NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, OCTOBER 6, 2016
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Todd Spitzer, Alternate

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

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

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

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

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
    a. California Children's Services Program
    b. National Committee for Quality Assurance (NCQA) Rating
    c. Program of All-Inclusive Care for the Elderly (PACE)
    d. Strategic Plan
    e. Key Meetings

PUBLIC COMMENTS

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

CONSENT CALENDAR

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

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

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

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

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

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

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

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

REPORTS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24. Consider Chief Executive Officer and Chief Counsel Performance Evaluation and Compensation *(to follow closed session)*

ADVISORY COMMITTEE UPDATES

25. Provider Advisory Committee Update

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

27. Member Advisory Committee Update

INFORMATION ITEMS

28. August 2016 Financial Summary

29. Compliance Report

30. Federal and State Legislative Advocates Reports

31. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

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

CS 2 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: (Mark Refowitz 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: (Mark Refowitz and Lee Penrose)
Unrepresented Employee: (Chief Counsel)

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, November 3, 2016 at 2:00 p.m.

MEMORANDUM

DATE:	October 6, 2016
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee

California Children's Services (CCS) Program
On September 25, Gov. Brown signed SB 586 into law, authorizing implementation of the Whole Child Model (WCM) for the CCS program no earlier than July 1, 2017. In selected counties, including Orange, this will transition CCS from a fee-for-service system run by counties to a benefit administered by Medi-Cal managed care plans. CalOptima will be responsible for providing most CCS services to approximately 11,810 members. We will also be responsible for establishing a local stakeholder process, including two new advisory committees. Many of the CCS services currently administered by the Orange County Health Care Agency will transition to CalOptima, such as care coordination, case management, service authorizations and provider referrals. However, some services will continue to be carved out of the WCM, such as CCS eligibility determinations, Medical Therapy Unit services and neonatal intensive care services. SB 586 also spells out other provisions of the transition, such as member notices, continuity of care rules and reporting requirements. During the past several months, CalOptima has been actively collaborating with state regulators and county officials to prepare for the change. We will keep your Board informed about our progress, as CalOptima works to ensure Orange County's CCS children experience a smooth transition.

National Committee for Quality Assurance (NCQA) Rating
CalOptima is California's top Medi-Cal plan for the third year in a row, according to the NCQA's Medicaid Health Insurance Plan Ratings 2016–2017. CalOptima received a score of 4 out of 5 — the highest score awarded to any Medi-Cal plan in the state. Further, only 15 Medicaid plans of the 171 reviewed nationwide scored higher. The ratings are based on three major performance categories: consumer satisfaction, prevention and treatment. CalOptima shared news about our top-plan status with our employees and community widely, using a variety of communications channels, including press releases, social media postings, emailed memos and an electronic newsletter. Health network partners, providers, community-based organizations and elected officials all received our message, and the congratulatory responses were gratifying! We will continue spreading the word using a custom graphic and tagline of "CalOptima Qualityx3: Top Medi-Cal Plan in California Three Years and Counting!"

Program of All-Inclusive Care for the Elderly (PACE)
CalOptima PACE enjoyed two successes in September: a positive regulatory audit and a proposed rate increase. On September 1, PACE completed its third audit in three years with good

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results. The auditors' preliminary findings showed that out of 14 elements (four operational and 10 clinical), PACE met 11. Three elements had findings:

- Transportation: Prior to the audit, PACE self-disclosed issues with the transportation program for exceeding the one-hour time limit.
- Infection Control: The glucometer disinfection process was deemed out of compliance with manufacturer recommendations.
- Quality: This finding also involved transportation and the level of oversight of the transportation vendor.

A final report is due in early October, and PACE will have 30 days to respond with a corrective action plan. Overall, the auditors were complimentary about our center and staff, noting that the program has come a long way in three years. Separately and for some time, CalOptima has been advocating for better PACE rates, based on the fact that our rates are among the lowest in the state. On September 20, the Department of Health Care Services (DHCS) responded with an increase to the PACE Medi-Cal rate for Calendar Year 2016. These rates are preliminary and awaiting federal approval. Our finance team is in the process of assessing the new rate's impact on overall financial performance. Medi-Cal represents about 68 percent of total PACE revenue, and the rest is Medicare. CalOptima is also taking an active approach to boosting PACE Medicare revenue by more fully capturing and reporting the acuity of our dual eligible PACE participants. I will keep your Board informed as the financial status of PACE crystallizes.

Strategic Plan

Work on CalOptima's next three-year strategic plan will continue with a special Board strategic planning session on Thursday, November 3, immediately following the regular Board meeting. Bobbie Wunsch of Pacific Health Consulting Group will facilitate the session, and DHCS Director Jennifer Kent will be guest speaker. To prepare, I plan to meet with individual Board members this month to lay the groundwork for the session and share the draft framework of the strategic plan that staff previously developed with Ms. Wunsch. After the November 3 session, the goal is to bring a final strategic plan for approval at your December meeting.

Key Meetings

- UCI Health: On September 2, as part of a continuing series of quarterly meetings, Dr. Richard Helmer, Ladan Khamseh and I met with the leadership team from UCI Health, including CEO Howard Federoff, CFO Jay Sial and others. Leaders are interested in increasing UCI's collaboration with CalOptima in the area of population health.
- Orange County Business Council (OCBC) Board of Directors: The OCBC is a leading organization in the local business community. I serve on the Board along with a number of other health care leaders from organizations such as CHOC and UCI. Monthly Board meetings address a variety of business topics, often including issues in the health care industry. The September 8 meeting touched on the tobacco tax initiative, which is on the November ballot and may help increase funding for Medi-Cal.
- Regional Center of Orange County (RCOC): On September 9, Dr. Helmer, Dr. Donald Sharps and I met with RCOC leaders to share an update regarding the transition of Applied Behavior Analysis services from RCOC to CalOptima Medi-Cal. From February to September, nearly 1,300 children have transitioned, and the process in nearly complete, with fewer than 100 children remaining to be transitioned.

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- Health Network Leadership Meeting: On September 20, CalOptima executives and network management staff met with 18 leaders from our contracted health network partners. The agenda included discussion of CalOptima's financial reserve requirements and upcoming audit of networks' medical loss ratio along with updates about quality and compliance issues. These CalOptima-network leadership meetings are tentatively planned to continue on a quarterly basis.
- Hospital Association of Southern California (HASC): On September 22, I facilitated a group discussion about patient education, navigation and coordination at the third HASC-sponsored Medi-Cal Task Force meeting. The group agreed that better patient education and care coordination leads to appropriate use of emergency rooms and prevents readmissions. To that end, I shared some of CalOptima's efforts in educating new moms, because the highest use of emergency rooms is in infants and children up to age 2, and in planning better hospital discharges, which prevents readmission. The participants discussed activities at their organizations and ideas for collaboration between hospitals and health plans. The task force meetings gather leaders from Southern California hospitals, public managed care plans and providers to create recommendations that will improve local delivery systems, develop a common policy agenda and forge an advocacy platform for HASC to use at the state level. The final task force meeting this month will summarize ideas from prior meetings and establish next steps.

