking information that is not readily accessible to CalOptima, CalOptima's Claims Department shall return the PDR to the Provider, and clearly identify the missing information necessary to resolve the PDR. A Provider may submit an amended PDR within thirty (30) business days after receipt of a returned PDR setting forth the missing information.

6. PDR processing

   a. Upon receipt of a complete PDR from a Provider, CalOptima's Claims Department shall:

      i. Review the initial claims decision, and all documents related to the determination of the original adjudicated claim; and

      ii. Prepare the case file for review by CalOptima's Claims PDR Unit.

   b. CalOptima shall utilize specialist consultants, as appropriate.

7. PDR resolution

   a. CalOptima's Claims PDR Unit shall resolve each Provider dispute, or amended Provider dispute, within applicable state and federal laws, regulations, and statutes within forty-five (45) business days after receipt of the PDR request.

      i. The Claims PDR unit shall send a written PDR Determination Letter to the Provider, as appropriate. Such written notice shall include information regarding a Provider's right to file a Provider Complaint, in accordance with CalOptima Policy HH.1101: CalOptima Provider Complaint.

      ii. If the Claims PDR Unit upholds the original claims adjudication, the Claims PDR Unit shall clearly specify the provisions for such determination.

iii. If the Claims PDR Unit overturns, in whole or in part, the original claims adjudication, the Claims PDR Unit shall pay any outstanding monies determined to be due, and all interest and penalties, if applicable, within five (5) business days of sending a PDR Determination Letter.

8. CalOptima shall retain copies of Provider disputes and determinations for at least ten (10) years, including all notes, documents and any other pertinent information upon which CalOptima PDR unit relied to resolve the Provider dispute.

K. CalOptima shall retain claims information data for a period of at least ten (10) years after the termination of its contract with the Department of Health Care Services (DHCS) and shall not remove or transfer such records and data from its offices, except in accordance with applicable laws.

IV. ATTACHMENTS

A. CMS-1500
B. UB-04 Form
C. PM160 INF Form
D. LTC-25-1 Claim Form
E. Provider Claims Dispute Resolution Request Form

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS)
B. CalOptima Contract for Health Care Services
C. CalOptima Provider Manual
D. CalOptima Policy DD.2003: Member Identification and Eligibility Verification
E. CalOptima Policy FF.1003: Payment for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared Risk Group
F. CalOptima Policy FF.2003: Coordination of Benefits
G. CalOptima Policy GG.1500: Authorization Instructions for CalOptima Direct and CalOptima Community Network Providers
H. CalOptima Policy GG.1508: Authorization and Processing of Referrals
I. CalOptima Policy HH.1101: CalOptima Provider Complaint
J. CalOptima Policy HH.2022Δ: Record Retention and Access
K. CalOptima Policy HH.5000Δ: Provider Overpayment Investigation and Determination
L. DHCS All Plan Letter 17-003: Treatment of Recoveries Made by the Managed Care Health Plan of Overpayments to Providers
M. Health and Safety Code, §§1371 through 1371.39
N. Medi-Cal Provider Manual
O. Title 22, California Code of Regulations, §§ 53220 and 53222
P. Title 28, California Code of Regulations, §§ 1300.71 and 1300.71.38
Q. Title 42, United States Code, § 1396a(a)(37)

VI. REGULATORY AGENCY APPROVALS

A. 06/09/17: Department of Health Care Services

VII. BOARD ACTIONS

A. Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/2006	CC.1202	CalOptima Direct Claims Processing	Medi-Cal
Revised	01/01/2007	FF.2001	CalOptima Direct Claims Processing	Medi-Cal
Revised	08/01/2008	FF.2001	CalOptima Direct Claims Processing	Medi-Cal
Revised	01/01/2009	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	03/01/2012	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	01/01/2013	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	12/01/2014	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members or Members Enrolled in a Shared-Risk Group	Medi-Cal
Revised	03/01/2015	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal

Version	Date	Policy Number	Policy Title	Line(s) of Business
Revised	01/01/2017	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal
Revised	07/01/2017	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal
Revised	06/07/2018	FF.2001	Claims Processing for Covered Services Rendered to CalOptima Direct-Administrative Members, CalOptima Community Network Members or Members Enrolled in a Shared Risk Group	Medi-Cal

IX. GLOSSARY

Term	Definition
CalOptima Community Network (CCN)	A managed care network operated by CalOptima that contracts directly with physicians and hospitals and requires a Primary Care Provider (PCP) to manage the care of the Members.
CalOptima Direct Administrative (COD-A)	The managed Fee-For-Service health care program operated by CalOptima that provides services to Members as described in CalOptima Policy DD.2006: Enrollment In/Eligibility with CalOptima Direct.
Child Health and Disability Prevention (CHDP) Program	California's Early Periodic Screening, Detection, and Treatment (EPSDT) program as defined in the Health and Safety Code, Section 12402.5 et seq. and Title 17 of the California Code of Regulations, Sections 6842 through 6852, that provides certain preventive services for persons eligible for Medi-Cal. For CalOptima Members, the CHDP Program is incorporated into CalOptima's Pediatric Preventive Services Program.
Clean Claim	A claim that can be processed without obtaining additional information from the provider of the service or from a third party.
Complete Claim	A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides: reasonably relevant information and information necessary to determine payer liability as defined in Title 28, California Code of Regulations section 1300.71 (a)(10) and (a)(11).
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Crossover Claims	A claim submitted for payment for a Medi-Medi Member for which Medicare has primary responsibility and Medi-Cal is the secondary payer.
Division of Financial Responsibility (DOFR)	A matrix that identifies how CalOptima identifies the responsible parties for components of medical associated with the provision of Covered Services. The responsible parties include, but are not limited to, Physician, Hospital, CalOptima and the County of Orange.
Emergency Services	Covered Services furnished by Provider qualified to furnish those health services needed to evaluate or stabilize an Emergency Medical Condition.

Term	Definition
Family Planning Services	Covered Services that are provided to individuals of childbearing age to enable them to determine the number and spacing of their children, and to help reduce the incidence of maternal and infant deaths and diseases by promoting the health and education of potential parents. Family Planning includes, but is not limited to 1. Medical and surgical services performed by or under the direct supervision of a licensed Physician for the purpose of Family Planning; 2. Laboratory and radiology procedures, drugs and devices prescribed by a license Physician and/or are associated with Family Planning procedures; 3. Patient visits for the purpose of Family Planning; 4. Family Planning counseling services provided during regular patient visit; 5. IUD and UCD insertions, or any other invasive contraceptive procedures or devices; 6. Tubal ligations; 7. Vasectomies; 8. Contraceptive drugs or devices; and 9. Treatment for the complications resulting from previous Family Planning procedures.
Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.
Pediatric Preventive Services (PPS)	Regular preventive health assessments, as recommended by the American Academy of Pediatrics or the Child Health and Disability Prevention (CHDP) Program. These include, but are not limited to, health and developmental history, physical examination, nutritional assessment, immunizations, vision testing, hearing testing, selected laboratory tests, health education, and anticipatory guidance.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.
Overpayment	Any payment made by CalOptima to a Provider to which the Provider is not entitled to under Title XIX of the Social Security Act
Shared Risk Group	A Health Network who accepts delegated clinical and financial responsibility for professional services for assigned Members, as defined by written contract and enters into a risk sharing agreement with CalOptima as the responsible partner for facility services.

Term	Definition
Unclean Claim	A claim from a Provider that does not have all the required data elements, documentation, or information necessary to process the claim or make a final disposition. Unclean claim shall have the same meaning as incomplete claim submission.

1

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1 MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

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1	2	3a PAT CNTL #	
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM THROUGH
			7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30

31 OCCURRENCE CODE DATE		32 OCCURRENCE CODE DATE		35 OCCURRENCE SPAN CODE FROM THROUGH		36 OCCURRENCE SPAN CODE FROM THROUGH		37

38		39 VALUE CODES CODE AMOUNT		41 VALUE CODES CODE AMOUNT	
	a				
	b				
	c				
	d				

	42 REV CD	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV DATE	46 SERV UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
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16								
17								
18								
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21								
22								
23		PAGE ____ OF ____	CREATION DATE					

50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST AMOUNT DUE	56 NPI	
A							
B						57 OTHER PRV ID	
C							

58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.
A				
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
A		
B		
C		

66 DX										68

69 ADMIT DX		70 PATIENT REASON DX				71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE DATE		b. OTHER PROCEDURE CODE DATE		75	76 ATTENDING	NPI	QUAL	
					LAST		FIRST	
d. OTHER PROCEDURE CODE DATE					77 OPERATING	NPI	QUAL	
					LAST		FIRST	

80 REMARKS	81CC			78 OTHER	NPI	QUAL	
	a			LAST		FIRST	
	b			79 OTHER	NPI	QUAL	
	c			LAST		FIRST	
	d						

UB-04 CMS-1450 APPROVED OMB NO.

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DO NOT STAPLE IN BAR AREA

CLAIM CONTROL NUMBER • FOR STATE USE ONLY

STAPLE HERE

PLEASE PRINT

PATIENT NAME (LAST) (FIRST) (INITIAL) | MEDICAL RECORD NO. | LA Code

BIRTHDATE Mo. Day Year | AGE | SEX M/F | PATIENT'S COUNTY OF RESIDENCE | CO. CODE | TELEPHONE NUMBER ( ) | NEXT CHDP EXAM Mo. Day Year

RESPONSIBLE PERSON (NAME) (STREET) (APT/SPACE #) (CITY) (ZIP)

Ethnic Code: 1 American Indian, 2 Asian, 3 Black, 4 Filipino, 5 Mex. Amer./Hispanic, 6 White, 7 Other, 8 Pacific Islander

CHDP ASSESSMENT

Indicate outcome for each screening procedure

	NO PROBLEM SUSPECTED ✓A	REFUSED, CONTRA-INDICATED, NOT NEEDED ✓B	PROBLEM SUSPECTED Enter Follow Up Code in Appropriate Column: NEW C	KNOWN D	DATE OF SERVICE Mo. Day Year / FEES
01 HISTORY and PHYSICAL EXAM					01
02 DENTAL ASSESSMENT/REFERRAL					
03 NUTRITIONAL ASSESSMENT					
04 ANTICIPATORY GUIDANCE/HEALTH EDUCATION					
05 DEVELOPMENTAL ASSESSMENT					
06 SNELLEN OR EQUIVALENT					06
07 AUDIOMETRIC					07
08 HEMOGLOBIN OR HEMATOCRIT					08
09 URINE DIPSTICK					09
10 COMPLETE URINALYSIS					10
12 TB MANTOUX					12

FOLLOW UP CODES
1. NO DX/RX INDICATED OR NOW UNDER CARE.
2. QUESTIONABLE RESULT, RECHECK SCHEDULED.
3. DX MADE AND RX STARTED
4. DX PENDING/RETURN VISIT SCHEDULED.
5. REFERRED TO ANOTHER EXAMINER FOR DX/RX.
6. REFERRAL REFUSED

REFERRED TO: | TELEPHONE NUMBER

REFERRED TO: | TELEPHONE NUMBER

COMMENTS/PROBLEMS

IF A PROBLEM IS DIAGNOSED THIS VISIT, PLEASE ENTER YOUR DIAGNOSIS IN THIS AREA

CODE	OTHER TESTS	PLEASE REFER TO THE CHDP LIST OF TEST CODES	CODE	OTHER TESTS

HEIGHT IN INCHES 0 4 | WEIGHT LBS OZS | BODY MASS INDEX (BMI) PERCENTILE | BLOOD PRESSURE /

HEMOGLOBIN . | HEMATOCRIT .0% | % | BIRTH WEIGHT LBS OZS

INFORMATION ONLY REPORTING

ROUTINE REFERRAL(S) (✓) ☐ BLOOD LEAD ☐ DENTAL

PATIENT IS A FOSTER CHILD (✓) ☐

DIAGNOSIS CODES 1 2

IMMUNIZATIONS PLEASE REFER TO THE CHDP LIST OF IMMUNIZATION CODES	GIVEN TODAY: NOW UP TO DATE FOR AGE A	GIVEN TODAY: STILL NOT UP TO DATE FOR AGE B	NOT GIVEN TODAY: ALREADY UP TO DATE FOR AGE C	NOT GIVEN TODAY: REFUSED OR CONTRA-INDICATED D

THE QUESTIONS BELOW MUST BE ANSWERED

1. Patient is Exposed to Passive (Second Hand) Tobacco Smoke. Yes ☐ No ☐
2. Tobacco Used by Patient Yes ☐ No ☐
3. Counseled About/Referred For Tobacco Use Prevention/ Cessation. Yes ☐ No ☐

PATIENT VISIT (✓) 1 New Patient or Extended Visit ☐ 2 Routine Visit ☐

TYPE OF SCREEN (✓) 1 Initial ☐ 2 Periodic ☐

TOTAL FEES

SERVICE LOCATION: Name, Address, Telephone Number (Please Include Area Code)

HEALTH PLAN CODE / PROVIDER NUMBER

PLACE OF SERVICE

1 Enrolled in WIC ☐ 2 Referred to WIC ☐

NOTE: WIC requires Ht., Wt. and Hemoglobin/Hematocrit

1 PARTIAL SCREEN ☐ 2 SCREENING PROCEDURE RECHECK ☐

ACCOMPANIES PRIOR PM 160 DATED

PATIENT ELIGIBILITY | COUNTY | AID | IDENTIFICATION NUMBER

RENDERING PROVIDER (PRINT NAME):

SIGNATURE OF PROVIDER | DATE

STATE OF CALIFORNIA-CHILD HEALTH AND DISABILITY PREVENTION PROGRAM

Medi-Cal/CHDP
P.O. Box 15300
Sacramento, CA 95851-1300

PM 160 INFORMATION ONLY (03/07)

CONFIDENTIAL SCREENING/BILLING REPORT

MAY WORD POSITION

COPY 2 - COMMUNITY CHDP PROGRAM

PLEASE PRESS HARD OR TYPE WHEN FILLING OUT THIS FORM

8610036218

FACE 2; SCREEN 10%, 15% & 25%

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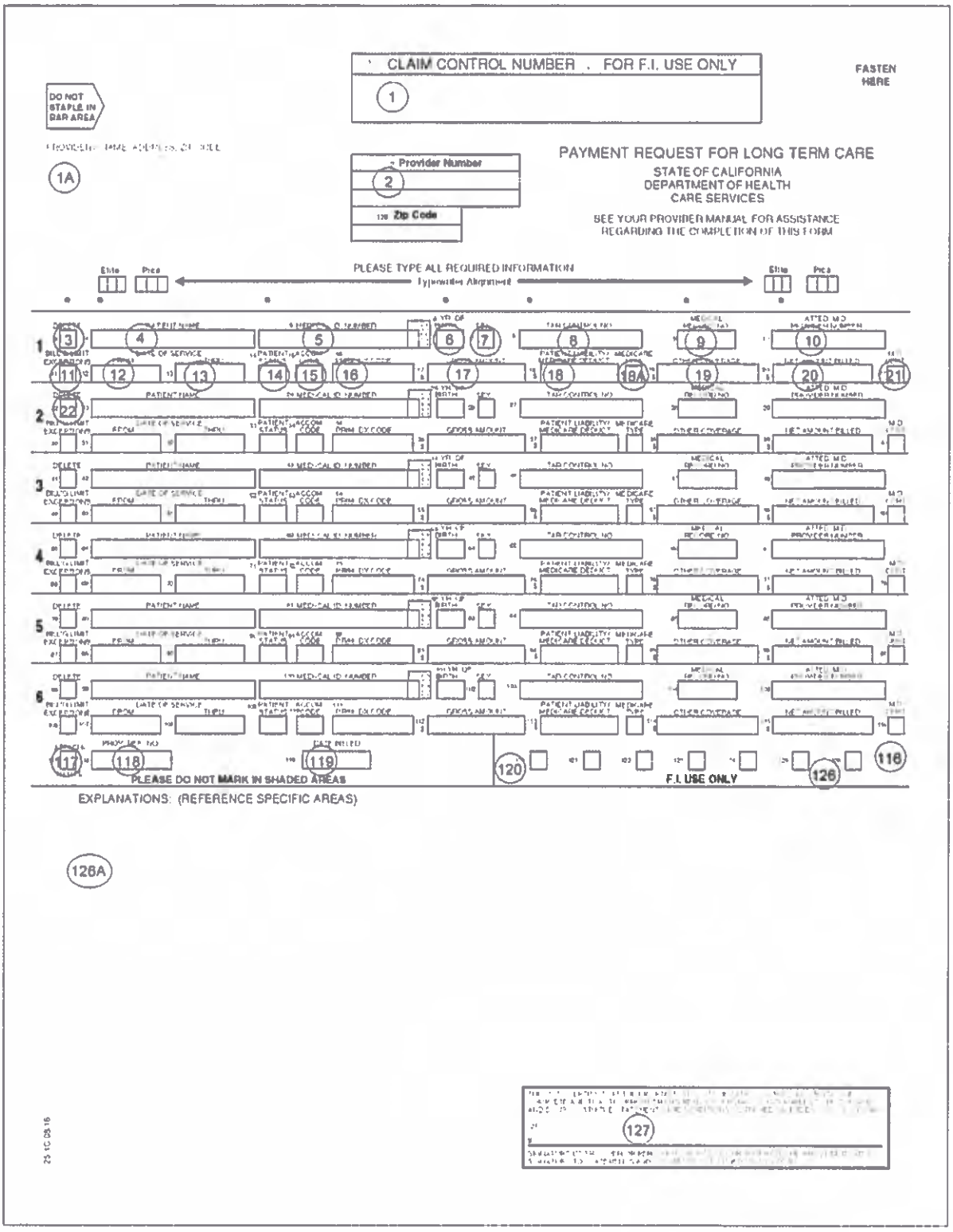

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PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.
- For routine follow-up regarding claims status, please contact the CalOptima Claims Provider Line: 714-246-8885
- Mail the completed form to: CalOptima Claims Provider Dispute
  P.O. Box 11037
  Orange, CA 92856

PRODUCT TYPE: ☐ MEDI-CAL ☐ MEDICARE ☐ COMMERCIAL

*PROVIDER NPI:	*PROVIDER TAX ID # / Medicare ID #:
*PROVIDER NAME:	CONTRACTED: ☑ YES ☐ NO
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC
☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

CLAIM INFORMATION ☐ Single ☐ Multiple "LIKE" Claims (complete attached spreadsheet) *Number of claims:* _____

* Patient Name:		Date of Birth:
* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number: (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Disputing Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Billing Determination
☐ Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	Title	( ) Phone Number
Signature	Date	( ) Fax Number

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**
(Please do not staple)

For Health Plan Use Only

TRACKING NUMBER _____ PROV ID# _____
CONTRACTED _____ NON-CONTRACTED _____

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PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

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☐ CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)

Policy #:	FF.2003
Title:	**Coordination of Benefits**
Department:	Claims Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	01/01/07
Last Review Date:	~~10/01/16~~06/07/18
Last Revised Date:	~~10/01/16~~06/07/18

I. PURPOSE

This policy describes the process for determining coordination of benefits (COB), or order of payment, for payment of Covered Services when a Member has active coverage by more than one (1) group health plan.

II. POLICY

A. If a Member has Other Health Coverage (OHC), CalOptima and a Health Network shall consider the OHC plan as the Member's primary health plan.

B. CalOptima and a Health Network shall remain the secondary health plan and payer of last resort.

C. If a Member has coverage for medical, other care, or treatment benefits under more than one (1) OHC plan, the primary health plan shall pay for the medical, other care, or treatment benefits. CalOptima and a Health Network, as a secondary health plan and payer of last resort, shall adjudicate the claim based on amounts allowed by CalOptima and the primary health plan, whichever is less.

D. If CalOptima identifies OHC unknown to the Department of Health Care Services (DHCS), the Customer Service Department shall report this information to the DHCS Third Party Liability Branch, Other Coverage Unit, within ten (10) calendar days of discovery in an automated format as prescribed by DHCS.

~~D.~~E. An OHC plan, as the primary health plan, shall make payment as appropriate for a Member that has received services that fall within the OHC plan's scope of coverage, or shall deny payment as non-covered benefits, prior to payment consideration by CalOptima or a Health Network.

~~E.~~F. If a Member has both Medicare and an OHC plan, both Medicare and the OHC plan shall pay claims for services prior to payment consideration by CalOptima or a Health Network.

~~F.~~G. CalOptima and a Health Network shall not consider a claim for a Member with a Medicare supplemental policy through an insurance carrier as a Medicare/Medi-Cal Crossover Claim. CalOptima and a Health Network shall consider the Medicare supplemental insurance carrier as the primary health plan and CalOptima and a Health Network as the secondary health plan and the payer of last resort.

~~G.~~H. CalOptima and a Health Network shall base the COB claim determination period upon the period of time that the Member is actively eligible for Medi-Cal benefits. If there is a break in

eligibility and the dates of service falls within the period of time when the Member is not covered by Medi-Cal, CalOptima and the Health Network shall not apply the COB rules to the claim.

~~H.~~I. CalOptima and a Health Network shall make reasonable efforts to recover the value of Covered Services, or appropriately determine payment of claims for Covered Services, rendered to a Member whenever the Member is fully or partially covered for the same service under any other State or Federal medical care program or under contractual or legal entitlement including, but not limited to, a private group or indemnification program. CalOptima shall rely only on the Medi-Cal Fame File eligibility data provided by ~~the Department of Health Care Services (~~DHCS~~)~~ and loaded into FACETS™ to recover such payment for OHC.

~~I.~~J. CalOptima and a Health Network may contract with a third~~-~~-party vendor to recover any payments as described in Section ~~III~~II.I. of this policy.

~~J.~~K. CalOptima and a Health Network shall have the right to obtain and release COB information and may do so without consent from the Member, or the Member's Authorized Representative. CalOptima and a Health Network shall require a Member to provide insurers with any information needed to make COB determinations, and to pay claims.

~~K.~~L. A Member shall satisfy the monthly share of cost (SOC) dollar amount for medical expenses prior to CalOptima certifying the Member to receive Medi-Cal benefits. Upon eligibility certification, the Medi-Cal host computer shall provide an Eligibility Verification Confirmation (EVC) number.

1. CalOptima and a Health Network shall reduce the reimbursement made to a Provider for services rendered to a Member with a SOC by the SOC amount.

2. CalOptima may require a Member with a SOC who has OHC to pay a deductible or a co-payment amount up to his or her SOC. A Provider may bill CalOptima or a Health Network the remaining balance of the deductible or co-payment amount. CalOptima shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less.

3. If a Member has no SOC obligations, a Provider may bill CalOptima or a Health Network for the co-payment or deductible amount. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less (up to the co-pay or deductible amount).

~~L.~~M. A Provider shall not bill or collect deductible or co-payment amounts from a Member, except as provided in Section III.~~K~~L. of this policy.

~~M.~~N. Medicare Crossover

1. CalOptima~~,~~ or a Health Network~~,~~ shall pay the annual deductible or co-payment amount for a Member with Medicare Part A, Medicare Part B, or Medicare Part A and Part B, as required by current regulations. CalOptima, or a Health Network, shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

2. CalOptima or a Health Network shall pay a deductible or co-payment for Medicare Part A acute care inpatient services for a Member, in accordance with current Medi-Cal regulations.

O. On a quarterly basis, CalOptima and a Health Network shall maintain COB reports in accordance with Section III.E. of this policy and shall retain COB records for a period of at least ten (10) years after the termination of its contract with the DHCS.

III. PROCEDURE

A. CalOptima and a Health Network shall use the following indicators to assess a Member's claim for possible OHC including, but not limited to:

1. Claim forms or Provider billings:

   a. CMS-1500;

   b. UB-04;

   c. PM160~~;~~ (for dates of service through June 30, 2018 only); or

   d. 25-1.

2. CalOptima or FACETS™:

   a. Health plan carrier codes; or

   b. Medi-Cal eligibility aid codes.

3. Health Network:

   a. Health plan carrier code;

   b. Medi-Cal eligibility aid codes; or

   c. Other insurance information included in the CalOptima Member Eligibility tapes or through the file transfer protocol (FTP) site.

4. Automated Eligibility Verification System (AEVS): As listed on the Supplemental to AEVS Carrier Codes for Other Health Coverage;

5. Photocopies of Remittance Advice Details (RAD);

6. Explanation of Medicare Benefits (EOMB); or

7. Explanation of payments to providers (EOP) from other insurance payers.

B. COB Claims Process

1. CalOptima and a Health Network shall review the submitted claim form for indication of OHC. Pursuant to CMS-1500 or UB-04 claim forms, CalOptima and a Health Network shall utilize the following questions to review the claim form including, but not limited to:

a. *Does the bill indicate the existence of other insurance coverage*?
Universal claim forms (CMS-1500, UB-04, PM160~~,~~ (for dates of service through June 30, 2018 only), 25-1) used by physicians, hospitals, and other Providers usually indicate the type of coverage and the insurance carrier, and may provide the group plan name and number. (See Box 11d on CMS-1500 – Is There Another Health Benefit Plan).

b. *Has the bill been paid in part or in whole?*
An attachment to the claim submitted as evidence or explanation of benefits (EOB) may indicate that another plan has already provided benefits. (See Box 29 on CMS-1500 – Amount Paid).

c. *Is the spouse employed?*
If the spouse is employed, the Member may have coverage under the spouse's employer's group health plan. Dependent children may have coverage as dependents under the spouse's coverage. (See Box 9c on CMS-1500 – Employer's Name)

d. *Is the claimant covered by other plans that provide benefits or services?*
Claim forms usually request this information, along with the type of coverage, the name of the insurance carrier, and the group number. (See Box 9a-d on CMS-1500 – Other Insured's Name and Insurance Information)

e. *If the claimant is a child, does the last name differ from that of the insured or covered member?*
This may indicate coverage through a second parent or a divorce situation in which natural and stepparents cover the child.

f. *Does the claim form indicate that the employee has a former employer?*
This may indicate that the claimant is receiving coverage as a retiree under the former employer's group health plan.

g. *Does the claim form indicate that the claimant is covered under the State or Federal health insurance continuation program?*
This may indicate coverage under a former employer's group health plan (e.g., COBRA).

h. *Is the claimant age sixty-five (65) or older?*
This may indicate the presence of Medicare coverage. (See Box 1 if the Medicare Box is checked and Box 3 on CMS-1500 – Patient's Birth Date)

i. *Is the claimant under age sixty-five (65) and diagnosed with end-stage renal disease (ESRD)?*
This may indicate that the claimant is entitled to Medicare coverage.

j. *If the claim was the result of an accident, where and how did it occur?*
This may indicate that the medical expenses are covered by a Third Party Liability carrier, such as auto insurance or a homeowner's policy. (See Box 10b on CMS-1500 – Is Patient's Condition Related to Auto Accident or Box 21 on CMS-1500 – Description of Injury)

k. *Were the bills submitted as photocopies?*
This may indicate that the original bills were sent to another health plan carrier for payment.

l. *Were copies of the other carrier's evidence or explanation of benefits or payment submitted instead of the provider's itemized bill?*
This usually indicates that the claimant has OHC.

m. *Does the system identify health plan carrier codes as evidence of OHC?*
If available, the Health Network information system should flag the claim for identification of OHC.

2. CalOptima~~,~~ or a Health Network~~,~~ shall not process a COB claim until the primary plan adjudicates the claim or OHC is verified.

3. CalOptima~~,~~ or a Health Network~~,~~ shall process a COB claim only if an Explanation of Benefits (EOB) from the primary carrier is attached. The primary payer shall pay, reject, or apply the COB claim to the deductible.

4. If CalOptima~~,~~ or a Health Network~~,~~ receives a COB claim without proof of disposition (i.e., EOB or reject letter) from the primary payer, CalOptima or a Health Network shall process the claim to the Provider using the appropriate denial reason code.

C. Application of COB rules

1. If a Provider is paid a fee-for-service rate or negotiated contract fee, CalOptima, or a Health Network, as the secondary payer, shall pay the difference between the amount paid by the OHC, as the primary plan, and the amount CalOptima, or a Health Network, would have paid in the absence of OHC.

a. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

b. The total of the payments issued by the OHC plan and CalOptima, or a Health Network, shall not exceed the normal plan benefits of CalOptima, or a Health Network.

2. If a claim is submitted by a Provider for a Covered Service that is not covered by the primary payer, CalOptima, or a Health Network, shall require that the Provider submit a denial letter or EOB from the primary payer with the claim prior to payment consideration.

3. In the absence of proof of payment or denial of benefits, the OHC plan shall certify that the policy had terminated, and the Member was no longer eligible at the time the services were rendered.

4. The Provider may bill CalOptima or a Health Network directly for payment for elective abortions not covered by TRICARE.

5. An OHC plan indicating coverage through TRICARE, Kaiser, other pre-paid health plan (PHP) or health maintenance organization (HMO), and other organizations not contracting with CalOptima, or a Health Network, to provide services, shall pay for services prior to reimbursement consideration by CalOptima~~,~~ or a Health Network~~,~~ for those services.

6. CalOptima~~,~~ or a Health Network~~,~~ shall pay for Covered Services that are not covered by a PHP, or HMO, if the claim is accompanied by a denial letter from the PHP or HMO.

D. A Provider shall submit a claim for a Member who is eligible for both Medicare and Medi-Cal to Medicare prior to billing CalOptima, or a Health Network.

1. Medicare Part A (hospital only)

a. If a Member has Medicare Part A only, a Provider shall submit a claim to Medicare for payment of the hospital charges and the facility or technical component fees of the ancillary charges.

b. CalOptima or a Health Network shall pay Crossover Claims for the Medicare co-insurance and the annual deductible amounts not payable by Medicare.

c. CalOptima or a Health Network shall pay the Medicare Part B component for inpatient services covered by Medicare.

d. Medicare Part A covered services include, but are not limited to:

i. Inpatient hospital care;

ii. Psychiatric hospital care;

iii. Skilled nursing facility;

iv. Hospice care; and

v. Respite care.

e. A Provider shall submit a Medicare RAD with the claim for payment of Medicare Part B services to CalOptima, or a Health Network, for payment consideration.

2. Medicare Part B (outpatient physician services)

a. If a Member has Medicare Part B only, a Provider shall submit a claim for inpatient hospital and facility charges up to the maximum allowed by CalOptima inpatient rates to CalOptima, or a Health Network, the primary payer for inpatient hospital and facility charges.

b. A Provider shall submit a claim for physician services and professional component fees of the hospital ancillary charges (e.g., laboratory, radiology, therapy) to Medicare, the primary payer for all physician services and professional component fees of the hospital ancillary charges.

c. CalOptima~~,~~ or a Health Network~~,~~ as the secondary payer, shall pay for the following:

i. Medicare Part A component less the Medicare payment;

ii. Medicare co-insurance; and

iii. Annual deductible amount for Medicare Part B services.

d. Medicare Part B covered services include, but are not limited to:

i. Physician services;

ii. Outpatient hospital treatments;

iii. Home health visits;

iv. Inpatient and outpatient medical services and supplies;

v. Blood supplies; and

vi. Other medical and health services, including but not limited to:

1) Transportation;

2) Home dialysis equipment;

3) Oral surgery;

4) Outpatient physical therapy;

5) Speech pathology;

6) Diagnostic radiology;

7) Radiation treatments;

8) Pathology and laboratory;

9) Psychology and occupational therapy (50% payable); and

10) Limited vision.

e. A Provider shall submit claims for Medicare Part B services to Medicare Part B carriers, in accordance with the EOMB.

f. A Provider shall submit claims for Medicare Part A services to Medicare Part A carriers, in accordance with the Remittance Advice Details.

3. Medicare Part A and Part B

a. If a Member has Medicare Part A and Part B, a Provider shall submit a claim to Medicare, the primary payer.

b. CalOptima, or a Health Network, as a secondary payer, shall pay the amount billed for the Medicare co-insurance or annual deductibles for Medicare Part A, Medicare Part B, or Medicare Part A and Part B coverage.

4. If a Member who is entitled to Medicare is enrolled in a Medicare risk-sharing HMO plan, a Provider shall submit a claim to the HMO plan, the primary payer. CalOptima shall remain the secondary payer.

E. In accordance with DHCS requirements, COB reports maintained by CalOptima and a Health Network shall display claim counts and dollar amounts of costs avoided and the amount of post-payment recoveries by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A, Part B, and Part D. CalOptima and a Health Network shall make the reports available to DHCS upon request.

IV. ATTACHMENTS

A. CMS-1500 Form
B. UB-04 Form

V. REFERENCES

A. CalOptima ~~Policy AA.1000: Glossary~~Contract with the Department of ~~Terms~~Health Care Services (DHCS) for Medi-Cal
B. Coordination of Benefits Handbook, Thompson Publishing Group, Copyright 1997
C. Title 22, California Code of Regulations (C.C.R), Division 3: Health Care Services, Chapter 2, Articles 12 & 15

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

~~None to Date~~
A. 06/07/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2007	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2008	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2009	FF.2003	Coordination of Benefits	Medi-Cal
Revised	10/01/2016	FF.2003	Coordination of Benefits	Medi-Cal
Revised	06/07/2018	FF.2003	Coordination of Benefits	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given such term in section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Crossover Claim	A claim submitted for payment for a Medi-Medi Member for which Medicare has primary responsibility and Medi-Cal is the secondary payer.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal Obligation, excluding tort liability.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		***PAGE _____ OF _____***	***CREATION DATE***		**TOTALS**				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS		81CC			
		a			
		b			
		c			
		d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO.

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Policy #: FF.2003
Title: **Coordination of Benefits**
Department: Claims Administration
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 01/01/07
Last Review Date: 06/07/18
Last Revised Date: 06/07/18

I. PURPOSE

This policy describes the process for determining coordination of benefits (COB), or order of payment, for payment of Covered Services when a Member has active coverage by more than one (1) group health plan.

II. POLICY

A. If a Member has Other Health Coverage (OHC), CalOptima and a Health Network shall consider the OHC plan as the Member's primary health plan.

B. CalOptima and a Health Network shall remain the secondary health plan and payer of last resort.

C. If a Member has coverage for medical, other care, or treatment benefits under more than one (1) OHC plan, the primary health plan shall pay for the medical, other care, or treatment benefits. CalOptima and a Health Network, as a secondary health plan and payer of last resort, shall adjudicate the claim based on amounts allowed by CalOptima and the primary health plan, whichever is less.

D. If CalOptima identifies OHC unknown to the Department of Health Care Services (DHCS), the Customer Service Department shall report this information to the DHCS Third Party Liability Branch, Other Coverage Unit, within ten (10) calendar days of discovery in an automated format as prescribed by DHCS.

E. An OHC plan, as the primary health plan, shall make payment as appropriate for a Member that has received services that fall within the OHC plan's scope of coverage, or shall deny payment as non-covered benefits, prior to payment consideration by CalOptima or a Health Network.

F. If a Member has both Medicare and an OHC plan, both Medicare and the OHC plan shall pay claims for services prior to payment consideration by CalOptima or a Health Network.

G. CalOptima and a Health Network shall not consider a claim for a Member with a Medicare supplemental policy through an insurance carrier as a Medicare/Medi-Cal Crossover Claim. CalOptima and a Health Network shall consider the Medicare supplemental insurance carrier as the primary health plan and CalOptima and a Health Network as the secondary health plan and the payer of last resort.

H. CalOptima and a Health Network shall base the COB claim determination period upon the period of time that the Member is actively eligible for Medi-Cal benefits. If there is a break in eligibility and

the dates of service falls within the period of time when the Member is not covered by Medi-Cal, CalOptima and the Health Network shall not apply the COB rules to the claim.

I. CalOptima and a Health Network shall make reasonable efforts to recover the value of Covered Services, or appropriately determine payment of claims for Covered Services, rendered to a Member whenever the Member is fully or partially covered for the same service under any other State or Federal medical care program or under contractual or legal entitlement including, but not limited to, a private group or indemnification program. CalOptima shall rely only on the Medi-Cal Fame File eligibility data provided by DHCS and loaded into FACETS™ to recover such payment for OHC.

J. CalOptima and a Health Network may contract with a third-party vendor to recover any payments as described in Section II.I. of this policy.

K. CalOptima and a Health Network shall have the right to obtain and release COB information and may do so without consent from the Member, or the Member's Authorized Representative. CalOptima and a Health Network shall require a Member to provide insurers with any information needed to make COB determinations, and to pay claims.

L. A Member shall satisfy the monthly share of cost (SOC) dollar amount for medical expenses prior to CalOptima certifying the Member to receive Medi-Cal benefits. Upon eligibility certification, the Medi-Cal host computer shall provide an Eligibility Verification Confirmation (EVC) number.

1. CalOptima and a Health Network shall reduce the reimbursement made to a Provider for services rendered to a Member with a SOC by the SOC amount.

2. CalOptima may require a Member with a SOC who has OHC to pay a deductible or a co-payment amount up to his or her SOC. A Provider may bill CalOptima or a Health Network the remaining balance of the deductible or co-payment amount. CalOptima shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less.

3. If a Member has no SOC obligations, a Provider may bill CalOptima or a Health Network for the co-payment or deductible amount. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount or the billed charge, whichever is less (up to the co-pay or deductible amount).

M. A Provider shall not bill or collect deductible or co-payment amounts from a Member, except as provided in Section III.L. of this policy.

N. Medicare Crossover

1. CalOptima or a Health Network shall pay the annual deductible or co-payment amount for a Member with Medicare Part A, Medicare Part B, or Medicare Part A and Part B, as required by current regulations. CalOptima, or a Health Network, shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

2. CalOptima or a Health Network shall pay a deductible or co-payment for Medicare Part A acute care inpatient services for a Member, in accordance with current Medi-Cal regulations.

O. On a quarterly basis, CalOptima and a Health Network shall maintain COB reports in accordance with Section III.E. of this policy and shall retain COB records for a period of at least ten (10) years after the termination of its contract with the DHCS.

III. PROCEDURE

A. CalOptima and a Health Network shall use the following indicators to assess a Member's claim for possible OHC including, but not limited to:

1. Claim forms or Provider billings:

   a. CMS-1500;

   b. UB-04;

   c. PM160 (for dates of service through June 30, 2018 only); or

   d. 25-1.

2. CalOptima or FACETS™:

   a. Health plan carrier codes; or

   b. Medi-Cal eligibility aid codes.

3. Health Network:

   a. Health plan carrier code;

   b. Medi-Cal eligibility aid codes; or

   c. Other insurance information included in the CalOptima Member Eligibility tapes or through the file transfer protocol (FTP) site.

4. Automated Eligibility Verification System (AEVS): As listed on the Supplemental to AEVS Carrier Codes for Other Health Coverage;

5. Photocopies of Remittance Advice Details (RAD);

6. Explanation of Medicare Benefits (EOMB); or

7. Explanation of payments to providers (EOP) from other insurance payers.

B. COB Claims Process

1. CalOptima and a Health Network shall review the submitted claim form for indication of OHC. Pursuant to CMS-1500 or UB-04 claim forms, CalOptima and a Health Network shall utilize the following questions to review the claim form including, but not limited to:

   a. *Does the bill indicate the existence of other insurance coverage*?

Universal claim forms (CMS-1500, UB-04, PM160 (for dates of service through June 30, 2018 only), 25-1) used by physicians, hospitals, and other Providers usually indicate the type of coverage and the insurance carrier, and may provide the group plan name and number. (See Box 11d on CMS-1500 – Is There Another Health Benefit Plan).

b. *Has the bill been paid in part or in whole?*
An attachment to the claim submitted as evidence or explanation of benefits (EOB) may indicate that another plan has already provided benefits. (See Box 29 on CMS-1500 – Amount Paid).

c. *Is the spouse employed?*
If the spouse is employed, the Member may have coverage under the spouse's employer's group health plan. Dependent children may have coverage as dependents under the spouse's coverage. (See Box 9c on CMS-1500 – Employer's Name)

d. *Is the claimant covered by other plans that provide benefits or services?*
Claim forms usually request this information, along with the type of coverage, the name of the insurance carrier, and the group number. (See Box 9a-d on CMS-1500 – Other Insured's Name and Insurance Information)

e. *If the claimant is a child, does the last name differ from that of the insured or covered member?*
This may indicate coverage through a second parent or a divorce situation in which natural and stepparents cover the child.

f. *Does the claim form indicate that the employee has a former employer?*
This may indicate that the claimant is receiving coverage as a retiree under the former employer's group health plan.

g. *Does the claim form indicate that the claimant is covered under the State or Federal health insurance continuation program?*
This may indicate coverage under a former employer's group health plan (e.g., COBRA).

h. *Is the claimant age sixty-five (65) or older?*
This may indicate the presence of Medicare coverage. (See Box 1 if the Medicare Box is checked and Box 3 on CMS-1500 – Patient's Birth Date)

i. *Is the claimant under age sixty-five (65) and diagnosed with end-stage renal disease (ESRD)?*
This may indicate that the claimant is entitled to Medicare coverage.

j. *If the claim was the result of an accident, where and how did it occur?*
This may indicate that the medical expenses are covered by a Third Party Liability carrier, such as auto insurance or a homeowner's policy. (See Box 10b on CMS-1500 – Is Patient's Condition Related to Auto Accident or Box 21 on CMS-1500 – Description of Injury)

k. *Were the bills submitted as photocopies?*
This may indicate that the original bills were sent to another health plan carrier for payment.

l. *Were copies of the other carrier's evidence or explanation of benefits or payment submitted instead of the provider's itemized bill?*
This usually indicates that the claimant has OHC.

m. *Does the system identify health plan carrier codes as evidence of OHC?*
If available, the Health Network information system should flag the claim for identification of OHC.

2. CalOptima or a Health Network shall not process a COB claim until the primary plan adjudicates the claim or OHC is verified.

3. CalOptima or a Health Network shall process a COB claim only if an Explanation of Benefits (EOB) from the primary carrier is attached. The primary payer shall pay, reject, or apply the COB claim to the deductible.

4. If CalOptima or a Health Network receives a COB claim without proof of disposition (i.e., EOB or reject letter) from the primary payer, CalOptima or a Health Network shall process the claim to the Provider using the appropriate denial reason code.