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CEO Report

Board of Directors Meeting

October 6, 2016

Michael Schrader

Chief Executive Officer

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California Children's Services (CCS)

- SB 586 authorizes the transition of CCS in certain counties to the Whole Child Model, which aims to deliver coordinated care for children with chronic conditions

- Responsibility for CCS services shifts from counties to managed care plans
  - No sooner than July 1, 2017

- CalOptima will coordinate efforts with Orange County Health Care Agency to ensure a smooth transition
  - Approximately 12,000 children

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PACE Rates

- Advocacy efforts resulted in a proposed increase to PACE Medi-Cal rates from the state
  - Effective Calendar Year 2016
  - Awaiting federal approval

- Financial analysis of the impact of this increase underway

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Strategic Plan 2016–19

- October: Individual Board member briefings about draft strategic plan framework

- November 3: Strategic planning session with full Board
  - Facilitator: Bobbie Wunsch, Partner, Pacific Health Consulting Group
  - Guest Speaker: Jennifer Kent, Director, Department of Health Care Services

- December 1: Board approval of strategic plan

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Top NCQA Rating

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

September 1, 2016

A Regular Meeting of the CalOptima Board of Directors was held on September 1, 2016, at CalOptima, 505 City Parkway West, Orange, California. Chair Mark Refowitz called the meeting to order at 2:02 p.m. Vice Chair Penrose led the Invocation, and Supervisor Do led the Pledge of Allegiance.

ROLL CALL

Members Present: Mark Refowitz, Chair (non-voting); Lee Penrose, Vice Chair; Supervisor Lisa Bartlett (at 2:11 p.m.), Ria Berger, Ron DiLuigi, Supervisor Andrew Do, Alexander Nguyen, M.D., Scott Schoeffel, Paul Yost, M.D.

Members Absent: Dr. Nikan Khatibi

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

Chair Refowitz announced the following change to the agenda: Item 6, Authorize Updated Financial Terms for Lease of Office Space at 1 City Boulevard West, Orange, California, was continued to a future Board meeting.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader reported that the PACE Modernization Act was recently signed by the governor as part of a state budget health trailer bill. The PACE Modernization Act will introduce a new process for calculating PACE reimbursement rates to account for geographic rate disparity and actual cost data for each PACE center. It was noted that CalOptima's Medi-Cal rates for PACE are among the lowest in the state. CalOptima will continue to work with CalPACE and the state as the new methodology is developed.

Mr. Schrader provided a brief overview of CalOptima's participation in various state associations including CalPACE, the California Association of Health Plans, and Local Health Plans of California. Additionally, CalOptima's federal and state advocates, James McConnell and Edelstein Gilbert Robson & Smith, respectively, represent CalOptima in legislative and regulatory matters.

It was also announced that CalOptima achieved a "Commendable" rating from the National Committee for Quality Assurance (NCQA), based on CalOptima's 2016 results for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

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PUBLIC COMMENTS
There were no requests for public comment.

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the August 4, 2016 Regular Meeting of the CalOptima Board of Directors; and
   b. Receive and File Minutes of the June 9, 2016 Meeting of the CalOptima Board of Directors' Provider Advisory Committee

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

REPORTS

3. Consider Authorization of Contract with a Managed Behavioral Health Organization (MBHO) Effective January 1, 2017 and Contract with Consultant to Assist with MBHO Contract Implementation; Consider Authorization of Extension of Current Behavioral Health Contracts with College Health Independent Practice Association and Windstone Behavioral Health
Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Richard Helmer, M.D., Chief Medical Officer, presented the following recommended actions for consideration: 1) Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into contract within 30 days with Magellan Health, Inc. to provide behavioral health services for CalOptima Medi-Cal, OneCare, and OneCare Connect members effective January 1, 2017, for a three (3) year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion; contract with a consultant(s) in an amount not to exceed $50,000, to assist with the implementation of the Behavioral Health MBHO contract; and extend the current contracts with College Health Independent Practice Association (CHIPA) and Windstone Behavioral Health (Windstone) for up to six months, if necessary; and 2) Direct the CEO to return to the Board with further recommendations in the event that a contract is not finalized with Magellan within 30 days.

Dr. Sharps presented a brief overview of the Behavioral Health Services at CalOptima, the Request for Proposal process, and evaluation results. As proposed, the contract with Magellan Health will meet CalOptima's goal of integration of care, regulatory compliance, operational efficiency, administrative simplification, best practices, as well as overall reasonableness of price.

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

Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors: 1) Authorized the CEO, with the assistance of legal counsel, to enter into a contract within 30 days with Magellan Health, Inc., to provide behavioral health services for CalOptima Medi-Cal, OneCare, and OneCare***

Connect members effective January 1, 2017, for a three-year term with two additional one-year extension options, each exercisable at CalOptima's sole discretion; contract with a consultant(s) in an amount not to exceed $50,000, to assist with the implementation of the Behavioral Health MBHO contract; and extend the current contracts with College Health Independent Practice Association (CHIPA) and Windstone Behavioral Health (Windstone) for up to six months, if necessary; and 2) Direct the CEO to return to the Board with further recommendations in the event that a contract is not finalized with Magellan within 30 days. (Motion carried 7-0-0; Directors Khatibi and Schoeffel absent)

4. Consider Authorization of Contract with Gym Benefit Vendor for OneCare and OneCare Connect

Ladan Khamseh, Chief Operating Officer, presented the recommended action to authorize the CEO, with the assistance of legal counsel, to enter into an agreement with American Specialty Health to serve as CalOptima's Gym Benefit Vendor for OneCare Connect and OneCare members effective January 1, 2017. The contract is for a two-year term with three additional one-year extension options, each exercisable at CalOptima's sole discretion.

Action: ***On motion of Vice Chair Bartlett, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to enter into an agreement with American Specialty Health to serve as CalOptima's Gym Benefit Vendor for OneCare Connect and OneCare members effective January 1, 2017, for a two-year term with three additional one-year extension options, each exercisable at CalOptima's sole discretion. (Motion carried 7-0-0; Supervisor Do and Director Khatibi absent)***

5. Consider Extension of Contracts Related to CalOptima's Core Systems

Len Rosignoli, Chief Information Officer, presented the following recommended actions: 1) Authorize the CEO to extend the contracts with the following vendors through the dates indicated in Tables 1, 2, and 3: Burgess-Burgess Reimbursement System, Medicare/Medi-Cal fee schedules and claims pricing; Meddecision, Provider Portal (CalOptima Link); Edifecs-XEngine, claims electronic transaction standardization tool; Microstrategy, enterprise business analytics and intelligence; Office Ally, claims clearinghouse; Change Healthcare, claims clearinghouse; HMS, Medi-Cal cost containment; SCIO Health Analytics-My Socrates, third party liability and subrogation recovery services; OptumInsight, credit balance recovery services; MCG-CareWebQI, evidence-based clinical guidelines; Intelli-Flex, telephone system and supporting customer service applications; TW Telecom/Level III, CalOptima's carrier for telecommunications as well as Internet connectivity; and 2) Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in Tables 1, 2, and 3.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors: 1) Authorized the CEO to extend contracts with Burgess-Burgess Reimbursement System, Meddecision, Edifecs-XEngine, Microstrategy, Office Ally, Change Healthcare, HMS, SCIO Health Analytics-My Socrates, OptumInsight, MCG-CareWebQI, Intelli-Flex, and TW Telecom/Level III through the dates indicated in Tables 1, 2 and 3; and 2) Authorized payment***

of maintenance and support fees to these vendors through the dates and up to the amounts indicated in Tables 1, 2 and 3. (Motion carried 8-0-0; Director Khatibi absent)

6. Authorize Updated Financial Terms for Lease of Office Space at 1 City Boulevard West, Orange, California

This item was continued to a future Board of Directors meeting.

7. Consider Authorization of an Expenditure in Support of the Development of an Orange County Strategic Plan for Aging, in Partnership with Alzheimer's Orange County, the County of Orange Health Care Agency, Orange County United Way and Other Community Partners

Phil Tsunoda, Public Policy and Public Affairs Executive Director, presented the following recommended actions for Board consideration: 1) Authorize an expenditure of $10,000 from existing reserves to support the development of an Orange County Strategic Plan for Aging (OCSPA) in partnership with Alzheimer's Orange County, the County of Orange Health Care Agency, Orange County United Way and other community partners; 2) Make a finding that such expenditure is 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 planning and development of the OCSPA.

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

Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors: 1) Authorized an expenditure of $10,000 from existing reserves to support the development of an Orange County Strategic Plan for Aging (OCSPA) in partnership with Alzheimer's Orange County, the County of Orange Health Care Agency, Orange County United Way and other community partners; 2) Made a finding that such expenditure is for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3) Authorized the CEO to execute agreements as necessary for the planning and development of the OCSPA. (Motion carried 8-0-0; Director Khatibi absent)***

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

Vice Chair Penrose commented on the need to develop criteria for event participation. Chair Refowitz responded that an ad hoc will be appointed to review the events policy and provide guidance and recommendations for Board consideration.

Action: ***On motion of Director Schoeffel, seconded and carried, the Board of Directors: 1) Authorized expenditures for CalOptima's participation in the following community events: up to $1,000 and staff participation at the 12th Annual NAMIWalks Orange County on Saturday, October 1, 2016 in Irvine; up to $1,000 and staff participation at the 4th Orange County Women's Health Summit on Friday, October 21, 2016 at Cal State University, Fullerton; up to $1,000 and staff participation at the 2016 California***

Association for Adult Day Services Fall Conference and Annual Meeting on Wednesday, November 16 through Friday, November 18, 2016 in Garden Grove; 2) Made a finding that such expenditure is for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3) Authorized the CEO to execute agreements as necessary for the events and expenditures. (Motion carried 8-0-0; Director Khatibi absent)

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

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors adopted Resolution No. 16-091, Approving CalOptima's Updated Human Resources Policy GA.8058: Salary Schedule, and approved proposed market adjustments for various positions as presented. (Motion carried 8-0-0; Director Khatibi absent)***

ADVISORY COMMITTEE UPDATES

10. Member Advisory Committee (MAC) Update

Mallory Vega, MAC Chair, provided an update on the recruitment efforts related to the vacant Recipients of CalWORKs MAC seat that ended on August 1, 2016, including outreach to community stakeholders and agencies that work with this population, notification to the CalOptima Board, and placement of vacancy notices on the CalOptima website. CalOptima received four applications from interested candidates. Recommendations will be presented to the Board for consideration at a future meeting.

11. Provider Advisory Committee (PAC) Update

Jenna Jensen, PAC Chair, reported on the activities at the August 11, 2016 PAC meeting, including presentations by Liberty Dental on OneCare Connect dental benefits, the SCAN Foundation regarding a survey on California's Coordinated Care Initiative, and the Illumination Foundation on the safety net system for the county's homeless population. The PAC also received updates on current Medical Affairs initiatives and Medi-Cal quality improvement performance measures for pediatric and adult care utilizing CalOptima's contracted health networks.

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

Patty Mouton, OCC MAC Chair, reported that a quorum was not reached at the Committee's scheduled July 28, 2016 meeting.

INFORMATION ITEMS

The following Information Items were accepted as presented:
13. July 2016 Financial Summary
14. Compliance Report
16. CalOptima Community Outreach and Program Summary

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15. Federal and State Legislative Advocates Reports

Trent Smith of Edelstein Gilbert Robson & Smith presented an overview of legislative activities and lobbying efforts at the state level during the past year, including the PACE Modernization Act, the Managed Care Organization Tax, and California Children's Services program reform.

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Members of the Board congratulated staff and CalOptima's provider partners on achieving NCQA Commendable status.

Supervisors Do and Bartlett reported that the Orange County Board of Supervisors recently approved $3 million in funding to expand crisis stabilization services in Orange County.

Chair Refowitz announced the formation of and appointments to the following ad hoc committees: 1) Health Network Contracts – Medi-Cal Expansion Population Ad Hoc, Directors Berger, Khatibi and Refowitz; 2) Health Network Payments to Providers/Medical Loss Ratio Ad Hoc, Directors Berger, DiLuigi, and Yost; 3) Events Policy Ad Hoc, Supervisors Bartlett and Do, Vice Chair Penrose, and Director Nguyen; and 4) Intergovernmental Transfers (IGT) Ad Hoc, Supervisor Do, and Directors Nguyen and Schoeffel.

ADJOURN TO CLOSED SESSION

The Board adjourned to closed session at 3:50 p.m. pursuant to Government Code Section 54956.9, subdivision (d)(2), Conference with Legal Counsel – Anticipated Litigation: Significant exposure to litigation (one case).

The Board of Directors reconvened to open session at 5:03 p.m. with no reportable action taken.

ADJOURNMENT

Hearing no further business, the meeting was adjourned at 5:03 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: October 6, 2016

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 18, 2016

CALL TO ORDER
Chair Viet Van Dang, M.D., called the meeting to order at 5:33 p.m., and led the Pledge of Allegiance.

Members Present: Viet Van Dang, M.D., Chair; Ellen Ahn; Tricia Nguyen

Members Absent: Theresa Boyd; Samara Cardenas, M.D.

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

MINUTES

1. Approve the Minutes of the March 23, 2016 Special Meeting of the CalOptima Board of Directors Quality Assurance Committee

Action: ***On motion of Director Ahn, seconded and carried, the Committee approved the Minutes of the March 23, 2016 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee as presented. (Motion carried 3-0-0; Directors Boyd and Cardenas absent)***

PUBLIC COMMENTS
There were no requests for public comment.

REPORTS

2. Recommend Board of Directors' Approval of Proposed Technical Changes to Policy GG. 1643: Minimum Physician Standards

Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to recommend Board of Directors' approval of the proposed technical changes to Policy GG. 1643: Minimum Physician Standards. Certain technical language issues requiring modification or clarification were identified subsequent to Board approval of Policy GG.1643 in April 2016. The following proposed technical changes to the policy were presented for review: the deletion of the definition of Healthcare Delivery Organizations; replace the date placeholder with the intended policy effective date of July 1, 2016;

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remove references related to the inclusion of physician assistants; and clarify that Health Networks must ensure that physicians providing services to CalOptima members meet the Minimum Physician Standards. It was noted that the manner in which the Health Networks incorporate verification of the Minimum Physician Standards in their processes is left to their discretion.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of the proposed technical changes to Policy GG. 1643; Minimum Physician Standards as presented. (Motion carried 3-0-0; Directors Boyd and Cardenas absent)***

INFORMATION ITEMS

3. PACE Member Advisory Committee Update

Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, reported that the PMAC met on April 25, 2016 and received a report from the PACE Director on the following topics: Secure Transportation will be adding another van to the PACE fleet due to the growth in PACE census; PACE is working with community providers to expand the network; and team education on patient-centered care. PMAC participant members discussed increasing physician hours at the center, and extended their thanks to PACE staff for the care received.

4. Behavioral Health Request for Proposal Update

Edwin Poon, PhD., Behavioral Health Services Director, presented an overview of Behavioral Health Services at CalOptima and the use of Managed Behavioral Health Organizations to provide expertise and specialization in the management of behavioral health benefits.