C. Application of COB rules

1. If a Provider is paid a fee-for-service rate or negotiated contract fee, CalOptima, or a Health Network, as the secondary payer, shall pay the difference between the amount paid by the OHC, as the primary plan, and the amount CalOptima, or a Health Network, would have paid in the absence of OHC.

a. CalOptima or a Health Network shall adjudicate the billed amount based upon the maximum allowed amount, the billed charge, the deductible, or the co-payment, whichever is less.

b. The total of the payments issued by the OHC plan and CalOptima, or a Health Network, shall not exceed the normal plan benefits of CalOptima, or a Health Network.

2. If a claim is submitted by a Provider for a Covered Service that is not covered by the primary payer, CalOptima, or a Health Network, shall require that the Provider submit a denial letter or EOB from the primary payer with the claim prior to payment consideration.

3. In the absence of proof of payment or denial of benefits, the OHC plan shall certify that the policy had terminated, and the Member was no longer eligible at the time the services were rendered.

4. The Provider may bill CalOptima or a Health Network directly for payment for elective abortions not covered by TRICARE.

5. An OHC plan indicating coverage through TRICARE, Kaiser, other pre-paid health plan (PHP) or health maintenance organization (HMO), and other organizations not contracting with CalOptima, or a Health Network, to provide services, shall pay for services prior to reimbursement consideration by CalOptima or a Health Network for those services.

6. CalOptima or a Health Network shall pay for Covered Services that are not covered by a PHP, or HMO, if the claim is accompanied by a denial letter from the PHP or HMO.

D. A Provider shall submit a claim for a Member who is eligible for both Medicare and Medi-Cal to Medicare prior to billing CalOptima, or a Health Network.

1. Medicare Part A (hospital only)

a. If a Member has Medicare Part A only, a Provider shall submit a claim to Medicare for payment of the hospital charges and the facility or technical component fees of the ancillary charges.

b. CalOptima or a Health Network shall pay Crossover Claims for the Medicare co-insurance and the annual deductible amounts not payable by Medicare.

c. CalOptima or a Health Network shall pay the Medicare Part B component for inpatient services covered by Medicare.

d. Medicare Part A covered services include, but are not limited to:

i. Inpatient hospital care;

ii. Psychiatric hospital care;

iii. Skilled nursing facility;

iv. Hospice care; and

v. Respite care.

e. A Provider shall submit a Medicare RAD with the claim for payment of Medicare Part B services to CalOptima, or a Health Network, for payment consideration.

2. Medicare Part B (outpatient physician services)

a. If a Member has Medicare Part B only, a Provider shall submit a claim for inpatient hospital and facility charges up to the maximum allowed by CalOptima inpatient rates to CalOptima, or a Health Network, the primary payer for inpatient hospital and facility charges.

b. A Provider shall submit a claim for physician services and professional component fees of the hospital ancillary charges (e.g., laboratory, radiology, therapy) to Medicare, the primary payer for all physician services and professional component fees of the hospital ancillary charges.

c. CalOptima or a Health Network as the secondary payer, shall pay for the following:

i. Medicare Part A component less the Medicare payment;

ii. Medicare co-insurance; and

iii. Annual deductible amount for Medicare Part B services.

d. Medicare Part B covered services include, but are not limited to:

i. Physician services;

ii. Outpatient hospital treatments;

iii. Home health visits;

iv. Inpatient and outpatient medical services and supplies;

v. Blood supplies; and

vi. Other medical and health services, including but not limited to:

1) Transportation;

2) Home dialysis equipment;

3) Oral surgery;

4) Outpatient physical therapy;

5) Speech pathology;

6) Diagnostic radiology;

7) Radiation treatments;

8) Pathology and laboratory;

9) Psychology and occupational therapy (50% payable); and

10) Limited vision.

e. A Provider shall submit claims for Medicare Part B services to Medicare Part B carriers, in accordance with the EOMB.

f. A Provider shall submit claims for Medicare Part A services to Medicare Part A carriers, in accordance with the Remittance Advice Details.

3. Medicare Part A and Part B

a. If a Member has Medicare Part A and Part B, a Provider shall submit a claim to Medicare, the primary payer.

b. CalOptima, or a Health Network, as a secondary payer, shall pay the amount billed for the Medicare co-insurance or annual deductibles for Medicare Part A, Medicare Part B, or Medicare Part A and Part B coverage.

4. If a Member who is entitled to Medicare is enrolled in a Medicare risk-sharing HMO plan, a Provider shall submit a claim to the HMO plan, the primary payer. CalOptima shall remain the secondary payer.

E. In accordance with DHCS requirements, COB reports maintained by CalOptima and a Health Network shall display claim counts and dollar amounts of costs avoided and the amount of post-payment recoveries by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A, Part B, and Part D. CalOptima and a Health Network shall make the reports available to DHCS upon request.

IV. ATTACHMENTS

A. CMS-1500 Form
B. UB-04 Form

V. REFERENCES

A. CalOptima Contract with the Department of Health Care Services (DHCS) for Medi-Cal
B. Coordination of Benefits Handbook, Thompson Publishing Group, Copyright 1997
C. Title 22, California Code of Regulations (C.C.R), Division 3: Health Care Services, Chapter 2, Articles 12 & 15

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2007	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2008	FF.2003	Coordination of Benefits	Medi-Cal
Revised	01/01/2009	FF.2003	Coordination of Benefits	Medi-Cal
Revised	10/01/2016	FF.2003	Coordination of Benefits	Medi-Cal
Revised	06/07/2018	FF.2003	Coordination of Benefits	Medi-Cal

IX. GLOSSARY

Term	Definition
Authorized Representative	Has the meaning given such term in section 164.502(g) of Title 45, Code of Federal Regulations. A person who has the authority under applicable law to make health care decisions on behalf of adults or emancipated minors, as well as parents, guardians or other persons acting in loco parentis who have the authority under applicable law to make health care decisions on behalf of unemancipated minors.
Covered Services	Those services provided in the Fee-For-Service Medi-Cal program, as set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840, which are included as Covered Services under CalOptima's Contract with DHCS and are Medically Necessary, along with chiropractic services (as defined in Section 51308 of Title 22, CCR), podiatry services (as defined in Section 51310 of Title 22, CCR), and speech pathology services and audiology services (as defined in Section 51309 of Title 22, CCR), which shall be covered for Members not withstanding whether such benefits are provided under the Fee-For-Service Medi-Cal program.
Crossover Claim	A claim submitted for payment for a Medi-Medi Member for which Medicare has primary responsibility and Medi-Cal is the secondary payer.
Health Network	A Physician Hospital Consortium (PHC), physician group under a shared risk contract, or health care service plan, such as a Health Maintenance Organization (HMO) that contracts with CalOptima to provide Covered Services to Members assigned to that Health Network.
Member	A Medi-Cal eligible beneficiary as determined by the County of Orange Social Services Agency, the California Department of Health Care Services (DHCS) Medi-Cal Program, or the United States Social Security Administration, who is enrolled in the CalOptima program.
Other Health Coverage	The responsibility of an individual or entity, other than CalOptima or a Member, for the payment of the reasonable value of all or part of the health care benefits provided to a Member. Such OHC may originate under any other state, federal, or local medical care program or under other contractual or legal entitlements, including but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal Obligation, excluding tort liability.
Provider	A physician, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, ancillary provider, health maintenance organization, or other person or institution that furnishes Covered Services.

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

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1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

31 OCCURRENCE CODE	DATE	32 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	34 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38		39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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16									16
17									17
18									18
19									19
20									20
21									21
22									22
23		***PAGE _____ OF _____***	***CREATION DATE***		**TOTALS**				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67 I	A J	B K	C L	D M	E N	F O	G P	H Q	68

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI				73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

80 REMARKS		81CC			
		a			
		b			
		c			
		d			

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
47. Consider Actions for the Implementation of Proposition 56 Provider Payment

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Action
Approve methodology for the disbursement of Proposition 56 physician services payments to eligible Medi-Cal providers.

Background
The California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) increases the excise tax rate on cigarettes and tobacco products. A portion of Proposition 56 revenue is allocated for existing health care programs administered by the Department of Health Care Services (DHCS), including reimbursement in the Denti-Cal and Medi-Cal programs. As part of the Budget Act of 2017, Proposition 56 funds were appropriated for State Fiscal Year (SFY) 2017-18. Under Proposition 56, Medi-Cal Managed Care Plans (MCPs) are required to provide additional compensation for certain Medi-Cal related services rendered in SFY 2017-18. Supplemental payments are to be made to providers based on a DHCS-provided set of procedure codes for certain physician services, Intermediate Care Facilities for the Developmentally Disabled (ICF-DDs), and women's health services for pregnancy termination. The Governor's May Revision released on May 11, 2018 proposes extension of Proposition 56 for SFY 2018-19.

DHCS released guidance related to Proposition 56 provider payment methodologies through All Plan Letter (APL) 18-010 on May 1, 2018. CalOptima began receiving initial funding for Proposition 56 payments in its monthly capitation received on April 30, 2018 and will continue to receive Proposition 56 funding in subsequent capitation payments. DHCS expects Proposition 56 payments be passed through to eligible providers for the initial payment within 90 calendar days of the MCP receiving capitation from DHCS. Subsequent payments are to be made within 90 calendar days of receiving a clean claim or accepted encounter.

Providers contracted with CalOptima or a delegated entity rendering one of the designated Medi-Cal covered services between July 1, 2017 and June 30, 2018 are eligible for Proposition 56 payments in addition to the provider's contract rate or capitation. However, the following provider types are not eligible to receive Proposition 56 payments: Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), American Indian Health Programs (AIHPs) and cost-based reimbursement clinics. The following DHCS-provided procedure codes are eligible for supplemental payments:

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Medi-Cal Covered Service Code	Service Code Description	Directed Payment
99201	Office/Outpatient Visit New	$10.00
99202	Office/Outpatient Visit New	$15.00
99203	Office/Outpatient Visit New	$25.00
99204	Office/Outpatient Visit New	$25.00
99205	Office/Outpatient Visit New	$50.00
99211	Office/Outpatient Visit Est	$10.00
99212	Office/Outpatient Visit Est	$15.00
99213	Office/Outpatient Visit Est	$15.00
99214	Office/Outpatient Visit Est	$25.00
99215	Office/Outpatient Visit Est	$25.00
90791	Psychiatric Diagnostic Eval	$35.00
90792	Psychiatric Diagnostic Eval with Medical Services	$35.00
90863	Pharmacologic Management	$5.00

The DHCS guidance requires MCPs to maintain a formal process for provider grievances with respect to payment and non-payment of Proposition 56 directed payments. Specific Proposition 56 reporting will be required by DHCS on a quarterly basis. MCPs are required to ensure that their delegated entities and subcontractors comply with the terms and requirements of the DHCS guidance.

Discussion

Proposition 56 provider payments apply to Medi-Cal covered medical and behavioral health services. CalOptima administers medical services through its direct networks, CalOptima Community Network (CCN) and CalOptima Direct (COD), or a delegated health network. Prior to January 1, 2018, CalOptima provided behavioral health services through a delegated Managed Behavioral Healthcare Organization (MBHO). Beginning January 1, 2018, CalOptima transitioned away from using a MBHO for its Medi-Cal program and began providing these services through providers contracted directly with CalOptima. To comply with Proposition 56 requirements, CalOptima staff recommends utilizing its current direct and delegated models for both the initial and ongoing payment distributions.

Initial Payments

Following the initial payment received from DHCS on April 30, 2018, CalOptima recommends providing an initial catch-up payment for dates of service (DOS) July 1, 2017 to the current date. In order to process the initial catch-up payment, historical claims and encounter data will be utilized to identify and process the additional payments retroactively. Initial payments must be distributed to providers no later than July 29, 2018. The following is recommended for initial payments:

- CalOptima Direct, CalOptima Community Network and behavioral health providers: CalOptima to utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date.

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- Health networks:
  Health networks utilize claims and encounter data to identify and appropriately pay providers retroactively for claims submitted for DOS July 1, 2017 through the initial catch-up date. CalOptima will prefund the health networks for estimated medical costs. Health networks will be required to submit a provider payment confirmation report to CalOptima. Once provider payment is confirmed, the remaining medical cost will be reconciled plus a 2% administrative component based on total medical costs will be remitted to the health networks

Ongoing Processing
Once the initial payment is distributed, future Proposition 56 provider payments must be made within 90 calendar days of receipt of a clean claim or adjusted encounter. The following is recommended for ongoing processing provided that CalOptima continues to receive Proposition 56 funds:

- CalOptima Direct, CalOptima Community Network and behavioral health providers:
  CalOptima will pay providers within 90 calendar days of receipt of a clean claim or accepted behavioral health encounter.

- Health Networks:
  Health networks will pay providers within 90 calendar days of receipt of a clean claim or accepted encounter. Concurrently, CalOptima will utilize existing health network reporting processes to identify claims and encounters eligible for Proposition 56 payments. Health networks will be required to submit provider payment confirmation that the eligible Proposition 56 claims and encounter payments were issued on a monthly basis or other agreed upon schedule. Reports will be due within 15 calendar days of the end of the reporting period. Once provider payment is confirmed, CalOptima will reimburse the health network medical costs plus a 2% administrative component.

Current processes will be leveraged for Proposition 56 specific reporting, provider grievances and health network claims payment audit and oversight to comply with the Proposition 56 requirements. Additionally, current policy and processes will be followed related to provider payment recoupment, where applicable.

This process applies to physician services only as outlined in Proposition 56 and APL 18-010. The same process will be leveraged should provisions under Proposition 56 be extended past SFY 2017-18. Separately, implementation of Proposition 56 will require modifications to the current health network contracts. CalOptima staff will seek subsequent Board action to the extent required.

Fiscal Impact
The recommended action to approve the Proposition 56 physician services payment methodology for eligible Medi-Cal providers is expected to be budget neutral to CalOptima. Based on the draft capitation rates provided by DHCS, Staff anticipates that Proposition 56 revenues will be sufficient to cover the total costs of the physician services payments during SFY 2017-18. However, since DHCS will not provide a retrospective reconciliation for Proposition 56 funding, plans will be at risk for any expense exceeding the funded amount. Assuming that actual utilization during the effective period will be similar to historic experience levels, Staff projects the net fiscal impact will be budget neutral.

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Rationale for Recommendation
The recommended action will enable CalOptima to be compliant with Proposition 56 requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

5/30/2018 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

48. Consider Authorizing a Contract Extension with the Healthcare Effectiveness Data and Information Set (HEDIS) Reporting Vendor, Inovalon, for Software Licensing, Maintenance, and Related Services

Contact

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

Recommended Actions

1. Authorize the CEO, with the assistance of legal counsel, to extend the contract with Inovalon, CalOptima's National Committee for Quality Assurance (NCQA)-certified Healthcare Effectiveness Data and Information Set (HEDIS) Reporting vendor, through October 31, 2022, with two optional one-year renewal terms through October 31, 2023, and October 31, 2024; and
2. Authorize payment of software licensing, maintenance, and services fees through the term of the contract.

Background

HEDIS reporting is a regulatory requirement of the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS), as well as a required component of the NCQA accreditation submission. HEDIS reporting uses established and standard measurement criteria in the monitoring of the effectiveness of healthcare delivery and management, or essentially the quality of the healthcare delivery system. HEDIS scores are a component of the NCQA overall health plan rating determination.

HEDIS reporting is complex and requires the support of a NCQA-certified HEDIS reporting vendor to adequately comply with regulations and to ensure accurate and timely reporting as well as auditability. CalOptima contracted with Inovalon as the vendor of choice for HEDIS reporting. Inovalon provides software to monitor HEDIS measures, software for reporting on the measures, customized measures and associated reporting, associated software maintenance, and a fixed amount of services and support for CalOptima-specific HEDIS measures and the related reporting.

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

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

In the summer of 2014, staff conducted a Request For Information (RFI) process to evaluate the HEDIS

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reporting marketplace and solicit input from HEDIS reporting vendors. Nine vendors responded to CalOptima's RFI. At the time, five of the responding vendors were either not NCQA certified or only partially certified and were disqualified. The remaining four were evaluated based on cost and functionality. Based on this process, staff supported the continuation of the Inovalon agreement based on three primary factors: cost, full functionality, and existing relationship.

Based on the RFI results from 2014, and the extension language within the Inovalon agreement, in August of 2016, the Board authorized exercising the remaining contract extension options. Currently, the contract is set to expire October 31, 2019.

Discussion

As HEDIS reporting is complex, any change in vendor would require significant planning for implementation – and would require an overlap of services for several months, with both the existing and new vendor. It is because of this long lead time that staff is approaching the Board with this recommended action more than one year before the current contract expires.

On a consistent basis, staff monitors research and performance of the HEDIS marketplace. Overall, staff's assessment is that little has changed in the past four years. Of the existing certified vendors, many are not suitable for CalOptima for a variety of reasons. Some have less than the required full functionality, some have little or no experience with Medi-Cal, some refuse to provide pricing unless selected as a finalist, and some utilize offshore resources. Some of the vendors that submitted a proposal four years ago are no longer certified, sometimes based on the challenges in maintaining currency with the increasing complexity of CMS and DHCS quality measure requirements. However, Inovalon has continued to provide full functionality and many improvements over the years.

This extension and amendment will include an increase in cost, as anticipated. The increase is less than staff expected, and in line with the current market. The proposal received from the incumbent vendor quotes pricing at an increase of approximately 16%.

The partial duplication of cost, the potential risk to the CalOptima NCQA rating and ranking, and the operational disruption of changing vendors for such a mission-critical business function supports the staff recommendation to continue with Inovalon. As a result, staff is recommending Board approval for a contract extension, and an exception to our bidding process for this business/system solution.

Fiscal Impact

The proposed FY 2018-19 Operating Budget pending Board approval includes annual fees for the existing HEDIS reporting vendor for the period of July 1, 2018, through June 30, 2019. Management will include expenses related to the recommended contract extension for the period of November 1, 2019, through October 31, 2022, in future operating budgets.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Board Action dated August 4, 2016, Consider Extension of Contract with National Committee for Quality Assurance (NCQA)-Certified Vendor Inovalon which Provides Healthcare Effectiveness Data and Information Set (HEDIS) Reporting Support.
    a. Board Action dated June 2, 2011, Authorize Extension of the Contract for Certified HEDIS Software.

/s/ Michael Schrader — *5/30/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO) to:

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

Background

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

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

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

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

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

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

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

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

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

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Attachments

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

/s/ Michael Schrader — *07/29/2016*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

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

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

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

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

- OneCare Model of Care
- HEDIS improvement initiatives

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

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

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

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

Attachments
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

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

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

This budget will fund, among other things, upgrades to computer hardware and software to enhance operational decision-making and allow staff to better monitor HEDIS scores.

Fiscal Impact
Investment in the capital budget will reduce CalOptima's investment principal by $3,037,560. At a three percent (3%) return rate, this will reduce annual interest income by $90,000.

Rationale for Recommendation
The proposed FY 06-07 Capital Budget will enhance operational efficiencies by making an investment in CalOptima's infrastructure as proposed.

Concurrence
Foley & Lardner LLP
Board of Directors' Finance Committee

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Attachments

Attachment A: CalOptima Fiscal Year 2006-07 Proposed Capital Budget

/s/ Richard Chambers — **Authorized Signature**

5/31/2006 — **Date**

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Proposed CalOptima Fiscal Year 2006-2007 Capital Budget

Budget Items	Budget Amount	
Hardware Retirement / Replacements	$208,000	
HP RISS System (data archiving & retrieval)	$160,000	
Facets Production Cluster Upgrade (Hardware)	$150,000	
UPS Power Distribution System	$150,000	
Backup Data Storage Appliance	$100,000	
HEDIS Server	$50,000	
Network Based Fax Tool	$40,000	
Networked Color Printer Replacement	$27,200	
Mailing Machine	$27,000	
6 Laptops w/ Docking Stations	$25,860	
Laptop Pool Replacements	$20,000	
Remote Authentication Security (RAS)	$20,000	
CareLink Server	$19,500	
Replace HP Cabinets	$13,000	
Spare Enterasys Blade	$12,000	
InFocus LitePro Projectors	$9,000	
Total Computer Hardware		**$1,004,560**
HEDIS Software	$600,000	
Fraud Detection Software Pharmacy	$300,000	
Pre Payment Claims Audit Software	$150,000	
Facets Production Cluster Upgrade (Software)	$110,000	
Contract Management Software System	$75,000	
Batch Scheduler Software	$65,000	
Symposium Software Upgrade	$60,000	
Upgrade PBX to New Version	$40,000	
Call Monitoring System	$33,000	
BRS Upgrade/SQL Upgrade	$25,000	
W2K3 Server Software	$20,000	
Antigen for MS Exchange	$10,000	
Calendaring/File Tracking SW	$10,000	
AutoCad 2006 Software	$6,800	
Reader Board Software	$2,200	
Software		**$1,507,000**
Remodel Common Areas	$413,000	
A/V Equipment for Meeting Rooms	$78,000	
Building Monument Sign	$35,000	
Tenant Improvements		**$526,000**
	Grand Total	**$3,037,560**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
49. Consider Adoption of Resolution Approving Revisions to CalOptima Policy GA. 5002: Purchasing

Contact
Greg Hamblin, Chief Financial Officer, (714) 246-8400

Recommended Actions
Adopt Resolution No. 18-0607-03, to approve proposed revisions to CalOptima Policy GA.5002: Purchasing.

Background
California Government Code section 54202 requires that local agencies adopt policies and procedures, including bidding regulations, governing the purchase of supplies and equipment by the local agency. Within the parameters of the legal framework in which CalOptima operates, the CalOptima Board may delegate certain authority to Staff to execute decisions on behalf of the CalOptima Board, provided that these delegations are accompanied by adequate transparency and safeguards to guide the use of the delegated power and prevent abuse.

On September 10, 1996, the Board adopted CalOptima Policy GA.5002: Purchasing Policy (Procurement Policy) to provide guidance on the procurement of all goods and services related to CalOptima operations. The existing board-approved Procurement Policy was last revised on March 1, 2012.

Since the last revision to the Procurement Policy, new federal guidance was issued governing federal awards to: better mitigate the risk of waste, fraud and abuse; explicitly require internal controls of how federal award money is used; and require that federal award recipients follow their own documented procurement procedures that reflect applicable state and local laws and regulations. In 2017, CalOptima opted to defer adopting the new uniform guidance for federal awards for one year through July 1, 2018, by electing to continue to comply with the previous version of the applicable standards until the new guidance is adopted.

Discussion
During the Fiscal Year 2016-17 financial audit, Moss-Adams, LLP, CalOptima's financial auditor, provided Staff with new guidance related to the procurement of goods and services using federal awards that are subject to OMB A-133 Single Audit Requirements. Moss-Adams recommended that CalOptima either proceed with adopting the new guidelines or elect to defer adoption of the new guidelines to July 1, 2018, while still complying with the previous version of the applicable standards. By letter dated August 9, 2017, CalOptima submitted a written document to the auditors stating our intent to defer the adoption of the new uniform guidance for federal awards until July 1, 2018.

To the extent these requirements apply to any part of CalOptima's programs, with the adoption of the new uniform guidance for federal awards, CalOptima will ensure applicable procurements follow the

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uniform guidance, as prescribed in the new Attachment A to the Procurement Policy. More detailed requirements consistent with the new uniform guidance for federal awards will be developed by staff as desktop procedures. With input from Legal Counsel, Staff recommends the following revision to the Procurement Policy, with the proposed Attachment A, to comply with federal requirements:

- New section II.S.1. Other Bidding Procedures: Federal Awards Subject to OMB A-133 Single Audit Requirements (such as Multipurpose Senior Services Program (MSSP)) shall follow the bidding procedures as prescribed in Attachment A – Policy for Awards subject to 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

Fiscal Impact
There is no fiscal impact due to the revisions to the Procurement Policy.

Rationale for Recommendation
Update to CalOptima Procurement Policy is recommended to ensure compliance with new uniform federal guidance for federal awards for the procurement of goods and services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 18-0607-03
2. Proposed Revised CalOptima Policy GA.5002: Purchasing (redlined and clean) – with new Attachment A

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

5/30/2018 — **Date**

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RESOLUTION NO. 18-0607-03

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

APPROVE REVISIONS TO CALOPTIMA POLICY GA. 5002: PURCHASING

WHEREAS, California Government Code section 54202 requires that local agencies adopt policies and procedures, including bidding regulations, governing the purchase of supplies and equipment by the local agency; and

WHEREAS, section 13.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, provide that the Board of Directors shall adopt by resolution, and may from time to time amend, procedures, practices and policies for, inter alia, purchasing and acquiring the use of equipment and supplies, and acquiring, constructing, and leasing real property and improvements; and

WHEREAS, the CalOptima Board of Directors adopted CalOptima Policy GA: 5002: Purchasing (the "Procurement Policy") in 1996, and later amended the Procurement Policy in 1997, 2000, 2004, and 2012; and

WHEREAS, the Board of Directors now wishes to further update CalOptima's purchasing processes to ensure compliance with Federal procurement requirements; and

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached revised CalOptima Procurement Policy, which shall supersede all prior Procurement Policies.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 7th day of June 2018.

AYES:
NOES:
ABSENT:
ABSTAIN:

/s/_____
Title: Chair, Board of Directors
Printed Name and Title: Paul Yost M.D., Chair, CalOptima Board of Directors

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

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Policy #: GA.5002
Title: **Purchasing ~~Policy~~**
Department: Finance
Section: Financial Affairs

CEO Approval: Michael Schrader

Effective Date: 09/96 ~~Revised: 10/97, 1/00, 1/04, 2/11, 3/1/12~~

Last Review Date:
06/07/18~~Board Approval: 9/96, 10/97, 1/00, 1/04, 3/1/12~~

Last Revised Date: 06/07/18

I. PURPOSE

This policy establishes the organization and administration of a unified, fair, and effective process for the procurement of goods and services essential to the operations of CalOptima, and may be amended from time to time in order that it remains consistent with current best business practices.

II. POLICY

A. Unless exempted by this policy herein and/or applicable law, the Chief Financial Officer (CFO) or his or her designee, with the assistance of the Purchasing Department, is charged with the authority and responsibility for the following:

1. Acquiring equipment, supplies and services for all departments in an economical, expeditious and reasonable manner, in accordance with this policy;

2. Identifying qualified vendors and developing and promoting good vendor relationships;

3. Educating and training employees and vendors on this policy and the purchasing process;

4. Providing assistance to departments in preparing specifications and in analysis of bids received; and

5. Awarding contracts and assuring vendor performance through contract administration.

B. A requisition for purchase of supplies, equipment or services, including Public Works projects, shall be approved only by a person who has been properly authorized in accordance with this policy. The Board of Directors has delegated requisition authority to the Chief Executive Officer (CEO). The Chief Executive Officer has further delegated that authority and in the amounts provided below. Any person in a position delegated authority below may appoint a designee, in writing, to act in his

or her stead when that person is unavailable. The Purchasing Department shall have full authority to question the quality, quantity, kind, and source of materials and services being requisitioned.

C. Requisition Approval Limits – Goods and Services except as specified in D. and E. below

Employee Position	Authority Limit
Manager	$ 1,000
Director	10,000
Executive Director or Officer	100,000
Chief Executive Officer	Over 100,000

D. Requisition Approval Limits – Public Works Projects

Employee Position	Authority Limit
Facilities Manager	$ 10,000
Facilities Director	50,000
Chief Administrative Officer	100,000
Chief Executive Officer	Over 100,000

E. Requisition Approval Limits – Computer Hardware, Software and Services Telecommunications Goods and Services

Employee Position	Authority Limit
I.S. Manager	$ 10,000
I.S. Director	$ 50,000
I.S. Executive Director, Chief Information Officer	100,000
Chief Executive Officer	Over 100,000

F. Funding for all requisitions shall be approved by the Board of Directors through:

1. The annual operating or capital budget;

2. Specific Board action; or

3. A Budget Allocation Change, in accordance with CalOptima Policy GA.5003: Budgets and Operations Forecasting.

G. To enable the Board of Directors to consider approval through the operating and capital budgets, the budget submission must meet the requirements ~~of Section III.B.2.~~ outlined in~~of~~ CalOptima Policy GA.3202: CalOptima Signature Authority.

H. Signature authorization for contracts, agreements, leases, and/or purchase orders resulting from this policy is addressed in CalOptima Policy GA.3202: CalOptima Signature Authority. For all CalOptima contracts requiring the vendor's signature, CalOptima authorized signature representatives shall sign the contract documents only after the contract documents have been signed by the vendor.

I. Informal Bidding

1. Set forth below are the generally accepted methods of purchasing, which may be adjusted from time to time for CalOptima's Best Interest and to reflect current best business practices. All formal and informal requests for prices in the form of bids, quotations or proposals for all

materials, services and equipment purchased, must be made by the Purchasing Department, unless otherwise delegated by the Purchasing Department in writing. Pre-qualified vendor relationships shall be reviewed periodically, at least every five (5) years, to ensure consistency in quality, service and competitive pricing. For the purposes of this policy, the response to any request for prices, requests for quotations or invitations for bids shall collectively be referred to as a "bid" or "bids."

2. Purchases of Goods and Services as specified in Section II. C., Public Works projects as specified in Section II. D. and Computer Hardware, Software and Services and Telecommunications Goods and Services as specified in Section II.E. above, valued at under ten thousand dollars ($10,000) per vendor per fiscal year, not including applicable taxes and freight charges, referred to as small procurements, may be made on a discretionary basis without solicitation of bids. The Purchasing Department may establish pre-qualified vendor relationships for common small purchases to leverage pricing to the maximum extent practicable.

3. Purchases of Goods and Services as specified in Section II. C. above valued from ten thousand dollars ($10,000) to fifty thousand dollars ($50,000) per vendor per fiscal year, or between ten thousand dollars ($10,000) and one hundred thousand dollars ($100,000) per vendor per fiscal year for computer equipment and telecommunications goods and services, not including applicable taxes and freight charges, require solicitation of at least two (2) informal bids and/or quotations from known suppliers.

4. Purchases for Public Works projects and Computer Hardware, Software and Services and Telecommunications Goods and Services specified in Section II.D. and Section II. E. above valued from ten thousand dollars ($10,000) or more per vendor per fiscal year, or one hundred thousand dollars or more for computer equipment and telecommunications goods and services to $100,000, excluding taxes and freight charges, shall be made in accordance with this policy under Section(s) II. M., or L. as applicable. Such purchases require solicitation of at least two (2) informal bids and/or quotations from known suppliers. Contracts for software licenses or software maintenance agreements, or computer equipment purchases must be approved in writing by the Information Services Department.

5. Public Works Projects shall be procured in accordance with the limits and procedures of Section II.M.

6. Contracts for the provision of healthcare services must be coordinated by the Provider Operations Department with approval of an appropriate signing party under CalOptima Policy GA.3202: CalOptima Signature Authority, within limits delegated by the Board of Directors, and with approval of the contract template and any deviations therefrom by the Legal Counsel.

J. Formal Bidding

1. Provisions Applicable to Purchasing of Goods and Non-Professional Services shall be made by Request for Quotations (RFQ), Request for Proposals (RFP) or Invitations for Bid (IFB.

   a. Unless exempted in Section II.J.2 below, or by applicable law, purchases of items under Section II.C., including any purchase of goods, material, supplies or non-professional services (e.g., printing, graphic design, mail processing, janitorial, or hard copy file storage, etc.) to be furnished, sold, or leased to CalOptima, involving an expenditure of more than

fifty thousand dollars ($50,000). Shall be procured using a formal request for bids in the form of formal Request for Quotations, Requests for Proposal and/or Invitations for Bid.

b. Unless exempted in Section II.J.2 below or by applicable law, Public Works projects under Section II.D. and the purchase of Computer Hardware, Software and Services and Telecommunications Goods and Services under Section II.E. valued at more than one hundred thousand dollars ($100,000) shall be procured using a formal request for bids in the form of a formal RFQ, RFP or IFB, as provided in Sections II.M. and II.L., respectively Public Works involving construction or demolition, including tenant improvements, shall include detailed plans and specifications prepared by an architect, engineer or other licensed professional acting within the scope of his or her license. Formal requests for bids for Public Works projects sent to Offerors will include a construction contract template, and any deviations therefrom, approved by Legal Counsel.

2. Exceptions to Bidding

a. Contracts for non-medical professional services, including special services and advice in financial, economic, accounting, engineering, legal, medical consulting and administrative matters, if such persons have the necessary experience, training, competence, and licensure (if applicable) to perform the special services required, may be made without soliciting or securing bids, but shall be awarded according to the guidelines in Section II.K. of this policy.

b. Contracts for the acquisition of computer hardware, software, and other peripheral equipment and related services (referred to as "computer equipment"), and telecommunications goods and services may be made without soliciting bids, but shall be awarded according to the guidelines specified in Section II.L. of this policy.

c. Contracts for the undertaking of Public Works Projects, which shall be awarded according to the provision of Section II.M. of this policy.

d. Contracts for the provision of health care and related services.

e. Sole source or emergency purchases, which shall only be undertaken in accordance with Sections II.O. and II.P. respectively.

f. Acquisitions or transfers of real property, which shall only be undertaken in accordance with Section II.Q.

g. Subcontracts and other agreements entered into by CalOptima in fulfilling its obligations under a federal, state, local or private grant, if the grant requires that an alternative set of procurement policies, rules, or regulations be used (e.g., the Federal Acquisition Regulation (FAR)).

3. Bid Procedures for formal bidding for goods and non-professional services.

a. Preparation: Before entering into any contract which requires formal bidding, CalOptima shall prepare or cause to be prepared a bid package. The bid package may take the form of a RFQ, RFP or IFB. To the extent practicable, the bid package shall include full, complete,

and accurate plans and specifications, giving such direction as will enable any competent vendor to ascertain and carry out the contract requirements.

b. Notice of formal bids: All prospective bidders who have not been suspended or debarred by any regulatory agency within the last three years, have notified CalOptima in writing or via the CalOptima website that they desire to bid on contracts, and all prospective bidders which CalOptima would like to bid on contracts, shall be furnished with an automated e-mail announcement that there is a request for quotation, request for proposal or invitation for bids (as applicable) posted on the CalOptima website for them to download. The RFQ, RFP or IFB shall include information as to the type, quality, quantity, date, location and other bid requirements. The notice shall specify the place bids are to be received and the time by which they are to be received. Notice may also be made by telephone, telegram, personal contact, letter, or other informal means. Any bids received after the due date and specified time shall be returned unopened, except as otherwise provided herein.

c. Advertising/Publication: Except in cases of emergency or where circumstances require the immediate letting of a contract, information advising interested parties how to obtain specifications, and specifying the place bids are to be received and the time by which they are to be received, shall be given via the automated e-mail system. The RFQ, RFP or IFB will be posted on the Website from the issue date until the date the proposal is due.

i. Methods of publicizing of the bids shall include at least two (2) of the following:

a) RFQ's, RFP's or IFB's will appear on the Supplier tab of CalOptima's Web Site on the date the documents will be issued; or

b) In a newspaper of general circulation once a week for two consecutive weeks published in such places most likely to reach prospective bidders; or

c) In trade journals or papers of general circulation as the Chief Financial Officer, or designee, deems proper.

d) The Chief Executive Officer or designee may waive any irregularity or informality in the publication procedures.

d. Bid Form: The bid package shall furnish to each prospective bidder an appropriate bid form and bid package prepared by CalOptima for the type of contract being let. Bids not presented on forms so furnished shall be disregarded as non-responsive. All bids must be accompanied by a non-collusion affidavit.

e. Presentation of Bids under Sealed Cover: All bids shall be presented under sealed cover on or before the bid deadline. After receipt, the bid shall be date-stamped.

f. Withdrawal of Bids: Bids may be withdrawn at any time prior to the time fixed in the notice for the opening of bids only by written request made to the person or entity designated in charge of the bidding procedure. The withdrawal of the bids does not prejudice the right of the bidder to timely file a new bid. No bidder may withdraw his bid after opening for at least a period of forty-five (45) days thereafter.

g. Bidder's Conference: CalOptima may hold a bidders' conference or conduct a site visit, as it deems necessary and appropriate. In such cases, CalOptima shall include the date, time and location in the bid documents. The conference or site visit shall be at least five (5) days after publication of the notice of formal bid.

4. Award of Contracts

a. Opening of Bids: On the day named in the bid notice, CalOptima shall open the sealed bids. Award of the contract shall be to the lowest-price qualified and responsive bidder, if at all, as determined in CalOptima's sole discretion. Award shall be made within forty-five (45) days after opening, unless the bid package specifies otherwise or the Chief Executive Officer or his or her designee extends the time. All bidders shall have complied with the foregoing bid procedures, except as otherwise provided herein. After a bid is opened it shall be deemed irrevocable for the period specified in the invitation to bid. Bids shall be irrevocable for a minimum of forty-five (45) days after the opening thereof.

b. Awards to the second and third lowest price Qualified Bidders: If it is deemed to be in CalOptima's Best Interest, CalOptima may, on refusal or failure of the successful bidder to execute the contract or comply with other bid requirements, award it to the second lowest price qualified bidder. If the second lowest price qualified bidder fails or refuses to execute the contract or comply with other bid requirements, CalOptima may likewise award it to the third lowest price qualified bidder.

c. Only one (1) Bid or Proposal Received: If only one (1) bid or proposal is received in response to the RFQ, RFP or IFB, an award may be made to the sole bidder provided that CalOptima finds that the price or proposal submitted is fair, reasonable and in CalOptima's Best Interest.

d. Qualified Bidder: CalOptima's determination of a qualified bidder shall be based on analysis of each bidder's ability to perform, financial statement (if required), experience, past record and any other factors it shall deem relevant. If the lowest price bidder is to be rejected because of an adverse determination of the bidder's responsibility based on CalOptima's decision, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility.

5. Contract Renewal: For contracts that are awarded through a formal bidding process, it is recommended that staff follow the industry best practice that contracts for goods and services not exceed five years in duration without being rebid.

6. Negotiated Purchase: CalOptima reserves the right and at its sole discretion, to informally solicit one or more alternative proposals from one or more qualified vendor(s), in the event that a procurement solicitation results in no acceptable vendor responses based on the criteria set forth in the solicitation package. The Chief Financial Officer or designee may use a procedure to select a vendor by "competitive means." This would include one or more the following methods when deemed by the CFO or designee as an appropriate means under the circumstances to permit CalOptima's Best Interests to be served:

a. The preparation and circulation of an RFP or RFQ to an adequate number of qualified sources. An adequate number shall be defined as two or more qualified sources, as determined by the Chief Financial Officer or designee based on the number of qualified

sources believed to be capable of submitting a satisfactory proposal after reasonable inquiry.

b. Posting to the Website, publishing, communicating telephonically or otherwise publicizing the RFP or RFQ in a manner intended to disseminate the RFP or RFQ to an adequate number of qualified sources.

c. Soliciting comparable rates charged by other vendors for similar services to ensure a competitive price.

d. Any other means determined by the CFO or his or her designee as reasonably expected to disseminate the RFQ or RFP to an adequate number of qualified sources.

7. Criteria for Award of Contract via Negotiated Purchase

a. Contracts shall be awarded based on the determination of which vendor has the most cost effective and beneficial solution. In making this determination, the following evaluation tools shall apply as appropriate:

i. Price.

ii. Payment or financial terms offered by contractor.

iii. The extent to which the proposal meets or exceeds CalOptima's technical requirements and, if purchased, can be expected to accomplish the specified goals.

iv. Offeror's relevant experience in the area of purchase/project.

v. A demonstrated quality, dependability and responsiveness of the Offeror and any subcontractors providing installation, integration, consulting maintenance or other goods and services including Public Works.

vi. For capital equipment, the anticipated salvage or resale value of the components, if any, based upon its anticipated useful life.

vii. For Computer Hardware, Software and Services and Telecommunications Goods and Services, the anticipated expense and disruption to CalOptima facilities and services involved in upgrading or integrating additional components to the system and/or maintaining the system which may be necessary to accommodate the expansion of CalOptima facilities, keep pace with technology, provide for system back-up or obtain necessary parts and service.

viii. Offeror's familiarity with CalOptima.

ix. Offeror's reputation in the community.

x. Special expertise in the area of purchase.

xi. Such other criteria, consistent with this policy and the goal of achieving the most cost-effective solution to CalOptima's requirements, as the CFO or his or her designee may establish.

b. These criteria shall be applied by the Chief Financial Officer or designee using a scoring or other system designed to determine which of the proposals submitted provides the most viable solution to CalOptima's requirements. The basis for such determination shall be documented by the Purchasing Department in a manner which permits the Board, the CFO or his or her designee to reasonably evaluate compliance with this policy.

8. Waiver and Rejection Rights: CalOptima reserves the right to reject any and all bids or proposals or to waive any informality or non-substantive defects in bids or proposals to serve CalOptima's Best Interest. Only those bids or proposals which are deemed by CalOptima to be responsive to the RFP or RFQ shall be considered. The Purchasing Department shall ensure maximum protection of CalOptima's Best Interest consistent with ensuring an equal opportunity and fair and equitable treatment for all bidders and Offerors.

9. Notice to Bidders Not Awarded the Contract: Whenever a contract is not to be awarded to a bidder, such bidder shall be notified by regular mail within ten (10) business days after the award of the contract to another bidder.

10. Qualified Bidder: CalOptima's determination of a qualified bidder shall be based on analysis of each bidder's ability to perform, financial statement (if required), experience, past record and any other factors it shall deem relevant. If the lowest price bidder is to be rejected because of an adverse determination of the bidder's responsibility based on CalOptima's decision, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility.

11. Extensions: The granting of an extension to the contractor is not a new contract. If a contractor makes an application for an extension in writing, CalOptima shall consider matters germane to the particular contract and shall not grant or deny the extension arbitrarily. However, in any contract which includes provisions for liquidated damages, CalOptima's decision to extend the contract without charge to the contractor shall be made only when the failure to complete the contract on time is not attributable to the contractor's unreasonable delay or default.

12. Contract Documents: Contract documents shall be prepared in advance, with the approval of Legal Counsel and shall be incorporated into the bid package.

13. Flexibility: In recognition of the fact that the contracting and purchasing needs of CalOptima may from time to time render certain procedures herein impracticable, the Chief Financial Officer or designee are authorized to permit or waive deviations from this policy, to the extent permitted by law, upon making a written finding that such deviation is in CalOptima's Best Interests. Additionally, provisions required to be included in Public Works and construction contracts (e.g. requirements for performance bonds, insurance, etc.) may be included in other contracts if appropriate.

K. Provisions Applicable to Procurement of Non-Medical Professional Services.

1. Except as otherwise provided for in this policy, all procurements for professional services shall be made, in accordance with limits as set forth in the Board-approved annual operating budget.

2. Exceptions: Contracts for professional services, including special services and advice in financial, economic, accounting, engineering, legal, or administrative matters, if such persons have the necessary experience, training, competence, and licensure (if applicable) to perform the special services required, may be made without soliciting or securing competitive offers, but shall be awarded according to Section II.K. of this policy. If proposals are solicited, the procedure set forth herein, modified as the Chief Executive Officer or designee shall determine to be in CalOptima's best interest, shall be followed.

3. The CEO or his or her designee may use a procedure to select a vendor involving an expenditure of more than fifty thousand dollars ($50,000) by "competitive means." This would include one or more the following methods when deemed by the CEO or his or her designee as an appropriate means under the circumstances to permit reasonable conclusion that the proposed contract is beneficial to CalOptima.

    a. Preparation and circulation of a request for proposal (RFP) to an adequate number of qualified sources.

    b. Posting, publishing, communicating telephonically or otherwise publicizing RFP in a manner intended to disseminate the RFP to an adequate number of qualified sources.

    c. Soliciting comparable rates charged by other vendors for similar services to ensure a competitive price.

4. Criteria for Award of Contract: Contracts for professional services shall be awarded based on the determination of which vendor has the most cost-effective and beneficial solution to CalOptima's requirements. In making this determination, the following evaluation tools shall apply as appropriate:

    a. Price.

    b. Payment or financial terms offered by contractor.

    c. The relevant experience in the area of purchase.

    d. A demonstrated quality, dependability and responsiveness.

    e. Familiarity with type of business CalOptima is operating.

    f. Familiarity with CalOptima.

    g. Reputation in the community.

    h. Special expertise in the area of purchase.

    i. Other selection criteria as may be deemed appropriate.

    j. These criteria shall be applied by the Board, CEO or his or her designee in selecting the vendor.

k. Exception: Pursuant to 40 U.S.C. §§ 1101-1104 and California Government Code §§ 4525-4529.5, any RFP or RFQ for architectural or engineering services shall not, for the purposes of ranking firms, be evaluated primarily on the basis of price. Once firms are determined to have the requisite technical capabilities to meet the services required (e.g. experience, proposal, technical expertise) CalOptima may then use price as a factor for the purposes of final ranking determinations. CalOptima then shall seek to negotiate a fair and reasonable price with the top ranked firm. If agreement on a fair and reasonable price cannot be reached, CalOptima shall cease negotiations and move to the second ranked firm and seek to negotiate a fair and reasonable price. This process shall continue until agreement with a firm is reached.

L. Provisions Applicable to Procurement of Computer Hardware, Software, and Other Peripheral Equipment and Related Services (collectively "computer equipment"), and Telecommunications Goods and Services.

1. CalOptima shall acquire computer equipment, and telecommunications goods and services involving an expenditure of more than one hundred thousand dollars ($100,000) or such other amount as may be specified by law, through "competitive means," except when the Chief Executive Officer or designee determines either that (a) the goods and services proposed for acquisition are the only goods and services which can meet CalOptima's needs, or (b) the goods and services are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare and safety.

2. As used in this policy, "competitive means" includes any one or more of the following methods, when deemed by the Chief Executive Officer or designee as an appropriate means under the circumstances to permit reasonable competition consistent with the nature and requirements of the proposed acquisition:

a. The preparation and circulation of a request for quotations (RFQ) or request for proposals (RFP) to an adequate number of qualified sources. An "adequate number" shall be defined as two or more qualified sources, as determined by the Chief Executive Officer or designee based upon the number of qualified sources believed to be capable of submitting a satisfactory proposal, after reasonable inquiry.

b. Posting, publishing, communicating telephonically or otherwise publicizing the RFP in a manner intended to disseminate the RFP to an adequate number of qualified sources.

c. Any other means determined by the Chief Executive Officer or designee as reasonably expected to disseminate the RFP to an adequate number of qualified sources.

3. Criteria for Award of Contract

a. Contracts for computer equipment or telecommunications goods and services subject to this policy shall be awarded based on a determination of which responsive proposal provides the most cost-effective and beneficial solution to CalOptima's requirements. In making this determination, the following evaluation criteria shall apply, as applicable:

i. The price of the components, installation and any related consulting, maintenance or other services.

ii. The payment and financing terms offered by the contractor.

iii. The extent to which the components meet or exceed CalOptima's technical requirements and can be expected to accomplish the specified goals.

iv. The demonstrated quality, dependability, and responsiveness of the contractor and any subcontractors providing installation, integration, consulting, maintenance or other services.

v. The anticipated expense and disruption to CalOptima services and facilities involved in integrating additional components or upgrades into the system which may be necessary to accommodate the expansion of CalOptima facilities or needs.

vi. The anticipated expense and disruption to CalOptima facilities and services involved in integrating upgrades or retrofits into the system as necessary to keep pace with technological improvements or refinements to the system.

vii. The anticipated expense and disruption to CalOptima facilities and services involved in maintaining or repairing the system, including but not limited to implementing back-up procedures while the system is down, and obtaining necessary parts and service.

viii. The quality and comprehensiveness of the warranty offered.

ix. The anticipated salvage or resale value of the components, if any, based upon its anticipated useful life to CalOptima.

x. Such other criteria, consistent with this policy and the goal of achieving the most cost-effective solution to CalOptima's requirements, as the CEO or his or her designee may establish.

b. These criteria shall be applied by the Chief Executive Officer or designee using a scoring or other system designed to determine which of the proposals submitted provides the most viable solution to CalOptima's requirements. The basis for such determination shall be documented by the Purchasing Department in a manner which permits the Board, the Chief Executive Officer or designee to reasonably evaluate compliance with this policy.

M. Provisions Applicable to Public Works Projects

1. CalOptima is not subject to the requirements of the California Public Contract Code calling for competitive bidding and award of contracts to the lowest responsive, qualified bidder. This policy establishes the generally accepted methods of procurement, which may be adjusted from time to time in order to serve CalOptima's Best Interests or to reflect current best business practices. All formal and informal requests for prices in the form of bids for all materials, services and equipment purchased, must be made by the Purchasing Department, unless otherwise delegated by the Purchasing Department in writing.

a. Purchases for less than ten thousand dollars ($10,000) not including applicable taxes and freight charges, referred to as small procurements, may be made on a discretionary basis without solicitation of bids.

b. Purchases for ten thousand dollars ($10,000) or more, but not exceeding one hundred thousand dollars ($100,000), require informal solicitation of bids and shall be made in accordance with this policy, including the procedures described in Section II.M.2.

c. Purchases amounting to over one hundred thousand dollars ($100,000) require formal solicitation of bids, and shall be made in accordance with this policy, including the procedures described in Section II.M.2.

d. All requests and contracts shall be based on forms approved by CalOptima's Legal Department.

2. Procurement of Alterations to and Maintenance of Real Property and Other Public Works Projects

a. This section II.M.2. shall apply to any acquisition of goods and services for the physical construction, alteration, demolition, installation or repair of real property, including fixtures, painting, wiring, carpeting and other things incorporated into or permanently affixed to real property. CalOptima may elect to pre-qualify contractors to participate in informal and formal bids.

b. No alteration to real property requiring a building permit, including tenant improvements in leased spaces, shall be undertaken, except pursuant to detailed plans and specifications, prepared by an architect, engineer, or other California-licensed professional acting within the scope of her or his license. Any such alterations to CalOptima's leased spaces shall be consistent with the terms and conditions of the lease, if any.

c. Purchases/Projects valued at less than $10,000 shall be made in accordance with Section II.M.1.

d. Purchases/Projects valued between $10,000 and $100,000 shall be made in accordance with Section II.M.2.h.

e. Purchases/Projects valued at $100,000 or more shall be made in accordance with Section II.M.2.i.

f. Projects where the architect's or engineer's estimate is over $100,000 must be bid through the formal bidding process set forth in Section II.M.2.i.

g. All bids must be accompanied by a non-collusion affidavit.

h. Informal Bid Procedures

i. Preparation: A written request shall be prepared which shall, at a minimum, contain: (i) appropriately detailed plans and specifications or scope of work considering the value and technical complexity of the goods and/or services to be procured; (ii) the CalOptima staff person to whom the bid must be addressed; (iii) the date and time by which CalOptima must receive the bid; (iv) a statement that the bid must be firm for a period of not less than ninety (90) days from receipt by CalOptima; and (v) a copy of the construction contract.

ii. Evaluation: The criteria for evaluating bids will be determined on a case-by-case basis, and will be stated in the written request.

iii. Bidder Pre-qualification: CalOptima may pre-qualify contractors for projects to be bid through this informal bid procedure, and may limit distribution of informal bid packets to pre-qualified contractors.

i. Formal Bid Procedures

i. Preparation: CalOptima shall prepare or cause to be prepared a bid package. To the extent practicable, the bid package shall include full, complete, and accurate plans and specifications and estimates of cost, giving such directions as will enable any competent contractor to ascertain and carry out the contract requirements. The bid package shall also include a statement of the date and time by which CalOptima must receive bids, the criteria upon which the bids will be evaluated; and a copy of the construction contract.

ii. Notice/Request for Bids: All prospective bidders who have notified CalOptima in writing that they desire to bid on contracts, and all prospective bidders which CalOptima would like to bid on contracts, shall be furnished with notice and a request for bids, including information as to the type, quality, quantity, date, location and other bid requirements. In addition to notifying all such persons, the notice shall specify the place bids are to be received and the time by which they are to be received.

iii. Advertising/Publication: Except in cases of emergency or where circumstances require the immediate letting of a contract, information advising interested parties how to obtain specifications, and specifying the place bids are to be received and the time by which they are to be received, shall be given by publication once a week for at least two (2) consecutive weeks, as follows:

a) In a newspaper of general circulation published in such places as are most likely to reach prospective bidders; or

b) In trade journals or papers of general circulation as the Chief Executive Officer, or designee, deems proper; or

c) Electronic media may be used in lieu of newspaper advertisements if and when it is believed this media will better serve the needs of CalOptima.

d) The Chief Executive Officer or designee may waive any irregularity or informality in the publication procedures.

iv. Bidders' Conference: CalOptima may hold a bidders' conference or conduct a site visit, as it deems necessary and appropriate. In such cases, CalOptima shall include the date, time and location in the bid documents. The conference or site visit shall be at least five (5) days after publication of the notice.

v. Bid Form: CalOptima shall furnish to each prospective bidder a bid package, including an appropriate bid form, prepared by CalOptima for the type of contract being let. Bids not presented on forms so furnished shall be disregarded.

vi. Presentation of Bids Under Sealed Cover: All bids shall be presented under sealed cover. Upon receipt of each, the bid shall be date-stamped. The bid shall be accompanied by a copy of the construction contract duly executed by the bidder, but which will not be executed by CalOptima until completion of the bid process and CalOptima Board approval, as necessary and appropriate.

vii. Withdrawal of Bids: Bids may be withdrawn at any time prior to the deadline for submitting bids fixed in the notice only by written request made to the person or entity designated in charge of the bidding procedure. The withdrawal of the bids does not prejudice the right of the bidder to timely file a new bid. No bidder may withdraw his bid after opening for at least a period of ninety (90) days thereafter.

viii. Opening of Bids and Award of Contract: At the scheduled date and time, CalOptima shall open the sealed bids. Award of the contract shall be to the lowest-price qualified and responsive bidder, if at all, within ninety (90) days after opening, unless the bid package specifies otherwise or the Chief Executive Officer or designee extends the time. All bidders shall have complied with the foregoing bid procedures, except as otherwise provided herein. After a bid is opened it shall be deemed irrevocable for the period specified in the request for bids. Bids shall be irrevocable for a minimum of ninety (90) days after the opening thereof.

ix. Awards to the Second and Third Lowest Price Qualified Bidders: If CalOptima deems it is in its best interest, it may, on refusal or failure of the successful bidder to execute the contract or comply with other bid requirements, award it to the second lowest-price qualified bidder. If the second lowest price qualified bidder fails or refuses to execute the contract or comply with other bid requirements, CalOptima may likewise award it to the third lowest price qualified bidder.

x. Only One Bid or Proposal Received: If only one bid or proposal is received in response to the request for bids, an award may be made to the sole bidder, provided that CalOptima finds that the price submitted is fair and reasonable.

xi. Notice to Bidders Not Awarded the Contract: Whenever a contract is not to be awarded to a bidder, such bidder shall be notified by regular mail within seventy-two (72) hours after the award of the contract to another bidder.

xii. Qualified Bidder: CalOptima's determination of a qualified bidder shall be based on analysis of each bidder's ability to perform, financial statement (if required), experience, past record and any other factors it shall deem relevant. If the lowest price bidder is to be rejected because of an adverse determination of the bidder's responsibility based on CalOptima's decision, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility.

xiii. Contract Documents: Contract documents shall be prepared in advance, with the approval of Legal Counsel, and shall be incorporated into the bid package as indicated above.

j. Waiver and Rejection Rights: CalOptima reserves the right to reject any and all bids, or to waive any informality or non-substantive defects in bids, as the interest of CalOptima may require. Only those bids shall be considered that are deemed by CalOptima to be responsive to the Request for Bid (RFB) or Request for Quotations (RFQ). The Purchasing Department shall ensure maximum protection of CalOptima's interest consistent with ensuring an equal opportunity and fair and equitable treatment for all bidders.

k. Extensions: The granting of an extension to the contractor is not a new contract. If a contractor makes an application for an extension in writing, CalOptima shall consider matters germane to the particular contract, and shall not grant or deny the extension arbitrarily. However, in any contract which includes provisions for liquidated damages, CalOptima's decision to extend the contract without charge to the contractor shall be made only when the failure to complete the contract on time is not attributable to the contractor's unreasonable delay or default.

l. Provisions of the policy may be waived by the CalOptima Board.

m. All contractors contracted by CalOptima for the performance of Public Works Projects, as defined in California Labor Code Section 1720, shall pay not less than the required prevailing wages, as provided in Section 1771 of the California Labor Code, if the total payments under that contract are more than $1,000.

n. Payment Bonds – Pursuant to California Civil Code § 9550, for any Public Works project in excess of $25,000, the prime contractor shall submit a payment bond, in a form approved by the Chief Financial Officer and from a surety authorized to do business in the State of California, in the amount of 100% of the contract price.

N. Cooperative Purchases

1. When it is in CalOptima's Best Interest, the Purchasing Department may enter into or use pre-existing cooperative purchasing agreements for acquisition of goods and services with any entity or group and execute respective contracts under those agreements.

O. Sole Source Purchases

1. Sole source purchases are not competitively bid and shall not be used unless there is clear and convincing evidence that only one (1) acceptable source exists to fulfill CalOptima's requirements. Sole source purchases involve goods or services that are unique or novel to only one (1) supplier, or products and/or services that are designed to match others already in use.

P. Emergency Purchases

1. The Chief Executive Officer, or designee, may authorize emergency purchases in cases that have or could impose significant provable loss to CalOptima or where human life or property is endangered. When an emergency condition arises, and the need cannot be met through normal procurement methods, the emergency purchase shall be made with such competition as is feasible under the circumstances. Contracts and other documents related to such emergency procurements shall be executed in accordance with the requirements of CalOptima Policy GA.3202: CalOptima Signature Authority.

2. The person responsible for the emergency purchase shall provide written documentation stating the basis of the emergency purchase and the reasoning for the selection of the particular contractor. A written account of the emergency circumstances shall be sent promptly to the Chief Executive Officer and the Board of Directors. Normal purchasing procedures shall be followed as soon as the emergency is over.

Q. Real Property Transactions

1. CalOptima shall not enter into any transaction for the purchase, sale, lease (including any sublease or lease assignment, whether CalOptima is the lessor, lessee, sublessor, sublessee, assignor or assignee), or termination of lease of any real property, or enter into negotiations related to such transactions, without the prior approval of the Board of Directors, pursuant to a Board action addressed solely to the transaction or set of related transactions, and setting forth the parameters under which the negotiations may proceed. Such negotiations and transactions on behalf of CalOptima shall be carried out exclusively by the person or persons designated by the Board of Directors.

R. Ethics

1. CalOptima employees shall conduct themselves in such a manner as to foster public confidence in the integrity of the CalOptima procurement process.

2. CalOptima employees shall perform their duties impartially to ensure that vendors have fair and competitive access to do business with CalOptima.

3. Employees, officers or agents of CalOptima shall be subject to the Conflict of Interest Laws of the State of California and the CalOptima Code of Conduct. Employees, officers or agents of CalOptima who violate these standards shall be subject to the penalties, sanctions or other disciplinary actions provided for therein.

4. Gratuities, Kickbacks, and Contingency Fees

   a. No CalOptima employee shall solicit, demand, or accept from any person anything of monetary value for, or because of, any action taken, or to be taken, in the performance of his/her duties. An employee failing to adhere to the above shall be subject to any disciplinary proceeding deemed appropriate by CalOptima, including possible dismissal.

   b. CalOptima employees shall adhere to all provisions of the CalOptima Policy AA.1204: Gift, Honoraria, and Travel Payment.

5. Confidential Information

   a. No CalOptima employee shall use confidential information for his or her actual or anticipated personal gain, or the actual or anticipated personal gain of any other person related to such CalOptima employee by blood, marriage, or by common commercial or financial interest. An employee failing to adhere to this requirement shall be subject to any disciplinary proceeding deemed appropriate by CalOptima, up to and including dismissal.

   b. CalOptima employees shall not divulge confidential information to any vendor, consultant, or contractor.

6. Vendor Relations

   a. CalOptima employees may discuss, on an informal basis, non-financial requirements with contractors, consultants, and vendors. Employees may also solicit information such as brochures and other descriptive material from vendors, consultants, and contractors.

   b. CalOptima employees shall not meet with vendors, consultants, and/or contractors regarding specific financial requirements unless a representative of the Purchasing Department is present at the meeting.

   c. CalOptima employees shall not bind, or appear to bind, CalOptima in any way, financially, or otherwise, except as provided for in accordance with CalOptima Policy GA.3202: CalOptima Signature Authority. Only the Board, Chief Executive Officer or his/her designee, and those staff designated as signing authorities in CalOptima Policy GA.3202: CalOptima Signature Authority may financially or contractually bind CalOptima.

   d. No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have a foreseeable impact on a vendor if a conflict of interest, real or implied, exists. Such a conflict arises when any one of the following has a financial or other interest in the firm selected for award:

      i. A CalOptima employee, officer, or agent;

      ii. The employee, officer or agent's spouse or dependent children;

      iii. The employee, officer or agent's domestic or business partner;

      iv. An organization that employs or has made an offer of employment to any of the above.

S. Other Bidding Procedures

1. Federal Awards Subject to OMB A-133 Single Audit Requirements (such as Multipurpose Senior Services Program (MSSP)) shall follow the bidding procedures as prescribed in Attachment A – Policy for Awards Subject to 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.~~.~~

III. PROCEDURE

Not Applicable

~~IV.~~I. ~~DEFINITIONS~~

~~A. Bidder's Conference: A meeting to discuss technical, operational and performance specifications, and/or the full extent of financial, security and other contractual obligations with potential bidders, related to bid solicitation before the bid closes.~~

~~B.~~A. ~~CalOptima's Best Interest: The discretionary rationale used by a purchasing official in taking action most advantageous to the jurisdiction when it is impossible to adequately delineate a specific response by law or regulation.~~

~~C.~~A. ~~Invitation for Bids (IFB): The document used to solicit bids from potential contractors for a fixed project with established plans and specifications. This is generally used for the procurement of Public Works.~~

~~D.~~A. ~~Pre-Qualification (of bidders):The screening of potential vendors in which such factors as financial capability, reputation, and management are considered in order to develop a list of qualified businesses who may then be allowed to submit bids.~~

~~E.~~A. ~~Public Works: Public Works means any work of improvement contracted for by a public entity (such as CalOptima). Work of improvement includes, but is not restricted to, the construction, alteration, addition to, or repair, in whole or in part, of any building, whether owned or leased by a public entity.~~

~~F.~~A. ~~Offeror: The person/entity who submits a proposal in response to a Request for Proposal or Request for Quotation.~~

~~G.~~A. ~~Request for Proposal (RFP): The document used to solicit proposals from potential vendors for goods and services. This is generally used when the specification for the good or service is known, but the vendor's advice is needed regarding how to buy the good or implement the service. The price is usually not the primary evaluation factor. It provides for the negotiation of all terms, including price prior to contract award. The RFP may include a provision for the negotiation of Best and Final offers. It may be a single or multi-step process.~~

~~H.~~A. ~~Request for Quotation (RFQ): A purchasing method generally used when specifications are known for goods and services of all types. A request is sent to vendors along with a specification of the commodity needed or a description of the services required. The vendor is asked to respond with price and other information by a pre-determined date. Evaluation and recommendation for award should be based on the quotation that best meets price, quality, delivery, service, past performance and reliability.~~

~~I.~~A. ~~Scope of Work: (SOW): A written description of the contractual requirements for materials and services contained within a RFQ or RFP. A well-conceived and clearly written SOW serves four main purposes:~~

- ~~Establishes clear understanding of what is needed;~~
- ~~Encourages competition in the marketplace and promotes economic stimulus;~~
- ~~Satisfies a critical need of government; and~~
- ~~Obtains the best value for the taxpayer.~~

~~V.~~IV. ATTACHMENTS

A. ~~Procurement Policy Process Flow – Acquisition Method Determination~~Policy for Awards Subject to 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards

~~A. Procurement Policy Acquisition Method Flows – Non-Public Works~~

~~B. Procurement Policy Acquisition Method Flows – Public Works~~

~~VI.~~V. REFERENCES

A. California Fair Political Practices Commission Form 700 - Statement of Economic Interests

B. CalOptima Code of Conduct
C. CalOptima Compliance Plan
~~B.~~D. CalOptima Compliance Program
E. CalOptima Conflict of Interest Code
~~C.~~F. CalOptima Policy AA.1001: Glossary of Terms
~~D.~~G. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
H. CalOptima Policy GA.3202: CalOptima Signature Authority
~~E.~~I. CalOptima Policy GA.5003: Budgets and Operations Forecasting
~~F.~~J. CalOptima Resolution No. 12-03101-01
~~G.A. CalOptima Code of Conduct~~
~~H. CalOptima Compliance Plan~~
~~I. CalOptima Conflict of Interest Code~~

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. ~~OR~~ BOARD ACTIONS

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 03/01/12: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board of Directors Meeting~~
~~B.~~C. 01/04: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board of Directors Meeting~~
~~C.~~D. 01/00: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board of Directors Meeting~~
~~D.~~E. 10/97: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board of Directors Meeting~~
~~E.~~F. 09/96: Regular Meeting of the CalOptima Board of Directors ~~Regular CalOptima Board of Directors Meeting~~

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	09/1996	GA.5002	Procurement Policy	Administrative
Revised	10/1997	GA.5002	Procurement Policy	Administrative
Revised	01/2000	GA.5002	Procurement Policy	Administrative
Revised	01/2004	GA.5002	Procurement Policy	Administrative
Revised	03/01/2012	GA.5002	Purchasing Policy	Administrative
Revised	06/07/2018	GA.5002	Purchasing	Administrative

~~A. 3/1/12: GA.5002: Purchasing Policy~~
~~B. 1/04: GA.5002: Procurement Policy~~
~~C. 1/00: GA.5002: Procurement Policy~~
~~D. 10/97: GA.5002: Procurement Policy~~
~~E. 9/96: GA.5002: Procurement Policy~~

IX. ~~DEFINITIONS~~GLOSSARY

Term	Definition
Bidder's Conference	A meeting to discuss technical, operational and performance specifications, and/or the full extent of financial, security and other contractual obligations with potential bidders, related to bid solicitation before the bid closes.
CalOptima's Best Interest	The discretionary rationale used by a purchasing official in taking action most advantageous to the jurisdiction when it is impossible to adequately delineate a specific response by law or regulation.
Invitation for Bids (IFB)	The document used to solicit bids from potential contractors for a fixed project with established plans and specifications. This is generally used for the procurement of Public Works.
Pre-Qualification (of bidders)	The screening of potential vendors in which such factors as financial capability, reputation, and management are considered in order to develop a list of qualified businesses who may then be allowed to submit bids.
Public Works	Works means any work of improvement contracted for by a public entity (such as CalOptima). Work of improvement includes, but is not restricted to, the construction, alteration, addition to, or repair, in whole or in part, of any building, whether owned or leased by a public entity.
Offeror	The person/entity who submits a proposal in response to a Request for Proposal or Request for Quotation.
Request for Proposal (RFP)	The document used to solicit proposals from potential vendors for goods and services. This is generally used when the specification for the good or service is known, but the vendor's advice is needed regarding how to buy the good or implement the service. The price is usually not the primary evaluation factor. It provides for the negotiation of all terms, including price prior to contract award. The RFP may include a provision for the negotiation of Best and Final offers. It may be a single or multi-step process.
Request for Quotation (RFQ)	A purchasing method generally used when specifications are known for goods and services of all types. A request is sent to vendors along with a specification of the commodity needed or a description of the services required. The vendor is asked to respond with price and other information by a pre-determined date. Evaluation and recommendation for award should be based on the quotation that best meets price, quality, delivery, service, past performance and reliability.
Scope of Work (SOW)	A written description of the contractual requirements for materials and services contained within a RFQ or RFP. A well-conceived and clearly written SOW serves four main purposes: • Establishes clear understanding of what is needed; • Encourages competition in the marketplace and promotes economic stimulus; • Satisfies a critical need of government; and • Obtains the best value for the taxpayer.

~~Bidder's Conference: A meeting to discuss technical, operational and performance specifications, and/or the full extent of financial, security and other contractual obligations with potential bidders, related to bid solicitation before the bid closes.~~

~~CalOptima's Best Interest: The discretionary rationale used by a purchasing official in taking action most advantageous to the jurisdiction when it is impossible to adequately delineate a specific response by law or regulation.~~

~~Invitation for Bids (IFB): The document used to solicit bids from potential contractors for a fixed project with established plans and specifications. This is generally used for the procurement of Public Works.~~

~~Pre-Qualification (of bidders):The screening of potential vendors in which such factors as financial capability, reputation, and management are considered in order to develop a list of qualified businesses who may then be allowed to submit bids.~~

~~Public Works: Public Works means any work of improvement contracted for by a public entity (such as CalOptima). Work of improvement includes, but is not restricted to, the construction, alteration, addition to, or repair, in whole or in part, of any building, whether owned or leased by a public entity.~~

~~Offeror: The person/entity who submits a proposal in response to a Request for Proposal or Request for Quotation.~~

~~Request for Proposal (RFP): The document used to solicit proposals from potential vendors for goods and services. This is generally used when the specification for the good or service is known, but the vendor's advice is needed regarding how to buy the good or implement the service. The price is usually not the primary evaluation factor. It provides for the negotiation of all terms, including price prior to contract award. The RFP may include a provision for the negotiation of Best and Final offers. It may be a single or multi-step process.~~

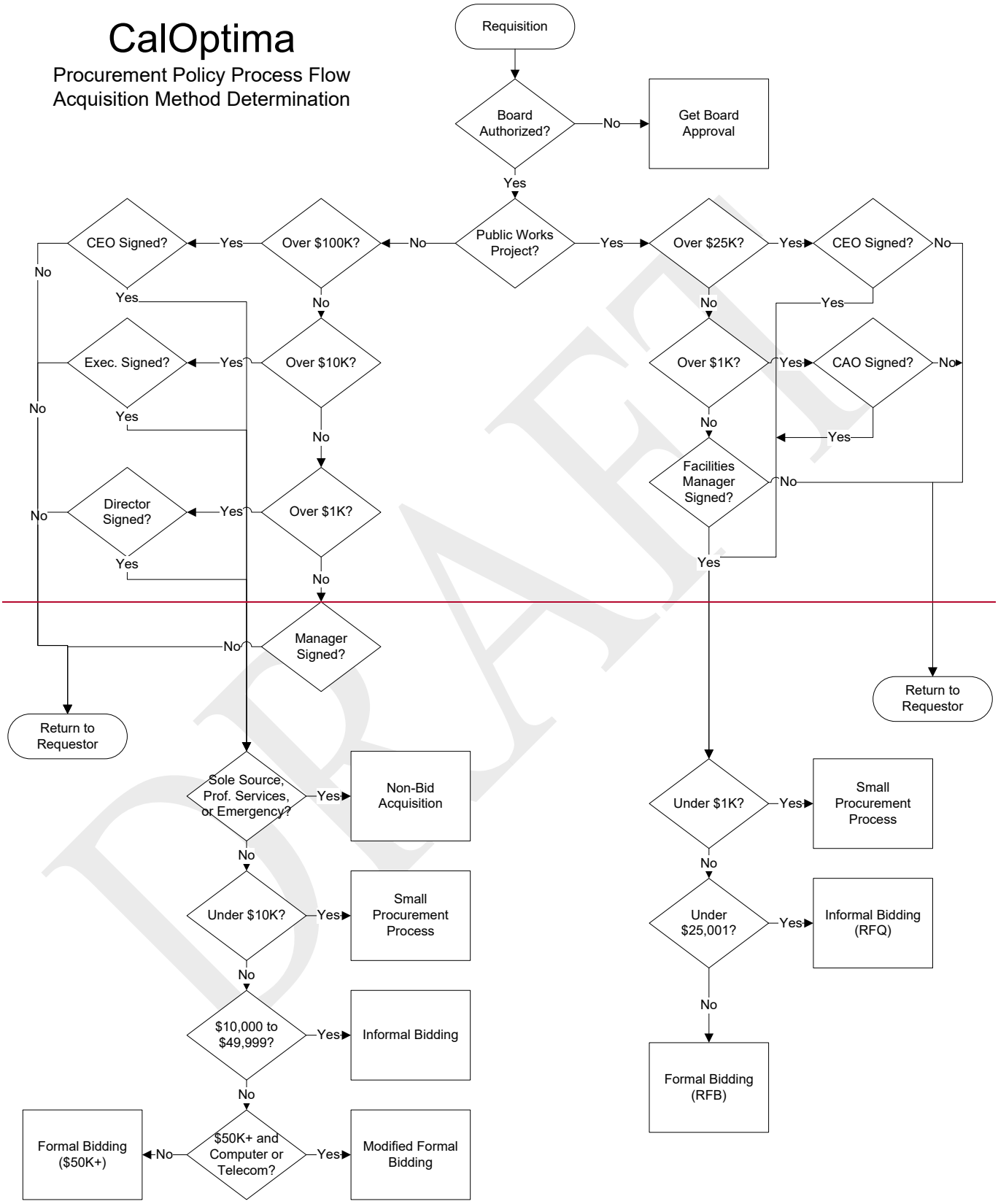
~~Request for Quotation (RFQ): A purchasing method generally used when specifications are known for goods and services of all types. A request is sent to vendors along with a specification of the commodity needed or a description of the services required. The vendor is asked to respond with price and other information by a pre-determined date. Evaluation and recommendation for award should be based on the quotation that best meets price, quality, delivery, service, past performance and reliability.~~

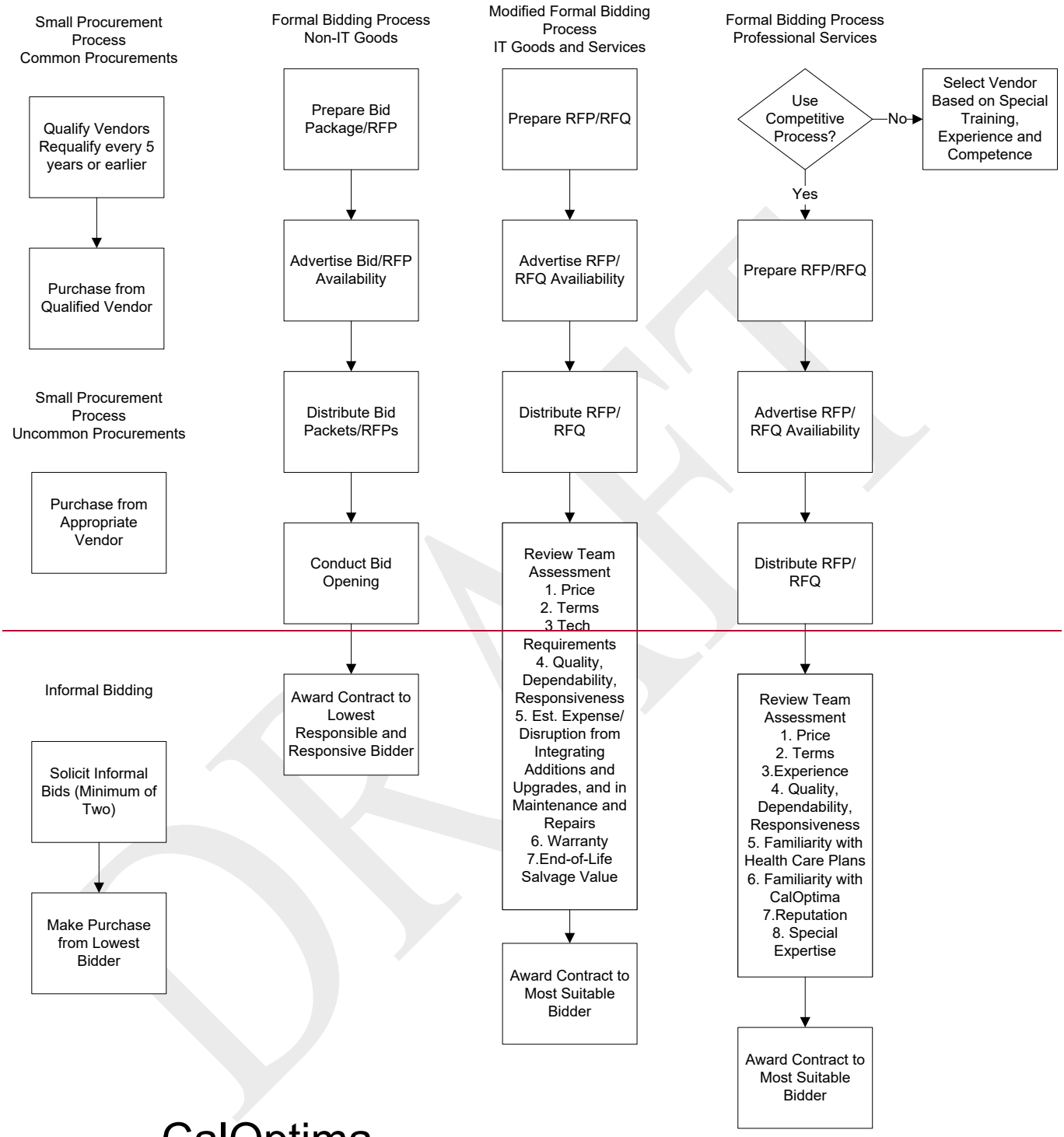
~~Scope of Work: (SOW): A written description of the contractual requirements for materials and services contained within a RFQ or RFP. A well-conceived and clearly written SOW serves four main purposes:~~
- ~~Establishes clear understanding of what is needed;~~
- ~~Encourages competition in the marketplace and promotes economic stimulus;~~
- ~~Satisfies a critical need of government; and~~
- ~~Obtains the best value for the taxpayer.~~

~~IX. KEYWORDS~~

~~Award~~
~~Bid~~

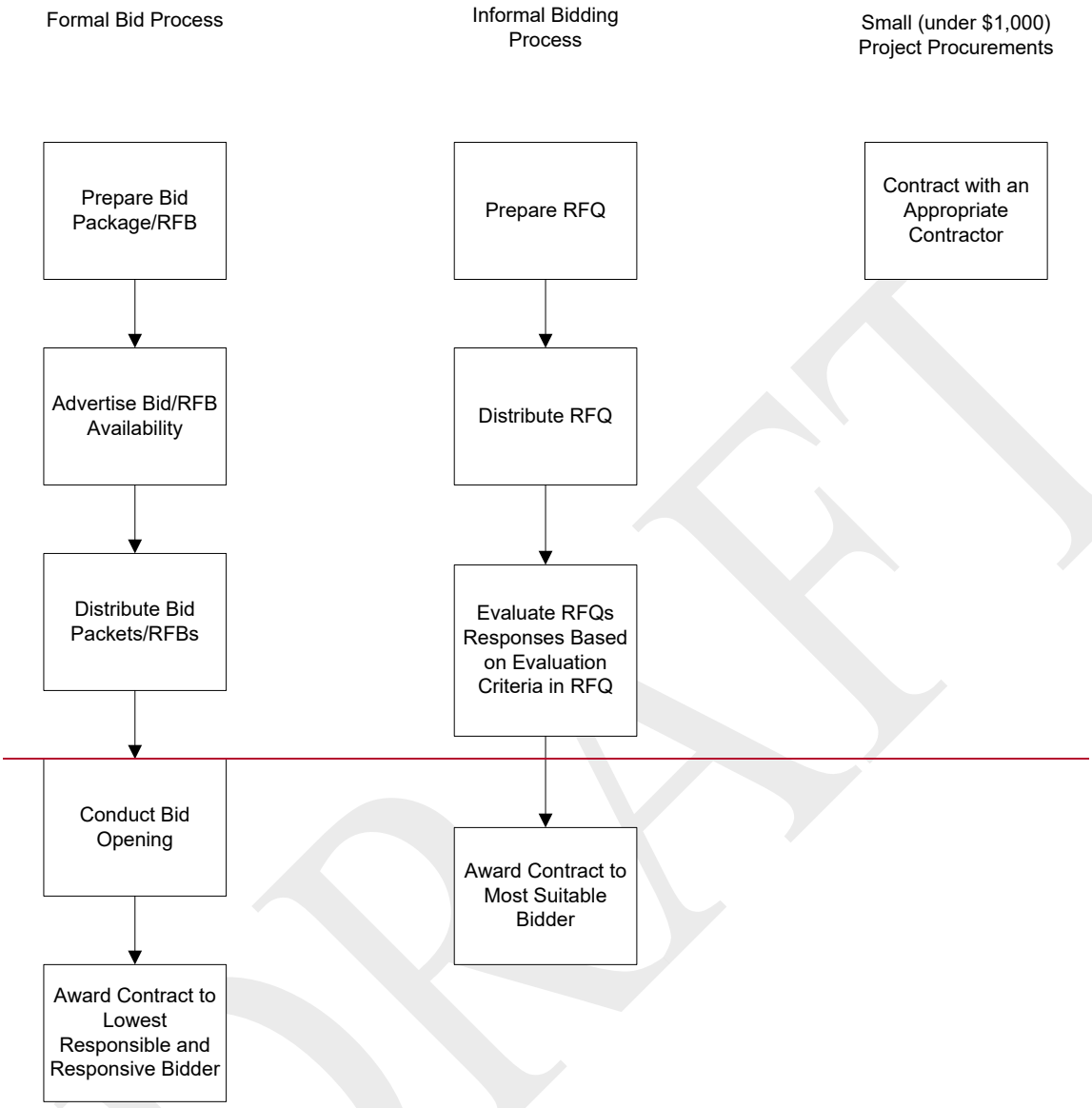
~~Contract~~
~~Procurement~~
~~Proposal~~
~~Request~~
~~Requisition~~
~~_____~~
~~_____~~


CalOptima
Procurement Policy Process Flow
Acquisition Method Determination
Requisition
Board Authorized?
No
Get Board Approval
Yes
Public Works Project?
No
Over $100K?
Yes
CEO Signed?
Yes
No
No
Yes
Exec. Signed?
Yes
Over $10K?
No
Yes
No
Director Signed?
Yes
Over $1K?
No
Yes
No
Manager Signed?
No
Return to Requestor
Yes
Over $25K?
Yes
CEO Signed?
No
Yes
No
Over $1K?
Yes
CAO Signed?
No
Yes
No
Facilities Manager Signed?
No
Yes
Return to Requestor
Sole Source, Prof. Services, or Emergency?
Yes
Non-Bid Acquisition
No
Under $10K?
Yes
Small Procurement Process
No
$10,000 to $49,999?
Yes
Informal Bidding
No
$50K+ and Computer or Telecom?
No
Formal Bidding ($50K+)
Yes
Modified Formal Bidding
Under $1K?
Yes
Small Procurement Process
No
Under $25,001?
Yes
Informal Bidding (RFQ)
No
Formal Bidding (RFB)



CalOptima

Procurement Policy
Acquisition Method Flows
Non-Public Works



CalOptima

Procurement Policy
Acquisition Method Flows
Public Works

Policy #: GA.5002
Title: **Purchasing**
Department: Finance
Section: Financial Affairs

CEO Approval: Michael Schrader

Effective Date: 09/96
Last Review Date: 06/07/18
Last Revised Date: 06/07/18

I. PURPOSE

This policy establishes the organization and administration of a unified, fair, and effective process for the procurement of goods and services essential to the operations of CalOptima, and may be amended from time to time in order that it remains consistent with current best business practices.

II. POLICY

A. Unless exempted by this policy herein and/or applicable law, the Chief Financial Officer (CFO) or his or her designee, with the assistance of the Purchasing Department, is charged with the authority and responsibility for the following:

1. Acquiring equipment, supplies and services for all departments in an economical, expeditious and reasonable manner, in accordance with this policy;

2. Identifying qualified vendors and developing and promoting good vendor relationships;

3. Educating and training employees and vendors on this policy and the purchasing process;

4. Providing assistance to departments in preparing specifications and in analysis of bids received; and

5. Awarding contracts and assuring vendor performance through contract administration.

B. A requisition for purchase of supplies, equipment or services, including Public Works projects, shall be approved only by a person who has been properly authorized in accordance with this policy. The Board of Directors has delegated requisition authority to the Chief Executive Officer (CEO). The Chief Executive Officer has further delegated that authority and in the amounts provided below. Any person in a position delegated authority below may appoint a designee, in writing, to act in his or her stead when that person is unavailable. The Purchasing Department shall have full authority to question the quality, quantity, kind, and source of materials and services being requisitioned.