Terri Stanley, Executive Director of Clinical Operations, provided an update on the Behavioral Health RFP opportunities, including the potential to contract with one vendor for all services for better coordination among lines of business, operational efficiencies, administrative simplicity for providers and CalOptima, update contracts to align with current standards and requirements, and innovation and best practices. Key RFP evaluation metrics were reviewed with the Committee, including experience working with Medi-Cal and managed Medicare, NCQA accreditation, demonstrated success, operational efficiency and flexibility, and the ability to manage all lines of business and products. It is anticipated that the RFP will be issued in June 2016.

5. Quality Improvement Committee Update

Caryn Ireland, Executive Director, Quality and Analytics, presented an overview of Quality Improvement Committee activities for the first quarter, including cultural and linguistic services, disease management, case management, credentialing, and highlights of potential quality issues.

6. Member Experience Update

Kelly Rex-Kimmet, Quality and Analytics Director, presented an update on member experience scores in the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. An enterprise-wide Member Experience Work Group was formed to identify the focus areas and implement strategies related to member satisfaction scores. Areas of focus are Rating of Health Plan, Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service. A supplemental survey was developed and administered by CalOptima to approximately 26,000 members. Preliminary findings indicate that the supplemental survey results were higher than CAHPS

on the Rating of Health Plan, Rating of Doctor, and Rating of Health Plan; Getting Needed Care, Getting Care Quickly, and How Doctors Communicate were in line with CAHPS survey results. Further analysis is in progress regarding provider specific results and other qualitative analysis.

COMMITTEE MEMBER COMMENTS

Chief Executive Officer Michael Schrader extended his appreciation to Committee members for their dedication and service to the Board of Directors' Quality Assurance Committee.

ADJOURNMENT

Hearing no further business, Chair Dang adjourned the meeting at 6:43 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: September 21, 2016

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MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

THURSDAY, MAY 19, 2016, 2:00 P.M.

CALL TO ORDER
Chair Lee Penrose called the meeting to order at 2:04 p.m., and led the Pledge of Allegiance.

Members Present: Lee Penrose, Chair; Peter Agarwal, Mark Refowitz

Members Absent: Mike Ryan (non-voting)

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

MANAGEMENT REPORTS

Chief Financial Officer Report
Chief Financial Officer Chet Uma presented an update on the Governor's May Revision to the Fiscal Year 2016-17 State Budget proposal that was released on May 13, 2016. The May Revision proposes a total budget of $173 billion, an increase of 1.37 percent compared with the governor's budget proposed in January. It was noted that the outlook for Medi-Cal program spending is positive, due primarily to funding related to California's Section 1115 Waiver and the Managed Care Organization tax.

PUBLIC COMMENT
There were no requests for public comment.

INVESTMENT ADVISORY COMMITTEE UPDATE

1. Treasurer's Report

Mr. Uma presented an overview of the Treasurer's Report for the period January 1, 2016 through March 31, 2016, and noted that based on a review by the Board of Directors' Investment Advisory Committee, all investments were compliant with Government Code Section 53600, *et seq*, and with CalOptima's Annual Investment Policy for Calendar Year 2016.

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CONSENT CALENDAR

2. Approve the Minutes of the February 18, 2016 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the January 25, 2016 Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

REPORTS

3. Receive and File Quarterly Internal Audit Report

John Valenta of Deloitte presented a summary of the Fiscal Year (FY) 2015-16 Internal Audit Plan. Caitlin Holleran of Deloitte provided an overview of the observations and management action plans for the following internal audits reported during this period: Phishing Awareness, Telework, Procurement, Vendor Contract Management, and Payroll.

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

Action: ***On motion of Director Agarwal, seconded and carried, the Committee received and filed the Quarterly Internal Audit Report as presented. (Motion carried 3-0-0)***

4. Recommend Adoption of Resolution Approving Updated CalOptima Policy GA.8058, Salary Schedule

Ron Santos, Executive Director, Human Resources, presented the action to recommend adoption of a resolution approving updates to CalOptima Policy GA.8058, Salary Schedule.

Director Agarwal suggested revising sections III. B, and IV. D, of Policy GA.8058 as follows: 1) section III. B., The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper to implement the salary schedule for all other employees not inconsistent therewith; and 2) section IV. D., insert the following language in line 3, No changes to the salary schedule or CEO compensation shall be effective unless and until approved by the CalOptima Board of Directors.

Action: ***On motion of Director Agarwal, seconded and carried, the Committee recommended Board adoption of a resolution approving updates to CalOptima Policy GA.8058, Salary Schedule as revised. (Motion carried 3-0-0)***

5. Recommend Approval of the CalOptima FY 2016-17 Operating Budget

Mr. Uma presented the action to recommend that the CalOptima Board of Directors: 1) Approve the CalOptima FY 2016-17 Operating Budget; 2) Authorize the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima policy; and 3) Approve continued Medi-Cal medical expenditures at payment rates in effect on June 30, 2016, until the Board approves a final FY 2016-17 Medi-Cal medical budget. In authorizing continued Medi-Cal medical expenditures, the Board expressly reserves the right to consider retroactive adjustments based on Board approved rate amendments from the State.

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Mr. Uma reported that the proposed FY 2016-17 Operating Budget assumes an average monthly enrollment of approximately 805,000 members, revenue at approximately $3.4 billion, medical costs of approximately $3.2 billion, operating income of $6.5 million, and a total change in net assets of $9 million. A detailed review of the proposed FY 2016-17 Operating Budget by line of business was presented to the Committee for discussion.

Chair Penrose directed staff to present a detailed presentation on the PACE Program at the next Board of Directors' Finance and Audit Committee meeting.

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

Action: ***On motion of Director Refowitz, seconded and carried, the Committee recommended that the Board of Directors: 1) Approve the CalOptima FY 2016-17 Operating Budget; 2) Authorize the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima policy; and 3) Approve continued Medi-Cal medical expenditures at payment rates in effect on June 30, 2016, until the Board approves a final FY 2016-17 Medi-Cal medical budget. In authorizing continued Medi-Cal medical expenditures, the Board expressly reserves the right to consider retroactive adjustments based on Board approved rate amendments from the State. (Motion carried 3-0-0)***

6. Recommend Approval of the CalOptima FY 2016-17 Capital Budget

Mr. Uma presented the action to recommend that the CalOptima Board of Directors approve the CalOptima FY 2016-17 Capital Budget composed of the following: information systems hardware, software and professional fees, $9.5 million; 505 Building improvements, $552,000; and PACE, $61,000. As proposed, the FY 2016-17 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.

Action: ***On motion of Director Refowitz, seconded and carried, the Committee recommended that the Board of Directors approve the CalOptima FY 2016-17 Capital Budget authorize the expenditure and appropriate the funds for the items listed in Attachment A: Capital Budget by Project, which shall be procured in accordance with CalOptima policy. (Motion carried 3-0-0)***

INFORMATION ITEMS

7. Behavioral Health Request for Proposal Update

Edwin Poon, PhD, Director of Behavioral Health Services, presented an overview of CalOptima Behavioral Health Services and Managed Behavioral Health Organizations (MBHOs) that provide expertise and specialization in the management of behavioral health benefits. Dr. Poon reported that a Request for Proposal (RFP) process will be conducted with a potential to contract with one vendor for all services that will provide better coordination among lines of business and products, operational efficiencies, and administrative simplicity. Key RFP evaluation metrics include the following: local

support, Medi-Cal and managed Medicare experience, NCQA accreditation, demonstrated success, operational efficiency and flexibility, and ability to manage all lines of business and products.

Chair Penrose requested that staff include a member of the Member and Provider Advisory Committees in the RFP evaluation process.