C. Requisition Approval Limits – Goods and Services except as specified in D. and E. below

Employee Position	Authority Limit
Manager	$ 1,000
Director	10,000
Executive Director or Officer	100,000
Chief Executive Officer	Over 100,000

D. Requisition Approval Limits – Public Works Projects

Employee Position	Authority Limit
Facilities Manager	$ 10,000
Facilities Director	50,000
Chief Administrative Officer	100,000
Chief Executive Officer	Over 100,000

E. Requisition Approval Limits – Computer Hardware, Software and Services Telecommunications Goods and Services

Employee Position	Authority Limit
I.S. Manager	$ 10,000
I.S. Director	$ 50,000
I.S. Executive Director, Chief Information Officer	100,000
Chief Executive Officer	Over 100,000

F. Funding for all requisitions shall be approved by the Board of Directors through:

1. The annual operating or capital budget;

2. Specific Board action; or

3. A Budget Allocation Change, in accordance with CalOptima Policy GA.5003: Budgets and Operations Forecasting.

G. To enable the Board of Directors to consider approval through the operating and capital budgets, the budget submission must meet the requirements outlined in CalOptima Policy GA.3202: CalOptima Signature Authority.

H. Signature authorization for contracts, agreements, leases, and/or purchase orders resulting from this policy is addressed in CalOptima Policy GA.3202: CalOptima Signature Authority. For all CalOptima contracts requiring the vendor's signature, CalOptima authorized signature representatives shall sign the contract documents only after the contract documents have been signed by the vendor.

I. Informal Bidding

1. Set forth below are the generally accepted methods of purchasing, which may be adjusted from time to time for CalOptima's Best Interest and to reflect current best business practices. All formal and informal requests for prices in the form of bids, quotations or proposals for all materials, services and equipment purchased, must be made by the Purchasing Department, unless otherwise delegated by the Purchasing Department in writing. Pre-qualified vendor relationships shall be reviewed periodically, at least every five (5) years, to ensure consistency in quality, service and competitive pricing. For the purposes of this policy, the response to any request for prices, requests for quotations or invitations for bids shall collectively be referred to as a "bid" or "bids."

2. Purchases of Goods and Services as specified in Section II. C., Public Works projects as specified in Section II. D. and Computer Hardware, Software and Services and

Telecommunications Goods and Services as specified in Section II.E. above, valued at under ten thousand dollars ($10,000) per vendor per fiscal year, not including applicable taxes and freight charges, referred to as small procurements, may be made on a discretionary basis without solicitation of bids. The Purchasing Department may establish pre-qualified vendor relationships for common small purchases to leverage pricing to the maximum extent practicable.

3. Purchases of Goods and Services as specified in Section II. C. above valued from ten thousand dollars ($10,000) to fifty thousand dollars ($50,000) per vendor per fiscal year, or between ten thousand dollars ($10,000) and one hundred thousand dollars ($100,000) per vendor per fiscal year for computer equipment and telecommunications goods and services, not including applicable taxes and freight charges, require solicitation of at least two (2) informal bids and/or quotations from known suppliers.

4. Purchases for Public Works projects and Computer Hardware, Software and Services and Telecommunications Goods and Services specified in Section II.D. and Section II. E. above valued from ten thousand dollars ($10,000) or more per vendor per fiscal year, or one hundred thousand dollars or more for computer equipment and telecommunications goods and services to $100,000, excluding taxes and freight charges, shall be made in accordance with this policy under Section(s) II. M., or L. as applicable. Such purchases require solicitation of at least two (2) informal bids and/or quotations from known suppliers. Contracts for software licenses or software maintenance agreements, or computer equipment purchases must be approved in writing by the Information Services Department.

5. Public Works Projects shall be procured in accordance with the limits and procedures of Section II.M.

6. Contracts for the provision of healthcare services must be coordinated by the Provider Operations Department with approval of an appropriate signing party under CalOptima Policy GA.3202: CalOptima Signature Authority, within limits delegated by the Board of Directors, and with approval of the contract template and any deviations therefrom by the Legal Counsel.

J. Formal Bidding

1. Provisions Applicable to Purchasing of Goods and Non-Professional Services shall be made by Request for Quotations (RFQ), Request for Proposals (RFP) or Invitations for Bid (IFB.

   a. Unless exempted in Section II.J.2 below, or by applicable law, purchases of items under Section II.C., including any purchase of goods, material, supplies or non-professional services (e.g., printing, graphic design, mail processing, janitorial, or hard copy file storage, etc.) to be furnished, sold, or leased to CalOptima, involving an expenditure of more than fifty thousand dollars ($50,000). Shall be procured using a formal request for bids in the form of formal Request for Quotations, Requests for Proposal and/or Invitations for Bid.

   b. Unless exempted in Section II.J.2 below or by applicable law, Public Works projects under Section II.D. and the purchase of Computer Hardware, Software and Services and Telecommunications Goods and Services under Section II.E. valued at more than one hundred thousand dollars ($100,000) shall be procured using a formal request for bids in the form of a formal RFQ, RFP or IFB, as provided in Sections II.M. and II.L., respectively Public Works involving construction or demolition, including tenant improvements, shall

include detailed plans and specifications prepared by an architect, engineer or other licensed professional acting within the scope of his or her license. Formal requests for bids for Public Works projects sent to Offerors will include a construction contract template, and any deviations therefrom, approved by Legal Counsel.

2. Exceptions to Bidding

   a. Contracts for non-medical professional services, including special services and advice in financial, economic, accounting, engineering, legal, medical consulting and administrative matters, if such persons have the necessary experience, training, competence, and licensure (if applicable) to perform the special services required, may be made without soliciting or securing bids, but shall be awarded according to the guidelines in Section II.K. of this policy.

   b. Contracts for the acquisition of computer hardware, software, and other peripheral equipment and related services (referred to as "computer equipment"), and telecommunications goods and services may be made without soliciting bids, but shall be awarded according to the guidelines specified in Section II.L. of this policy.

   c. Contracts for the undertaking of Public Works Projects, which shall be awarded according to the provision of Section II.M. of this policy.

   d. Contracts for the provision of health care and related services.

   e. Sole source or emergency purchases, which shall only be undertaken in accordance with Sections II.O. and II.P. respectively.

   f. Acquisitions or transfers of real property, which shall only be undertaken in accordance with Section II.Q.

   g. Subcontracts and other agreements entered into by CalOptima in fulfilling its obligations under a federal, state, local or private grant, if the grant requires that an alternative set of procurement policies, rules, or regulations be used (e.g., the Federal Acquisition Regulation (FAR)).

3. Bid Procedures for formal bidding for goods and non-professional services.

   a. Preparation: Before entering into any contract which requires formal bidding, CalOptima shall prepare or cause to be prepared a bid package. The bid package may take the form of a RFQ, RFP or IFB. To the extent practicable, the bid package shall include full, complete, and accurate plans and specifications, giving such direction as will enable any competent vendor to ascertain and carry out the contract requirements.

   b. Notice of formal bids: All prospective bidders who have not been suspended or debarred by any regulatory agency within the last three years, have notified CalOptima in writing or via the CalOptima website that they desire to bid on contracts, and all prospective bidders which CalOptima would like to bid on contracts, shall be furnished with an automated e-mail announcement that there is a request for quotation, request for proposal or invitation for bids (as applicable) posted on the CalOptima website for them to download. The RFQ, RFP or IFB shall include information as to the type, quality, quantity, date, location and

other bid requirements. The notice shall specify the place bids are to be received and the time by which they are to be received. Notice may also be made by telephone, telegram, personal contact, letter, or other informal means. Any bids received after the due date and specified time shall be returned unopened, except as otherwise provided herein.

c. Advertising/Publication: Except in cases of emergency or where circumstances require the immediate letting of a contract, information advising interested parties how to obtain specifications, and specifying the place bids are to be received and the time by which they are to be received, shall be given via the automated e-mail system. The RFQ, RFP or IFB will be posted on the Website from the issue date until the date the proposal is due.

i. Methods of publicizing of the bids shall include at least two (2) of the following:

a) RFQ's, RFP's or IFB's will appear on the Supplier tab of CalOptima's Web Site on the date the documents will be issued; or

b) In a newspaper of general circulation once a week for two consecutive weeks published in such places most likely to reach prospective bidders; or

c) In trade journals or papers of general circulation as the Chief Financial Officer, or designee, deems proper.

d) The Chief Executive Officer or designee may waive any irregularity or informality in the publication procedures.

d. Bid Form: The bid package shall furnish to each prospective bidder an appropriate bid form and bid package prepared by CalOptima for the type of contract being let. Bids not presented on forms so furnished shall be disregarded as non-responsive. All bids must be accompanied by a non-collusion affidavit.

e. Presentation of Bids under Sealed Cover: All bids shall be presented under sealed cover on or before the bid deadline. After receipt, the bid shall be date-stamped.

f. Withdrawal of Bids: Bids may be withdrawn at any time prior to the time fixed in the notice for the opening of bids only by written request made to the person or entity designated in charge of the bidding procedure. The withdrawal of the bids does not prejudice the right of the bidder to timely file a new bid. No bidder may withdraw his bid after opening for at least a period of forty-five (45) days thereafter.

g. Bidder's Conference: CalOptima may hold a bidders' conference or conduct a site visit, as it deems necessary and appropriate. In such cases, CalOptima shall include the date, time and location in the bid documents. The conference or site visit shall be at least five (5) days after publication of the notice of formal bid.

4. Award of Contracts

a. Opening of Bids: On the day named in the bid notice, CalOptima shall open the sealed bids. Award of the contract shall be to the lowest-price qualified and responsive bidder, if at all, as determined in CalOptima's sole discretion. Award shall be made within forty-five (45)

days after opening, unless the bid package specifies otherwise or the Chief Executive Officer or his or her designee extends the time. All bidders shall have complied with the foregoing bid procedures, except as otherwise provided herein. After a bid is opened it shall be deemed irrevocable for the period specified in the invitation to bid. Bids shall be irrevocable for a minimum of forty-five (45) days after the opening thereof.

b. Awards to the second and third lowest price Qualified Bidders: If it is deemed to be in CalOptima's Best Interest, CalOptima may, on refusal or failure of the successful bidder to execute the contract or comply with other bid requirements, award it to the second lowest price qualified bidder. If the second lowest price qualified bidder fails or refuses to execute the contract or comply with other bid requirements, CalOptima may likewise award it to the third lowest price qualified bidder.

c. Only one (1) Bid or Proposal Received: If only one (1) bid or proposal is received in response to the RFQ, RFP or IFB, an award may be made to the sole bidder provided that CalOptima finds that the price or proposal submitted is fair, reasonable and in CalOptima's Best Interest.

d. Qualified Bidder: CalOptima's determination of a qualified bidder shall be based on analysis of each bidder's ability to perform, financial statement (if required), experience, past record and any other factors it shall deem relevant. If the lowest price bidder is to be rejected because of an adverse determination of the bidder's responsibility based on CalOptima's decision, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility.

5. Contract Renewal: For contracts that are awarded through a formal bidding process, it is recommended that staff follow the industry best practice that contracts for goods and services not exceed five years in duration without being rebid.

6. Negotiated Purchase: CalOptima reserves the right and at its sole discretion, to informally solicit one or more alternative proposals from one or more qualified vendor(s), in the event that a procurement solicitation results in no acceptable vendor responses based on the criteria set forth in the solicitation package. The Chief Financial Officer or designee may use a procedure to select a vendor by "competitive means." This would include one or more the following methods when deemed by the CFO or designee as an appropriate means under the circumstances to permit CalOptima's Best Interests to be served:

a. The preparation and circulation of an RFP or RFQ to an adequate number of qualified sources. An adequate number shall be defined as two or more qualified sources, as determined by the Chief Financial Officer or designee based on the number of qualified sources believed to be capable of submitting a satisfactory proposal after reasonable inquiry.

b. Posting to the Website, publishing, communicating telephonically or otherwise publicizing the RFP or RFQ in a manner intended to disseminate the RFP or RFQ to an adequate number of qualified sources.

c. Soliciting comparable rates charged by other vendors for similar services to ensure a competitive price.

d. Any other means determined by the CFO or his or her designee as reasonably expected to disseminate the RFQ or RFP to an adequate number of qualified sources.

7. Criteria for Award of Contract via Negotiated Purchase

a. Contracts shall be awarded based on the determination of which vendor has the most cost effective and beneficial solution. In making this determination, the following evaluation tools shall apply as appropriate:

i. Price.

ii. Payment or financial terms offered by contractor.

iii. The extent to which the proposal meets or exceeds CalOptima's technical requirements and, if purchased, can be expected to accomplish the specified goals.

iv. Offeror's relevant experience in the area of purchase/project.

v. A demonstrated quality, dependability and responsiveness of the Offeror and any subcontractors providing installation, integration, consulting maintenance or other goods and services including Public Works.

vi. For capital equipment, the anticipated salvage or resale value of the components, if any, based upon its anticipated useful life.

vii. For Computer Hardware, Software and Services and Telecommunications Goods and Services, the anticipated expense and disruption to CalOptima facilities and services involved in upgrading or integrating additional components to the system and/or maintaining the system which may be necessary to accommodate the expansion of CalOptima facilities, keep pace with technology, provide for system back-up or obtain necessary parts and service.

viii. Offeror's familiarity with CalOptima.

ix. Offeror's reputation in the community.

x. Special expertise in the area of purchase.

xi. Such other criteria, consistent with this policy and the goal of achieving the most cost-effective solution to CalOptima's requirements, as the CFO or his or her designee may establish.

b. These criteria shall be applied by the Chief Financial Officer or designee using a scoring or other system designed to determine which of the proposals submitted provides the most viable solution to CalOptima's requirements. The basis for such determination shall be documented by the Purchasing Department in a manner which permits the Board, the CFO or his or her designee to reasonably evaluate compliance with this policy.

8. Waiver and Rejection Rights: CalOptima reserves the right to reject any and all bids or proposals or to waive any informality or non-substantive defects in bids or proposals to serve

CalOptima's Best Interest. Only those bids or proposals which are deemed by CalOptima to be responsive to the RFP or RFQ shall be considered. The Purchasing Department shall ensure maximum protection of CalOptima's Best Interest consistent with ensuring an equal opportunity and fair and equitable treatment for all bidders and Offerors.

9. Notice to Bidders Not Awarded the Contract: Whenever a contract is not to be awarded to a bidder, such bidder shall be notified by regular mail within ten (10) business days after the award of the contract to another bidder.

10. Qualified Bidder: CalOptima's determination of a qualified bidder shall be based on analysis of each bidder's ability to perform, financial statement (if required), experience, past record and any other factors it shall deem relevant. If the lowest price bidder is to be rejected because of an adverse determination of the bidder's responsibility based on CalOptima's decision, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility.

11. Extensions: The granting of an extension to the contractor is not a new contract. If a contractor makes an application for an extension in writing, CalOptima shall consider matters germane to the particular contract and shall not grant or deny the extension arbitrarily. However, in any contract which includes provisions for liquidated damages, CalOptima's decision to extend the contract without charge to the contractor shall be made only when the failure to complete the contract on time is not attributable to the contractor's unreasonable delay or default.

12. Contract Documents: Contract documents shall be prepared in advance, with the approval of Legal Counsel and shall be incorporated into the bid package.

13. Flexibility: In recognition of the fact that the contracting and purchasing needs of CalOptima may from time to time render certain procedures herein impracticable, the Chief Financial Officer or designee are authorized to permit or waive deviations from this policy, to the extent permitted by law, upon making a written finding that such deviation is in CalOptima's Best Interests. Additionally, provisions required to be included in Public Works and construction contracts (e.g. requirements for performance bonds, insurance, etc.) may be included in other contracts if appropriate.

K. Provisions Applicable to Procurement of Non-Medical Professional Services.

1. Except as otherwise provided for in this policy, all procurements for professional services shall be made, in accordance with limits as set forth in the Board-approved annual operating budget.

2. Exceptions: Contracts for professional services, including special services and advice in financial, economic, accounting, engineering, legal, or administrative matters, if such persons have the necessary experience, training, competence, and licensure (if applicable) to perform the special services required, may be made without soliciting or securing competitive offers, but shall be awarded according to Section II.K. of this policy. If proposals are solicited, the procedure set forth herein, modified as the Chief Executive Officer or designee shall determine to be in CalOptima's best interest, shall be followed.

3. The CEO or his or her designee may use a procedure to select a vendor involving an expenditure of more than fifty thousand dollars ($50,000) by "competitive means." This would include one or more the following methods when deemed by the CEO or his or her designee as

an appropriate means under the circumstances to permit reasonable conclusion that the proposed contract is beneficial to CalOptima.

a. Preparation and circulation of a request for proposal (RFP) to an adequate number of qualified sources.

b. Posting, publishing, communicating telephonically or otherwise publicizing RFP in a manner intended to disseminate the RFP to an adequate number of qualified sources.

c. Soliciting comparable rates charged by other vendors for similar services to ensure a competitive price.

4. Criteria for Award of Contract: Contracts for professional services shall be awarded based on the determination of which vendor has the most cost-effective and beneficial solution to CalOptima's requirements. In making this determination, the following evaluation tools shall apply as appropriate:

a. Price.

b. Payment or financial terms offered by contractor.

c. The relevant experience in the area of purchase.

d. A demonstrated quality, dependability and responsiveness.

e. Familiarity with type of business CalOptima is operating.

f. Familiarity with CalOptima.

g. Reputation in the community.

h. Special expertise in the area of purchase.

i. Other selection criteria as may be deemed appropriate.

j. These criteria shall be applied by the Board, CEO or his or her designee in selecting the vendor.

k. Exception: Pursuant to 40 U.S.C. §§ 1101-1104 and California Government Code §§ 4525-4529.5, any RFP or RFQ for architectural or engineering services shall not, for the purposes of ranking firms, be evaluated primarily on the basis of price. Once firms are determined to have the requisite technical capabilities to meet the services required (e.g. experience, proposal, technical expertise) CalOptima may then use price as a factor for the purposes of final ranking determinations. CalOptima then shall seek to negotiate a fair and reasonable price with the top ranked firm. If agreement on a fair and reasonable price cannot be reached, CalOptima shall cease negotiations and move to the second ranked firm and seek to negotiate a fair and reasonable price. This process shall continue until agreement with a firm is reached.

L. Provisions Applicable to Procurement of Computer Hardware, Software, and Other Peripheral Equipment and Related Services (collectively "computer equipment"), and Telecommunications Goods and Services.

1. CalOptima shall acquire computer equipment, and telecommunications goods and services involving an expenditure of more than one hundred thousand dollars ($100,000) or such other amount as may be specified by law, through "competitive means," except when the Chief Executive Officer or designee determines either that (a) the goods and services proposed for acquisition are the only goods and services which can meet CalOptima's needs, or (b) the goods and services are needed in cases of emergency where immediate acquisition is necessary for the protection of the public health, welfare and safety.

2. As used in this policy, "competitive means" includes any one or more of the following methods, when deemed by the Chief Executive Officer or designee as an appropriate means under the circumstances to permit reasonable competition consistent with the nature and requirements of the proposed acquisition:

   a. The preparation and circulation of a request for quotations (RFQ) or request for proposals (RFP) to an adequate number of qualified sources. An "adequate number" shall be defined as two or more qualified sources, as determined by the Chief Executive Officer or designee based upon the number of qualified sources believed to be capable of submitting a satisfactory proposal, after reasonable inquiry.

   b. Posting, publishing, communicating telephonically or otherwise publicizing the RFP in a manner intended to disseminate the RFP to an adequate number of qualified sources.

   c. Any other means determined by the Chief Executive Officer or designee as reasonably expected to disseminate the RFP to an adequate number of qualified sources.

3. Criteria for Award of Contract

   a. Contracts for computer equipment or telecommunications goods and services subject to this policy shall be awarded based on a determination of which responsive proposal provides the most cost-effective and beneficial solution to CalOptima's requirements. In making this determination, the following evaluation criteria shall apply, as applicable:

      i. The price of the components, installation and any related consulting, maintenance or other services.

      ii. The payment and financing terms offered by the contractor.

      iii. The extent to which the components meet or exceed CalOptima's technical requirements and can be expected to accomplish the specified goals.

      iv. The demonstrated quality, dependability, and responsiveness of the contractor and any subcontractors providing installation, integration, consulting, maintenance or other services.

v. The anticipated expense and disruption to CalOptima services and facilities involved in integrating additional components or upgrades into the system which may be necessary to accommodate the expansion of CalOptima facilities or needs.

vi. The anticipated expense and disruption to CalOptima facilities and services involved in integrating upgrades or retrofits into the system as necessary to keep pace with technological improvements or refinements to the system.

vii. The anticipated expense and disruption to CalOptima facilities and services involved in maintaining or repairing the system, including but not limited to implementing back-up procedures while the system is down, and obtaining necessary parts and service.

viii. The quality and comprehensiveness of the warranty offered.

ix. The anticipated salvage or resale value of the components, if any, based upon its anticipated useful life to CalOptima.

x. Such other criteria, consistent with this policy and the goal of achieving the most cost-effective solution to CalOptima's requirements, as the CEO or his or her designee may establish.

b. These criteria shall be applied by the Chief Executive Officer or designee using a scoring or other system designed to determine which of the proposals submitted provides the most viable solution to CalOptima's requirements. The basis for such determination shall be documented by the Purchasing Department in a manner which permits the Board, the Chief Executive Officer or designee to reasonably evaluate compliance with this policy.

M. Provisions Applicable to Public Works Projects

1. CalOptima is not subject to the requirements of the California Public Contract Code calling for competitive bidding and award of contracts to the lowest responsive, qualified bidder. This policy establishes the generally accepted methods of procurement, which may be adjusted from time to time in order to serve CalOptima's Best Interests or to reflect current best business practices. All formal and informal requests for prices in the form of bids for all materials, services and equipment purchased, must be made by the Purchasing Department, unless otherwise delegated by the Purchasing Department in writing.

a. Purchases for less than ten thousand dollars ($10,000) not including applicable taxes and freight charges, referred to as small procurements, may be made on a discretionary basis without solicitation of bids.

b. Purchases for ten thousand dollars ($10,000) or more, but not exceeding one hundred thousand dollars ($100,000), require informal solicitation of bids and shall be made in accordance with this policy, including the procedures described in Section II.M.2.

c. Purchases amounting to over one hundred thousand dollars ($100,000) require formal solicitation of bids, and shall be made in accordance with this policy, including the procedures described in Section II.M.2.

d. All requests and contracts shall be based on forms approved by CalOptima's Legal

Department.

2. Procurement of Alterations to and Maintenance of Real Property and Other Public Works Projects

   a. This section II.M.2. shall apply to any acquisition of goods and services for the physical construction, alteration, demolition, installation or repair of real property, including fixtures, painting, wiring, carpeting and other things incorporated into or permanently affixed to real property. CalOptima may elect to pre-qualify contractors to participate in informal and formal bids.

   b. No alteration to real property requiring a building permit, including tenant improvements in leased spaces, shall be undertaken, except pursuant to detailed plans and specifications, prepared by an architect, engineer, or other California-licensed professional acting within the scope of her or his license. Any such alterations to CalOptima's leased spaces shall be consistent with the terms and conditions of the lease, if any.

   c. Purchases/Projects valued at less than $10,000 shall be made in accordance with Section II.M.1.

   d. Purchases/Projects valued between $10,000 and $100,000 shall be made in accordance with Section II.M.2.h.

   e. Purchases/Projects valued at $100,000 or more shall be made in accordance with Section II.M.2.i.

   f. Projects where the architect's or engineer's estimate is over $100,000 must be bid through the formal bidding process set forth in Section II.M.2.i.

   g. All bids must be accompanied by a non-collusion affidavit.

   h. Informal Bid Procedures

      i. Preparation: A written request shall be prepared which shall, at a minimum, contain: (i) appropriately detailed plans and specifications or scope of work considering the value and technical complexity of the goods and/or services to be procured; (ii) the CalOptima staff person to whom the bid must be addressed; (iii) the date and time by which CalOptima must receive the bid; (iv) a statement that the bid must be firm for a period of not less than ninety (90) days from receipt by CalOptima; and (v) a copy of the construction contract.

      ii. Evaluation: The criteria for evaluating bids will be determined on a case-by-case basis, and will be stated in the written request.

      iii. Bidder Pre-qualification: CalOptima may pre-qualify contractors for projects to be bid through this informal bid procedure, and may limit distribution of informal bid packets to pre-qualified contractors.

i. Formal Bid Procedures

i. Preparation: CalOptima shall prepare or cause to be prepared a bid package. To the extent practicable, the bid package shall include full, complete, and accurate plans and specifications and estimates of cost, giving such directions as will enable any competent contractor to ascertain and carry out the contract requirements. The bid package shall also include a statement of the date and time by which CalOptima must receive bids, the criteria upon which the bids will be evaluated; and a copy of the construction contract.

ii. Notice/Request for Bids: All prospective bidders who have notified CalOptima in writing that they desire to bid on contracts, and all prospective bidders which CalOptima would like to bid on contracts, shall be furnished with notice and a request for bids, including information as to the type, quality, quantity, date, location and other bid requirements. In addition to notifying all such persons, the notice shall specify the place bids are to be received and the time by which they are to be received.

iii. Advertising/Publication: Except in cases of emergency or where circumstances require the immediate letting of a contract, information advising interested parties how to obtain specifications, and specifying the place bids are to be received and the time by which they are to be received, shall be given by publication once a week for at least two (2) consecutive weeks, as follows:

a) In a newspaper of general circulation published in such places as are most likely to reach prospective bidders; or

b) In trade journals or papers of general circulation as the Chief Executive Officer, or designee, deems proper; or

c) Electronic media may be used in lieu of newspaper advertisements if and when it is believed this media will better serve the needs of CalOptima.

d) The Chief Executive Officer or designee may waive any irregularity or informality in the publication procedures.

iv. Bidders' Conference: CalOptima may hold a bidders' conference or conduct a site visit, as it deems necessary and appropriate. In such cases, CalOptima shall include the date, time and location in the bid documents. The conference or site visit shall be at least five (5) days after publication of the notice.

v. Bid Form: CalOptima shall furnish to each prospective bidder a bid package, including an appropriate bid form, prepared by CalOptima for the type of contract being let. Bids not presented on forms so furnished shall be disregarded.

vi. Presentation of Bids Under Sealed Cover: All bids shall be presented under sealed cover. Upon receipt of each, the bid shall be date-stamped. The bid shall be accompanied by a copy of the construction contract duly executed by the bidder, but which will not be executed by CalOptima until completion of the bid process and CalOptima Board approval, as necessary and appropriate.

vii. Withdrawal of Bids: Bids may be withdrawn at any time prior to the deadline for submitting bids fixed in the notice only by written request made to the person or entity designated in charge of the bidding procedure. The withdrawal of the bids does not prejudice the right of the bidder to timely file a new bid. No bidder may withdraw his bid after opening for at least a period of ninety (90) days thereafter.

viii. Opening of Bids and Award of Contract: At the scheduled date and time, CalOptima shall open the sealed bids. Award of the contract shall be to the lowest-price qualified and responsive bidder, if at all, within ninety (90) days after opening, unless the bid package specifies otherwise or the Chief Executive Officer or designee extends the time. All bidders shall have complied with the foregoing bid procedures, except as otherwise provided herein. After a bid is opened it shall be deemed irrevocable for the period specified in the request for bids. Bids shall be irrevocable for a minimum of ninety (90) days after the opening thereof.

ix. Awards to the Second and Third Lowest Price Qualified Bidders: If CalOptima deems it is in its best interest, it may, on refusal or failure of the successful bidder to execute the contract or comply with other bid requirements, award it to the second lowest-price qualified bidder. If the second lowest price qualified bidder fails or refuses to execute the contract or comply with other bid requirements, CalOptima may likewise award it to the third lowest price qualified bidder.

x. Only One Bid or Proposal Received: If only one bid or proposal is received in response to the request for bids, an award may be made to the sole bidder, provided that CalOptima finds that the price submitted is fair and reasonable.

xi. Notice to Bidders Not Awarded the Contract: Whenever a contract is not to be awarded to a bidder, such bidder shall be notified by regular mail within seventy-two (72) hours after the award of the contract to another bidder.

xii. Qualified Bidder: CalOptima's determination of a qualified bidder shall be based on analysis of each bidder's ability to perform, financial statement (if required), experience, past record and any other factors it shall deem relevant. If the lowest price bidder is to be rejected because of an adverse determination of the bidder's responsibility based on CalOptima's decision, the bidder shall be entitled to be informed of the adverse evidence and afforded an opportunity to rebut that evidence and to present evidence of responsibility.

xiii. Contract Documents: Contract documents shall be prepared in advance, with the approval of Legal Counsel, and shall be incorporated into the bid package as indicated above.

j. Waiver and Rejection Rights: CalOptima reserves the right to reject any and all bids, or to waive any informality or non-substantive defects in bids, as the interest of CalOptima may require. Only those bids shall be considered that are deemed by CalOptima to be responsive to the Request for Bid (RFB) or Request for Quotations (RFQ). The Purchasing Department shall ensure maximum protection of CalOptima's interest consistent with ensuring an equal opportunity and fair and equitable treatment for all bidders.

k. Extensions: The granting of an extension to the contractor is not a new contract. If a contractor makes an application for an extension in writing, CalOptima shall consider matters germane to the particular contract, and shall not grant or deny the extension arbitrarily. However, in any contract which includes provisions for liquidated damages, CalOptima's decision to extend the contract without charge to the contractor shall be made only when the failure to complete the contract on time is not attributable to the contractor's unreasonable delay or default.

l. Provisions of the policy may be waived by the CalOptima Board.

m. All contractors contracted by CalOptima for the performance of Public Works Projects, as defined in California Labor Code Section 1720, shall pay not less than the required prevailing wages, as provided in Section 1771 of the California Labor Code, if the total payments under that contract are more than $1,000.

n. Payment Bonds – Pursuant to California Civil Code § 9550, for any Public Works project in excess of $25,000, the prime contractor shall submit a payment bond, in a form approved by the Chief Financial Officer and from a surety authorized to do business in the State of California, in the amount of 100% of the contract price.

N. Cooperative Purchases

1. When it is in CalOptima's Best Interest, the Purchasing Department may enter into or use pre-existing cooperative purchasing agreements for acquisition of goods and services with any entity or group and execute respective contracts under those agreements.

O. Sole Source Purchases

1. Sole source purchases are not competitively bid and shall not be used unless there is clear and convincing evidence that only one (1) acceptable source exists to fulfill CalOptima's requirements. Sole source purchases involve goods or services that are unique or novel to only one (1) supplier, or products and/or services that are designed to match others already in use.

P. Emergency Purchases

1. The Chief Executive Officer, or designee, may authorize emergency purchases in cases that have or could impose significant provable loss to CalOptima or where human life or property is endangered. When an emergency condition arises, and the need cannot be met through normal procurement methods, the emergency purchase shall be made with such competition as is feasible under the circumstances. Contracts and other documents related to such emergency procurements shall be executed in accordance with the requirements of CalOptima Policy GA.3202: CalOptima Signature Authority.

2. The person responsible for the emergency purchase shall provide written documentation stating the basis of the emergency purchase and the reasoning for the selection of the particular contractor. A written account of the emergency circumstances shall be sent promptly to the Chief Executive Officer and the Board of Directors. Normal purchasing procedures shall be followed as soon as the emergency is over.

Q. Real Property Transactions

1. CalOptima shall not enter into any transaction for the purchase, sale, lease (including any sublease or lease assignment, whether CalOptima is the lessor, lessee, sublessor, sublessee, assignor or assignee), or termination of lease of any real property, or enter into negotiations related to such transactions, without the prior approval of the Board of Directors, pursuant to a Board action addressed solely to the transaction or set of related transactions, and setting forth the parameters under which the negotiations may proceed. Such negotiations and transactions on behalf of CalOptima shall be carried out exclusively by the person or persons designated by the Board of Directors.

R. Ethics

1. CalOptima employees shall conduct themselves in such a manner as to foster public confidence in the integrity of the CalOptima procurement process.

2. CalOptima employees shall perform their duties impartially to ensure that vendors have fair and competitive access to do business with CalOptima.

3. Employees, officers or agents of CalOptima shall be subject to the Conflict of Interest Laws of the State of California and the CalOptima Code of Conduct. Employees, officers or agents of CalOptima who violate these standards shall be subject to the penalties, sanctions or other disciplinary actions provided for therein.

4. Gratuities, Kickbacks, and Contingency Fees

   a. No CalOptima employee shall solicit, demand, or accept from any person anything of monetary value for, or because of, any action taken, or to be taken, in the performance of his/her duties. An employee failing to adhere to the above shall be subject to any disciplinary proceeding deemed appropriate by CalOptima, including possible dismissal.

   b. CalOptima employees shall adhere to all provisions of the CalOptima Policy AA.1204: Gift, Honoraria, and Travel Payment.

5. Confidential Information

   a. No CalOptima employee shall use confidential information for his or her actual or anticipated personal gain, or the actual or anticipated personal gain of any other person related to such CalOptima employee by blood, marriage, or by common commercial or financial interest. An employee failing to adhere to this requirement shall be subject to any disciplinary proceeding deemed appropriate by CalOptima, up to and including dismissal.

   b. CalOptima employees shall not divulge confidential information to any vendor, consultant, or contractor.

6. Vendor Relations

   a. CalOptima employees may discuss, on an informal basis, non-financial requirements with contractors, consultants, and vendors. Employees may also solicit information such as brochures and other descriptive material from vendors, consultants, and contractors.

   b. CalOptima employees shall not meet with vendors, consultants, and/or contractors regarding specific financial requirements unless a representative of the Purchasing Department is present at the meeting.

   c. CalOptima employees shall not bind, or appear to bind, CalOptima in any way, financially, or otherwise, except as provided for in accordance with CalOptima Policy GA.3202: CalOptima Signature Authority. Only the Board, Chief Executive Officer or his/her designee, and those staff designated as signing authorities in CalOptima Policy GA.3202: CalOptima Signature Authority may financially or contractually bind CalOptima.

   d. No employee, officer or agent of CalOptima shall participate in the selection, award or administration of an agreement, or in any decision that may have a foreseeable impact on a vendor if a conflict of interest, real or implied, exists. Such a conflict arises when any one of the following has a financial or other interest in the firm selected for award:

      i. A CalOptima employee, officer, or agent;

      ii. The employee, officer or agent's spouse or dependent children;

      iii. The employee, officer or agent's domestic or business partner;

      iv. An organization that employs or has made an offer of employment to any of the above.

S. Other Bidding Procedures

   1. Federal Awards Subject to OMB A-133 Single Audit Requirements (such as Multipurpose Senior Services Program (MSSP)) shall follow the bidding procedures as prescribed in Attachment A – Policy for Awards Subject to 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

III. PROCEDURE

Not Applicable

IV. ATTACHMENTS

A. Policy for Awards Subject to 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards

V. REFERENCES

A. California Fair Political Practices Commission Form 700 - Statement of Economic Interests
B. CalOptima Code of Conduct

C. CalOptima Compliance Plan
D. CalOptima Compliance Program
E. CalOptima Conflict of Interest Code
F. CalOptima Policy AA.1001: Glossary of Terms
G. CalOptima Policy AA.1204: Gifts, Honoraria, and Travel Payments
H. CalOptima Policy GA.3202: CalOptima Signature Authority
I. CalOptima Policy GA.5003: Budgets and Operations Forecasting
J. CalOptima Resolution No. 12-03101-01

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 06/07/18: Regular Meeting of the CalOptima Board of Directors
B. 03/01/12: Regular Meeting of the CalOptima Board of Directors
C. 01/04: Regular Meeting of the CalOptima Board of Directors
D. 01/00: Regular Meeting of the CalOptima Board of Directors
E. 10/97: Regular Meeting of the CalOptima Board of Directors
F. 09/96: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	09/1996	GA.5002	Procurement Policy	Administrative
Revised	10/1997	GA.5002	Procurement Policy	Administrative
Revised	01/2000	GA.5002	Procurement Policy	Administrative
Revised	01/2004	GA.5002	Procurement Policy	Administrative
Revised	03/01/2012	GA.5002	Purchasing Policy	Administrative
Revised	06/07/2018	GA.5002	Purchasing	Administrative

IX. GLOSSARY

Term	Definition
Bidder's Conference	A meeting to discuss technical, operational and performance specifications, and/or the full extent of financial, security and other contractual obligations with potential bidders, related to bid solicitation before the bid closes.
CalOptima's Best Interest	The discretionary rationale used by a purchasing official in taking action most advantageous to the jurisdiction when it is impossible to adequately delineate a specific response by law or regulation.
Invitation for Bids (IFB)	The document used to solicit bids from potential contractors for a fixed project with established plans and specifications. This is generally used for the procurement of Public Works.
Pre-Qualification (of bidders)	The screening of potential vendors in which such factors as financial capability, reputation, and management are considered in order to develop a list of qualified businesses who may then be allowed to submit bids.
Public Works	Works means any work of improvement contracted for by a public entity (such as CalOptima). Work of improvement includes, but is not restricted to, the construction, alteration, addition to, or repair, in whole or in part, of any building, whether owned or leased by a public entity.
Offeror	The person/entity who submits a proposal in response to a Request for Proposal or Request for Quotation.
Request for Proposal (RFP)	The document used to solicit proposals from potential vendors for goods and services. This is generally used when the specification for the good or service is known, but the vendor's advice is needed regarding how to buy the good or implement the service. The price is usually not the primary evaluation factor. It provides for the negotiation of all terms, including price prior to contract award. The RFP may include a provision for the negotiation of Best and Final offers. It may be a single or multi-step process.
Request for Quotation (RFQ)	A purchasing method generally used when specifications are known for goods and services of all types. A request is sent to vendors along with a specification of the commodity needed or a description of the services required. The vendor is asked to respond with price and other information by a pre-determined date. Evaluation and recommendation for award should be based on the quotation that best meets price, quality, delivery, service, past performance and reliability.
Scope of Work (SOW)	A written description of the contractual requirements for materials and services contained within a RFQ or RFP. A well-conceived and clearly written SOW serves four main purposes: • Establishes clear understanding of what is needed; • Encourages competition in the marketplace and promotes economic stimulus; • Satisfies a critical need of government; and • Obtains the best value for the taxpayer.

ATTACHMENT A

Policy for Awards Subject to 2 CFR Part 200 – Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards

Purchase Type	*Characteristics & Requirements*	
Below simplified acquisition threshold of $150,000		
Micropurchases	• Under the micropurchase threshold (currently $3,500 and recently adjusted from $3,000) • No bid or quote process required • No cost or price analysis required • Should be distributed among a range of qualified vendors • Use interentity agreements where applicable	Written policies and procedures for: • Procurement standards • Conflicts of Interest in procurement • Allowable cost standards
Small purchases	• Under $150,000 • Price or rate quotes required from an adequate number of sources • Should be distributed among a range of vendors • Use interentity agreements where applicable	
Above simplified acquisition threshold of $150,000		
Sealed bids	• Typically used for construction contracts • Bids must be publicly solicited • Two or more bidders are willing and able to compete and qualified to do the work • Complete, adequate, and realistic specification or purchase description is available • Firm fixed-price contract is feasible; a bidder can be selected based on price	
Competitive proposals	• Requires request-for-proposal process and solicitation of an adequate number of bidders • Written method of evaluation, considering price as well as other factors advantageous to the program	
Above or below simplified acquisition threshold		
Noncompetitive proposals	Falls into one or more of these four circumstances: • Item available only from a single source • Public exigency or emergency won't permit a delay resulting from competitive solicitation • Expressly authorized by the awarding agency or pass-through entity • Competition is determined to be inadequate after solicitation	

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Definitions

2 CFR §200.88 Simplified acquisition threshold.

Simplified acquisition threshold means the dollar amount below which a non-Federal entity may purchase property or services using small purchase methods. Non-Federal entities adopt small purchase procedures in order to expedite the purchase of items costing less than the simplified acquisition threshold. The simplified acquisition threshold is set by the Federal Acquisition Regulation at 48 CFR Subpart 2.1 (Definitions) and in accordance with 41 U.S.C. 1908. This threshold is periodically adjusted for inflation.

2 CFR §200.67 Micro-purchase.

Micro-purchase means a purchase of supplies or services using simplified acquisition procedures, the aggregate amount of which does not exceed the micro-purchase threshold. Micro-purchase procedures comprise a subset of a non-Federal entity's small purchase procedures. The non-Federal entity uses such procedures in order to expedite the completion of its lowest-dollar small purchase transactions and minimize the associated administrative burden and cost. This threshold is periodically adjusted for inflation.

2 CFR §200.74 Pass-through entity.

Pass-through entity means a non-Federal entity that provides a subaward to a subrecipient to carry out part of a Federal program.

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AGENDA ITEM 50 TO FOLLOW CLOSED SESSION

Consider Authorizing the Chief Executive Officer (CEO) to Submit OneCare Connect Bid for Calendar Year 2019 and Execute Contract with the Centers for Medicare & Medicaid Services and the California Department of Health Care Services; Authorize the CEO to Amend/Execute OneCare Connect Health Network Contracts and Take Other Actions as Necessary to Implement

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AGENDA ITEM 51 TO FOLLOW CLOSED SESSION

Consider Chief Executive Officer and Chief Counsel Performance Review and Compensation

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 7, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
52. Election of Officers of the Board of Directors for Fiscal Year 2018-19

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

Recommended Action
Elect Board Chair and Vice Chair for terms effective July 1, 2018 through June 30, 2019, or until the election of a successor(s), unless the Board Chair or Vice Chair shall sooner resign or be removed from office.

Background/Discussion
In accordance with Article VIII, Section 8.1 of CalOptima's Bylaws, the Board shall elect one of its Directors as Chair at an organizational meeting. The Chair shall be the principal officer of the Board and shall preside at all meetings of the Board, shall appoint all members of the Ad Hoc Committees, as well as the chair of the Ad Hoc Committees and all Committees other than the Member and Provider Advisory Committees. The Chair shall perform all duties incident to the office and such other duties as may be prescribed by the Board from time to time.