8. 2016 Audit Planning

John Blakey and Aparna Venkateswaran of Moss-Adams LLP, presented a review of the scope of services for the annual consolidated financial statement audit for the year ending June 30, 2016. The interim fieldwork is scheduled to begin on May 23, 2016, and the draft audited financial statements will be presented to the Finance and Audit Committee for review at the September meeting.

9. March 2016 Financial Summary

Mr. Uma presented a summary of the consolidated enrollment, revenues, and medical expenses for the month ending March 31, 2016. Overall enrollment reached 793,328 members; revenues, $265.3 million; medical expenses, $251.3 million; and a change in net assets of $7.2 million.

10. CalOptima Computer Systems Security Update

Len Rosignoli, Chief Information Officer, presented a brief update on CalOptima's information systems, including a report on commonly triggered attempts against entire areas of the Internet, and a summary of a recent Ransomeware attack involving a single user. The following enhancements to CalOptima information security infrastructure are in progress to maximize protection against future Ransomeware attacks: additional user defined rules added to anti-virus software; updated filters to block all web traffic to specific countries known for malicious computer activity; the installation of intrusion prevention system software; and ensuring all systems and applications are up to date with all patches and security enhancements.

11. CalOptima Insurance Coverage Summary for 2016-17

Kelly Klipfel, Financial Compliance Director, provided a review of business insurance coverage for policy year 2017. It was reported that staff conducted an RFP process for insurance broker services, and AON was awarded a three-year contract effective April 1, 2016, with two options for annual renewals. Policy year 2016 coverage for 505 City Parkway West, Data Center and PACE Center includes the following: Managed Care and Excess E&O, PACE Medical Malpractice, D&O/Excess D&O, Umbrella and Excess Liability, Network & Privacy, Pollution, Earthquake, and Workers Comp.

The following Information Items were accepted as presented:

12. Cost Containment Improvements/Initiatives
13. Catastrophic Claims Update
14. Quarterly Reports: Shared Risk Pool Performance, Reinsurance Report, Health Network Financial Report, and Purchasing Report

COMMITTEE MEMBER COMMENTS

Committee members thanked staff for their work on the proposed FY 2016-17 Operating and Capital Budget.

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ADJOURNMENT

Hearing no further business, Chair Penrose adjourned the meeting at 4:25 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: September 15, 2016

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MINUTES

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

August 11, 2016

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, August 11, 2016 at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Jena Jensen, PAC Chair, called the meeting to order at 8:06 a.m., and Member Caliendo led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Alan Edwards, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Stephen N. Flood; Jena Jensen; Pamela Kahn, R.N.; George Orras, Ph.D.; FAAP; Pamela Pimentel, R.N.; Barry Ross, R.N., MPH, MBA
Members Absent:	Anjan Batra, M.D.; Teri Miranti; John Nishimoto, O.D.; Mary Pham, Pharm.D, CHC; Suzanne Richards, RN, MBA, FACHE; Jacob Sweidan, M.D.
Others Present:	Michael Schrader, Chief Executive Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Ladan Khamseh, Chief Operating Officer; Nancy Huang, Director, Finance; Arif Shaikh, Director, Government Affairs; Kelly Rex Kimmet, Director, Quality Analytics; Cheryl Simmons, Staff to the PAC

MINUTES

Approve the Minutes of the June 9, 2016 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Pimentel seconded and carried, the Committee approved the minutes of the June 9, 2016 meeting. (Motion carried 10-0-0; Members Batra, Miranti, Nishimoto, Pham, Richards and Sweidan absent)***

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PUBLIC COMMENTS

No requests for public comments were received.

On behalf of the PAC, Chair Jensen welcomed new PAC member Donald Bruhns as the Long Term Services and Support Representative. The PAC also presented recognition awards to Camille Fitzpatrick, Non-Physician Medical Practitioner Representative, and Cheryl Petterson, Long-Term Services and Support Representative in honor of their service on the PAC.

PAC Chair Jensen reordered the agenda to hear Agenda Items VII.B, Liberty Dental Presentation, VII.C, SCAN Foundation Cal MediConnect Satisfaction Survey Results presentation and VII.D, Illumination Foundation Presentation before continuing with the CEO and Management Reports.

PRESENTATIONS

Liberty Dental

Edward Bynam, Director of Special Projects, provided the PAC members with an overview of the current supplemental benefits provided to OneCare Connect members. Mr. Bynam noted that all Cal MediConnect providers in Liberty's network are also contracted with Denti-Cal to ensure seamless coordination of benefits.

The SCAN Foundation

Megan Juring, Program Officer, shared findings from Waves 1-3 of the Rapid Cycle Polling Project, a survey on California's Coordinated Care Initiative (CCI), which evaluated and tracked beneficiary transitions into Cal MediConnect (CMC) over time. Wave 3 included CMC enrollees and opt-outs in Orange and San Mateo Counties. Data for Wave 3 was collected between February and April 2016 and indicated that CMC enrollees had an 84% confidence in the Orange and San Mateo Plans. This was compared to the other counties who were surveyed in Waves 1 (76%) and 2 (73%). Waves 1 and 2 covered five counties - Los Angeles, Riverside, San Bernardino, San Diego and Santa Clara Counties.

Illumination Foundation

Aiko Tan, Executive Director of Healthcare, and Paul Cho, Chief Financial Officer, presented on the safety net system for Orange County's chronically homeless population, and the Foundation's partnership with other health care organizations recuperative care program.

CEO AND MANAGEMENT REPORTS

Chief Financial Officer Update

Nancy Huang, Controller, presented CalOptima's Financial Summary for June 2016. Ms. Huang reviewed the financial highlights with the members noted that the total current assets were $1,768,751,279, total current liabilities were $1,608,744,299 and reserves as of June 20, 2016 were $476,135,365. Ms. Huang also reviewed the Health Network Enrollment Summary by Health Network and noted that total Medi-Cal enrollment was at 782,413 at the end of the fiscal year.

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Chief Medical Officer Update
Dr. Richard Bock, Deputy Chief Medical Officer, provided a progress report on MedImpact, the new Pharmacy Benefits Manager (PBM).

He also discussed a supplemental survey that is being completed with help from the PAC CAHPS Ad Hoc Committee. Dr. Bock updated the PAC on how physicians are being educated about combating the current opioid epidemic. As part of the CMO report, Kelly Rex-Kimmet, Director, Quality Analytics, gave a HEDIS update on the Medi-Cal quality improvement performance measures and scores for both pediatric and adult care.

Chief Operating Officer Update
Ladan Khamseh, Chief Operating Officer, notified the PAC that the Board of Directors approved the PAC's recommendation for a change to the Health Network Minimum Medi-Cal Enrollment Requirements, and authorized a change to CalOptima's Medi-Cal Policy EE.1106. Ms. Khamseh also noted that the Board approved a full 36 months for new Health Networks to reach and maintain a minimum 5,000 members. She noted that the Board expressed its appreciation to the PAC for its input and consideration.

Ms. Khamseh also updated the members on the ongoing Behavioral Health RFP process. Vendor interviews are currently in process. Member Ross inquired whether any of the comments from the joint MAC/PAC meeting on behavioral health in January 2016 were being taken into consideration when interviewing these vendors. Ms. Khamseh confirmed that they were.

INFORMATION ITEMS

Federal and State Budget Update
Arif Shaikh, Director, Government Affairs, provided a brief review of the State Budget Update and the Legislative Tracking Matrix that follows healthcare bills currently pending in the State Legislature.

PAC Member Comments
Member Caliendo thanked CalOptima for sponsoring the autism program that provides pediatric physicians with the tools and training necessary to make autism diagnoses. Dr. Caliendo noted that the program was well worth the time spent, and he would recommend it to his colleagues.