Section 8.2 of the CalOptima Bylaws states that the Board shall elect one of its Directors to serve as Vice Chair at an organizational meeting. The Vice Chair shall perform the duties of the Chair if the Chair is absent from the meeting or is otherwise unable to act.

The Chair and Vice Chair terms shall commence on the first day of the month after the organizational meeting at which they are elected to their respective positions.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommended actions are in accordance with Article VIII of the CalOptima Bylaws.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/30/2018*
Authorized Signature — **Date**

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Board of Directors Meeting
June 7, 2018

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

At the April 26, 2018 OneCare Connect Member Advisory Committee (OCC MAC) meeting, OCC MAC received the following informational presentations. Albert Cardenas, Director, Customer Service (Medicare) provided an overview on how the OneCare Connect dental plan, Liberty Dental, coordinates with Denti-Cal, noting that Liberty Dental covers several procedure codes not covered by Denti-Cal. Member Sandy Finestone presented an overview of the Centers for Medicare & Medicaid Services (CMS) Quality Conference. Ms. Finestone, who attended as a member of the CMS Beneficiary and Family Advisory Council (BFAC), reported that this was the first time that patients and caregivers were invited to attend and participate in the conference. She added that the theme of the conference was putting patients first.

OCC MAC also considered and approved the following Report Items at its April meeting: FY 2017-18 Accomplishments, highlighting OCC MAC's activities for the past fiscal year; FY 2018-19 OCC MAC meeting schedule; and FY 2018-19 Goals and Objectives, outlining OCC MAC's goals for the upcoming fiscal year. In addition, OCC MAC considered a Chair, Vice Chair and a slate of candidates for five seats expiring on June 30, 2018, including: Community-Based Adult Services (CBAS) Provider, Seniors representative, Long-Term Care (LTC) Facility representative, Member Advocate and an OCC Member/Family Member representative. The candidates will serve a two-year term from July 1, 2018 to June 30, 2020. After considering the proposed slate of candidates, Chair and Vice Chair, OCC MAC has recommended the following candidates for the Board of Directors' consideration:

- Reappointment of the following individuals:
  - Gio Corzo as the CBAS Provider Representative;
  - Patty Mouton as the Seniors Representative;
  - Ted Chigaros as the LTC Facility Representative; and
  - Christine Chow as the Member Advocate Representative.
- Appointment of Keiko Gamez as the OCC Member/Family Member Representative.
- Reappointment of Gio Corzo as Chair and Patty Mouton as Vice Chair for a one-year terms ending June 30, 2019.

OCC MAC members received the following updates from CalOptima's executive staff, including the Chief Executive Officer update, Chief Medical Officer update and the State and Federal Legislative update.

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

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OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan)

OneCare Connect Member Advisory Committee
FY 2017-2018 Accomplishments

During FY 2017-2018, the OneCare Connect Member Advisory Committee (OCC MAC) of the CalOptima Board of Directors provided input to ensure that OneCare Connect members receive quality health care services. The following list highlights the accomplishments:

- OCC MAC members outreached to Orange County organizations and agencies to invite community stakeholders to present on member needs and concerns at OCC MAC meetings. Presentations included palliative care, end-of-life considerations, homelessness, mental illness and opioid/substance abuse.

- OCC MAC member, whose agency serves as Orange County's Cal MediConnect Ombudsman Program, provided quarterly updates and feedback from dual-eligible members and the community regarding the OneCare Connect program.

- An OCC MAC Nomination Ad Hoc Subcommittee convened to select the proposed slate of candidates, Chair and Vice Chair for the positions expiring on June 30, 2018. The OCC MAC reviewed the proposed candidates at its April 26, 2018 meeting and forwarded their recommendations to the Board for consideration and approval at the June 7, 2018 meeting.

- An OCC MAC Goals and Objectives Ad Hoc Subcommittee convened to develop goals and objectives for FY 2018-19. Based on the Board-approved Strategic Plan, OCC MAC approved the FY 2018-19 OCC MAC Goals and Objectives on April 26, 2018 and submitted them to the Board as an informational item on June 7, 2018.

- OCC MAC members provided input on CalOptima's strategies to maximize enrollment, retention, and member outreach efforts to OneCare Connect members.

- An OCC MAC member volunteered to present an overview on the agency or organization they represent at each OCC MAC meeting.

- OCC MAC members attended CalOptima sponsored community education events, including Community Alliance Forums and Awareness and Education Seminars.

- All OCC MAC members completed the annual Compliance Training.

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- OCC MAC Chair or Vice Chair presented monthly OCC MAC Reports at CalOptima Board of Directors' meetings to provide the Board with input and updates on the OCC MAC's activities.

- OCC MAC members contributed over 200 "official" hours to CalOptima during FY 2018-19, including OCC MAC meetings, ad hoc meetings, and Board meetings. These hours do not account for the innumerable hours that OCC MAC members dedicate to members on a day-to-day basis.

The OCC MAC thanks the CalOptima Board for the opportunity to provide updates on the OCC MAC's activities. The OCC MAC welcomes direction or assignment from the Board on any issues or items requiring study, research, and input.

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CalOptima Board of Directors'
OneCare Connect Member Advisory Committee
Goals and Objectives

GOALS AND OBJECTIVES FY 2018-2019				
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**OCC MAC Activities**	**OCC MAC Progress**
I. 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.	•Provide input to ensure member access to health care services. •Provide input to improve and streamline access between CalOptima and delegated networks.	
		2. Program Integration - Implement programs and services that create an integrated service experience for members, including an integrated physical and behavioral health service model.	• Monitor and provide input on access and care coordination of behavioral health services. • Provide input on coordinating and integrating physical and behavioral health care for OCC members. •OCC MAC members to report at OCC MAC meetings on outreach efforts to community stakeholders on increasing awareness of behavioral health services.	
		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.	• Provide input on proposed programs addressing areas of unmet needs (i.e. substance abuse, homelessness, palliative care) •Provide input on IGT funding prior to Board approval. •Encourage OCC MAC participation as needed at CalOptima work groups, forums and meetings, etc. that address unmet needs.	

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CalOptima Board of Directors'
OneCare Connect Member Advisory Committee
Goals and Objectives

GOALS AND OBJECTIVES FY 2018-2019				
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**OCC MAC Activities**	**OCC MAC Progress**
II. 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.	• Provide input, as needed, to improve efficiencies and systems/processes that affect OCC members.	
		2. Pay for Value - Launch pay-for performance and quality incentive initiatives that encourage provider participation, facilitate accurate encouter data submissions, improved clinical quality and member experience outcomes, and the spread of best practices.	• Provide input on CalOptima's pay-for-value program, including member and provider quality incentive initiatives • Provide input on findings from Member Experience program, CAHPS and HEDIS. • Provide input to improve member experience outcomes.	
		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.	• Provide input, as needed, to ensure OneCare Connect maximizes health care dollars.	

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CalOptima Board of Directors'
OneCare Connect Member Advisory Committee
Goals and Objectives

GOALS AND OBJECTIVES FY 2018-2019				
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**OCC MAC Activities**	**OCC MAC Progress**
III. 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.	• Work with CalOptima and the advisory committees to ensure members have access to providers.	
		2. Member Engagement - Seek input from the Member Advisory Committee and 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.	•Ensure that the Board is aware of member issues/concerns prior to the Board's action or decision on initiatives. • Ensure OCC MAC has strong committee member representation. • Provide input to improve OCC member experience and health outcomes. •Provide input on provider access and availability, including related grievances •Provide inpute on CalOptima's efforts to address findings related to Member Health Needs Assessment.	
		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.	•OCC MAC members to conduct at least one presentation/announcement to community on OCC's benefits to vulnerable populations. •Encourage OCC MAC members to attend at least one CalOptima educational event to increase awareness of member issues (i.e. Awareness & Education Seminars, Informational Series and Community Alliance Forums).	

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CalOptima Board of Directors'
OneCare Connect Member Advisory Committee
Goals and Objectives

GOALS AND OBJECTIVES FY 2018-2019				
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**OCC MAC Activities**	**OCC MAC Progress**
		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.	•Work with CalOptima, as needed, to inform stakeholders about health policy issues that impact CalOptima. •OCC MAC members to report at least one time on outreach efforts to colleagues/community on value of OCC benefits and services.	

Charge of the Advisory Committees pursuant to Resolution No 2-14-95:

1 Provide advice and recommendations to the Board on issues concerning CalOptima as directed by the Board.

2 Engage in study, research and analysis on issues assigned by the Board or generated by the committees.

3 Serve as liaisons between interested parties and the Board.

4 Assist the Board in obtaining public opinion on issues related to CalOptima.

5 Initiate recommendations on issues of study to the Board for their approval and consideration.

6 Facilitate community outreach for CalOptima and the CalOptima Board.

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Board of Directors Meeting
June 7, 2018

Member Advisory Committee Update

At the May 10, 2018 Member Advisory Committee (MAC) meeting, MAC received the following informational updates. MAC Member Jaime Munoz presented a follow-up from the March 8, 2018 Joint MAC/OneCare Connect MAC/Provider Advisory Committee meeting on the Orange County Community Coalition for Behavioral Health, an integrated, community-based coalition to address coordination of mental health services and resources. Strategic Development staff provided an update on the intergovernmental transfer (IGT) timeline to guide the community grant process for projects in three approved categories: opioid and other substance overuse, children's mental health, and homeless health. Process Excellence staff provided an overview of the Health Homes Program (HHP), which is designed to serve eligible Medi-Cal beneficiaries with multiple chronic conditions who may benefit from enhanced care management and coordination.

MAC also considered and approved the following Report Items at its May 10, 2018 meeting: FY 2017-18 Accomplishments, highlighting MAC's activities for the past fiscal year; FY 2018-19 MAC meeting schedule; and FY 2018-19 Goals and Objectives that outline MAC's goals for the upcoming fiscal year. In addition, MAC considered a slate of candidates for seven of the MAC seats expiring on June 30, 2018 and eleven candidates for the new Whole-Child Model Family Advisory committee (WCM FAC).

The proposed MAC candidates will serve a two-year term from July 1, 2018 to June 30, 2020. After considering the proposed slate of candidates, Chair and Vice Chair, MAC has recommended the following candidates for the Board of Directors' consideration:

- Reappointment of the following individuals:
  - Jaime Muñoz as the Foster Children Representative;
  - Sally Molnar as the Medically Indigent Persons Representative;
  - Sr. Mary Therese Sweeney as the Persons with Mental Illness Representative; and
  - Christine Tolbert as the Persons with Special Needs Representative.
- Appointment of the following individuals:
  - Luisa Santa as the Children's Representative; and
  - Elizabeth Anderson as the Long-Term Services and Support (LTSS) Representative.
- Appointment of Diana Cruz-Toro as the Recipients of CalWORKs Representative for a term ending June 30, 2019.
- Reappointment of Sally Molnar as the Chair and reappointment of Patty Mouton as the Vice Chair for fiscal year 2018-19.

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The Consumer seat did not receive any candidate applications by the original deadline, so the recruitment was extended until May 25, 2018. During the extension, CalOptima received one application, which will be submitted for Board consideration at the August 2, 2018 Board meeting.

The proposed WCM FAC candidates will serve one or two-year terms as indicated below, beginning July 1, 2018. MAC selected the following WCM FAC candidates for the Board of Directors' consideration:

- Family Member Representatives:
  - Maura Byron for a two-year term ending June 30, 2020;
  - Melissa Hardaway for a one-year term ending June 30, 2019;
  - Grace Leroy-Loge for a two-year term ending June 30, 2020;
  - Pam Patterson for a one-year term ending June 30, 2019;
  - Kristin Rogers for a two-year term ending June 30, 2020; and
  - Malissa Watson for a one-year term ending June 30, 2019.
- Community Representatives:
  - Michael Arnot for a two-year term ending June 30, 2020;
  - Sandra Cortez-Schultz for a one-year term ending June 30, 2019;
  - Gabriela Huerta for a two-year term ending June 30, 2020; and
  - Diane Key for a one-year term ending June 30, 2019.

MAC members also received the updates from CalOptima's executive staff, including the Chief Executive Officer, Chief Medical Officer, Chief Operating Officer and State and Federal Legislative updates.

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

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Member Advisory Committee
FY 2017-2018 Accomplishments

During FY 2017-2018, the Member Advisory Committee (MAC) of the CalOptima Board of Directors provided input on member issues to ensure that CalOptima members receive high quality health care services. The following list highlights the accomplishments:

- MAC members wrote letters of support to Senators Feinstein and Harris to urge their support to renew federal funding for the Children's Health Insurance Program (CHIP).

- MAC members reviewed the intergovernmental transfer (IGT) projects and supported the funding of the proposed programs, as well as the proposed recommendations for the use of the remaining IGT funds.

- MAC participated in two joint advisory committee meetings during FY 2017-18. The first joint meeting was MAC/ Provider Advisory Committee (PAC) on September 14, 2018 and the second was MAC/OneCare Connect MAC (OCC MAC)/PAC on March 8, 2018. MAC would like to continue to participate in joint advisory committee meetings.

- MAC members and individuals from the community gave informative presentations at MAC meetings to help MAC stay connected to those they represent. Topics included: difficult to access providers, homelessness, mental health coalition, palliative care and opioid/substance abuse.

- MAC Seniors' representative participates on the PACE Advisory Committee to provide input and reports to the Quality Assurance Committee of the Board regarding the PACE Center.

- A MAC Nomination Ad Hoc Subcommittee convened to select the proposed slate of candidates, Chair and Vice Chair for the positions due to expire on June 30, 2018. The MAC reviewed the proposed candidates at its May 10, 2018 meeting and forwarded their recommendations to the Board for consideration and approval at its June 7, 2018 meeting.

- Three MAC members participated on the Whole-Child Model Family Advisory Committee (WCM FAC) Nominations Ad Hoc Subcommittee to evaluate candidates to fill the family member seats and the community representative seats until the WCM is established. In addition the MAC reviewed the slate of

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candidates at its May 10, 2018 meeting and forwarded their recommendations to the Board for consideration at its June 7, 2018 meeting.

- A MAC Goals and Objectives Ad Hoc Subcommittee convened to develop goals and objectives for FY 2018-19. Based on the Board-approved Strategic Plan, MAC approved the FY 2018-19 MAC Goals and Objectives on May 10, 2018 and submitted them to the Board as an informational item on June 7, 2018.

- Several MAC members attended CalOptima sponsored community education events, such as Community Alliance Forums and Awareness and Education Seminars.

- All MAC members completed the annual Compliance Training.

- MAC Chair or Vice Chair presented a monthly MAC Report at CalOptima Board of Directors' meetings to provide the Board with input and updates on the MAC's activities.

- MAC members contributed at least 225 "official" hours to CalOptima during FY 2016-17, including MAC meetings, ad hoc meetings, and Board meetings. These hours do not account for the innumerable hours that MAC members dedicate to members on a day-to-day basis.

The MAC thanks the CalOptima Board for the opportunity to provide updates on the MAC's activities. The MAC welcomes direction or assignment from the Board on any issues or items requiring study, research, and input.

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CalOptima Board of Directors'
Member Advisory Committee
Goals and Objectives

GOALS AND OBJECTIVES FY 2018-2019				
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**MAC Activities**	**MAC Progress**
I. 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.	Explore new and emerging service delivery models with potential to cost-effectively improve member access and increase quality of care.	
		2. Program Integration - Implement programs and services that create an integrated service experience for members, including an integrated physical and behavioral health service model.	• Monitor and provide input on access and care coordination of behavioral health services and ensure expedited access. • Provide input on coordinating and integrating physical and behavioral health care	
		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.	• Provide input on collaborating with community based organizations to identify community resources and address unmet needs • Provide input on programs addressing areas of unmet needs (i.e. substance abuse, homelessness, palliative care) • Provide input on CalOptima's role in the Whole Person Care program •Provide input on IGT funding initiatives.	

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CalOptima Board of Directors'
Member Advisory Committee
Goals and Objectives

GOALS AND OBJECTIVES FY 2018-2019				
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**MAC Activities**	**MAC Progress**
II. 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.	• Provide input, as needed, to improve efficiencies and systems/processes that affect members.	
		2. Pay for Value - Launch pay-for performance and quality incentive initiatives that encourage provider participation, facilitate accurate encouter data submissions, improved clinical quality and member experience outcomes, and the spread of best practices.	• Provide input on pay-for-value program, including member and provider quality incentive initiatives • Review and provide input on member experience results, HEDIS and CAHPS indicators and other surveys • Provide input to improve member experience outcomes. •Provide input on IGT funding initiatives on access to care impacted by reimbursement	
		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.	• Provide input, as needed, to ensure CalOptima maximizes health care dollars.	

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CalOptima Board of Directors'
Member Advisory Committee
Goals and Objectives

GOALS AND OBJECTIVES FY 2018-2019				
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**MAC Activities**	**MAC Progress**
III. 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.	• Work with the advisory committees to ensure members have access to providers.	
		2. Member Engagement - Seek input from the Member Advisory Committee and 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.	•Ensure that the Board is aware of member issues/concerns prior to the Board's action or decision on initiatives • Ensure MAC provides input into proposed services and programs that improve member experience and health outcomes. •areas to consider include hospital readmissions, palliative care, substance abuse, ABA/mental health, LTSS, developmental and memory loss screenings •Provide input on CalOptima's efforts related to the Member Health Needs Assessment.	
		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.	• Provide input to ensure collaboration with community stakeholders and members. •Provide input to CalOptima to address health disparities among vulnerable populations. • Provide input on CalOptima's role in the Whole Person Care. • Provide input on unmet needs of homeless.	

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CalOptima Board of Directors'
Member Advisory Committee
Goals and Objectives

GOALS AND OBJECTIVES FY 2018-2019				
CalOptima Strategic Priority	**CalOptima Goals**	**CalOptima Objectives**	**MAC Activities**	**MAC Progress**
		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.	•Work with CalOptima and community stakeholders to respond to changes and impact health policy, such as OneCareConnect. •Ensure MAC has strong representation. •Encourage MAC members to attend 1-2 CalOptima education events to increase awareness of member issues (i.e. Awareness & Education Seminars, Informational Series and Community Alliance Forums).	

Charge of the Advisory Committees pursuant to Resolution No 2-14-95:

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6 Facilitate community outreach for CalOptima and the CalOptima Board.

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Board of Directors Meeting
June 7, 2018

Provider Advisory Committee (PAC) Update

May 10, 2018 PAC Meeting

Twelve (12) PAC members were in attendance at the May PAC meeting.

PAC approved their schedule for Fiscal Year (FY) 2018-19 and reviewed and approved their accomplishments for FY 2017-18.

Candice Gomez, Executive Director, Program Implementation, provided status updates to the PAC on the following programs:

- Whole Child Model - CalOptima continues its collaboration with the Orange County Health Care Agency (OCHCA). She stressed the priority being placed by CalOptima on this new program by continuing to update internal processes, reviewing member communications and finalizing the delivery model.

- Proposition 56 additional funding for physician services relating to 13 specific CPT procedure codes for services rendered between July 1, 2017 and June 30, 2018. Ms. Gomez notified the PAC the State provided clarification that only contracted network providers as defined by CalOptima's contracting regulations are eligible for this payment. The provider must be contracted with CalOptima or one of the contracted health networks to be eligible to receive the additional payment.

Ladan Khamseh, Chief Operating Officer, provided an update on the Medi-Cal rates recently received from the state. It was reported that staff anticipates that rates will remain the same, and CalOptima will recommend extending the contracts with the health networks from July 1, 2018 through December 31, 2018 to the Board for consideration at the June meeting.

Richard Bock, M.D., Deputy Chief Medical Officer, requested PAC's help in recruiting candidates for the new Whole Child Model (WCM) Clinical Advisory Committee that is being formed. Members should be clinical level staff who have experience with the WCM program. CalOptima anticipates the first meeting would be calendared in the Fall, 2018.

Phil Tsunoda, Executive Director, Public Affairs briefed the PAC on the anticipated release of Governor Brown's May revise of the State Budget and discussed the possible uses of the State's $6.1B surplus.

PAC reviewed candidates for open seats on the PAC based on the Nominations Ad Hoc subcommittee's recommendations. PAC also held a roll call vote and recommended John Nishimoto, O.D. serve as the new PAC Chair for FY 2018-19 and Teri Miranti, current PAC Chair as their new Vice Chair. All recommendations have been submitted for Board consideration.

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PAC received a verbal update report from Cheryl Meronk, Director, Strategic Development on the Intergovernmental Transfer Funds (IGT) 5, 6 and 7. The PAC requested that CalOptima staff create a timeline of the two separate IGT funds to mitigate confusion and enhance transparency on how funding from these two IGTs will be distributed.

PAC received a presentation on the Health Homes Program. The PAC commented there may be overlap between this program and others – Whole Person Pilot that should be recognized during the implementation process.

Dr. Federico, Medical Director, gave an informative presentation on the Emergency Room Appropriate Use and Collaboration Project. Several of the PAC members commented although this may be a difficult issue to tackle for the Medi-Cal population, many of our organizations continue to educate members and providers.

The PAC also reviewed their second quarter accomplishments as it relates to their Goals and Objectives.

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

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Provider Advisory Committee
FY 2017 - 2018 Accomplishments

During FY 2017-2018 the Provider Advisory Committee (PAC) of the CalOptima Board of Directors provided input on provider issues to ensure that CalOptima members continue to receive high quality health care services. The following list highlights their accomplishments:

- The PAC Allied Health Representative helped to recruit two new Member Advisory Committee (MAC) members during FY2017-2018 who were approved by the Board. Member also assisted in the recruitment of two more possible representatives, one for Family Whole Child Advisory Committee member and an applicant for MAC. Member assisted with the Member Needs Assessment Survey by being a key informant and allowing CalOptima to use MOMs facility for the focus group meetings. MOMs staff assisted with the recruitment of the members MOMs serves for their participation and feedback.

- PAC members shared the news with their constituencies and professional organizations regarding CalOptima's ranking as California's top-ranked Medi-Cal health plan, according to the National Committee for Quality Assurance's (NCQA's) Medicaid Health Insurance Plan Rankings for 2017–2018.

- One of the three PAC Physician Representatives (Dr. Sweidan) served on the CalOptima's Quality Improvement Committee (QIC): this committee provides overall direction for the continuous improvement process and oversees activities that are consistent with CalOptima's strategic goals and priorities; promotes an interdisciplinary approach to driving continuous improvement and makes certain that adequate resources are committed to the program; supports compliance with regulatory and licensing requirements and accreditation standards related to quality improvement projects, activities and initiatives; also monitors and evaluates the care and services members are provided to promote quality of care.

- PAC LTSS Representative continues to participate in the Long-Term Services and Supports Quality Subcommittee (LTSS QISC). His role is to provide input in CalOptima LTSS Quality Program. This has resulted in improvements to the quality metrics used to measure LTSS providers and the educational programs used to improve knowledge and services at the provider level.

- PAC Health Network Representative shared information with all the health networks at the monthly Health Network Forum. She gathered feedback from them on topics to bring forward for discussion. Topics included: rate discussions, IGT funding, difficult to access providers, transgender services, Prop 56 and Opioid Epidemic.

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- All PAC members completed the annual Compliance Training for 2017/18 by the deadline.

- PAC held a total of two joint meetings during the 2017-18. The first meeting was a MAC/PAC meeting and was held on September 14, 2018 and the second meeting was held March 8, 2018 with MAC and OCC MAC. PAC hopes to continue to share feedback with the other advisory committees on a yearly basis.

- 2018 PAC Nomination Ad Hoc subcommittee met on April 18, 2018, to select new PAC members for the four PAC vacancies: Allied Health, Behavioral Health, Health Network, and Nurse Representatives. The ad hoc members presented the slate of candidates to the full PAC on May 10, 2018 with their recommendations.

- PAC members supported the intergovernmental transfer (IGT) projects that are completed or in progress, as well as the proposed recommendations for the use of the remaining IGT funds.

- The PAC Chair submitted and presented the PAC Report at CalOptima's Board of Directors' monthly meetings to provide the Board with input and updates on the PAC's current activities.

- The PAC Chair solicited discussion topics/presentations from other PAC members which led to sharing their expertise about programs we were not aware of. The Chair monitored and documented the quarterly PAC Goals and Objectives. As Chair she spent on average three hours a month working with staff to the PAC to formalize the agenda and review and edit PAC's Report to the Board. The Chair worked with CalOptima staff to review the Member Needs Assessment report. As the Chair, she discussed issues with other committee members to ensure their concerns were addressed at a PAC meeting.

- PAC members attendance equals on average over 82% of members attending each monthly meeting and there are 12 out of 15 members attending each meeting.

- In addition to meeting monthly during FY 2017-18, PAC members have participated in at least five (5) ad hoc subcommittees and dedicated approximately 403 hours or the equivalent of 50 business days. This does not account for the time spent preparing for meetings, reviewing reports, participating in their professional associations and communicating with CalOptima staff and their respective constituencies.

- Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's activities during the monthly Board Meetings. In addition, the PAC welcomes direction or assignment from the Board on any issues or items requiring study, research, and input.

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Financial Summary

April 2018

Board of Directors Meeting

June 7, 2018

Greg Hamblin

Chief Financial Officer

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FY 2017-18: Consolidated Enrollment

- April 2018 MTD:
  - Overall enrollment was 790,609 member months
    - Actual lower than budget by 14,008 or 1.7%
      - Medi-Cal: unfavorable variance of 13,239 members
        - TANF unfavorable variance of 14,984 members
        - Senior Persons with Disabilities (SPD) unfavorable variance of 4,074 members
        - Medi-Cal Expansion (MCE) favorable variance of 5,637 members
        - Long-Term Care (LTC) favorable variance of 182 members
      - OneCare Connect: unfavorable variance of 725 members
    - 1,909 increase from prior month
      - Medi-Cal: increase of 1,759 from March
      - OneCare Connect: increase of 118 from March
      - OneCare: increase of 30 from March
      - PACE: increase of 2 from March

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FY 2017-18: Consolidated Enrollment

- April 2018 YTD:
  - Overall enrollment was 7,907,768 member months
    - Actual lower than budget by 124,011 or 1.5%
      - Medi-Cal: unfavorable variance of 119,704 members or 1.5%
        - TANF unfavorable variance of 133,071 members
        - SPD unfavorable variance of 17,904 members
        - MCE favorable variance of 29,486 members
        - LTC favorable variance of 1,760 members
      - OneCare Connect: unfavorable variance of 4,353 members or 2.8%
      - OneCare: favorable variance of 87 members or 0.6%
      - PACE: unfavorable variance of 41 members or 1.7%

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FY 2017-18: Consolidated Revenues

- April 2018 MTD:
  - Actual higher than budget by $46.8 million or 18.3%
    - Medi-Cal: favorable to budget by $46.8 million or 20.6%
      - Unfavorable volume variance of $3.8 million
      - Favorable price variance of $50.6 million due to:
        - $26.7 million of FY18 Proposition 56 revenue
        - $4.8 million of FY18 LTC revenue
        - $3.0 million of FY18 Applied Behavior Analysis (ABA) revenue
        - $12.8 million of prior year In-Home Supportive Services (IHSS) revenue
        - $3.1 million of prior year LTC revenue from non-LTC aid codes

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FY 2017-18: Consolidated Revenues (cont.)

- April 2018 MTD:
  - OneCare Connect: unfavorable to budget by $0.02 million or 0.1%
    - Unfavorable volume variance of $1.2 million due to lower enrollment
    - Favorable price variance of $1.1 million due to FY18 rate adjustment
  - OneCare: unfavorable to budget by $64.2 thousand or 4.3%
    - Unfavorable volume variance of $38.1 thousand
    - Unfavorable price variance of $26.1 thousand
  - PACE: favorable to budget by $58.7 thousand or 3.3%
    - Unfavorable volume variance of $54.0 thousand
    - Favorable price variance of $112.7 thousand

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FY 2017-18: Consolidated Revenues (cont.)

- April 2018 YTD:
  - Actual higher than budget by $122.2 million or 4.6%
    - Medi-Cal: favorable to budget by $106.5 million or 4.5%
      - Unfavorable volume variance of $36.3 million
      - Favorable price variance of $142.8 million due to:
        - $26.0 million of FY18 Proposition 56 revenue
        - $21.3 million of FY18 ABA revenue
        - $20.7 million of FY18 LTC revenue from non-LTC aid codes
        - $32.7 million of prior year SPD revenue
        - $30.2 million of prior year LTC revenue from non-LTC aid codes
        - $8.4 million of prior year ABA revenue, offset by:
        - ($15.7) million of Hepatitis C revenue

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FY 2017-18: Consolidated Revenues (cont.)

- April 2018 YTD:
  - OneCare Connect: favorable to budget by $15.9 million or 6.0%
    - Unfavorable volume variance of $7.4 million
    - Favorable price variance of $23.3 million
  - OneCare: Unfavorable to budget by $1.1 million or 7.9%
    - Favorable volume variance of $0.1 million
    - Unfavorable price variance of $1.2 million
  - PACE: favorable to budget by $0.9 million or 5.5%
    - Unfavorable volume variance of $0.3 million
    - Favorable price variance of $1.1 million

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FY 2017-18: Consolidated Medical Expenses

- April 2018 MTD:
  - Actual higher than budget by $51.1 million or 20.9%
    - Medi-Cal: unfavorable variance of $48.3 million
      - Favorable volume variance of $3.7 million
      - Unfavorable price variance of $52.0 million
        - Professional Claims unfavorable variance of $24.8 million due to Proposition 56 and Behavioral Health Treatment (BHT) transition in-house
        - Managed Long-Term Services and Support (MLTSS) unfavorable variance of $19.1 million due to prior year IHSS and LTC claims
        - Provider Capitation is unfavorable to budget $7.6 million due to Proposition 56 and BHT transition in-house
        - Facilities favorable variance of $4.9 million due Crossover claims and Shared Risk Pool (SRP)
    - OneCare Connect: unfavorable variance of $2.4 million
      - Favorable volume variance of $1.1 million due to lower enrollment
      - Unfavorable price variance of $3.5 million due to prior year SRP

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FY 2017-18: Consolidated Medical Expenses (cont.)

- April 2018 YTD:
  - Actual higher than budget by $146.7 million or 5.7%
    - Medi-Cal: unfavorable variance of $134.3 million
      - Favorable volume variance of $34.7 million
      - Unfavorable price variance of $169.0 million
        - MLTSS expenses unfavorable variance of $66.7 million
        - Professional Claims expenses unfavorable variance of $62.5 million
        - Provider Capitation expenses unfavorable variance of $17.6 million
    - OneCare Connect: unfavorable variance of $14.0 million
      - Favorable volume variance of $6.9 million
      - Unfavorable price variance of $20.9 million
- Medical Loss Ratio (MLR):
  - April 2018 MTD: Actual: 97.8% Budget: 95.8%
  - April 2018 YTD: Actual: 96.6% Budget: 95.5%

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FY 2017-18: Consolidated Administrative Expenses

- April 2018 MTD:
  - Actual lower than budget by $1.5 million or 12.3%
    - Salaries, wages and benefits: favorable variance of $0.6 million
    - Purchased Services: favorable variance of $0.3 million
    - Other categories: favorable variance of $0.6 million

- April 2018 YTD:
  - Actual lower than budget by $23.6 million or 19.3%
    - Purchased Services: favorable variance of $9.2 million
    - Salaries, wages and benefits: favorable variance of $7.5 million
    - Other categories: favorable variance of $6.8 million

- Administrative Loss Ratio (ALR):
  - April 2018 MTD: Actual: 3.4% Budget: 4.6%
  - April 2018 YTD: Actual: 3.5% Budget: 4.6%

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FY 2017-18: Change in Net Assets

- April 2018 MTD:
  - $1.9 million deficit
  - $1.0 million unfavorable to budget
    - Higher than budgeted revenue of $46.8 million
    - Higher than budgeted medical expenses of $51.1 million
    - Lower than budgeted administrative expenses of $1.5 million
    - Higher than budgeted investment and other income of $1.8 million

- April 2018 YTD:
  - $13.6 million surplus
  - $12.2 million favorable to budget
    - Higher than budgeted revenue of $122.2 million
    - Higher than budgeted medical expenses of $146.7 million
    - Lower than budgeted administrative expenses of $23.6 million
    - Higher than budgeted investment and other income of $13.2 million

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Enrollment Summary: April 2018

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
63,042	65,354	(2,312)	(3.5%)	Aged	632,240	636,020	(3,780)	(0.6%)
633	618	15	2.4%	BCCTP	6,146	6,180	(34)	(0.6%)
47,047	48,824	(1,777)	(3.6%)	Disabled	473,779	487,869	(14,090)	(2.9%)
310,490	328,834	(18,344)	(5.6%)	TANF Child	3,204,387	3,294,422	(90,035)	(2.7%)
106,771	103,412	3,359	3.2%	TANF Adult	994,304	1,037,340	(43,036)	(4.1%)
3,450	3,268	182	5.6%	LTC	34,440	32,680	1,760	5.4%
242,647	237,010	5,637	2.4%	MCE	2,395,262	2,365,776	29,486	1.2%
774,080	**787,319**	**(13,239)**	**(1.7%)**	**Medi-Cal**	**7,740,558**	**7,860,262**	**(119,704)**	**(1.5%)**
14,911	**15,636**	**(725)**	**(4.6%)**	**OneCare Connect**	**151,199**	**155,552**	**(4,353)**	**(2.8%)**
253	**261**	**(8)**	**(3.1%)**	**PACE**	**2,344**	**2,385**	**(41)**	**(1.7%)**
1,365	**1,401**	**(36)**	**(2.6%)**	**OneCare**	**13,667**	**13,580**	**87**	**0.6%**
790,609	**804,617**	**(14,008)**	**(1.7%)**	**CalOptima Total**	**7,907,768**	**8,031,779**	**(124,011)**	**(1.5%)**

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CalOptima A Public Agency Better. Together.

Financial Highlights: April 2018

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
790,609	804,617	(14,008)	(1.7%)	Member Months	7,907,768	8,031,779	(124,011)	(1.5%)
302,427,059	255,644,949	46,782,110	18.3%	Revenues	2,797,169,134	2,674,990,020	122,179,114	4.6%
295,899,888	244,839,517	(51,060,371)	(20.9%)	Medical Expenses	2,700,837,408	2,554,108,292	(146,729,116)	(5.7%)
10,428,262	11,884,285	1,456,023	12.3%	Administrative Expenses	98,271,329	121,840,907	23,569,577	19.3%
(3,901,091)	**(1,078,853)**	**(2,822,239)**	**(261.6%)**	**Operating Margin**	**(1,939,604)**	**(959,179)**	**(980,425)**	**(102.2%)**
2,037,269	231,157	1,806,111	781.3%	Non Operating Income (Loss)	15,559,740	2,354,344	13,205,396	560.9%
(1,863,823)	**(847,696)**	**(1,016,127)**	**(119.9%)**	**Change in Net Assets**	**13,620,136**	**1,395,166**	**12,224,971**	**876.2%**
97.8%	95.8%	(2.1%)		Medical Loss Ratio	96.6%	95.5%	(1.1%)	
3.4%	4.6%	1.2%		Administrative Loss Ratio	3.5%	4.6%	1.0%	
(1.3%)	(0.4%)	(0.9%)		Operating Margin Ratio	(0.1%)	(0.0%)	(0.0%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima A Public Agency Better. Together.

Consolidated Performance Actual vs. Budget: April (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(0.5)	(0.2)	(0.3)	Medi-Cal	(3.8)	3.1	(6.9)
(3.1)	(0.9)	(2.2)	OCC	1.2	(2.8)	4.0
(0.4)	(0.1)	(0.3)	OneCare	(0.6)	(1.2)	0.6
0.1	0.1	0.0	PACE	1.1	(0.0)	1.2
(3.9)	**(1.1)**	**(2.8)**	**Operating**	**(2.1)**	**(1.0)**	**(1.1)**
2.0	0.2	1.8	Inv./Rental Inc, MCO tax	15.7	2.4	13.3
2.0	**0.2**	**1.8**	**Non-Operating**	**15.7**	**2.4**	**13.3**
(1.9)	**(0.8)**	**(1.0)**	**TOTAL**	**13.6**	**1.4**	**12.2**

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Consolidated Revenue & Expense: April 2018 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	531,433	242,647	774,080	14,911	1,365	253	790,609
REVENUES							
Capitation Revenue	$ 152,553,983	$ 121,776,564	$ 274,330,548	$ 24,857,464	$ 1,418,481	$ 1,820,566	$ 302,427,059
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	152,553,983	121,776,564	274,330,548	24,857,464	1,418,481	1,820,566	302,427,059
MEDICAL EXPENSES							
Provider Capitation	38,956,238	55,459,970	94,416,208	11,811,706	460,472	-	106,688,386
Facilities	19,071,469	19,891,136	38,962,605	6,207,909	756,959	385,801	46,313,274
Ancillary	-	-	-	547,581	69,198	-	616,779
Skilled Nursing	-	-	-	-	31,323	-	31,323
Professional Claims	27,350,127	11,989,509	39,339,636	-	-	416,608	39,756,244
Prescription Drugs	18,370,120	19,723,630	38,093,749	4,837,117	390,222	129,697	43,450,786
Quality Incentives	-	-	-	-	-	-	-
MLTSS Facility Payments	48,048,607	3,204,871	51,253,478	1,430,557	-	-	52,684,036
Medical Management	2,484,887	930,776	3,415,663	1,141,921	32,928	527,293	5,117,806
Reinsurance & Other	514,121	307,468	821,588	294,338	10,000	115,329	1,241,255
Total Medical Expenses	154,795,568	111,507,359	266,302,927	26,271,131	1,751,102	1,574,728	295,899,888
Medical Loss Ratio	**101.5%**	**91.6%**	**97.1%**	**105.7%**	**123.4%**	**86.5%**	**97.8%**
GROSS MARGIN	**(2,241,584)**	**10,269,205**	**8,027,620**	**(1,413,668)**	**(332,621)**	**245,839**	**6,527,171**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,621,480	789,134	20,593	75,736	6,506,943
Professional fees			74,711	4,167	13,333	15,600	107,811
Purchased services			976,023	198,606	17,584	15,115	1,207,327
Printing and Postage			407,084	34,839	6,960	6,151	455,034
Depreciation and Amortization			406,648	-	-	2,074	408,722
Other expenses			1,359,596	28,549	0	8,692	1,396,836
Indirect cost allocation, Occupancy expense			(306,090)	612,391	36,135	3,152	345,588
Total Administrative Expenses			8,539,452	1,667,685	94,605	126,520	10,428,262
Admin Loss Ratio			**3.1%**	**6.7%**	**6.7%**	**6.9%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			(511,832)	(3,081,353)	(427,226)	119,319	(3,901,091)
INVESTMENT INCOME							2,035,597
NET GRANT INCOME			1,672	-	-	-	1,672
IGT			(4,435,678)	-	-	-	0
QAF			4,435,678	-	-	-	0
CHANGE IN NET ASSETS			**$ (510,160)**	**$ (3,081,353)**	**$ (427,226)**	**$ 119,319**	**$ (1,863,823)**

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Consolidated Revenue & Expense: April 2018 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	5,345,296	2,395,262	7,740,558	151,199	13,667	2,344	7,907,768
REVENUES							
Capitation Revenue	$ 1,398,018,377	$ 1,089,044,718	$ 2,487,063,095	$ 280,310,337	13,059,575	$ 16,736,127	$ 2,797,169,134
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	1,398,018,377	1,089,044,718	2,487,063,095	280,310,337	13,059,575	16,736,127	2,797,169,134
MEDICAL EXPENSES							
Provider Capitation	380,422,139	506,770,865	887,193,005	113,883,870	1,774,609	-	1,002,851,483
Facilities	216,315,029	206,090,796	422,405,825	34,244,190	5,132,694	3,103,255	464,885,963
Ancillary	-	-	-	6,274,489	565,755	-	6,840,244
Skilled Nursing	-	-	-	-	256,986	-	256,986
Professional Claims	148,588,189	56,311,475	204,899,664	-	-	3,699,061	208,598,725
Prescription Drugs	184,041,622	182,887,471	366,929,093	51,236,031	4,421,494	1,298,117	423,884,736
MLTSS Facility Payments	468,645,237	25,992,066	494,637,303	44,391,572	-	17,988	539,046,864
Medical Management	19,838,332	7,440,979	27,279,311	10,132,676	521,765	5,317,935	43,251,686
Reinsurance & Other	5,443,473	3,014,510	8,457,982	1,677,925	71,146	1,013,667	11,220,720
Total Medical Expenses	1,423,294,022	988,508,162	2,411,802,183	261,840,752	12,744,449	14,450,024	2,700,837,408
Medical Loss Ratio	**101.8%**	**90.8%**	**97.0%**	**93.4%**	**97.6%**	**86.3%**	**96.6%**
GROSS MARGIN	**(25,275,644)**	**100,536,556**	**75,260,912**	**18,469,585**	**315,126**	**2,286,103**	**96,331,726**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			54,912,248	7,688,429	233,566	771,712	63,605,954
Professional fees			1,379,759	258,789	146,015	54,108	1,838,671
Purchased services			6,886,539	1,735,782	189,699	95,202	8,907,223
Printing and Postage			3,254,267	617,668	69,221	31,119	3,972,275
Depreciation and Amortization			4,114,724	-	-	21,326	4,136,050
Other expenses			11,789,751	422,075	(578)	125,217	12,336,464
Indirect cost allocation, Occupancy expense			(3,411,561)	6,520,510	305,371	60,373	3,474,692
Total Administrative Expenses			78,925,725	17,243,253	943,293	1,159,058	98,271,329
Admin Loss Ratio			**3.2%**	**6.2%**	**7.2%**	**6.9%**	**3.5%**
INCOME (LOSS) FROM OPERATIONS			(3,664,814)	1,226,332	(628,167)	1,127,045	(1,939,604)
INVESTMENT INCOME			-	-	-	-	15,624,253
NET RENTAL INCOME			-	-	-	-	54,103
NET GRANT INCOME			(118,615)	-	-	-	(118,615)
OTHER INCOME			993	-	-	-	993
CHANGE IN NET ASSETS			**$ (3,782,436)**	**$ 1,226,332**	**$ (628,167)**	**$ 1,127,045**	**$ 13,621,130**

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Balance Sheet: As of April 2018

ASSETS			LIABILITIES & FUND BALANCES	
Current Assets			Current Liabilities	
	Operating Cash	$824,639,879	Accounts payable	$28,739,671
	Investments	624,461,924	Medical claims liability	1,304,233,540
	Capitation receivable	200,095,669	Accrued payroll liabilities	12,024,970
	Receivables - Other	22,499,666	Deferred revenue	55,163,337
	Prepaid Expenses	6,944,627	Deferred lease obligations	133,535
			Capitation and withholds	101,811,861
	Total Current Assets	**1,678,641,764**	**Total Current Liabilities**	**1,502,106,913**
Capital Assets	Furniture and equipment	34,328,849	Other employment benefits liability	30,321,020
	Building/Leasehold improvements	5,990,043		
	505 City Parkway West	49,743,943	Net Pension Liabilities	16,026,570
		90,062,834	Long Term Liabilities	100,000
	Less: accumulated depreciation	(39,647,404)		
	Capital assets, net	**50,415,430**	**TOTAL LIABILITIES**	**1,548,554,503**
Other Assets	Restricted deposit & Other	300,000	Deferred inflows of Resources - Excess Earnings	-
			Deferred inflows of Resources - Changes in Assumptions	1,340,010
	Board-designated assets			
	Cash and cash equivalents	21,897,434	Tangible net equity (TNE)	87,500,253
	Long term investments	514,142,267	Funds in excess of TNE	639,579,269
	Total Board-designated Assets	536,039,701		
	Total Other Assets	**536,339,701**	**Net Assets**	**727,079,522**
	Deferred outflows of Resources - Pension Contributions	5,234,198		
	Deferred outflows of Resources - Difference in Experience	1,072,771		
	Deferred outflows of Resources - Excess Earnings	5,270,171		
TOTAL ASSETS & OUTFLOWS		**2,276,974,035**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,276,974,035**

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Board Designated Reserve and TNE Analysis
As of April 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,658,083				
	Tier 1 - Logan Circle	146,601,781				
	Tier 1 - Wells Capital	146,033,660				
Board-designated Reserve		439,293,524	295,459,331	459,584,867	143,834,193	(20,291,343)
TNE Requirement	Tier 2 - Logan Circle	96,746,176	87,500,252	87,500,252	9,245,924	9,245,924
	Consolidated:	536,039,701	382,959,584	547,085,120	153,080,117	(11,045,419)
	Current reserve level	1.96	1.40	2.00		

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UNAUDITED FINANCIAL STATEMENTS

April 2018

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CalOptima - Consolidated
Financial Highlights
For the Ten Months Ended April 30, 2018

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
790,609	804,617	(14,008)	(1.7%)	Member Months	7,907,768	8,031,779	(124,011)	(1.5%)
302,427,059	255,644,949	46,782,110	18.3%	Revenues	2,797,169,134	2,674,990,020	122,179,114	4.6%
295,899,888	244,839,517	(51,060,371)	(20.9%)	Medical Expenses	2,700,837,408	2,554,108,292	(146,729,116)	(5.7%)
10,428,262	11,884,285	1,456,023	12.3%	Administrative Expenses	98,271,329	121,840,907	23,569,577	19.3%
(3,901,091)	**(1,078,853)**	**(2,822,239)**	**(261.6%)**	**Operating Margin**	**(1,939,604)**	**(959,179)**	**(980,425)**	**(102.2%)**
2,037,269	231,157	1,806,111	781.3%	Non Operating Income (Loss)	15,559,740	2,354,344	13,205,396	560.9%
(1,863,823)	**(847,696)**	**(1,016,127)**	**(119.9%)**	**Change in Net Assets**	**13,620,136**	**1,395,166**	**12,224,971**	**876.2%**
97.8%	95.8%	(2.1%)		Medical Loss Ratio	96.6%	95.5%	(1.1%)	
3.4%	4.6%	1.2%		Administrative Loss Ratio	3.5%	4.6%	1.0%	
(1.3%)	(0.4%)	(0.9%)		Operating Margin Ratio	(0.1%)	(0.0%)	(0.0%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima
Financial Dashboard
For the Ten Months Ended April 30, 2018

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	774,080	787,319	(13,239)	(1.7%)
OneCare Connect	14,911	15,636	(725)	(4.6%)
OneCare	1,365	1,401	(36)	(2.6%)
PACE	253	261	(8)	(3.1%)
Total	790,609	804,617	(14,008)	(1.7%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (510)	$ (179)	$ (332)	(185.7%)
OneCare Connect	(3,081)	(903)	(2,179)	(241.3%)
OneCare	(427)	(88)	(339)	(382.9%)
PACE	119	91	28	31.3%
505 Bldg.	-	(19)	19	100.0%
Investment Income & Other	2,036	250	1,786	714.2%
Total	$ (1,864)	$ (848)	$ (1,016)	(119.9%)

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.1%	95.8%	(1.3)
OneCare Connect	105.7%	95.9%	(9.8)
OneCare	123.4%	99.4%	(24.0)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 8,539	$ 9,701	$ 1,162	12.0%
OneCare Connect	1,668	1,931	263	13.6%
OneCare	95	97	2	2.3%
PACE	127	155	29	18.4%
Total	$ 10,428	$ 11,884	$ 1,456	12.3%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	915	900	(14)
OneCare Connect	216	237	21
OneCare	3	3	(0)
PACE	57	67	10
Total	1,191	1,207	16

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	846	874	(28)
OneCare Connect	69	66	3
OneCare	453	467	(14)
PACE	4	4	1
Total	1,373	1,411	(38)

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	7,740,558	7,860,262	(119,704)	(1.5%)
OneCare Connect	151,199	155,552	(4,353)	(2.8%)
OneCare	13,667	13,580	87	0.6%
PACE	2,344	2,385	(41)	(1.7%)
Total	7,907,768	8,031,779	(124,011)	(1.5%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (3,782)	$ 3,076	$ (6,858)	(223.0%)
OneCare Connect	1,226	(2,820)	4,046	143.5%
OneCare	(628)	(1,181)	553	46.8%
PACE	1,127	(34)	1,162	3370.6%
505 Bldg.	54	(146)	200	137.1%
Investment Income & Other	15,624	2,500	13,124	525.0%
Total	$ 13,621	$ 1,395	$ 12,226	876.3%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.0%	95.7%	(1.3)
OneCare Connect	93.4%	93.7%	0.3
OneCare	97.6%	101.4%	3.8

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 78,926	$ 99,968	$ 21,043	21.0%
OneCare Connect	17,243	19,382	2,139	11.0%
OneCare	943	980	37	3.7%
PACE	1,159	1,511	351	23.3%
Total	$ 98,271	$ 121,841	$ 23,570	19.3%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	8,944	9,004	60
OneCare Connect	2,193	2,371	178
OneCare	30	30	(0)
PACE	547	641	93
Total	11,714	12,045	331

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	865	873	(8)
OneCare Connect	69	66	3
OneCare	449	453	(4)
PACE	4	4	1
Total	1,387	1,395	(8)

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CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended April 30, 2018

	Month					
	Actual		Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	790,609		804,617		(14,008)	
Revenues						
Medi-Cal	$ 274,330,548	$ 354.40	$ 227,525,214	$ 288.99	$ 46,805,334	$ 65.41
OneCare Connect	24,857,464	1,667.06	24,875,258	1,590.90	(17,794)	76.16
OneCare	1,418,481	1,039.18	1,482,636	1,058.27	(64,155)	(19 09)
PACE	1,820,566	7,195.91	1,761,841	6,750.35	58,725	445 57
Total Operating Revenue	302,427,059	382.52	255,644,949	317.72	46,782,110	64 80
Medical Expenses						
Medi-Cal	266,302,927	344.03	218,002,439	276.89	(48,300,488)	(67.13)
OneCare Connect	26,271,131	1,761.86	23,846,936	1,525.13	(2,424,195)	(236.73)
OneCare	1,751,102	1,282.86	1,474,241	1,052.28	(276,861)	(230 58)
PACE	1,574,728	6,224.22	1,515,901	5,808.05	(58,827)	(416.17)
Total Medical Expenses	295,899,888	374.27	244,839,517	304.29	(51,060,371)	(69 98)
Gross Margin	6,527,171	8.26	10,805,432	13.43	(4,278,261)	(5.17)
Administrative Expenses						
Salaries and Benefits	6,506,943	8.23	7,089,919	8.81	582,976	0 58
Professional fees	107,811	0.14	397,189	0.49	289,378	0 36
Purchased services	1,207,327	1.53	1,516,110	1.88	308,783	0 36
Prin ing and Postage	455,034	0.58	529,870	0.66	74,836	0 08
Deprecia ion and Amortization	408,722	0.52	463,298	0.58	54,576	0 06
Other	1,396,836	1.77	1,547,483	1.92	150,647	0.16
Indirect cost alloca ion, Occupancy expense	345,588	0.44	340,416	0.42	(5,172)	(0 01)
Total Administrative Expenses	10,428,262	13.19	11,884,285	14.77	1,456,023	1 58
Income (Loss) From Operations	(3,901,091)	(4.93)	(1,078,853)	(1.34)	(2,822,239)	(3 59)
Investment income						
Interest income	2,822,151	3.57	250,000	0.31	2,572,151	3 26
Realized gain/(loss) on investments	(244,491)	(0.31)	-	-	(244,491)	(0 31)
Unrealized gain/(loss) on investments	(542,063)	(0.69)	-	-	(542,063)	(0.69)
Total Investment Income	2,035,597	2.57	250,000	0.31	1,785,597	2 26
Net Rental Income	-	-	(18,843)	(0.02)	18,843	0 02
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	1,672	0.00	-	-	1,672	0 00
IGT	(4,435,678)	(5.61)	-	-	(4,435,678)	(5.61)
QAF	4,435,678	5.61	-	-	4,435,678	5.61
Other Income	-	-	-	-	-	-
Change In Net Assets	**(1,863,823)**	**(2.36)**	**(847,696)**	**(1.05)**	**(1,016,127)**	**(1.30)**
Medical Loss Ratio	**97.8%**		**95.8%**		**(2.1%)**	
Administrative Loss Ratio	**3.4%**		**4.6%**		**1.2%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

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CalOptima - Consolidated
Statement of Revenue and Expenses
For the Ten Months Ended April 30, 2018

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	7,907,768		8,031,779		(124,011)	
Revenues						
Medi-Cal	$ 2,487,063,095	$ 321.30	$ 2,380,526,536	$ 302.86	$ 106,536,559	$ 18.45
OneCare Connect	280,310,337	1,853.92	264,420,341	1,699.88	15,889,996	154 03
OneCare	13,059,575	955.56	14,173,035	1,043.67	(1,113,460)	(88.11)
PACE	16,736,127	7,139.99	15,870,108	6,654.13	866,019	485 85
Total Operating Revenue	2,797,169,134	353.72	2,674,990,020	333.05	122,179,114	20.67
Medical Expenses						
Medi-Cal	2,411,802,183	311.58	2,277,482,462	289.75	(134,319,721)	(21 83)
OneCare Connect	261,840,752	1,731.76	247,857,540	1,593.41	(13,983,212)	(138 36)
OneCare	12,744,449	932.50	14,374,240	1,058.49	1,629,791	125 99
PACE	14,450,024	6,164.69	14,394,050	6,035.24	(55,974)	(129.44)
Total Medical Expenses	2,700,837,408	341.54	2,554,108,292	318.00	(146,729,116)	(23 54)
Gross Margin	96,331,726	12.18	120,881,728	15.05	(24,550,002)	(2 87)
Administrative Expenses						
Salaries and Benefits	63,605,954	8.04	71,129,806	8.86	7,523,852	0 81
Professional fees	1,838,671	0.23	3,849,897	0.48	2,011,226	0 25
Purchased services	8,907,223	1.13	18,147,982	2.26	9,240,760	1.13
Prin ing and Postage	3,972,275	0.50	5,318,224	0.66	1,345,949	0.16
Deprecia ion and Amortization	4,136,050	0.52	4,632,980	0.58	496,930	0 05
Other	12,336,464	1.56	15,357,851	1.91	3,021,387	0 35
Indirect cost alloca ion, Occupancy expense	3,474,692	0.44	3,404,167	0.42	(70 525)	(0 02)
Total Administrative Expenses	98,271,329	12.43	121,840,907	15.17	23,569,577	2.74
Income (Loss) From Operations	(1,939,604)	(0.25)	(959,179)	(0.12)	(980,425)	(0.13)
Investment income						
Interest income	22,749,634	2.88	2,500,000	0.31	20,249,634	2 57
Realized gain/(loss) on investments	(1,877,670)	(0.24)	-	-	(1,877,670)	(0 24)
Unrealized gain/(loss) on investments	(5,247,711)	(0.66)	-	-	(5,247,711)	(0.66)
Total Investment Income	15,624,253	1.98	2,500,000	0.31	13,124,253	1.66
Net Rental Income	54,103	0.01	(145,656)	(0.02)	199,758	0 02
Total Net Operating Tax	(0)	(0.00)	-	-	(0)	(0)
Total Net Grant Income	(118,615)	(0.01)	-	-	(118,615)	(0 01)
IGT	-	-	-	-	-	-
QAF	(0)	(0.00)	-	-	(0)	(0)
Other Income	993	0.00	-	-	993	0 00
Change In Net Assets	**13,621,130**	**1.72**	**1,395,166**	**0.17**	**12,225,964**	**1.55**
Medical Loss Ratio	**96.6%**		**95.5%**		**(1.1%)**	
Administrative Loss Ratio	**3.5%**		**4.6%**		**1.0%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended April 30, 2018

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	531,433	242,647	774,080	14,911	1,365	253	790,609
REVENUES							
Capitation Revenue	$ 152,553,983	$ 121,776,564	$ 274,330,548	$ 24,857,464	$ 1,418,481	$ 1,820,566	$ 302,427,059
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	152,553,983	121,776,564	274,330,548	24,857,464	1,418,481	1,820,566	302,427,059
MEDICAL EXPENSES							
Provider Capitation	38,956,238	55,459,970	94,416,208	11,811,706	460,472	-	106,688,386
Facilities	19,071,469	19,891,136	38,962,605	6,207,909	756,959	385,801	46,313,274
Ancillary	-	-	-	547,581	69,198	-	616,779
Skilled Nursing	-	-	-	-	31,323	-	31,323
Professional Claims	27,350,127	11,989,509	39,339,636	-	-	416,608	39,756,244
Prescription Drugs	18,370,120	19,723,630	38,093,749	4,837,117	390,222	129,697	43,450,786
Quality Incentives	-	-	-	-	-	-	-
MLTSS Facility Payments	48,048,607	3,204,871	51,253,478	1,430,557	-	-	52,684,036
Medical Management	2,484,887	930,776	3,415,663	1,141,921	32,928	527,293	5,117,806
Reinsurance & Other	514,121	307,468	821,588	294,338	10,000	115,329	1,241,255
Total Medical Expenses	154,795,568	111,507,359	266,302,927	26,271,131	1,751,102	1,574,728	295,899,888
Medical Loss Ratio	**101.5%**	**91.6%**	**97.1%**	**105.7%**	**123.4%**	**86.5%**	**97.8%**
GROSS MARGIN	**(2,241,584)**	**10,269,205**	**8,027,620**	**(1,413,668)**	**(332,621)**	**245,839**	**6,527,171**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,621,480	789,134	20,593	75,736	6,506,943
Professional fees			74,711	4,167	13,333	15,600	107,811
Purchased services			976,023	198,606	17,584	15,115	1,207,327
Printing and Postage			407,084	34,839	6,960	6,151	455,034
Depreciation and Amortization			406,648	-	-	2,074	408,722
Other expenses			1,359,596	28,549	0	8,692	1,396,836
Indirect cost allocation, Occupancy expense			(306,090)	612,391	36,135	3,152	345,588
Total Administrative Expenses			8,539,452	1,667,685	94,605	126,520	10,428,262
Admin Loss Ratio			**3.1%**	**6.7%**	**6.7%**	**6.9%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			(511,832)	(3,081,353)	(427,226)	119,319	(3,901,091)
INVESTMENT INCOME							2,035,597
NET GRANT INCOME			1,672	-	-	-	1,672
IGT			(4,435,678)	-	-	-	(4,435,678)
QAF			4,435,678	-	-	-	4,435,678
CHANGE IN NET ASSETS			**$ (510,160)**	**$ (3,081,353)**	**$ (427,226)**	**$ 119,319**	**$ (1,863,823)**
BUDGETED CHANGE IN ASSETS			(178,555)	(902,717)	(88,466)	90,885	(847,696)
VARIANCE TO BUDGET - FAV (UNFAV)			(331,606)	(2,178,636)	(338,760)	28,434	(1,016,127)

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Ten Months Ended April 30, 2018

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	5,345,296	2,395,262	7,740,558	151,199	13,667	2,344	7,907,768
REVENUES							
Capitation Revenue	$ 1,398,018,377	$ 1,089,044,718	$ 2,487,063,095	$ 280,310,337	13,059,575	$ 16,736,127	$ 2,797,169,134
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	1,398,018,377	1,089,044,718	2,487,063,095	280,310,337	13,059,575	16,736,127	2,797,169,134
MEDICAL EXPENSES							
Provider Capitation	380,422,139	506,770,865	887,193,005	113,883,870	1,774,609	-	1,002,851,483
Facilities	216,315,029	206,090,796	422,405,825	34,244,190	5,132,694	3,103,255	464,885,963
Ancillary	-	-	-	6,274,489	565,755	-	6,840,244
Skilled Nursing	-	-	-	-	256,986	-	256,986
Professional Claims	148,588,189	56,311,475	204,899,664	-	-	3,699,061	208,598,725
Prescription Drugs	184,041,622	182,887,471	366,929,093	51,236,031	4,421,494	1,298,117	423,884,736
MLTSS Facility Payments	468,645,237	25,992,066	494,637,303	44,391,572	-	17,988	539,046,864
Medical Management	19,838,332	7,440,979	27,279,311	10,132,676	521,765	5,317,935	43,251,686
Reinsurance & Other	5,443,473	3,014,510	8,457,982	1,677,925	71,146	1,013,667	11,220,720
Total Medical Expenses	1,423,294,022	988,508,162	2,411,802,183	261,840,752	12,744,449	14,450,024	2,700,837,408
Medical Loss Ratio	**101.8%**	**90.8%**	**97.0%**	**93.4%**	**97.6%**	**86.3%**	**96.6%**
GROSS MARGIN	**(25,275,644)**	**100,536,556**	**75,260,912**	**18,469,585**	**315,126**	**2,286,103**	**96,331,726**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			54,912,248	7,688,429	233,566	771,712	63,605,954
Professional fees			1,379,759	258,789	146,015	54,108	1,838,671
Purchased services			6,886,539	1,735,782	189,699	95,202	8,907,223
Printing and Postage			3,254,267	617,668	69,221	31,119	3,972,275
Depreciation and Amortization			4,114,724	-	-	21,326	4,136,050
Other expenses			11,789,751	422,075	(578)	125,217	12,336,464
Indirect cost allocation, Occupancy expense			(3,411,561)	6,520,510	305,371	60,373	3,474,692
Total Administrative Expenses			78,925,725	17,243,253	943,293	1,159,058	98,271,329
Admin Loss Ratio			**3.2%**	**6.2%**	**7.2%**	**6.9%**	**3.5%**
INCOME (LOSS) FROM OPERATIONS			(3,664,814)	1,226,332	(628,167)	1,127,045	(1,939,604)
INVESTMENT INCOME			-	-	-	-	15,624,253
NET RENTAL INCOME			-	-	-	-	54,103
NET OPERATING TAX			(0)	-	-	-	(0)
NET GRANT INCOME			(118,615)	-	-	-	(118,615)
QAF/IGT			(0)	-	-	-	0
OTHER INCOME			993	-	-	-	993
CHANGE IN NET ASSETS			**$ (3,782,436)**	**$ 1,226,332**	**$ (628,167)**	**$ 1,127,045**	**$ 13,621,130**
BUDGETED CHANGE IN ASSETS			3,075,832	(2,819,508)	(1,181,042)	(34,460)	1,395,166
VARIANCE TO BUDGET - FAV (UNFAV)			(6,858,268)	4,045,840	552,875	1,161,505	12,225,964

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SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is ($1.9) million, $1.0 million unfavorable to budget
- Operating deficit is $3.9 million with a surplus in non-operating of $2.0 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $13.6 million, $12.2 million favorable to budget
- Operating deficit is $2.1 million, $1.1 million unfavorable to budget

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(0.5)	(0.2)	(0.3)	Medi-Cal	(3.8)	3.1	(6.9)
(3.1)	(0.9)	(2.2)	OCC	1.2	(2.8)	4.0
(0.4)	(0.1)	(0.3)	OneCare	(0.6)	(1.2)	0.6
0.1	0.1	0.0	PACE	1.1	(0.0)	1.2
(3.9)	**(1.1)**	**(2.8)**	**Operating**	**(2.1)**	**(1.0)**	**(1.1)**
2.0	0.2	1.8	Inv./Rental Inc, MCO tax	15.7	2.4	13.3
2.0	**0.2**	**1.8**	**Non-Operating**	**15.7**	**2.4**	**13.3**
(1.9)	**(0.8)**	**(1.0)**	**TOTAL**	**13.6**	**1.4**	**12.2**

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CalOptima

Enrollment Summary

For the Ten Months Ended April 30, 2018

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
63,042	65,354	(2,312)	(3.5%)	Aged	632,240	636,020	(3,780)	(0.6%)
633	618	15	2.4%	BCCTP	6,146	6,180	(34)	(0.6%)
47,047	48,824	(1,777)	(3.6%)	Disabled	473,779	487,869	(14,090)	(2.9%)
310,490	328,834	(18,344)	(5.6%)	TANF Child	3,204,387	3,294,422	(90,035)	(2.7%)
106,771	103,412	3,359	3.2%	TANF Adult	994,304	1,037,340	(43,036)	(4.1%)
3,450	3,268	182	5.6%	LTC	34,440	32,680	1,760	5.4%
242,647	237,010	5,637	2.4%	MCE	2,395,262	2,365,776	29,486	1.2%
774,080	**787,319**	**(13,239)**	**(1.7%)**	**Medi-Cal**	**7,740,558**	**7,860,262**	**(119,704)**	**(1.5%)**
14,911	**15,636**	**(725)**	**(4.6%)**	**OneCare Connect**	**151,199**	**155,552**	**(4,353)**	**(2.8%)**
253	**261**	**(8)**	**(3.1%)**	**PACE**	**2,344**	**2,385**	**(41)**	**(1.7%)**
1,365	**1,401**	**(36)**	**(2.6%)**	**OneCare**	**13,667**	**13,580**	**87**	**0.6%**
790,609	**804,617**	**(14,008)**	**(1.7%)**	**CalOptima Total**	**7,907,768**	**8,031,779**	**(124,011)**	**(1.5%)**
				Enrollment (By Network)				
168,619	174,769	(6,150)	(3.5%)	HMO	1,701,595	1,743,552	(41,957)	(2.4%)
221,726	224,788	(3,062)	(1.4%)	PHC	2,226,694	2,259,918	(33,224)	(1.5%)
196,528	208,045	(11,517)	(5.5%)	Shared Risk Group	1,994,288	2,092,782	(98,494)	(4.7%)
187,207	179,717	7,490	4.2%	Fee for Service	1,817,981	1,764,010	53,971	3.1%
774,080	**787,319**	**(13,239)**	**(1.7%)**	**Medi-Cal**	**7,740,558**	**7,860,262**	**(119,704)**	**(1.5%)**
14,911	**15,636**	**(725)**	**(4.6%)**	**OneCare Connect**	**151,199**	**155,552**	**(4,353)**	**(2.8%)**
253	**261**	**(8)**	**(3.1%)**	**PACE**	**2,344**	**2,385**	**(41)**	**(1.7%)**
1,365	**1,401**	**(36)**	**(2.6%)**	**OneCare**	**13,667**	**13,580**	**87**	**0.6%**
790,609	**804,617**	**(14,008)**	**(1.7%)**	**CalOptima Total**	**7,907,768**	**8,031,779**	**(124,011)**	**(1.5%)**

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CalOptima
Enrollment Trend by Network Type
Fiscal Year 2018

Network Type	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	MMs
HMO													
Aged	4,058	4,045	4,051	3,864	4,020	3,980	3,982	3,958	3,941	3,897	-	-	39,796
BCCTP	1	1	1	5	1	5	1	1	1	1	-	-	18
Disabled	6,749	6,740	6,729	6,703	6,733	6,743	6,743	6,777	6,780	6,740	-	-	67,437
TANF Child	61,492	61,733	61,361	61,023	60,598	60,595	53,730	59,508	59,394	56,629	-	-	596,063
TANF Adult	30,429	30,420	30,313	30,127	29,905	30,059	36,236	30,408	30,207	32,475	-	-	310,579
LTC	3	4	6	4	4	3	2	3	4	4	-	-	37
MCE	68,020	68,792	69,169	68,294	68,764	69,313	68,665	68,888	68,887	68,873	-	-	687,665
	170,752	171,735	171,630	170,020	170,025	170,698	169,359	169,543	169,214	168,619	-	-	1,701,595
PHC													
Aged	1,480	1,493	1,530	1,401	1,561	1,581	1,603	1,608	1,615	1,618	-	-	15,490
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	7,318	7,264	7,258	7,236	7,229	7,221	7,264	7,256	7,298	7,248	-	-	72,592
TANF Child	162,801	163,976	163,202	162,046	162,030	162,046	154,874	160,957	160,820	157,117	-	-	1,609,869
TANF Adult	12,604	12,571	12,410	12,356	12,311	12,312	19,241	13,212	13,146	16,043	-	-	136,206
LTC	-	-	1	1	-	-	1	1	-	2	-	-	6
MCE	38,398	38,821	39,088	38,681	39,261	39,620	39,555	39,715	39,694	39,698	-	-	392,531
	222,601	224,125	223,489	221,721	222,392	222,780	222,538	222,749	222,573	221,726	-	-	2,226,694
Shared Risk Group													
Aged	3,809	3,756	3,831	3,029	3,765	3,641	3,706	3,680	3,687	3,598	-	-	36,502
BCCTP	-	-	-	1	-	-	-	-	-	-	-	-	1
Disabled	8,108	8,058	8,035	7,951	7,978	7,887	7,873	7,810	7,756	7,694	-	-	79,150
TANF Child	72,723	72,861	72,102	71,427	71,139	70,753	63,054	69,468	69,054	65,203	-	-	697,784
TANF Adult	32,775	32,737	32,316	31,441	31,785	31,475	39,189	32,293	31,899	35,168	-	-	331,078
LTC	-	1	2	-	-	2	-	3	3	-	-	-	11
MCE	85,799	86,330	86,191	81,677	85,025	84,995	84,574	85,241	85,065	84,865	-	-	849,762
	203,214	203,743	202,477	195,526	199,692	198,753	198,396	198,495	197,464	196,528	-	-	1,994,288
Fee for Service (Dual)													
Aged	48,036	48,599	48,846	48,863	49,108	49,578	53,851	53,491	49,628	49,537	-	-	499,537
BCCTP	25	22	25	23	22	23	21	24	18	17	-	-	220
Disabled	20,343	20,528	20,516	20,448	20,494	20,691	22,065	22,052	20,849	20,711	-	-	208,697
TANF Child	3	3	2	2	1	1	1	2	2	2	-	-	19
TANF Adult	1,205	1,226	1,184	1,156	1,118	1,165	1,160	1,093	1,095	1,109	-	-	11,511
LTC	3,002	3,124	3,126	3,068	3,137	3,112	3,106	3,068	3,108	3,084	-	-	30,935
MCE	2,816	2,848	2,758	2,831	2,113	1,660	1,713	1,774	1,888	2,020	-	-	22,421
	75,430	76,350	76,457	76,391	75,993	76,230	81,917	81,504	76,588	76,480	-	-	773,340
Fee for Service (Non-Dual)													
Aged	3,580	3,855	4,031	3,714	4,250	4,117	4,197	4,347	4,432	4,392	-	-	40,915
BCCTP	601	602	599	523	598	589	588	590	602	615	-	-	5,907
Disabled	4,466	4,559	4,578	4,364	4,703	4,604	4,721	4,656	4,598	4,654	-	-	45,903
TANF Child	27,513	31,414	31,119	30,822	28,520	31,545	27,514	29,694	30,972	31,539	-	-	300,652
TANF Adult	18,753	19,744	20,087	19,517	19,142	20,210	23,898	21,546	20,057	21,976	-	-	204,930
LTC	372	364	379	194	363	353	366	359	341	360	-	-	3,451
MCE	43,457	44,664	44,438	40,986	42,402	44,767	44,918	44,580	45,480	47,191	-	-	442,883
	98,742	105,202	105,231	100,120	99,978	106,185	106,202	105,772	106,482	110,727	-	-	1,044,641
MEDI-CAL TOTAL													
Aged	60,963	61,748	62,289	60,871	62,704	62,897	67,339	67,084	63,303	63,042	-	-	632,240
BCCTP	627	625	625	552	621	617	610	615	621	633	-	-	6,146
Disabled	46,984	47,149	47,116	46,702	47,137	47,146	48,666	48,551	47,281	47,047	-	-	473,779
TANF Child	324,532	329,987	327,786	325,320	322,288	324,940	299,173	319,629	320,242	310,490	-	-	3,204,387
TANF Adult	95,766	96,698	96,310	94,597	94,261	95,221	119,724	98,552	96,404	106,771	-	-	994,304
LTC	3,377	3,493	3,514	3,267	3,504	3,470	3,475	3,434	3,456	3,450	-	-	34,440
MCE	238,490	241,455	241,644	232,469	237,565	240,355	239,425	240,198	241,014	242,647	-	-	2,395,262
	770,739	781,155	779,284	763,778	768,080	774,646	778,412	778,063	772,321	774,080	-	-	7,740,558
PACE	215	221	228	227	233	235	236	245	251	253	-	-	2,344
OneCare	1,367	1,386	1,404	1,406	1,378	1,372	1,320	1,334	1,335	1,365	-	-	13,667
OneCare Connect	15,365	15,229	15,265	15,234	15,254	15,223	14,989	14,936	14,793	14,911	-	-	151,199
TOTAL	787,686	797,991	796,181	780,645	784,945	791,476	794,957	794,578	788,700	790,609	-	-	7,907,768

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ENROLLMENT:

Overall MTD enrollment was 790,609

- Unfavorable to budget by 14,008 or 1.7%
- Increased 1,909 from prior month (March 2018)
- Decreased 1,902 from prior year (March 2017)

Medi-Cal enrollment was 774,080

- Unfavorable to budget by 13,239
    - TANF unfavorable by 14,984
    - SPD unfavorable by 4,074
    - Expansion favorable by 5,637
    - LTC favorable by 182
- Increased 1,759 from prior month

OneCare Connect enrollment was 14,911

- Unfavorable to budget by 725
- Increased 118 from prior month

OneCare enrollment was 1,365

- Unfavorable to budget by 36
- Increased 30 from prior month

PACE enrollment was 253

- Unfavorable to budget by 8
- Increased 2 from prior month

CalOptima - Medi-Cal Total
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2018

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
774,080	787,319	(13,239)	(1.7%)	Member Months	7,740,558	7,860,262	(119,704)	(1 5%)
				Revenues				
274,330,548	227,525,214	46,805,334	20 6%	Capitation revenue	2,487,063,095	2,380,526,536	106,536,559	4 5%
274,330,548	227,525,214	46,805,334	20 6%	Total Operating Revenues	2,487,063,095	2,380,526,536	106,536,559	4 5%
				Medical Expenses				
94,416,208	86,816,239	(7,599,969)	(8 8%)	Provider capitation	887,193,005	869,596,587	(17,596,418)	(2 0%)
38,962,605	43,843,031	4,880,426	11.1%	Facilities	422,405,825	437,832,526	15,426,701	3 5%
39,339,636	14,535,367	(24,804,269)	(170 6%)	Professional Claims	204,899,664	142,446,318	(62,453,346)	(43 8%)
38,093,749	37,097,181	(996,568)	(2.7%)	Prescription drugs	366,929,093	363,933,608	(2,995,485)	(0 8%)
51,253,478	32,123,304	(19,130,174)	(59 6%)	MLTSS	494,637,303	427,904,989	(66,732,314)	(15 6%)
3,415,663	3,272,300	(143,363)	(4.4%)	Medical Management	27,279,311	32,618,264	5,338,953	16.4%
821,588	315,017	(506,571)	(160 8%)	Reinsurance & other	8,457,982	3,150,170	(5,307,812)	(168 5%)
266,302,927	218,002,439	(48,300,488)	(22 2%)	Total Medical Expenses	2,411,802,183	2,277,482,462	(134,319,721)	(5 9%)
8,027,620	9,522,775	(1,495,155)	(15.7%)	Gross Margin	75,260,912	103,044,074	(27,783,162)	(27 0%)
				Administrative Expenses				
5,621,480	6,055,332	433,852	7 2%	Salaries, wages & employee benefits	54,912,248	60,750,395	5,838,147	9 6%
74,711	340,522	265,811	78.1%	Professional fees	1,379,759	3,283,230	1,903,471	58 0%
976,023	1,243,115	267,092	21 5%	Purchased services	6,886,539	15,417,890	8,531,351	55 3%
407,084	401,236	(5,848)	(1 5%)	Printing and postage	3,254,267	4,024,370	770,103	19.1%
406,648	461,246	54,598	11 8%	Depreciation & amortization	4,114,724	4,612,460	497,736	10 8%
1,359,596	1,478,664	119,068	8.1%	Other operating expenses	11,789,751	14,667,748	2,877,997	19 6%
(306,090)	(278,785)	27,305	9 8%	Indirect cost allocation	(3,411,561)	(2,787,850)	623,711	22.4%
8,539,452	9,701,330	1,161,878	12 0%	Total Administrative Expenses	78,925,725	99,968,243	21,042,517	21 0%
				Operating Tax				
16,994,045	0	(16,994,045)	0 0%	Tax Revenue	122,534,608	0	(122,534,608)	0 0%
16,994,045	0	(16,994,045)	0 0%	Premium tax expense	108,871,212	0	(108,871,212)	0 0%
0	0	0	0 0%	Sales tax expense	13,663,396	0	(13,663,396)	0 0%
0	0	0	0 0%	Total Net Operating Tax	(0)	0	(0)	0 0%
				Grant Income				
91,853	291,249	(199,396)	(68 5%)	Grant Revenue	341,393	2,912,490	(2,571,097)	(88 3%)
70,550	258,276	187,726	72.7%	Grant expense - Service Partner	227,375	2,582,760	2,355,385	91 2%
19,632	32,973	13,341	40 5%	Grant expense - Administrative	232,634	329,730	97,096	29.4%
1,672	0	1,672	0 0%	Total Net Grant Income	(118,615)	0	(118,615)	0 0%
(4,435,678)	0	4,435,678	0 0%	IGT Net	0	0	0	0 0%
0	0	0	0 0%	QAF Revenue	271,635,914	0	271,635,914	0 0%
(4,435,678)	0	4,435,678	0 0%	QAF Fees	271,635,914	0	(271,635,914)	0 0%
4,435,678	0	(4,435,678)	0 0%	QAF Net	(0)	0	0	0 0%
0	0	0	0 0%	Other income	993	0	993	0 0%

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MEDI-CAL INCOME STATEMENT – APRIL MONTH:

REVENUES of $274.3 million are favorable to budget by $46.8 million, driven by:

- Unfavorable volume related variance of $3.8 million
- Favorable price related variance of $50.6 million due to:
    - $26.7 million for fiscal year 2018 Proposition 56 revenue
    - $4.8 million of fiscal year 2018 Long-Term Care (LTC) revenue from non-LTC aid codes
    - $3.0 million of fiscal year 2018 revenue for Applied Behavior Analysis (ABA)
    - $12.8 million for prior year In-Home Supportive Services (IHSS) revenue
    - $3.1 million of prior year LTC revenue from non-LTC aid codes

MEDICAL EXPENSES: Overall $266.3 million, unfavorable to budget by $48.3 million due to:

- **Professional Claims** expense is unfavorable to budget $24.8 million due to Proposition 56 and Behavioral Health Treatment's (BHT) transition in-house
- **Managed Long-Term Services and Support (MLTSS)** is unfavorable to budget $19.1 million due to prior year IHSS and LTC claims
- **Provider Capitation** is unfavorable to budget by $7.6 million due to Proposition 56 and Behavioral Health Treatment's (BHT) transition in-house
- **Facilities** expense is favorable to budget $4.9 million due to Crossover claims and Shared Risk Pool

ADMINISTRATIVE EXPENSES are $8.5 million, favorable to budget $1.2 million, driven by:

- **Salary & Benefits**: $0.4 million favorable to budget
- **Professional Fees**: $0.3 million favorable to budget
- **Other Non-Salary**: $0.5 million favorable to budget

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CHANGE IN NET ASSETS is ($0.5) million for the month, unfavorable to budget by $0.3 million

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2018

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
14,911	15,636	(725)	(4.6%)	Member Months	151,199	155,552	(4,353)	(2.8%)
				Revenues				
3,419,530	4,059,039	(639,509)	(15.8%)	Medi-Cal Capitation revenue	62,587,265	61,243,615	1,343,650	2.2%
16,969,991	15,712,389	1,257,602	8.0%	Medicare Capitation revenue part C	164,683,946	150,919,675	13,764,271	9.1%
4,467,943	5,103,830	(635,887)	(12.5%)	Medicare Capitation revenue part D	53,039,126	52,257,051	782,075	1.5%
24,857,464	24,875,258	(17,794)	(0.1%)	Total Operating Revenue	280,310,337	264,420,341	15,889,996	6.0%
				Medical Expenses				
11,811,706	8,991,488	(2,820,218)	(31.4%)	Provider capitation	113,883,870	87,077,936	(26,805,934)	(30.8%)
6,207,909	5,168,460	(1,039,449)	(20.1%)	Facilities	34,244,190	51,032,971	16,788,781	32.9%
547,581	628,715	81,134	12.9%	Ancillary	6,274,489	6,232,168	(42,321)	(0.7%)
1,430,557	2,370,044	939,487	39.6%	Long Term Care	44,391,572	34,855,431	(9,536,141)	(27.4%)
4,837,117	5,386,533	549,416	10.2%	Prescription drugs	51,236,031	55,389,029	4,152,998	7.5%
1,141,921	1,176,875	34,954	3.0%	Medical management	10,132,676	12,086,552	1,953,876	16.2%
294,338	124,821	(169,517)	(135.8%)	Other medical expenses	1,677,925	1,183,453	(494,472)	(41.8%)
26,271,131	23,846,936	(2,424,195)	(10.2%)	Total Medical Expenses	261,840,752	247,857,540	(13,983,212)	(5.6%)
(1,413,668)	1,028,322	(2,441,990)	(237.5%)	Gross Margin	18,469,585	16,562,801	1,906,784	11.5%
				Administrative Expenses				
789,134	914,462	125,328	13.7%	Salaries, wages & employee benefits	7,688,429	9,214,607	1,526,178	16.6%
4,167	38,333	34,166	89.1%	Professional fees	258,789	383,335	124,545	32.5%
198,606	239,869	41,263	17.2%	Purchased services	1,735,782	2,398,783	663,000	27.6%
34,839	103,800	68,961	66.4%	Printing and postage	617,668	1,038,006	420,338	40.5%
28,549	50,147	21,598	43.1%	Other operating expenses	422,075	503,299	81,224	16.1%
612,391	584,428	(27,963)	(4.8%)	Indirect cost allocation, Occupancy Expense	6,520,510	5,844,280	(676,230)	(11.6%)
1,667,685	1,931,039	263,354	13.6%	Total Administrative Expenses	17,243,253	19,382,309	2,139,056	11.0%
				Operating Tax				
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
(3,081,353)	(902,717)	(2,178,636)	(241.3%)	Change in Net Assets	1,226,332	(2,819,508)	4,045,840	143.5%
105.7%	95.9%	-9.8%	-10.2%	Medical Loss Ratio	93.4%	93.7%	0.3%	0.3%
6.7%	7.8%	1.1%	13.6%	Admin Loss Ratio	6.2%	7.3%	1.2%	16.1%

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ONECARE CONNECT INCOME STATEMENT – APRIL MONTH:

REVENUES of $24.9 million are unfavorable to budget by $0.02 million driven by:

- Unfavorable volume related variance of $1.2 million due to lower enrollment
- Favorable price related variance of $1.1 million due to fiscal year 2018 rate adjustment

MEDICAL EXPENSES of $26.3 million are unfavorable to budget $2.4 million due to:

- Favorable volume related variance of $1.1 million due to lower enrollment
- Unfavorable price related variance of $3.5 million due to prior year Shared Risk Pool