Chair Jensen reported that the addition of an advisory committee vice chair position was approved by the Board at its August meeting. She also noted that nominations for FY 2016-17 PAC Chair will be reopened as directed by the Board. Chair Jensen requested that any PAC member interested in the chair or vice chair position submit their name to the Staff to the PAC by August 19, 2016. The Nominations Ad Hoc Committee will be reconvened if necessary before the next PAC meeting to review, and recommend candidates for the chair and vice chair positions at the next PAC meeting.

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ADJOURNMENT

There being no further business before the Committee, the PAC Chair adjourned the meeting at 10:05 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: September 8, 2016

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MINUTES

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

August 25, 2016

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on August 25, 2016, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Patty Mouton called the meeting to order at 3:07 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Ted Chigaros, Christine Chow, Gio Corzo, Josefina Diaz, John Dupies, Donta Harrison, Sara Lee, Patty Mouton, OCC MAC Chair
Members Absent:	Sandy Finestone, Susie Gordee, Lena Berlove (non-voting), George Crits (non-voting), Jorge Sole (non-voting), Erin Ulibarri (non-voting)
Others Present:	Ladan Khamseh, Chief Operating Officer; Candice Gomez, Executive Director, Program Implementation; Emily Fonda, M.D., Medical Director; Richard Bock, M.D. , Deputy Chief Medical Officer; Caryn Ireland, Executive Director, Quality Analytics; Phil Tsunoda, Executive Director, Public Affairs; Albert Cardenas, Associate Director, Customer Service; Belinda Abeyta, Director, Customer Service; Tracy Hitzeman, Interim Executive Director, Clinical Operations

MINUTES

Approve the Minutes of the June 23, 2016 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Member Gio Corzo, seconded and carried, the OCC MAC approved the June 23, 2016 minutes as submitted.***

PUBLIC COMMENT
Theresa Boyd – Oral re: community resources.

PRESENTATION

The SCAN Foundation
Megan Juring, Program Officer, SCAN Foundation, presented an overview on the findings from waves 1-3 on the Coordinated Care Initiative (CCI) evaluation survey. The survey evaluated and tracked beneficiary transitions over time into Cal MediConnect (CMC). The SCAN Foundation

collaborated with the Department of Health Care Services (DHCS) and Field Research Corporation to conduct the rapid cycle polling project. Data collection periods were conducted in three separate waves starting in June 2015 and ending in April 2016. The three key measures included the following: confidence and satisfaction with health services; CMC enrollee comparison to opt-outs and others in non-participating counties; and characteristics of CMC opt-outs. Rapid cycle polling for wave four will be conducted in fall 2016.

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Medical Officer (CMO) Update

Richard Bock, M.D., Deputy Chief Medical Officer, reported that CalOptima completed the Request for Proposal (RFP) process for a behavioral health vendor. CalOptima will forward the recommendation to the CalOptima Board for consideration at the September 1, 2016 Board meeting. Implementation of the behavioral health vendor is scheduled for January 1, 2017.

Dr. Bock updated the committee on the opioid epidemic in Orange County, noting that Medi-Cal beneficiaries are prescribed opioids at twice the rate of non- Medi-Cal beneficiaries. The Centers for Medicare & Medicaid Services (CMS) released an information bulletin on safe prescribing practices. DHCS provided information on quality improvement in health care, including an initiative on opioid related morbidity and mortality. CalOptima will review prescribing processes and will discuss with the State the possibility of pharmacy lock-in provisions for members receiving opioid prescriptions from more than three physicians.

INFORMATION ITEMS

Healthcare Effectiveness Data and Information Set (HEDIS) Update

Caryn Ireland, Executive Director, Quality and Analytics, presented a Healthcare Effectiveness Data and Information Set (HEDIS) update, which rates the care members receive by line of business on an annual basis. Ms. Ireland reported the ratings for Medi-Cal and OneCare, noting that OneCare Connect measures would be included in next year's report. For Medi-Cal, CalOptima's performance was as follows: met six goals; scored higher than last year on 14 goals; did not meet the goal on 27 measures; and performed below minimal performance level (MPL) on two measures. For OneCare, CalOptima's performance was as follows: met eight goals; scored higher than last year on nine measures; and did not meet the goal on 17 measures.

Update on OneCare Connect Dental Benefit

Albert Cardenas, Associate Director, Customer Service, provided an overview of the dental plan for OneCare Connect members. He reported that OneCare Connect members have Denti-Cal as the primary carrier and Liberty Dental as the supplemental carrier. Upon enrollment, every member receives a list of benefits covered at no cost to the member and a fee schedule outlining the procedures that are not covered and have co-pays.

Legislative Update

Phil Tsunoda, Executive Director, Public Affairs, reported that the State Legislature would adjourn on Wednesday, August 31, 2016. He also reported that CalOptima invited Sacramento

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lobbyist Trent Smith to present at the September 1, 2016 Board of Directors meeting, and OCC MAC members are invited to attend to hear the Sacramento advocate report on the legislative session that ends on August 31.

OCC Member Enrollment Update

Belinda Abeyta, Director, Customer Service, provided an update on the OneCare Connect member enrollment. As of August 2016, OCC enrollment was 18, 273 with an opt-out rate of 57.09%. The three health networks with the highest enrollment were Monarch, Prospect Medical, and CalOptima Community Network.

OCC Update

Candice Gomez, Executive Director, Program Implementation, reported that the Long-Term Care (LTC) facility passive enrollment ended July 2016. Ms. Gomez provided the following OneCare Connect member enrollment demographics: language break down indicated that 44% speak English, 28% speak Spanish and 13% speak Vietnamese; and member break down by age indicated that 23% of the members are between 21-64 years of age, 21% are between 65-69 years of age, and 34% are between 70-79 years of age. The majority of OneCare Connect members reside in Anaheim, Santa Ana, Garden Grove and Westminster. In addition, the highest percentages of opt-outs within a language were Korean at 74%, Vietnamese at nearly 70% and Farsi at 56%.

OCC MAC Member Presentation on Quarterly Ombudsman Update

Sara Lee, Supervising Attorney, Legal Aid Society of Orange County (LASOC), reported that LASOC receives less than five OCC referrals from CalOptima monthly regarding OneCare Connect enrollment issues. Member Lee provided a few examples of the types of calls LASOC receives, such as termination of Medi-Cal benefits when a member changes county of residence and prescription refill problems upon enrollment in OCC. She also reported there is still confusion about the supplemental dental benefits, as many members are not aware of the supplemental coverage and some members believe they must pay an additional premium for the supplemental dental benefits. In addition, LASOC discovered an error in the welcome dental letter issued by Liberty Dental regarding cleaning services for OCC members. CalOptima notified Liberty Dental and the letter was corrected. CalOptima will cover cleaning benefits for OCC members who tried to access services relying on the incorrect information.

OCC MAC Member Updates

Chair Mouton announced that the Board approved the OCC MAC vice-chair position at the August 4, 2016 meeting with a directive to revisit the nomination of the committees' chairs at the same time as the committee is reviewing and selecting the vice-chair candidate. Chair Mouton indicated that the directive requires OCC MAC to reopen the nominations for the OCC MAC chair position and open nominations for the vice-chair position. OCC MAC members may apply for both positions simultaneously. The deadline to apply for either position is August 31, 2016. The OCC MAC Nominations Ad Hoc Subcommittee will be reconvened with members who have not indicated an interest in either position. The Ad Hoc will make a recommendation on its selection of the chair and vice-chair for full OCC MAC approval. Upon OCC MAC's approval, the Board will consider the recommendation at an upcoming Board meeting.