ADMINISTRATIVE EXPENSES of $1.7 million are favorable to budget $0.3 million

CHANGE IN NET ASSETS is ($3.1) million, $2.2 million unfavorable to budget

CalOptima - OneCare
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2018

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,365	1,401	(36)	(2.6%)	Member Months	13,667	13,580	87	0.6%
				Revenues				
0	0	0	0 0%	Medi-Cal Capitation revenue	0	0	0	0.0%
1,110,503	994,707	115,796	11.6%	Medicare Part C Revenue	8,880,107	9,395,439	(515,332)	(5 5%)
307,978	487,929	(179,951)	(36.9%)	Medicare Part D Revenue	4,179,468	4,777,596	(598,128)	(12.5%)
1,418,481	1,482,636	(64,155)	(4.3%)	Total Operating Revenue	13,059,575	14,173,035	(1,113,460)	(7 9%)
				Medical Expenses				
460,472	414,290	(46,182)	(11.1%)	Provider capitation	1,774,609	3,920,726	2,146,117	54.7%
756,959	446,530	(310,429)	(69.5%)	Inpa ient	5,132,694	4,435,161	(697,533)	(15.7%)
69,198	49,227	(19,971)	(40.6%)	Ancillary	565,755	482,955	(82,800)	(17.1%)
31,323	43,065	11,742	27 3%	Skilled nursing facilities	256,986	419,302	162,316	38.7%
390,222	490,547	100,325	20 5%	Prescription drugs	4,421,494	4,817,931	396,437	8.2%
32,928	21,820	(11,108)	(50.9%)	Medical management	521,765	221,973	(299,792)	(135.1%)
10,000	8,762	(1,238)	(14.1%)	Other medical expenses	71,146	76,192	5,046	6.6%
1,751,102	1,474,241	(276,861)	(18.8%)	Total Medical Expenses	12,744,449	14,374,240	1,629,791	11.3%
(332,621)	8,395	(341,016)	(4,062.1%)	Gross Margin	315,126	(201,205)	516,331	256.6%
				Administrative Expenses				
20,593	20,170	(423)	(2.1%)	Salaries, wages & employee benefits	233,566	205,316	(28,250)	(13.8%)
13,333	13,334	1	0 0%	Professional fees	146,015	133,332	(12,683)	(9 5%)
17,584	11,990	(5,594)	(46.7%)	Purchased services	189,699	119,950	(69,749)	(58.1%)
6,960	19,287	12,327	63 9%	Prin ing and postage	69,221	200,378	131,157	65.5%
0	171	171	100 0%	Other operating expenses	(578)	1,764	2,342	132.8%
36,135	31,909	(4,226)	(13.2%)	Indirect cost allocation, Occupancy Expense	305,371	319,097	13,726	4.3%
94,605	96,861	2,256	2 3%	Total Administrative Expenses	943,293	979,837	36,544	3.7%
(427,226)	(88,466)	(338,760)	(382.9%)	Change in Net Assets	(628,167)	(1,181,042)	552,875	46.8%
123.4%	99.4%	-24.0%	-24 2%	Medical Loss Ra io	97.6%	101.4%	3.8%	3.8%

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CalOptima - PACE
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2018

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
253	261	(8)	(3.1%)	Member Months	2,344	2,385	(41)	(1.7%)
				Revenues				
1,411,141	1,361,286	49,855	3.7%	Medi-Cal capitation revenue	12,538,158	12,226,390	311,768	2.5%
320,198	319,620	578	0 2%	Medicare part C revenue	3,309,692	2,883,812	425,880	14.8%
89,227	80,935	8,292	10 2%	Medicare part D revenue	888,277	759,906	128,371	16.9%
1,820,566	1,761,841	58,725	3 3%	Total Operating Revenues	16,736,127	15,870,108	866,019	5.5%
				Medical Expenses				
527,293	597,394	70,101	11.7%	Medical Management	5,317,935	5,915,576	597,641	10.1%
385,801	365,683	(20,118)	(5.5%)	Claims payments to hospitals	3,103,255	3,379,418	276,163	8.2%
416,608	300,905	(115,703)	(38.5%)	Professional Claims	3,699,061	2,786,409	(912,652)	(32.8%)
129,697	126,479	(3,218)	(2.5%)	Prescription drugs	1,298,117	1,171,931	(126,186)	(10.8%)
0	11,095	11,095	100 0%	Long-term care facility payments	17,988	115,103	97,115	84.4%
107,329	104,345	(2,984)	(2.9%)	Patient Transportation	949,667	965,613	15,946	1.7%
0	0	0	0 0%	Reinsurance	0	0	0	0.0%
8,000	10,000	2,000	20 0%	Other Expenses	64,000	60,000	(4,000)	(6.7%)
1,574,728	1,515,901	(58,827)	(3.9%)	Total Medical Expenses	14,450,024	14,394,050	(55,974)	(0.4%)
245,839	245,940	(101)	(0.0%)	Gross Margin	2,286,103	1,476,058	810,045	54.9%
				Administrative Expenses				
75,736	99,955	24,219	24 2%	Salaries, wages & employee benefits	771,712	959,488	187,776	19.6%
15,600	5,000	(10,600)	(212.0%)	Professional fees	54,108	50,000	(4,108)	(8.2%)
15,115	21,136	6,021	28 5%	Purchased services	95,202	211,360	116,158	55.0%
6,151	5,547	(604)	(10.9%)	Printing and postage	31,119	55,470	24,351	43.9%
2,074	2,052	(22)	(1.1%)	Depreciation & amortization	21,326	20,520	(806)	(3.9%)
8,692	18,501	9,809	53 0%	Other operating expenses	125,217	185,040	59,823	32.3%
3,152	2,864	(288)	(10.1%)	Indirect cost allocation, Occupancy Expense	60,373	28,640	(31,733)	(110.8%)
126,520	155,055	28,535	18.4%	Total Administrative Expenses	1,159,058	1,510,518	351,460	23.3%
				Operating Tax				
3,532	0	3,532	0 0%	Tax Revenue	48,410	0	48,410	0.0%
3,532	0	(3,532)	0 0%	Premium tax expense	48,410	0	(48,410)	0.0%
0	0	0	0 0%	Total Net Operating Tax	0	0	0	0.0%
119,319	90,885	28,434	31 3%	Change in Net Assets	1,127,045	(34,460)	1,161,505	3,370.6%
86 5%	86.0%	-0.5%	-0 5%	Medical Loss Ratio	86.3%	90.7%	4.4%	4.8%
6 9%	8.8%	1.9%	21 0%	Admin Loss Ratio	6.9%	9.5%	2 6%	27.2%

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CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2018

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	0	0	0.0%	Rental income	155,426	42,774	112,652	263.4%
0	0	0	0.0%	Total Operating Revenue	155,426	42,774	112,652	263.4%
				Administrative Expenses				
40,310	23,186	(17,125)	(73.9%)	Purchase services	342,568	231,859	(110,709)	(47.7%)
161,406	161,474	68	0.0%	Depreciation & amortization	1,609,006	1,614,737	5,731	0.4%
15,816	9,117	(6,699)	(73.5%)	Insurance expense	150,035	91,167	(58,868)	(64.6%)
78,147	156,517	78,371	50.1%	Repair and maintenance	1,053,418	1,565,171	511,753	32.7%
28,528	1,605	(26,924)	(1,678.0%)	Other Operating Expense	423,984	16,045	(407,939)	(2,542.5%)
(324,207)	(333,055)	(8,848)	(2.7%)	Indirect allocation, Occupancy Expense	(3,477,687)	(3,330,549)	147,138	4.4%
0	18,843	18,843	100.0%	Total Administrative Expenses	101,324	188,430	87,106	46.2%
0	(18,843)	18,843	100.0%	Change in Net Assets	54,103	(145,656)	199,758	137.1%

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OTHER STATEMENTS – APRIL MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($427.2) thousand, $338.8 thousand unfavorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $119.3 thousand, $28.4 thousand favorable to budget

505 CITY PARKWAY BUILDING INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $0.0 thousand, $18.8 thousand favorable to budget

CalOptima
BALANCE SHEET
April 30, 2018

ASSETS			**LIABILITIES & FUND BALANCES**		
Current Assets			Current Liabilities		
	Operating Cash	$824,639,879		Accounts payable	$28,739,671
	Investments	624,461,924		Medical claims liability	1,304,233,540
	Capitation receivable	200,095,669		Accrued payroll liabilities	12,024,970
	Receivables - Other	22,499,666		Deferred revenue	55,163,337
	Prepaid Expenses	6,944,627		Deferred lease obligations	133,535
				Capitation and withholds	101,811,861
	Total Current Assets	**1,678,641,764**		**Total Current Liabilities**	**1,502,106,913**
Capital Assets	Furniture and equipment	34,328,849	Other employment benefits liability		30,321,020
	Building/Leasehold improvements	5,990,043			
	505 City Parkway West	49,743,943	Net Pension Liabilities		16,026,570
		90,062,834	Long Term Liabilities		100,000
	Less: accumulated depreciation	(39,647,404)			
	Capital assets, net	**50,415,430**	**TOTAL LIABILITIES**		**1,548,554,503**
Other Assets	Restricted deposit & Other	300,000	Deferred inflows of Resources - Excess Earnings		-
			Deferred inflows of Resources - Changes in Assumptions		1,340,010
	Board-designated assets				
	Cash and cash equivalents	21,897,434	Tangible net equity (TNE)		87,500,253
	Long term investments	514,142,267	Funds in excess of TNE		639,579,269
	Total Board-designated Assets	536,039,701			
	Total Other Assets	**536,339,701**	**Net Assets**		**727,079,522**
	Deferred outflows of Resources - Pension Contributions	5,234,198			
	Deferred outflows of Resources - Difference in Experience	1,072,771			
	Deferred outflows of Resources - Excess Earnings	5,270,171			
TOTAL ASSETS & OUTFLOWS		**2,276,974,035**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**		**2,276,974,035**

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CalOptima
Board Designated Reserve and TNE Analysis
as of April 30, 2018

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,658,083				
	Tier 1 - Logan Circle	146,601,781				
	Tier 1 - Wells Capital	146,033,660				
Board-designated Reserve		439,293,524	295,459,331	459,584,867	143,834,193	(20,291,343)
TNE Requirement	Tier 2 - Logan Circle	96,746,176	87,500,252	87,500,252	9,245,924	9,245,924
	Consolidated:	536,039,701	382,959,584	547,085,120	153,080,117	(11,045,419)
	Current reserve level	1.96	1.40	2.00		

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CalOptima
Statement of Cash Flows
April 30, 2018

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	(1,863,823)	13,621,130
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	570,128	5,745,056
Changes in assets and liabilities:		
Prepaid expenses and other	(1,647,296)	(1,289,980)
Catastrophic reserves		
Capitation receivable	3,621,104	320,953,400
Medical claims liability	(130,115,249)	57,807,520
Deferred revenue	40,597,452	(48,809,788)
Payable to providers	17,811,382	(479,027,850)
Accounts payable	17,896,909	(8,999,734)
Other accrued liabilities	206,727	2,267,239
Net cash provided by/(used in) operating activities	(52,922,666)	(137,733,007)
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	4,851,430	457,963,828
Change in property and equipment	(54,470)	(1,859,460)
Change in Board designated reserves	145,175	(901,327)
Net cash provided by/(used in) investing activities	4,942,135	455,203,042
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(47,980,530)	317,470,034
CASH AND CASH EQUIVALENTS, beginning of period	872,620,409	507,169,844
CASH AND CASH EQUIVALENTS, end of period	**$ 824,639,879**	**$ 824,639,879**

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BALANCE SHEET:

ASSETS decreased $55.5 million from March

- **Cash and Cash Equivalents** decreased by $48.0 million based upon capitation receipts
- **Investments** decreased $4.9 million based upon month end cut-off and the timing of receipts and transfers for daily payments.
- **Net Capitation Receivables** decreased $3.8 million due timing of payments

LIABILITIES decreased $53.6 million from March

- **Medical Claims Liability** by line of business decreased $130.1 million due to DHCS recoupment of overpayment and reclass to Deferred Revenue
- **Deferred Revenue** increased $40.6 million due to Shared Risk Pool and reclass from Medical Claims Liability
- **Capitation Payable** increased $17.8 million due to Proposition 56 and Shared Risk Pool
- **Accrued Expenses** increased $17.3 million due to timing of sales tax payments

NET ASSETS are $727.1 million, a decrease of $1.9 million from March

CalOptima Foundation
Statement of Revenues and Expenses
For the Ten Months Ended April 30, 2018
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	0	0	0.0%	Total Operating Revenue	0	0	0	0.0%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	0	61,842	61,842	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	29,848	29,848	100.0%
0	0	0	0.0%	Travel	0	0	0	0.0%
0	0	0	0.0%	Supplies	0	0	0	0.0%
0	0	0	0.0%	Contractual	0	0	0	0.0%
2,083	231,923	229,840	99.1%	Other	20,830	2,319,230	2,298,400	99.1%
2,083	241,092	239,009	99.1%	Total Operating Expenditures	20,830	2,410,920	2,390,090	99.1%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
(2,083)	(241,092)	(239,009)	(99.1%)	Program Income	(20,830)	(2,410,920)	(2,390,090)	(99.1%)

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CalOptima Foundation
Balance Sheet
April 30, 2018

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,868,139	Accounts payable-Current	20,830
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,868,139**	Grants-Foundation	0
		Total Current Liabilities	**20,830**
		Total Liabilities	20,830
		Net Assets	**2,847,309**
TOTAL ASSETS	**2,868,139**	**TOTAL LIABILITIES & NET ASSETS**	**2,868,139**

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CALOPTIMA FOUNDATION - APRIL MONTH

INCOME STATEMENT:

OPERATING REVENUE

- No activity

OPERATING EXPENSES

- Audit Fees $2.1 thousand

BALANCE SHEET:

ASSETS

- Cash--$2.9 million remains from the FY14 $3.0 million transferred by CalOptima for grants and programs in support of providers and community

LIABILITIES

- Accrued Payables--$20.8 thousand for Audit fees

NET INCOME is ($2.1) thousand, ($20.8) thousand YTD

Budget Allocation Changes
Reporting Changes for April 2018

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	IS - Infrastructure - Professional Fee (Virtualization Architecture Assessment)	IS - Infrastructure - Professional Fee (On-Site Staff for the Phone System)	$48,600	Re-Purpose $48,600 from Professional Fees (Virtualization Architecture Assessment) to pay for an on-site staff for the phone system	2018
July	Medi-Cal	Facilities - Purchased Services (Restacking Services)	Facilities - Purchased Services (Reconfiguration Services)	$15,000	Re-Purpose $15,000 from Purchased Services (Restacking Services) to reconfiguration and breakdown of furniture for the mail room and the Rover Rock Offices and other related expenses	2018
August	Medi-Cal	Health Education & Disease Mgmt. - Purchased Services (Adult Weight Management Vendor)	Health Education & Disease Mgmt. - Purchased Services (Ansafone)	$30,000	Re-Purpose $30,000 from Purchased Services (Adult Weight Management Vendor) to pay for Ansafone services	2018
August	Medi-Cal	Health Education & Disease Mgmt. - Purchased Services (Pediatric Weight Management Vendor)	Health Education & Disease Mgmt. - Purchased Services (Captivate contract and other initiatives)	$25 000	Re-Purpose $25,000 from Purchased Services (Pediatric Weight Management Vendor) to pay for Captivate contract and other initiatives	2018
August	PACE	PACE Administrative - Purchased Services (Encounter Reporting & Translation Services)	PACE Administrative - Purchased Services (Satisfaction Survey)	$12,208	Re-Purpose $12,208 from Purchased Services (Encounter Reporting & Translation Services) to pay for Satisfaction Survey	2018
August	Medi-Cal	Facilities - Capital Project (Upgrade CalOptima and Building Access System)	Facilities - Capital Project (Mail Room/Basement/ Property Management Office)	$15,000	Reallocate $15,000 from Capital Project (Upgrade CalOptima and Building Access System) to Capital Project (Mail Room/Basement/Property Management Office)	2018
September	Medi-Cal	Other G&A - Other Operating Expenses	Facilities - Building Repair and Maintenance	$65,000	Reallocate $65,000 from Other G&A (other operating expenses) to cover cost to conduct a review/study from soil engineer and the necessary repairs of the east entry sinkhole.	2018
September	OCC	Health Education & Disease Management - Member Communications	Health Education & Disease Management - Purchased Services	$12 000	Reallocate $12,000 within medical management activities budget for additional funding needed on CareNet in OneCare Connect.	2018
November	Medi-Cal	Human Resources - Purchased Services -Temporary Outsource Service	Human Resources - Purchased Services - General	$10,000	Re-Purpose $10,000 from Purchased Services (Temporary Outsource Service) to fund for training module design and other department initiatives in Purchased Services	2018
November	Medi-Cal	IS - Application Development capital project - Disaster Recovery	IS - Application Development capital project - Fraud, Waste and Abuse	$27,500	Reallocate $65,000 from Disaster Recovery project to cover additional funds needed for Fraud, Waste and Abuse project.	2018
January	Medi-Cal	10th Floor Building Improvement Project	Budget Planning Software Project	$70,000	Reallocate $70,000 from 10th Floor Building Improvement project for upgrade to BI 360 Budget Planning Tool	2018
January	PACE	PACE Clinic - Professional Claims - Emergent Transpiration	PACE Clinic - Professional Claims - Interpreters	$15,000	Reallocate $15,000 from Emergent Transportation medical expenses to cover for interpreting services	2018
March	Medi-Cal	Facilities - Replace Lights in Passenger Elevator Project	Facilities - Fire Proofing Project	$40,000	Reallocate $40,000 capital from Replace Lights in Passenger Elevator project to Fire Proofing project	
March	Medi-Cal	Facilities - Convert Pneumatic Controls Project	Facilities - Fire Proofing Project	$10,000	Reallocate $10,000 capital from Convert Pneumatic Controls project to Fire Proofing project	
March	Medi-Cal	Cultural & Linguistic Services - Member Communications - Mailings	Cultural & Linguistic Services - Member Communications - Newsletter	$45,000	Reallocate $45,000 from member communication mailings to member communication newsletters	

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

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Board of Directors Meeting
June 7, 2018

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- 2016 CMS Financial Audit:

  On August 24, 2017, the Centers for Medicare & Medicaid Services (CMS) notified CalOptima that its OneCare program has been selected for a 2016 financial audit. By way of background, at least one-third of Medicare Advantage Organizations (MAOs) are selected for CMS' annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CMS contracted with Bland & Associates to conduct the review of claims data, solvency, enrollment, base year entries on the bids, medical and/or drug expenses, related party transactions, general administrative expenses, and direct and indirect remuneration (DIR). The onsite audit date took place from February 28, 2018 through March 1, 2018. On March 1, 2018, Bland & Associates concluded their onsite visit and discussed the pending action items and deadlines. The official exit conference occurred on April 25, 2018, with a review of the preliminary audit findings. CalOptima expects to receive the final report sixty (60) days after the exit conference.

- CMS Timeliness Monitoring Project:

  On December 12, 2017, CMS announced its efforts to collect data for organization determinations, appeals and grievances (ODAG) and coverage determinations, appeals and grievances (CDAG) for the requested review period of March 1, 2017 through May 31, 2017. On February 5, 2018, CMS' contractor, Conrad LLP (Conrad), notified CalOptima of its requirement to submit data, also known as universes, as part of the CMS Timeliness Monitoring Project for its OneCare program. Conrad conducted the data integrity webinars for CDAG on March 12, 2018 and ODAG on March 13, 2018. A follow up webinar session for ODAG was completed on March 20, 2018. On March 27, 2018, Conrad reviewed and accepted the updated universes. CalOptima is awaiting final results from Conrad.

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- Medicare Data Validation Audit (OneCare and OneCare Connect):

  On an annual basis, CMS requires all plan sponsors to engage an independent consultant to conduct a validation audit of all Medicare Parts C and D data reported for the prior calendar year. The validation audit takes place starting in March and is expected to go through June 2018, with final results to be reported to CMS by 6/30/18. The virtual onsite audit took place on April 18, 2018, and source documentation review for the following Medicare Parts C and D measures is currently ongoing and expected to continue through June 2018:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Medicare Therapy Management (MTM) Program
  - Special Needs Plan (SNP) Care Management
  - Improving Drug Utilization Review (DUR) Controls

- CY 2016 OneCare Medical Loss Ratio (MLR) Desk Review:

  On February 22, 2018, CalOptima received notification from CMS regarding the CY 2016 Desk Review for the MLR reporting for OneCare. CMS has engaged Actuarial Research Corporation (ARC) to facilitate the review to ensure that the data entries in the MLR reporting:

  - Contain all required data entries for all entities (e.g., plans, contracts).
  - Comply with all relevant guidance (CY2016 MLR Report Filing Instructions, Final Rule, etc.).
  - Are comprised of values that are logical, consistent and supportable.
  - Use values that are comparable (i.e., reasonably close or reconcilable) to CMS data.

  CalOptima has submitted all requested documents and is awaiting final results from ARC.

3. Medi-Cal

- 2018 Medi-Cal Audit:

  The Department of Health Care Services (DHCS) conducted its annual audit of CalOptima's Medi-Cal program from February 26, 2018 through March 9, 2018. The audit covered the period from February 1, 2017 through January 31, 2018. The audit consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, organization and administration of CalOptima, facility site reviews, and medical records review. CalOptima is now waiting for DHCS to provide a draft audit report and schedule a formal exit conference.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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4. PACE

- 2018 PACE Audit:

  On March 7, 2018, CMS notified CalOptima of its intent to conduct a focused audit of CalOptima's PACE program in the following areas --- Service Delivery Requests, Appeals and Grievances (SDAG), Clinical Appropriateness and Care Planning, Personnel Records, Onsite Review, and Quality Assessment. CMS and the DHCS conducted their onsite review from April 30, 2018 through May 3, 2018. During the exit conference on May 3, 2018, CMS and DHCS provided a verbal overview of the preliminary audit findings, which included twelve (12) possible conditions out of a total of sixty-eight (68) conditions. The majority of the findings were related to one (1) audit element – Service Delivery Requests. CalOptima expects to receive a draft report within sixty (60) days after the exit conference.

B. Regulatory Notices of Non-Compliance

1. CalOptima did not receive any notices of non-compliance from its regulators for the month of April 2018.

C. Updates on Internal and Health Network Audits

1. Internal Audits: Medi-Cal [a\]

- 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 Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
December 2017	67%	89%	94%	0%	70%	97%	98%	80%	100%	100%	0%	17%	45%
January 2018	0%	N/A	N/A	0%	90%	93%	99%	70%	100%	90%	0%	0%	0%
February 2018	0%	N/A	N/A	0%	70%	93%	98%	50%	100%	100%	0%	N/A	N/A

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Routine – 5 business days; Deferral – 14 business days; Urgent – 72 hours)
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- The lower score for clinical decision making was due to the following reason:
  - Failure to use criteria for decision

- The lower letter score was due to the following reason:
  - Failure to describe why the request did not meet criteria in lay language

- Medi-Cal Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
December 2017	100%	100%	100%	100%
January 2018	100%	89%	100%	90%
February 2018	100%	100%	100%	90%

- No significant trends to report.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Letter Accuracy	Determination Timeliness	Acknowledgement Timeliness
December 2017	100%	100%	100%
January 2018	100%	100%	100%
February 2018	100%	100%	100%

- No significant trends to report.

- Medi-Cal Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	Medi-Cal Call Center	Member Liaison Call Center
December 2017	100%	88%
January 2018	100%	100%
February 2018	Results Pending	Results Pending

- No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- Medi-Cal GARS: Exempt Grievances

Month	Classification/ Categorization	Document Score	Complete Resolution	Universe Submission
December 2017	100%	100%	100%	100%
January 2018	100%	100%	100%	100%
February 2018	100%	100%	100%	100%

  - No significant trends to report.

- Medi-Cal GARS: Standard Grievances

Month	Universe Submission	Timeliness	Categorization/ Classification	Language Preference	Complete Resolution	Member Notice Content
December 2017	100%	100%	100%	100%	100%	100%
January 2018	100%	100%	100%	100%	100%	100%
February 2018	100%	100%	100%	100%	100%	100%

  - No significant trends to report.

- Medi-Cal GARS: Appeals (Approvals)

Month	Universe Submission	Timeliness	Categorization/ Classification	Language Preference	Complete Resolution	Member Notice Content
December 2017	100%	100%	100%	100%	100%	100%
January 2018	100%	100%	100%	100%	100%	100%
February 2018	100%	100%	100%	100%	100%	100%

  - No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- Medi-Cal GARS: Appeals (Denials)

Month	Timeliness	Categorization/ Classification	Language Preference	Complete Resolution	Member Notice Content
December 2017	100%	100%	100%	100%	100%
January 2018	100%	100%	100%	100%	100%
February 2018	100%	100%	100%	100%	100%

  - No significant trends to report.

- Medi-Cal Pharmacy: Pharmacy Decision Timeliness Review

Month	Timeliness	Clinical Decision Making	Categorization/ Classification	Language Preference	Member Notice	Provider Notice	Authorization
December 2017	100%	100%	100%	100%	100%	100%	100%
January 2018	100%	100%	100%	100%	100%	100%	100%
February 2018	100%	100%	100%	100%	100%	100%	100%

  - No significant trends to report.

- Medi-Cal Pharmacy: Pharmacy Denials

Month	Timeliness
December 2017	100%
January 2018	99%
February 2018	100%

  - No significant trends to report.

2. Internal Audits: OneCare [a\]

- OneCare Utilization Management

  - Due to low membership for the months of December 2017 through February 2018, there were no prior authorization requests reported for this time period.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- OneCare Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
December 2017	100%	100%	100%	100%
January 2018	100%	100%	100%	100%
February 2018	90%	100%	100%	100%

  - The compliance rate for paid claims timeliness decreased from 100% in January 2018 to 90% in February 2018 due to untimely processing of clean claims.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
December 2017	100%	100%	100%	100%
January 2018	100%	100%	100%	N/A
February 2018	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - No significant trends to report.

- OneCare Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Customer Service
December 2017	100%
January 2018	100%
February 2018	Results Pending

  - No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- OneCare Grievance and Appeal Resolution Services (GARS): Part C Oral Grievances

Month	Timeliness	Categorization/ Classification	Documentation of Oral Notification	Complete Resolution Score
December 2017	100%	100%	100%	100%
January 2018	100%	100%	100%	100%
February 2018	100%	100%	100%	100%

  - No significant trends to report.

- OneCare Grievance and Appeal Resolution Services (GARS): Part C Grievances

Month	Timeliness	Categorization/ Classification	Language Preference	Complete Resolution Score	Member Notice Content
December 2017	100%	100%	100%	100%	100%
January 2018	100%	100%	100%	100%	100%
February 2018	100%	100%	100%	100%	100%

  - No significant trends to report.

- OneCare Grievance and Appeal Resolution Services (GARS): Part C Appeals – Effectuation Timeliness (ET) Approvals

  - Due to low membership for the months of December 2017 through February 2018, there were no Part C Appeals – ET approvals reported for this time period.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- OneCare Grievance and Appeal Resolution Services (GARS): Part C Appeals – Clinical Decision Making (CDM) Denials

Month	Timeliness	Categorization/ Classification	Language Preference	Complete Resolution	Member Notice Content
December 2017	100%	100%	100%	100%	100%
January 2018	100%	100%	100%	100%	100%
February 2018	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - No significant trends to report.

- OneCare Grievance and Appeal Resolution Services (GARS): Part C Appeals - Dismissals

  - Due to low membership for the months of December 2017 through February 2018, there were no Part C Appeals – Dismissals reported for this time period.

- OneCare Pharmacy: Pharmacy Decision Timeliness Review

Month	Standard Coverage Determinations	Standard Coverage Determination Exception Requests	Expedited Coverage Determinations	Expedited Coverage Determination Exception Requests	Standard Redeterminations	Expedited Redeterminations
December 2017	100%	100%	100%	100%	100%	N/A
January 2018	100%	100%	100%	100%	N/A	100%
February 2018	100%	100%	100%	100%	100%	100%

  - No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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3. Internal Audits: OneCare Connect [a\]

- OneCare Connect Utilization Management: Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness for Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials
December 2017	100%	67%	88%	0%	50%	89%	89%	86%
January 2018	0%	N/A	0%	0%	33%	100%	100%	100%
February 2018	0%	N/A	N/A	0%	0%	93%	67%	96%

  - The lower scores for timeliness were due to the following reasons:
    - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days)
    - Failure to meet timeframe for provider written notification (2 business days)
    - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)
    - Failure to meet timeframe for member initial notification (2 business days)

  - The lower scores for clinical decision making were due to the following reasons:
    - Failure to use criteria for decision
    - Failure to obtain adequate clinical information for decision making

  - The lower letter scores were due to the following reasons:
    - Failure to provide letter in member preferred language
    - Failure to describe why the request did not meet criteria in lay language

- OneCare Connect Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
December 2017	100%	100%	100%	100%
January 2018	90%	90%	100%	100%
February 2018	100%	100%	100%	100%

  - No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
December 2017	75%	93%	100%	N/A
January 2018	100%	100%	100%	100%
February 2018	100%	100%	100%	100%

  - ➢ No significant trends to report.

- OneCare Connect Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Connect Customer Service
December 2017	100%
January 2018	100%
February 2018	Results Pending

  - ➢ No significant trends to report.

- OneCare Connect Grievance and Appeal Resolution Services (GARS): Part C Oral Grievances

Month	Timeliness	Categorization/ Classification	Documentation of Oral Notification	Complete Resolution	Universe Submission
December 2017	100%	100%	100%	100%	100%
January 2018	100%	100%	100%	100%	100%
February 2018	100%	100%	100%	100%	100%

  - ➢ No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- OneCare Connect Grievance and Appeal Resolution Services (GARS): Part C Grievances

Month	Universe Submission	Timeliness	Categorization/ Classification	Language Preference	Complete Resolution	Member Notice Content
December 2017	100%	100%	100%	100%	100%	100%
January 2018	100%	100%	100%	100%	100%	100%
February 2018	100%	100%	100%	100%	100%	100%

  - No significant trends to report.

- OneCare Connect Grievance and Appeal Resolution Services (GARS): Part C Appeals – Effectuation Timeliness (ET) Approvals

Month	Universe Submission	Timeliness	Categorization/ Classification	Language Preference	Complete Resolution	Member Notice Content
December 2017	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
January 2018	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
February 2018	100%	50%	100%	100%	50%	100%

  - The lower score for timeliness in February 2018 was due to a case aged 59 days for resolution. Regulatory requirement for resolution is thirty (30) calendar days.

  - The lower score for complete resolution in February 2018 was due to untimely processing of one (1) case.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- OneCare Connect Grievance and Appeal Resolution Services (GARS): Part C Appeals – Clinical Decision Making (CDM) Denials

Month	Timeliness	Categorization/ Classification	Language Preference	Complete Resolution	Member Notice Content
December 2017	100%	100%	100%	100%	100%
January 2018	100%	100%	100%	100%	100%
February 2018	Results Pending	Results Pending	Results Pending	Results Pending	Results Pending

  - No significant trends to report.

- OneCare Connect Grievance and Appeal Resolution Services (GARS): Part C Appeals – Dismissals

  - Due to low membership for the months of December 2017 through February 2018, there were no dismissals for Part C Appeals reported for this time period.

- OneCare Connect Grievance and Appeal Resolution Services (GARS): Oral Grievances

Month	Timeliness	Categorization/ Classification	Documentation of Oral Notification	Complete Resolution
December 2017	100%	100%	100%	100%
January 2018	100%	100%	100%	100%
February 2018	Results Pending	Results Pending	Results Pending	Results Pending

  - No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- OneCare Connect Pharmacy: Pharmacy Decision Timeliness Review

Month	Standard Coverage Determinations	Standard Coverage Determination Exception Requests	Expedited Coverage Determinations	Expedited Coverage Determination Exception Requests	Standard Redeterminations	Expedited Redeterminations
December 2017	100%	100%	100%	100%	100%	100%
January 2018	100%	100%	98%	100%	54%	100%
February 2018	100%	100%	100%	100%	100%	100%

➢ No significant trends to report.

4. Internal Audits: PACE [a\]

- PACE Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
December 2017	100%	100%	100%	100%
January 2018	100%	100%	100%	100%
February 2018	100%	100%	100%	100%

➢ No significant trends to report.

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check LAG
December 2017	100%	100%	100%	N/A
January 2018	100%	100%	100%	100%
February 2018	0%	100%	100%	100%

➢ The compliance rate for payment determination accuracy decreased from 100% in January 2018 to 0% in February 2018 due to one (1) claim upheld in error for timely filing.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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5. Health Network Audits: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

  For the month of December 2017, CalOptima's Audit & Oversight department suspended its monthly file reviews for health networks' UM files due to the 2017 delegation oversight annual audits in progress. As a less resource intensive alternative, CalOptima's Audit & Oversight department conducted webinars for each health network to assess the processing of the networks' UM files from their medical management system. CalOptima's auditors reviewed UM files for timeliness, clinical decision making, and appropriate use of letter templates.

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
January 2018	71%	90%	85%	64%	69%	86%	85%	62%	78%	77%	62%	69%	80%
February 2018	63%	85%	77%	64%	66%	83%	82%	65%	81%	87%	98%	84%	98%

  - 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 written notification (2 business days)
    - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)

  - The lower scores for clinical decision making were due to the following reasons:
    - Failure to cite criteria for decision
    - Failure to obtain adequate clinical information
    - Failure to have appropriate professional make decision

  - The lower letter scores were due to the following reasons:
    - Failure to provide letter in member's primary language
    - Failure to provide member with information on how to file a grievance
    - Failure to provide member-specific denial reason for not meeting the criteria in lay language
    - Failure to provide language assistance program (LAP) insert in approved threshold languages
    - Failure to provide letter with description of services in lay language
    - Failure to provide peer-to-peer discussion of the decision with medical reviewer
    - Failure to provide referral back to primary care provider (PCP) on denial letter

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- Failure to include name and contact information for health care professional responsible for denial decision
- Failure to notify enrollee of delayed decision and anticipated decision date
- Failure to notify provider of delayed decision and anticipated decision date

- Medi-Cal Claims: Professional Claims

For the month of December 2017, CalOptima's Audit & Oversight department suspended its monthly file reviews for health networks' claims files due to the 2017 delegation oversight annual audits in progress. As a less resource intensive alternative, CalOptima's Audit & Oversight department conducted webinars for each health network to assess the processing of the networks' files from their claims processing system. CalOptima's auditors reviewed claim files for timeliness, accuracy, and misclassifications.

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
January 2018	92%	92%	95%	92%
February 2018	92%	98%	97%	95%

➢ No significant trends to report.

- Medi-Cal Claims: Misclassified Hospital Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
January 2018	100%	100%
February 2018	98%	98%

➢ No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
January 2018	100%	100%	100%	100%
February 2018	100%	95%	100%	100%

  - No significant trends to report.

- OneCare Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timelines for Denials	Clinical Decision Making for Denials	Letter Score for Denials
January 2018	96%	N/A	96%	74%	79%	33%	46%	59%
February 2018	91%	100%	94%	76%	72%	100%	73%	94%

  - The lower scores for timeliness were due to the following reasons:
    - Failure to meet timeframe for member written notification (Routine – 14 calendar days; Urgent– 2 business days)
    - Failure to meet timeframe for provider notification (Routine – 14 calendar days; Urgent– 24 hours)

  - The lower letter scores were due to the following reasons:
    - Failure to use approved CMS letter template
    - Failure to provide description of requested services in lay language
    - Failure to use CalOptima logo

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- OneCare Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
January 2018	100%	99%
February 2018	100%	97%

  - No significant trends to report.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
January 2018	97%	97%	98%	100%
February 2018	98%	85%	96%	99%

  - The compliance rate for paid claims accuracy decreased from 97% in January 2018 to 85% in February 2018 due to check date reported on universe did not match what was presented in files reviewed.

  - The compliance rate for denied claims timeliness decreased from 98% in January 2018 to 96% in February 2018 due to untimely processing of claims.

- OneCare Connect Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds
January 2018	83%	67%	82%	68%	78%	50%	67%	62%	75%	67%	84%
February 2018	89%	81%	89%	69%	81%	95%	87%	100%	100%	63%	86%

  - The lower scores for clinical decision making were due to the following reasons:
    - Failure to obtain adequate clinical information
    - Failure to use criteria for decision

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- OneCare Connect Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
January 2018	100%	90%
February 2018	99%	92%

  - No significant trends to report.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
January 2018	87%	85%	95%	96%
February 2018	92%	99%	96%	93%

  - The compliance rate for denied claims accuracy decreased from 96% in January 2018 to 93% in February 2018 due to claims being denied in error.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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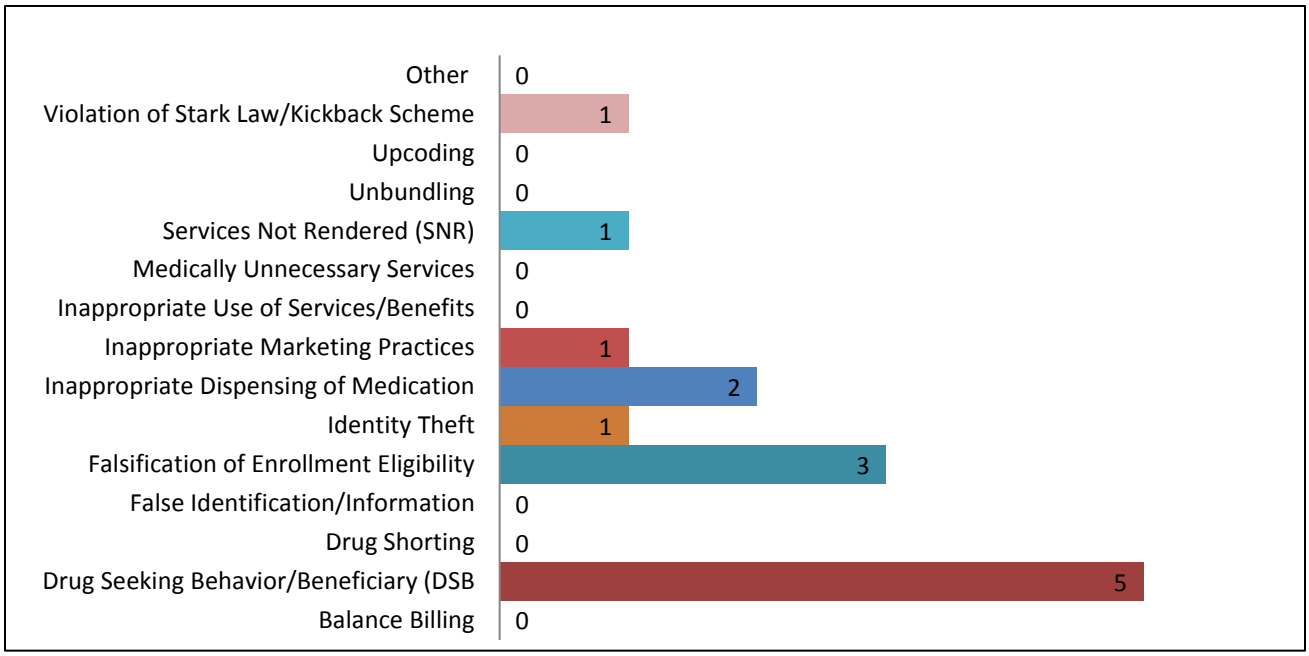
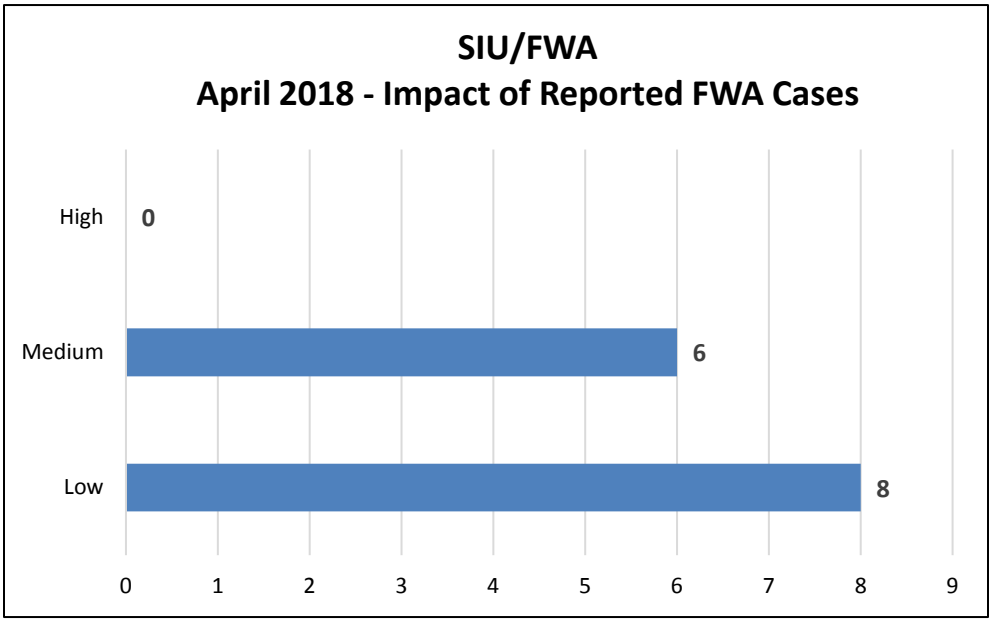
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in April 2018)





a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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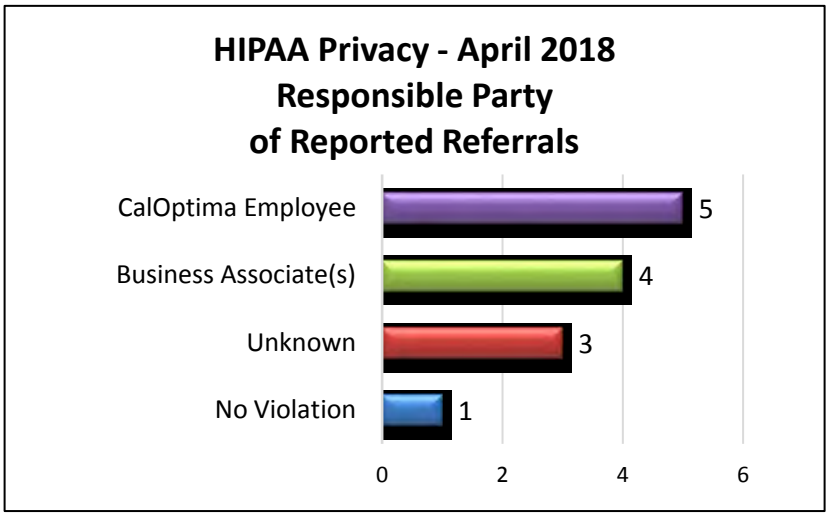
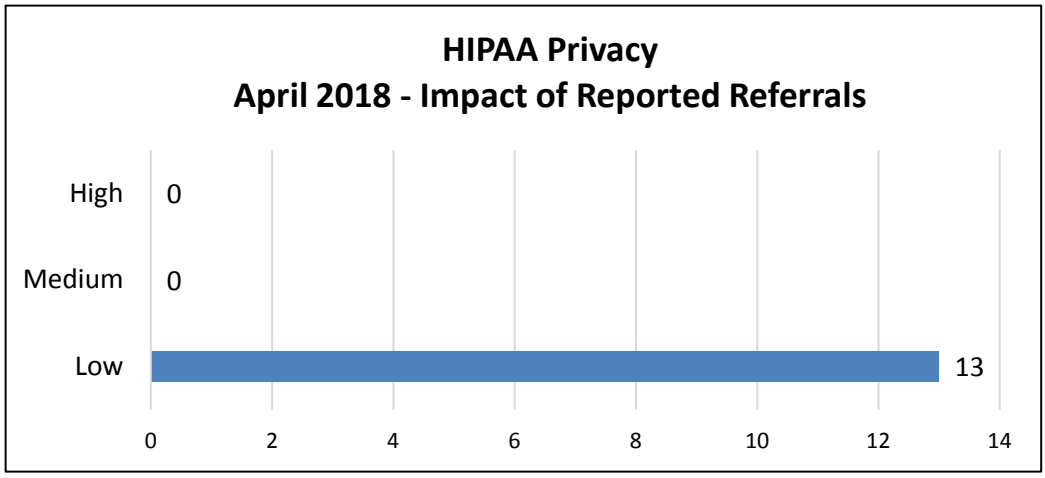
E. Privacy Update (April 2018)





PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	13
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**13**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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CalOptima
A Public Agency
Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting
June 7, 2018

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

May 14, 2018

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: May Board of Directors Report

While lawmakers continue to negotiate Fiscal Year (FY) 2019 appropriations, several House and Senate committees are committed to moving opioid legislation in short order. A final opioid package may be the only health care vehicle to move before the midterm elections while other pending health care proposals include Medicare reforms and drug pricing measures. This report provides an update on legislative activity through May 11, 2018.