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Chair Mouton reported that at the last meeting, the committee talked about doing a service project as a committee; however, this is outside the scope of this committee. In addition, the committee discussed a possible tour of the Program of All-Inclusive Care for the Elderly (PACE) Center at an upcoming meeting. A presentation on the PACE program will be provided at the next meeting. OCC MAC members who want to tour the PACE Center should contact Becki Melli, CalOptima Staff to the OCC MAC.

Member Josefina Diaz will present at the next OCC MAC meeting in September on the Legal Aid Society of Orange County, and Member Susie Gordee will present the OCC MAC presentation in October.

Chair Mouton requested agenda items for upcoming OCC MAC meetings. A suggestion was made for information on hospice care.

Chair Mouton announced that the next OneCare Connect MAC meeting is September 22, 2016 at 3:00 p.m.

ADJOURNMENT
Hearing no further business, Chair Mouton adjourned the meeting at 4:43 p.m.

/s/ Cindi Reichert
Cindi Reichert
Program Assistant

Approved: September 22, 2016

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MINUTES

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

June 23, 2016

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on June 23, 2016, at CalOptima, 505 City Parkway West, Orange, California.

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

ESTABLISH QUORUM

Members Present: Ted Chigaros, Christine Chow, Gio Corzo, Josefina Diaz, Susie Gordee, Donta Harrison, Sara Lee, Patty Mouton, George Crits, M.D., (non-voting), Jorge Sole (non-voting), Erin Ulibarri (non-voting)

Members Absent: Sandy Finestone, Lena Berlove (non-voting)

Others Present: Michael Schrader, Chief Executive Officer, Ladan Khamseh, Chief Operating Officer; Candice Gomez, Executive Director Program Implementation; Emily Fonda, M.D., Medical Director; Richard Bock, M.D. , Deputy Chief Medical Officer; Caryn Ireland, Executive Director Quality Analytics; Phil Tsunoda, Executive Director Public Affairs; Albert Cardenas, Associate Director Customer Service; Belinda Abeyta, Director Customer Service; Becki Melli, Customer Service

MINUTES

Approve the Minutes of the May 26, 2016 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Action: ***On motion of Member Susie Gordee, seconded and carried, the OCC MAC approved the May 26, 2016 minutes as submitted.***

PUBLIC COMMENT
There were no requests for public comment.

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer (CEO) Report
Michael Schrader, Chief Executive Officer, provided an update on the Managed Care Organization Tax (MCO) approval. On May 17, 2016, the Centers for Medicare & Medicaid Services (CMS) signed off on California's MCO tax enabling the state to draw down additional

money to pay for the growing Medi-Cal program. The approval came after Governor Jerry Brown released the May Revision to his state budget proposal, which included revenue from the MCO tax. The tax will bring in an estimated $1.1 billion for Medi-Cal in the coming fiscal year, as well as allocate more money for programs that serve people with developmental disabilities. The May Revision also authorizes continuation of the Coordinated Care Initiative (CCI), including CalOptima's OneCare Connect program, through January 1, 2018.

Chief Medical Officer (CMO) Update

Richard Bock, M.D., Deputy Chief Medical Officer, provided several brief medical updates. Dr. Bock reported that CalOptima has begun the Request for Proposal (RFP) process to identify a potential behavioral health vendor that could contract with CalOptima for all lines of business. He added that one vendor would be preferable, but is not a requirement. Dr. Bock reported that the Member Experience work group continues to work on improving patient satisfaction and member experience. The Pay for Value program, which is nearing completion, will offer physicians various incentives. Dr. Bock added that this program incorporates multiple lines of business and numerous health networks. CalOptima completed the pharmacy mock audit for the Pharmacy Benefit Management (PBM) and the process went smoothly with minimal changes.

INFORMATION ITEMS

Supplemental Transportation Benefits

Albert Cardenas, Associate Director, Customer Service, presented an overview of the OneCare Connect Supplemental Transportation Benefit. This supplemental benefit provides 30 one-way taxi trips per calendar year for health care related services. Trips are limited to a ten-mile radius from the OneCare Connect service area (Orange County line). Mr. Cardenas reported that approximately 2,158 OneCare Connect members, or 11.89%, utilized the transportation benefit as of May 31, 2016. The number of trips provided totaled 18,798, with members utilizing this service most frequently to go to their doctor's office and dialysis centers. The highest utilizers of the benefit were members between 70-79 years of age. Mr. Cardenas noted that American Logistics is the contracted vendor for this benefit.

Legislative Update

Phil Tsunoda, Executive Director, Public Affairs, provided an update on the 2016 Orange County open primary election results. As of Thursday, June 23, 2016, the Orange County Registrar of Voters had approximately 11,000 ballots remaining to be counted before officially certifying the election results. Mr. Tsunoda noted that several races were too close to call until all ballots were counted. The top two candidates in each race will move on to the November General Election. The Orange County Registrar of Voters anticipated finalizing the ballot count by June 24, 2016. After the final count, the candidates have five days to contest the results and ask for a recount. Any delay would prolong the period before we know who would advance to the General Election in November.

OCC Member Enrollment Update

Belinda Abeyta, Director, Customer Service, provided an update on the OneCare Connect member enrollment. As of June 16, 2016, OCC enrollment was 18, 431 with an opt-out rate of

60.12%. The three health networks with the highest enrollment were Monarch, Prospect Medical, and CalOptima Community Network.

Candice Gomez, Executive Director, Program Implementation, updated the committee on the Long-Term Care (LTC) facility passive enrollment for OneCare Connect. There are 58 facilities remaining for passive enrollment for the month of July, which is the last month of passive enrollment. Many of these facilities have less than five members. The LTC opt-out rate for June is 69.75%.

OneCare Connect Update

Ms. Gomez reported on the state's dual Medicare and Medi-Cal beneficiaries survey for individuals enrolled in the Cal MediConnect (CMC) program. The survey measured the member's satisfaction with their transition to the new program and was conducted on behalf of the SCAN Foundation and in conjunction with the Department of Health Care Services (DHCS). The survey indicated that Cal MediConnect enrollees are expressing increased confidence in the program and increased satisfaction with their health care services over time. The most commonly cited problem was a member's physician not being available through the Cal MediConnect program. About two thirds of the members reported that having a main contact in the plan, such as a Care Navigator or Case Manager, has helped improve their care.

OCC MAC Member Presentation – Overview of the Orange County Social Services Agency Adult Services Division

Member Jorge Sole, Deputy Director, Social Service Agency (SSA), provided an overview of the Orange County SSA Adult Services Division. The Adults Services division has responsibility for Adult Protective Services (APS) and In-Home Supportive Services (IHSS). APS is a state mandated program that responds to allegations of elder and dependent adult abuse. Mr. Sole explained that the incidence of elder abuse increases significantly with age, as seniors who are 85 years and over are almost six times more likely to be suffering from abuse as those between the ages of 64-69. IHSS is a state program that helps pay for services provided to low-income elderly, blind or disabled individuals so they can remain safely in their homes. IHSS is an alternative to out-of-home care, such as nursing homes or board and care facilities. Mr. Sole noted that 21,432 IHSS providers are in active status in Orange County and approximately 70% of these providers are relatives of the recipient. The IHSS Public Authority (PA) keeps a registry of about 5,000 providers for recipients looking for a care provider.

OCC MAC Member Updates

Chair Mouton announced that the Alzheimer's Orange County and Orange County Advance Care Planning Partners are sponsoring a leadership forum on end of life care that will be held August 4, 2016.