Opioid Legislation
Congress continues to move forward on the opioid crisis, advancing legislation at an ambitious pace in both the House and Senate. Lawmakers appear to have set a goal of sending a final legislative package to the President's desk by the August recess.

On April 24, the Senate Health, Education, Labor and Pensions (HELP) Committee voted 23-0 to advance bipartisan opioid legislation. The Opioid Crisis Response Act (S. 2680) includes 40 bills from 38 senators, including proposals to accelerate research on non-addictive pain medications, support state prescription drug monitoring programs, expand access to substance use disorder treatment services, and improve detection of illegal imported drugs. HELP Committee Chairman Lamar Alexander (R-TN) suggested the full Senate could take up the bill sometime this summer. The Committee agreed to several amendments during the markup, but rejected an amendment offered by Sen. Bernie Sanders (I-VT) to impose civil penalties on companies that market opioid products as non-addictive. The panel also defeated an amendment from Sen. Chris Murphy (D-CT) related to mental health parity enforcement, and another amendment from Sen. Sanders that would increase funding for the National Health Services Corps.

Chairman Alexander expects to merge the bill with proposals from other committees, such as the Senate Finance and Judiciary Committees. While these committees have yet to draft legislation, the Senate Finance Committee held a hearing on April 19 to look at tackling opioid abuse in Medicare and Medicaid. Kimberly Brandt, Principal Deputy Administrator for Operations at the Centers for Medicare and Medicaid Services (CMS), discussed some of the tools state Medicaid agencies are using to limit opioid prescriptions and ensure treatment access. She noted that CMS has approved several Section 1115 waivers to allow states to use federal Medicaid funds to pay for residential substance use disorder treatment services provided by institutions for mental diseases (IMDs). Meanwhile, the Senate Judiciary Committee Subcommittee on Crime and

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Terrorism held a hearing on April 11 to examine the risks associated with fentanyl and other synthetic opioids.

On the House side, lawmakers continue to mark up dozens of bills related to the opioid epidemic. During a marathon mark-up on April 25, the House Energy and Commerce Committee Health Subcommittee advanced 57 bills to combat the crisis. The Full Committee advanced several dozen of those bills to the floor on May 9, and is expected to mark up the remaining bills on Thursday, May 17. Several Medicaid-related bills were not considered by the Health Subcommittee, and it is unclear whether they will be taken up at the Full Committee mark-up. These include:

- H.R. __, Improving Medicaid Data Timeliness Act, which would reduce the filing window for Medicaid claims from two years to one year.
- H.R. 4005, Medicaid Reentry Act, which would allow state Medicaid programs to receive federal matching dollars for medical services furnished to an incarcerated individual during the 30-day period preceding the individual's release.
- H.R. 4998, Health Insurance for Former Foster Youth Act, which would allow foster youth enrolled in Medicaid to continue to receive benefits even if they move to another state.
- H.R. __, Protecting NAS Babies Act, which would require HHS to establish a strategy to implement the recommendations in a recent Substance Abuse and Mental Health Services Administration (SAMHSA) report that will enhance the treatment and care of newborns suffering from Neonatal Abstinence Syndrome.
- H.R. 5477, Rural Development of Opioid Capacity Services Act, which would create a demonstration project for five years for up to 10 states that have committed to Medicaid delivery system advancements through substance use disorder demonstration waivers.

The House Ways and Means Committee is also moving forward with opioid legislation. The Committee will hold a markup the week of May 14. Members have been introducing standalone bills, which will be combined into four packages:

- H.R. 5773, Preventing Addiction for Susceptible Seniors (PASS) Act
- H.R. 5774, Combatting Opioid Abuse for Care in Hospitals (COACH) Act
- H.R. 5775, Providing Reliable Options for Patients and Educational Resources (PROPER) Act
- H.R. 5776, Medicare and Opioid Safe Treatment (MOST) Act

The House may consider opioid legislation on the floor the week of June 11.

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FY 2019 Appropriations
Appropriators are hopeful they can move at least a handful of individual FY 2019 appropriations measures through both chambers this summer. House Republicans have discussed the possibility of "pre-conferencing" with the Senate on a number of less controversial spending bills, such as the Legislative Branch, Energy-Water, and Military Construction-VA measures. It is unclear how House Republicans plan to package the bills for FY 2019.

In the Senate, meanwhile, Appropriations Committee Chairman Richard Shelby (R-AL) announced that both sides had reached a preliminary agreement on an open amendment process for spending bills. Leadership hopes this change will limit time consuming cloture votes that require 60 votes for passage. The Appropriations Committee expects to markup bills in May and send at least some of them to the floor in June.

CHIP Rescission
House Republicans on May 10 released legislative text for their budget rescissions package, the Spending Cuts to Expired and Unnecessary Programs Act (H.R. 3). The bill, which is nearly identical to the package released by the White House, includes about $15.4 billion in spending cuts. The House could vote as soon as this week on the bill, but Senate action is on hold while leadership resolves a legal dispute over cuts to the Children's Health Insurance Program (CHIP). About half of the spending cut proposals ($7 billion) come from unspent CHIP funds. Some appropriators have raised concerns that the CHIP cut eliminates an offset often used to help pay for the Labor-HHS-Education appropriations measure.

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EDELSTEIN GILBERT ROBSON & SMITH LLP

Donald B. Gilbert Michael R. Robson Trent E. Smith Alan L. Edelstein OF COUNSEL

CalOptima Legislative Report
By Don Gilbert and Trent Smith
May 11, 2018

It is the time of year in the legislative calendar where the crush of committee hearings necessary to hear thousands of bills overlaps with budget hearings. Policy committees in the Assembly must hear all Assembly bills by May 18. The Senate faces the same deadline for Senate bills. Then the Appropriations Committees in both houses must review bills for fiscal impacts on the state. This work must be completed by May 25. Meanwhile, the Governor released his May Revise budget proposal on May 11. Now that the May Revise has been released, budget committees will rush through their work to finalize a State Budget by the Constitutional deadline of June 15.

We continue to closely monitor AB 2416 by Assemblyman Wood (D-Healdsburg). This measure is part of a package of health care bills introduced by the Assembly Democratic Caucus as an alternative to the single payer health care proposal currently pending in the State Assembly. AB 2416 requires Medi-Cal managed care to negotiate with Covered California regarding offering individual products on the Exchange in the health plan's service areas that overlap with counties where there are two or fewer health plans offering products on the Exchange as of 2018. The author's goal is to get more health plans to participate in the Exchange in underserved areas. We have been informed by the author's office that he intends to amend the bill to exclude County Organized Health Systems (COHS) from the bill, although those amendments have not yet been added to the bill.

We were also very concerned with AB 2472, also authored by Assemblyman Wood. This measure originally required the Department of Healthcare Services (DHCS) to apply to the U.S. Department of Health and Human Services for federal waivers to permit individuals whose income is greater than the income eligibility threshold for Medi-Cal benefits to purchase coverage under the Medi-Cal program through a separate public purchase option. However, AB 2472 was amended to require the Exchange board to prepare an analysis and evaluation to determine the feasibility of a public health insurance plan option to increase competition and choice for health care consumers.

Another bill of interest to CalOptima is AB 2965 by Assemblyman Arambula (D-Fresno), which would extend eligibility for full-scope Medi-Cal benefits to individuals of all ages who are otherwise eligible for those benefits but for their immigration status. This bill, as well as AB 2416 and AB 2472, are pending resolution in the Assembly Appropriations Committee.

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www.edelsteingilbert.com

This issue addressed in AB 2965, providing health care to undocumented immigrants, is also the subject of debate in the state budget process. The Assembly has added $1 billion to the Governor's proposed budget to fund their health care reform bill package, including an earmark of $250 million to provide care for undocumented immigrants. The big question is whether the Governor will agree to the additional funding. Traditionally, the Governor has opposed large ongoing funding obligations.

Based on projections that were included in the Governor's January budget proposal, the State enjoyed a budget surplus of approximately $6 billion. The Governor called for $5 billion to be placed in the State's "rainy day" fund. However, the May Revise projects a budget surplus approaching $8 billion. The large budget surplus will only exacerbate the "save versus spend" tug-of-war between the Governor and the Legislature.

Meanwhile, patient advocates and other health care groups have also been pushing for enhanced state funding for various health care programs. For example, the Western Center on Law and Poverty is leading a coalition requesting the restoration of optional benefits that were eliminated in 2009 as part of a budget compromise needed to overcome a record State Budget deficit. In recent years many of the optional benefits that were eliminated in 2009 have been restored. However, a handful of Medi-Cal benefits, including Audiology, Chiropractic, Incontinence Creams/ Washes, Optician/Optical Lab, Podiatry, and Speech Therapy have yet to be restored. Western Center on Law and Poverty has requested $13.7 million in General Fund money ($50.2 total funds) to restore these optional Medi-Cal benefits.

Another $13 million in General Fund money is being requested for asthma home visiting benefits, hypertension treatment, and mobile vision services. The American Diabetes Association is requesting $13 million in state funds to provide continuous glucose monitoring equipment under the Medi-Cal program. Recognizing the preventative health care benefits provided by these products, CalOptima is supporting this proposal. It should be noted that last year the Governor vetoed a bill proposing the same policy.

Debate continues between the Legislature, the California Medical Association (CMA), and the Governor over the allocation of Proposition 56 funding. Proposition 56, approved by voters in 2016, increases the excise tax rate on cigarettes by $2 per pack, with an equivalent increase on other tobacco products, including electronic cigarettes, to provide funding for various public health and tobacco-related law enforcement programs.

Beginning with the Governor's 2017 January Budget, the Administration interpreted the statutory provisions of Proposition 56 to allow allocation of revenue to fund growth in Medi-Cal program expenditures over the level contained in the 2016 Budget Act. Although these expenditures would have otherwise been funded with state General Fund, the Administration asserts this use of funds does not violate the non-supplantation provisions of Proposition 56. The CMA and the Legislature have argued that more Proposition 56 funding should be allocated to the Medi-Cal program to increase physician reimbursement rates.

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Furthermore, DHCS has submitted a State Plan Amendment (SPA) to the federal government for Proposition 56 supplemental payments only for the 2017-18 Budget year. A new SPA must be submitted for the new fiscal year, which could delay supplemental payments to physicians. This delay and uncertainty could discourage physicians from participating in Medi-Cal. While the May Revise projects a net increase of $32 for Medi-Cal from Proposition 56 funding, it is likely that the Legislature will push to earmark more Proposition 56 for Medi-Cal provider reimbursement. The Governor has committed to work with stakeholders to submit a new SPA by September 2018.

The May Revise maintains the Administration's January proposal to prohibit the use of federal 340B Drug Pricing Program reimbursements within the Medi-Cal program beginning July 1, 2019, to prevent duplicate discounts and overpayments, and reduce drug rebate disputes. The Administration estimates this proposal will result in $16.6 million General Fund savings annually beginning in 2020-21. Prior to the May Revise, the Administration had not provided a projected cost savings for this proposal. In budget hearings, the Legislature had signaled strong opposition to this proposal. The low-cost estimate provided by the Administration likely signals that a deal can be reached to preserve the program, but provide better accounting practices to avoid duplicative rebates.

Because homelessness can impact Medi-Cal spending, it is worth noting that the May Revise proposes allocating $359 million to assist local governments in their immediate efforts to address homelessness, including $50 million for individuals with mental illness.

In addition, the May Revise includes funding for enhanced early detection of mental health problems and the education of mental health professionals. The proposals include the repayment of $254 million plus interest in mandate claims to give counties additional resources for youth with mental illness. The May Revision also proposes to place the $2 billion No Place Like Home bond on the November ballot to accelerate the delivery of housing projects to serve the mentally ill.

Local governments had requested $1.5 billion in state funds to help address homelessness. The Governor appears to have met local officials "half way", which could lead to more debate in the coming weeks.

The balance of May and the month of June will be very busy as the Legislature passes the State Budget and moves bills out of their house of origin (the house - Senate/Assembly - in which they were introduced). The Legislature will break for the month of July before returning in August to conclude their business for the year.

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2017–18 Legislative Tracking Matrix

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H.R. 1625 Royce	**FY 2018 Federal Budget/Omnibus Spending Bill:** Funds the federal government for the remainder of the 2018 budget year, through September 30. The bill includes: • $1.3 trillion in overall spending • $403 billion in Medicaid spending (an increase of $25 billion or 7 percent, accounting for 1.8 million more Medicaid beneficiaries and an increase in opioid related funding, among other factors) • $3.6 billion for opioid-addiction and mental health services (an increase of $2.55 billion or 244 percent) Of note, the bill did not include any stabilization measures for the individual market, such as the cost-sharing reduction payments or a federal reinsurance program.	**03/22/2018** Signed into law	Watch
H.R. 1892 Larson	**FY 2018 Federal Budget/Previous Spending Levels Continued:** • Establishes a two-year budget framework and continues current federal spending levels until March 23, 2018. • Permanently reauthorizes Dual Eligible Special Needs Plans (including CalOptima's OneCare program). • Extends reauthorization for the Children's Health Insurance Program (CHIP) until 2027. • Extends the Community Health Center Fund (CHCF) for two years.	**02/09/2018** Signed into law	CalOptima sent letter of support for CHIP, D-SNP and CHCF
H.R. 195 Russell	**FY 2018 Federal Budget/Previous Spending Levels Continued:** Extends current federal discretionary spending until February 8, 2018. Also authorizes CHIP funding for six years, until 2023, and gradually phases down the enhanced federal matching rate – 88/12 federal/state, to the regular CHIP rate – 65/35 federal/state in FY 2021.	**01/22/2018** Signed into law	CalOptima sent letter of support for CHIP
H.R. 4957 Sanchez	**Improving Alzheimer's Care:** Among other provisions, would establish Alzheimer's models of care based on a comprehensive continuum of care, similar to care delivery in the Program of All-Inclusive Care for the Elderly (PACE).	**02/09/2018** Referred to Subcommittee on Health **02/07/2018** Introduced in the House	Watch
H.R. 1 Brady	**Tax Cuts and Jobs Act:** Amends portions of the Internal Revenue Code that address corporate and individual tax rates and deductions. It also eliminates the Affordable Care Act's (ACA) individual mandate, effective December 31, 2018.	**12/22/2017** Signed into law	Watch
H.R. 3922 Walden	**Five Year CHIP Re-authorization:** Would extend federal CHIP funding, which expired on September 30, 2017, for five years. Would retain the current ACA mandated state/federal CHIP matching rate (88/12 for California) for two years, reduce it by 11.5 percent for one year (76.5/23.5), and revert to pre-ACA levels for two years (65/35). Also includes spending offsets such as increasing Medicare premiums for beneficiaries who make more than $500,000 annually, requires Medicaid beneficiaries to report lottery winnings as income, and decreases funding for the ACA-enacted Prevention and Public Health Fund.	**11/03/2017** Passed House, ordered to Senate **02/09/2018** 10-year reauthorization of CHIP funding included as part of H.R. 1892 (Larson)	CalOptima sent letter of support for CHIP

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
H. Concurrent Resolution 71 Black	**FY 18 Budget Resolution:** The annual budget resolution sets the budgetary framework for the upcoming fiscal year and allows the majority party to pass reconciliation legislation, which requires 51 votes to pass the Senate rather than the normal 60-vote threshold. While the budget resolution is non-binding and does not appropriate federal dollars, it does outline spending priorities for the remainder of the unfunded fiscal year (December 9, 2017 - September 30, 2018).	**10/26/2017** Passed House and Senate (Budget resolutions do not require a Presidential signature)	Watch
H.R. 601 Lowey	**FY 2018 Federal Budget/Previous Spending Levels Continued:** Extends current federal discretionary spending ($1.24 trillion overall) and raises the debt ceiling through December 8, 2017. Ensures funding for federal agencies such as the U.S. Department of Health and Human Services (HHS) continues at approximately $65 billion per year. Mandatory spending ($2.54 trillion overall) for programs such as Medicare and Medicaid continues at previous levels, less a small percentage, as required by the terms of the Budget Control Act of 2011.	**09/08/2017** Signed into law	Watch
Bipartisan Health Care Stabilization Act of 2017 Alexander/ Murray	**Marketplace Stabilization:** Would fund cost-sharing reductions (CSRs) – federal payments to marketplace insurers to reduce deductibles and co-pays for consumers earning between 139-250 percent of the federal poverty level (FPL) who have a "silver" level plan – through 2019. Also, would increase flexibility and streamline the state waiver approval process, among other changes. While this bill does not impact Medicaid directly, it is of interest to CalOptima because of its impact on the health care system, and, because it is common for Medicaid members to "churn" between Medicaid and the individual market.	**10/19/2017** Draft bill text released	Watch
S. 1804 Sanders	**Medicare for All**: Would replace the current U.S. health care system with a single-payer system, known as "Medicare for All." This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs, as well as most forms of private insurance, and enroll all eligible individuals into the new universal plan.	**09/13/2017** Referred to Senate Committee on Finance	Watch
H.R. 676 Ellison	**Medicare for All**: Similar to S. 1804, would replace the current U.S. health care system with a single-payer system, known as "Medicare for All." This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs as well as most forms of private insurance. The program would be funded via existing sources of government revenues for health care and by increasing personal income taxes on the top five percent of income earners, among other measures.	**01/24/2018** Referred to House Committee on Energy and Commerce	Watch

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
RN 1802014 Trailer Bill – 340B Drug Program	**340B Drug Purchasing Program:** Would prohibit the use of 340B discounted drugs in Medi-Cal starting July 1, 2019, pending approval from CMS. Section 340B of the Public Health Service Act allows certain hospitals and clinics to purchase pharmaceuticals at discounted prices. Federal and state agencies have found inconsistencies with the program's implementation. According to the Department of Health Care Services (DHCS), these inconsistencies create a substantial administrative burden on the state. As such, the Department's proposed trailer bill language seeks to prohibit the use of 340B drugs in Medi-Cal. In the event that CMS does not grant the state permission to entirely exclude 340B drugs from Medi-Cal, the state will seek CMS approval for limiting the use of 340B drugs in Medi-Cal.	**05/15/2018** Heard in Senate Budget Subcommittee No. 3: Health and Human Services **01/16/2018** Trailer bill language published on the Department of Finance website	Watch CalOptima provided feedback as part of the CAHP and LHPC comment letters to DHCS
AB 2331 Weber	**Medi-Cal Eligibility Redetermination:** Would allow developmentally disabled individuals receiving services at regional centers to remain continuously eligible for Medi-Cal. Rather than the beneficiary being responsible for ensuring that annual redetermination is performed, counties will use information provided by the California Department of Developmental Services (DDS) and DHCS to ensure that they meet Medi-Cal eligibility criteria.	**05/25/2018** Held under submission in Assembly Appropriations Committee **02/13/2018** Introduced	CalOptima sent letter of support LHPC: Support
AB 1963 Waldron	**Opioids – Treatment:** Would increase provider reimbursement rates for Medication-Assisted Treatments (MAT). MAT requires that patients receive counseling, behavioral therapies, and recovery support services in combination with prescribed medication, such as buprenorphine/naloxone, methadone, buprenorphine, and naltrexone. These therapies have proven to be very effective in treating opioid addiction. There is a significant shortage of providers certified to administer MAT treatments. Depending on how the reimbursement structure is constructed, a rate increase could potentially help CalOptima expand access to MAT services in Orange County.	**05/25/2018** Held under submission in Assembly Appropriations Committee **01/30/2018** Introduced	Watch CalOptima provided feedback to the bill author
AB 2741 Burke	**Opioids – Supply Limit:** Would prohibit providers from prescribing more than a five-day opioid supply to a minor, except in the case of pain associated with cancer, palliative or hospice care, and chronic pain.	**05/17/2018** Referred to Senate Business, Professions and Economic Development Committee **05/07/2018** Passed Assembly Floor and ordered to the Senate **02/16/2018** Introduced	Watch CalOptima provided feedback to the bill author

2017–18 Legislative Tracking Matrix *(continued)*

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 1998 Rodriguez	**Opioids – Prescription Controls:** Would institute more stringent prescription controls related to opioids, including limiting opioid prescriptions to amounts sufficient for not more than three days.	**05/25/2018** Passed Assembly Appropriations Committee **02/01/2018** Introduced	Watch
AB 2430 Arambula	**Medi-Cal Eligibility for Seniors:** Would adjust the income threshold for seniors eligible for Medi-Cal under the Aged and Disabled Federal Poverty Level Program from 123 percent FPL to 138 percent FPL, bringing it in line with other Medi-Cal programs for adult beneficiaries. Currently, seniors with income levels above 123 percent FPL are only eligible for Medi-Cal if they pay an added out of pocket expense known as "share of cost." Under share of cost, beneficiaries must take full responsibility for health care expenses up to a predetermined amount (share of cost) for the month in which they receive services. Once they meet their share of cost, Medi-Cal pays for any additional covered services for that month. This bill aims to ensure that low-income seniors have access to Medi-Cal at the same income level as most other adult beneficiaries, without incurring extra financial burdens.	**05/25/2018** Passed Assembly Appropriations Committee **02/14/2018** Introduced	Watch CAHP: Support LHPC: Support
SB 945 Atkins	**Breast and Cervical Cancer Treatment Program (BCCTP):** Would remove the 18 to 24-month cap on coverage under the state Breast and Cervical Cancer Treatment Program (BCCTP), which would allow members to remain in the program and CalOptima to continue receiving adequate reimbursement for the duration of their treatment. Currently, DHCS administers BCCTP, which provides cancer treatment coverage to individuals diagnosed with breast and/or cervical cancer that meet certain screening and income eligibility criteria. Currently, for individuals enrolled in the state BCCTP program, treatment coverage is limited to 18 months for breast cancer and 24 months for cervical cancer.	**05/25/2018** Passed Senate Appropriations Committee **01/29/2018** Introduced	Watch LHPC: Support
AB 2275 Arambula	**Medi-Cal Quality Requirements:** Would create new quality requirements for Medi-Cal managed care plans, which would be a significant departure from the state's current quality assurance and performance improvement program and could potentially require CalOptima to extensively modify its reporting processes.	**05/25/2018** Passed Assembly Appropriations Committee **02/13/2018** Introduced	Watch CAHP: Oppose CalOptima provided feedback to the bill author
AB 2299 Chu	**Materials for Medi-Cal Members:** Requires all Medi-Cal managed care plans' (MCPs) written health education and informational materials to meet a readability and suitability checklist established by DHCS. The materials would also be required to go through a "community review" process prior to submission to DHCS. Under current state policy, MCPs are already required to meet readability and suitability standards for all written materials. Currently, CalOptima's Health Education and Cultural Linguistic Services departments already review all informational materials released to members in all threshold languages. This bill would add an additional step – the community review process – on top of the current process. This additional step could delay the release of member materials for an additional 60 days. According to analysis conducted by staff, while the intent of the bill appears to benefit members, these added requirements would create unnecessary delays in releasing information to members.	**05/21/2018** Passed Assembly Appropriations Committee **02/13/2018** Introduced	Watch CAHP: Oppose LHPC: Oppose CalOptima provided feedback to the bill author

2017–18 Legislative Tracking Matrix *(continued)*

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2579 Burke	**WIC to Medi-Cal Express Lane:** Would establish an "express lane" eligibility pathway for pregnant women and children from the California Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to Medi-Cal. WIC is a federally funded program that provides supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and infants and children up to age five. The bill intends to leverage the similarity between WIC and Medi-Cal eligibility rules, to ensure that uninsured children and pregnant women who are eligible for Medi-Cal, are able to conveniently enroll in the program.	**05/25/2018** Passed Assembly Appropriations Committee **02/15/2018** Introduced	Watch CAHP: Support LHPC: Support
SB 1125 Atkins	**Access to Mental Health at FQHCs:** Would allow a Federally Qualified Health Center (FQHC) to be reimbursed by the state for a mental health visit that occurs on the same day as a medical face-to-face visit. Currently, a patient must seek mental health treatment on a subsequent day for an FQHC to receive reimbursement for that service. This bill would give members access to both primary care and on-site mental health care on the same day, while ensuring that clinics are appropriately reimbursed for both services. Currently, approximately 138,000 CalOptima members receive care at FQHCs.	**05/25/2018** Passed Senate Appropriations Committee **02/13/2018** Introduced	CalOptima sent letter of support LHPC: Support
AB 2965 Arambula	**Medi-Cal Eligibility:** Extends full scope Medi-Cal coverage to eligible individuals who are under 26 years of age, regardless of immigration status.	**05/25/2018** Passed Assembly Appropriations Committee	Watch CAHP: Support
SB 974 Lara	**Medi-Cal Eligibility:** Extends full scope Medi-Cal coverage to eligible individuals who are 65 years of age or older, regardless of immigration status.	**05/25/2018** Passed Senate Appropriations Committee	Watch LHPC: Support
AB 2718 Friedman	**Transitional Medi-Cal Eligibility for CalWORKs Recipients:** Extends Medi-Cal eligibility from six months to twelve months for families transitioning off the California Work Opportunity and Responsibility to Kids program (CalWORKs). Current state policy allows for a six-month extension of coverage after a family exits the program, and an additional six months if their income remains at or below 185 percent FPL. This bill would allow families to retain access to Medi-Cal coverage for twelve months, regardless of income, by requiring the state to implement the federally allowable twelve-month period option.	**05/25/2018** Passed Assembly Appropriations Committee **02/15/2018** Introduced	Watch
AB 2203 Gray	**Medi-Cal Provider Rates:** Beginning July 1, 2019, would require DHCS to increase Medi-Cal primary care provider rates to the rate paid for those services under the federal Medicare program.	**05/25/2018** Held under submission in Assembly Appropriations Committee **02/12/2018** Introduced	Watch
AB 2122 Reyes	**Pediatric Blood Lead Testing:** Would require DHCS to notify parents of children enrolled in Medi-Cal of lead testing requirements and inform them when their children have missed the test. Under current law, children are to be tested at 12 months of age and again at 24 months. This bill would require DHCS to report its progress in meeting the lead testing requirements on an annual basis. According to the bill language, a disproportionate number of children who test positive for lead-poisoning are enrolled in Medi-Cal.	**05/25/2018** Passed Assembly Appropriations Committee **02/08/2018** Introduced	Watch CalOptima provided feedback to the bill author

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
AB 2472 Wood	**Medi-Cal Public Purchasing Feasibility Study:** Would require Covered California to prepare a feasibility study to assess the possibility of establishing a public health insurance plan. The plan would permit individuals whose income is greater than 138 percent of the federal poverty level to purchase Medi-Cal coverage.	**05/08/2018** Passed Assembly Appropriations Committee **02/14/2018** Introduced	Watch
AB 3175 Rubio	**Child Life Specialist:** Would require that services provided by certified child life specialists be covered under the California Children's Services (CCS) program. CCS provides diagnostic and treatment services, medical case management, and physical and occupational therapy services to children under age 21 with specialized health care conditions such as cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer, traumatic injuries, among others. CCS-eligible children living in select counties, including Orange County, will transition from fee-for-service to Medi-Cal managed care as part of the Whole Child Model (WCM), established as part of SB 586 (Chapter 625, Statutes of 2016). In Orange County, the CCS WCM transition is scheduled to take place in January 2019. Certified child life specialists are allied health care professionals that support children and families coping with the stress and uncertainty of life altering healthcare crises.	**05/25/2018** Held under submission in Assembly Appropriations Committee **02/16/2018** Introduced	Watch
SB 906 Beall	**Medi-Cal Mental Health Services Peer Certification:** Would require DHCS to establish a statewide certification program for peer and family support specialists and to include as a service to be reimbursed under the Medi-Cal program. Among other responsibilities, a peer and family support specialist would provide individualized support services to members with mental health care needs and substance use disorders.	**05/25/2018** Passed Senate Appropriations Committee **01/17/2018** Introduced	Watch
SB 399 Portantino	**Behavioral Health:** Would make changes to current law related to the treatment of Autism Spectrum Disorder, such that managed care plans would be required to cover certain treatment protocols that are not currently covered, such as the Developmental Individual-difference Relationship (DIR) model and "Floortime." These therapies are intended to be spontaneous play sessions between a child with autism and an adult. Also, this bill would reduce the required educational levels of autism service paraprofessionals.	**04/16/2018** Referred to Assembly Health Committee **01/29/2018** Passed Senate Floor and ordered to the Assembly	Watch CAHP: Oppose LHPC: Oppose
AB 2565 Chiu	**Covered California Premium Assistance:** Would require Covered California to offer enhanced premium assistance to individuals between 200 percent and 400 percent FPL who enroll in health care coverage through the Exchange. The enhanced premium assistance would be in addition to the current federal subsidies. According to the bill author, the cost to the state would be $300 million, and would increase financial assistance to approximately 550,000 people enrolled in Covered California. While this bill does not impact Medi-Cal directly, it is of interest to CalOptima because individuals often "churn" between Medi-Cal and the individual market.	**05/25/2018** Passed Assembly Appropriations Committee **02/15/2018** Introduced	Watch
AB 205 Wood	**Mega-Reg:** Implements certain provisions of the CMS Medicaid Managed Care Final Rule by making changes at the state level regarding Medi-Cal managed care plans. Specifically, this bill changes the grievance and appeals process for plans by lengthening the amount of time members have to request a state fair hearing from 90 days to 120 days. It also establishes new time and distance standards for members to access primary and specialty care services.	**10/13/2017** Signed into law	Watch

Bill Number (Author)	Bill Summary	Bill Status	Position/Notes
SB 171 Hernandez	**Mega-Reg:** Implements certain provisions of the CMS Medicaid Managed Care Final Rule by making changes at the state level regarding Medi-Cal managed care plans. Specifically, this bill changes the way public hospitals receive supplemental payments and creates a new, across-the-board Medical Loss Ratio (MLR) standard for Medi-Cal managed care plans.	**10/13/2017** Signed into law	Watch
SB 608 Hernandez	**Hospital Quality Assurance Fee (QAF):** Would modify the QAF to bring it into compliance with CMS Medicaid Managed Care Final Rule requirements. The current language of the bill only reflects a portion of the California Hospital Association's proposal to reform the QAF. The bill's language is likely to be substantially amended in the current legislative session.	**09/01/2017** Held under submission	Watch

CAHP: California Association of Health Plans
LHPC: Local Health Plans of California

2018 Federal Legislative Dates

January 3	Congress convenes 2nd session
March 26–April 9	Spring recess
July 27–September 3	Summer recess
November 6	General Election

2018 State Legislative Dates

January 3	Legislature reconvenes
February 16	Last day for legislation to be introduced
April 27	Last day for policy committees to hear and report bills to fiscal committees
May 11	Last day for policy committees to hear and report non-fiscal bills to the floor
May 25	Last day for fiscal committees to report fiscal bills to the floor
May 29–June1	Floor session only
June 1	Last day to pass bills out of their house of origin
June 5	Statewide Primary Election
June 15	Budget bill must be passed by midnight
June 28	Last day for a legislative measure to qualify for the Nov. 6 General Election ballot
July 6–August 5	Summer recess
August 7	Special Election for CA Senate District 32
August 17	Last day for fiscal committees to report bills to the floor
August 20 – 31	Floor session only
August 31	Last day for bills to be passed. Final recess begins upon adjournment
September 30	Last day for Governor to sign or veto bills passed by the Legislature
November 6	General Election
November 30	Adjournment *Sine Die* at midnight
December 3	Convening of the 2019-20 session

Sources: 2018 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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Board of Directors Meeting
June 7, 2018

CalOptima Community Outreach Summary – May 2018

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 a CalOptima program.
- 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.

We consider requests for sponsorship based on several factors as indicated pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including, but not limited to: 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 several community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

Community Alliances Forum

In collaboration with the Community Alliances Advisory Committee, Community Relations will host a Community Alliances Forum on Wednesday, June 6, 2018, from 9 a.m. to 11a.m. at the Delhi Center in Santa Ana.

The topic of the forum is **Mental Health in Orange County: Signs, Services and Supports.** The objectives for the forum are for attendees to gain a better understanding of common mental health conditions in children, adolescents and adults/older adults, learn about early warning signs of these common mental health conditions and learn about community resources available to support their clients' mental health needs. The forum will also feature a resource fair with various community-based organizations sharing information about their programs and services to support clients with mental illness.

For additional information or questions, please contact Tiffany Kaaiakamanu, manager of Community Relations, at 657-235-6872 or email tkaaiakamanu@caloptima.org.

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Summary of Public Activities

During May 2018, CalOptima participated in 36 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
5/01/18	• Collaborative to Assist Motel Families Meeting
5/04/18	• Covered Orange County General Meeting
5/07/18	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting
5/08/18	• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting • Susan G. Komen Orange County — Unidos Contra el Cancer del Seno Coalition Meeting
5/10/18	• FOCUS Collaborative Meeting • State Council on Developmental Disabilities Regional Advisory Committee Meeting
5/14/18	• Fullerton Collaborative Meeting • Orange County Veterans and Military Families Collaborative Meeting
5/15/18	• Orange County Cancer Coalition Meeting • Placentia Community Collaborative
5/16/18	• Covered Orange County Steering Committee Meeting • Minnie Street Family Resource Center Professional Roundtable • Orange County Promotoras Meeting • La Habra Move More, Eat Healthy Campaign Meeting • Orange County Communication Workgroup Meeting
5/17/18	• Orange County Children's Partnership Committee • Orange County Women's Health Project Advisory Board Meeting
5/22/18	• Orange County Senior Roundtable • Santa Ana Building Healthy Communities
5/24/18	• Disability Coalition of Orange County • Orange County Care Coordination for Kids

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TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff to Attend	Events/Meetings
5/02/18	2	• Mental Health and Aging Education Forum hosted by Oasis Senior Center
5/03/18	3	• Annual Mental Health Awareness Month Event hosted by Child Abuse Prevention Center's Well Program
5/05/18	1	• Wellness Resource Fair hosted by Orange County Asian and Pacific Islander Community Alliance, Western Youth Services and Child Abuse Prevention Center
	2	• Spring Health and Resource Fair hosted by City of Anaheim Active Older Adult Program
5/09/18	4	• 2018 Annual Orange County Hiring Fair hosted by the Office of Supervisor Michelle Steel
5/12/18	2	• Community Resource Fair hosted by KidWorks
	1	• Independent Living Skills Event hosted by Independent City, Orange County Social Service Agency and Orangewood Foundation
5/17/18	2	• FaCT Annual Sponsorship hosted by FaCT Orange County (Sponsorship Fee: $1,000 included five tickets for staff to attend conference and agency recognition at the conference)
5/19/18	1	• Healthy Brain Fair hosted by Alzheimer's Family Center (Registration Fee: $1,000 included mention of community sponsor in press release, agency logo on promotional collateral, on banner, host website, social media and a table for outreach)
	1	• Community Resource and Health Fair hosted by Anaheim Community Services Department
5/22/18	1	• Health Resource Fair hosted by City of Stanton
5/26/18	2	• Community Resource Fair hosted by Solidarity
5/30/18	2	• Meeting of the Minds Conference hosted by Mental Health Association of Orange County
5/31/18	1	• Parent Support Services Faire hosted by Orange County Department of Education (Registration Fee: $100 included one table for outreach)

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CalOptima organized or convened the following four community stakeholder events, meetings and presentations:

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
5/01/18	• CalOptima Transportation Benefit Presentation for the Collaborative to Assist Motel Families
5/23/18	• County Community Service Center Health Seminar — Topic: Autism 101 (Vietnamese) • Community-based Organization Health Seminar for Madison Elementary School — Topic: Memory Loss
5/24/18	• CalOptima New Member Orientation for Medi-Cal members

CalOptima provided one endorsement for events during this reporting period (e.g., letters of support, program/public activity event with support, or use of name/logo).

1. Letter of Support for the Laguna Beach Community Clinic's application to the U.S. Department of Health and Human Services, Health Resources Services Administration's (HRSA) Bureau of Primary Health Care (BPHC) to be designated as a Federally Qualified Health Center (FQHC) Look-Alike.

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CalOptima Board of Directors
Community Activities

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

June

Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Friday, 6/1 10-11am	++Help Me Grow Advisory Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana
Saturday, 6/2 9-11am	+CHOC Children's Breathmobile Annual Track and Field Day Resource Fair	Health/Resource Fair Open to the Public	2 Staff	Santa Ana College 1530 W. 17th St. Santa Ana
Saturday, 6/2 9am-2pm	+River Church Health Fair	Health/Resource Fair Open to the Public	2 Staff	River Church 201 E. Broadway Blvd. Anaheim
Saturday, 6/2 11am-3pm	+OC Iranian American Chamber of Commerce and Alzheimer's OC OC Iranian Health Expo	Health/Resource Fair Open to the Public	$2,500 Sponsorship 2 Staff	Alzheimer's OC 2515 McCabe Way Irvine
Monday, 6/4 1-4pm	++OCHCA Mental Health Services Act Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 6/5 9:30-11am	++Collaborative to Assist Motel Families	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim

* *CalOptima Hosted*

\+ *Exhibitor/Attendee*
++ *Meeting Attendee*

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Wednesday, 6/6 9-11am	*Community Alliances Forum	Community Presentation Health/Resource Fair Open to the Public *Registration recommended*	N/A	Delhi Community Center 505 E. Central Ave. Santa Ana
Thursday, 6/7 8:30am-12pm	+Wraparound OC and Family Support Network OC Wraparound Resource Fair	Health Resource Fair Open to the Public	2 Staff	Mariners Church 5001 Newport Coast Dr. Irvine
Thursday 6/7 9-11am	++Homeless Provider Forum	Steering Committee Meeting: Open to Collaborative Members	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Friday, 6/8 9:30-11am	++Senior Citizen Advisory Council Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies
Saturday, 6/9 11am-3pm	+Team of Advocates for Special Kids 40th Anniversary Family Fun Day & Resource Fair	Health/Resource Fair Open to the Public	$1,000 Sponsorship 2 Staff	Tewinkle Park 970 Arlington Dr. Costa Mesa
Monday, 6/11 1-2:30pm	++OC Veterans and Military Families Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 6/11 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 6/12 9-10:30am	++Orange County Strategic Plan for Aging-Social Engagement Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Tuesday, 6/12 12-1pm	++Buena Clinton Neighborhood Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Clinton Youth and Family Center 12661 Sunswept Ave. Garden Grove

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

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Wednesday, 6/13 10-11:30am	++Buena Park Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Library 7150 La Palma Ave. Buena Park
Wednesday, 6/13 12-1:30pm	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Thursday, 6/14 11:30am-12:30pm	++FOCUS Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Magnolia Park Family Resource Center 11402 Magnolia St. Garden Grove
Friday, 6/15 8:30am-1pm	+OC Aging Services Collaborative, OC Social Services Agency and North OC Senior Collaborative World Elder Abuse Awareness Day	Community Presentation Health/Resource Fair Open to the Public *Registration recommended*	$1,000 Sponsorship 2 Staff	Buena Park Senior Activity Center 8150 Knott Ave. Buena Park
Tuesday, 6/19 10-11:30am	++Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Trinity Center Placentia Presbyterian Church 849 Bradford Ave. Placentia
Wednesday, 6/20 9:15-11am	++Covered Orange County Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Wednesday, 6/20 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana
Wednesday, 6/20 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location Varies
Wednesday, 6/20 1:30-3pm	++La Habra Move More, Eat Health Campaign	Steering Committee Meeting: Open to Collaborative Members	N/A	Friends of Family Community Clinic 501 S. Idaho St. La Habra

Thursday, 6/21 8:30-10am	++OC Children's Partnership Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 6/21 9:30am-12pm	+The Center at Founders Village Annual Senior Expo	Health/Resource Fair Open to the Public	$1,000 Sponsorship 2 Staff	The Center at Founders Village 17967 Bushard St. Fountain Valley
Thursday, 6/21 2:30-4:30pm	++OC Women's Health Project Advisory Board Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Saturday, 6/23 10am-3pm	+Anaheim Indoor Marketplace 14th Annual Community Health Fair	Health/Resource Fair Open to the Public	2 Staff	Anaheim Indoor Marketplace 1440 S. Anaheim Blvd. Anaheim
Monday, 6/25 9-11am	++Community Health Research Exchange	Steering Committee Meeting: Open to Collaborative Members	N/A	Healthy Smiles for Kids 2101 E. Fourth St. Santa Ana
Monday, 6/25 12:30-1:10pm	++Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 6/26 7:30-9am	++OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange
Tuesday, 6/26 3:30-4:30pm	++Santa Ana Building Healthy Communities	Steering Committee Meeting: Open to Collaborative Members	N/A	KidWorks 1902 W. Chestnut Ave. Santa Ana
Thursday, 6/28 8:30-10am	++Disability Coalition of Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Dayle McIntosh Center 501 N. Brookhurst St. Anaheim
Thursday, 6/28 1-3pm	++Orange County Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Red Hill Ave. Santa Ana