Member Sole announced that social workers in the APS division welcome donations for two charitable programs, including 'Senior Santa & Friends' and 'Operation Santa Claus'. He added that he would inquire about having a presentation on these programs at an upcoming OCC MAC meeting. Member Sole also said that he would try to arrange a presentation on Medi-Cal

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eligibility to give OCC MAC committee members a better understanding of what the eligibility requirements are.

Member Erin Ulibarri will present on the Orange County Office on Aging at the July OCC MAC meeting and Member Sara Lee will present her Quarterly Ombudsman Update in August. Members Josefina Diaz and Susie Gordee volunteered to present at upcoming meetings.

Chair Mouton announced that the next OneCare Connect MAC meeting is July 28, 2016 at 3:00 p.m.

ADJOURNMENT
Hearing no further business, Chair Mouton adjourned the meeting at 4:35 p.m.

/s/ Cindi Reichert
Cindi Reichert
Program Assistant

Approved: August 25, 2016

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

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

Recommended Action
Consider reappointment of the following individual to fill a current vacancy on the CalOptima Investment Advisory Committee:

1. David Young for a two-year term beginning October 6, 2016.

Background
At the September 10, 1996, Special meeting, the CalOptima Board of Directors authorized the creation of the CalOptima Investment Advisory Committee (IAC), established qualifications for committee members, and directed staff to begin recruitment of volunteer members to the IAC. IAC members do not make recommendations on individual investments. However, their role is to make recommendations to the Finance and Audit Committee (FAC) on changes to the Annual Investment Policy (AIP), and to monitor the performance of CalOptima's investments, investment advisor and investment managers.

When creating the IAC, the CalOptima Board stipulated that the committee would consist of five members. One member would automatically serve on the committee by virtue of his or her position as CalOptima's Chief Financial Officer (CFO). The remaining four members would be Orange County residents possessing experience in one or more of the following areas: investment banking, investment brokerage and sales, investment management, financial management and planning, commercial banking, or financial accounting.

At the September 5, 2000, meeting, the Board approved expanding the composition of the IAC from five members to seven members in order to have more diverse opinions and backgrounds to advise CalOptima on its investment activities.

Discussion
The following candidate recommended for reappointment has consistently provided leadership and service to CalOptima's investment strategies through his participation as a member of the IAC.

David Young has served as a member of the IAC since June 4, 2009. Mr. Young is founder and Chief Executive Officer of Anfield Group, LLC, a financial consulting and investment advisory firm. In 2008, he retired as Executive Vice President and Account Manager of Pacific Investment Management Company (PIMCO) and rejoined the University of California, Irvine (UCI) Paul Merage School of Business as Adjunct Professor. From 1999 to 2006, he was head of PIMCO's account management group in London. Prior to that, Mr. Young held positions at Analytic Investment Management, Smith Barney, and Harris Upham. He has over 30 years of investment experience, and is a Certified Financial Advisor (CFA). In addition, Mr. Young is a member of the CFA Society of Orange County Board of

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Directors, and the chair of its Investment Committee. He also is board member of the UCI Paul Merage School of Business Center for Investment & Wealth Management Executive Committee, and chairs its Journal editorial board. Mr. Young received his undergraduate degree and M.B.A from UCI. His current IAC term expired on June 5, 2016.

Mr. Young was previously appointed to the IAC by the CalOptima Board of Directors on June 4, 2015, for a one-year term beginning June 6, 2015.

Fiscal Impact
There is no fiscal impact. An individual appointed to the IAC would assist and advise CalOptima in safely maintaining an acceptable return on investment on invested funds.

Rationale for Recommendation
The individual recommended for re-appointment for CalOptima's IAC has extensive experience that meets or exceeds the specified qualifications for membership on the IAC. In addition, the candidate has a long history of providing outstanding service as a member of the IAC.

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

Attachments
None

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

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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

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into a contract with Provencio Advisory Services, with the assistance of legal counsel, to conduct a Medical Loss Ratio (MLR) audit of CalOptima's contracted health networks participating in the Medi-Cal and OneCare Connect Programs effective October 10, 2016. As recommended, the contract will be for a three (3) year term, with two additional one-year extension options, each exercisable at CalOptima's sole discretion; and
2. Approve allocation of $233,200 from existing reserves to fund the contract through June 30, 2017.

Background

Minimum MLR requirement for Medi-Cal Classic
At the May 7, 2002, meeting, the CalOptima Board of Directors (Board) established a minimum MLR for CalOptima's contracted health networks at eighty-five percent (85%) as part of a health network's participation requirement. At the time, the minimum MLR requirement for health networks was not a state-mandated requirement. The Board approved the minimum MLR of 85% for medical services to ensure that a reasonable portion of capitated payments went to medical care for members.

The Centers for Medicare & Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program (CHIP) managed care final rule (CMS-2390-F) in the May 6, 2016, Federal Register. The regulations stipulate that states must ensure through its Medicaid managed care contracts beginning on or after July 1, 2017, that plans calculate and report an MLR. If a state elects to mandate a minimum MLR, it must be equal to or higher than 85%.

Minimum MLR requirement for Medi-Cal Expansion
At the December 5, 2013, meeting, the Board authorized the CEO to execute amendment 17 (A-17) to the Primary Agreement with the California Department of Health Care Services (DHCS). A-17 incorporated provisions to implement Medi-Cal Expansion in accordance with the Affordable Care Act (ACA), including MLR requirements for medical services provided to the Medi-Cal Expansion population. CalOptima is required to spend at least 85% of net capitation payments received on allowed medical expenses for adult expansion members. Specifically:

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CalOptima MLR	Action
≤85%	CalOptima returns payment to DHCS Amount: Difference between 85% of total net capitation payments received and the actual allowed medical expenses incurred
>85% and ≤95%	No action required
>95%	DHCS makes payment to CalOptima Amount: Difference between the actual allowed medical expenses incurred and 95% percent of total net capitation payments received

In addition, CalOptima's current Physician Hospital Consortium (PHC), Shared Risk Group (SRG) and Health Maintenance Organization (HMO) contracts include the requirement to maintain a minimum acceptable MLR of 85% in accordance with CalOptima Policy FF.3003 Minimum Medical Loss Ratio.

Minimum MLR requirement for OneCare Connect
Although not a program requirement from CMS, CalOptima includes a minimum MLR ratio requirement of 85% in all health network contracts, in accordance with CalOptima Policy FF.3003 Minimum Medical Loss Ratio, to ensure adequate and efficient delivery of services to this vulnerable population.

Previous MLR audits
KPMG performed CalOptima's initial Agreed-Upon Procedures (AUP) audit of health networks' MLRs for Calendar Year 2003 data. After this initial AUP audit, CalOptima conducted a Request for Proposal (RFP), and awarded a five year contract to Provencio on March 15, 2005. This contract was extended on an annual basis, until it expired in 2014 while CalOptima Finance staff evaluated the usefulness of the AUP audits.

Discussion
Since Provencio's contract expired in 2014, CalOptima has not conducted an audit of health networks' MLR. At the Board's request during the May 5, 2016 meeting, and in order to ensure compliance with contractual requirements, as well as federal and state regulations, on June 6, 2016, CalOptima initiated an RFP for a consultant to conduct an MLR audit performed under the American Institute of Certified Public Accountants (AICPA) Standards for Consulting Services. The selected vendor will use the CMS definition of MLR to determine allowable expenses for Accounting Years 2014 and 2015 for each health network or other standards as appropriate. The audit results will report MLR by each line of business (Medi-Cal Classic, Medi-Cal Expansion, and OneCare Connect) and in aggregate (Medi-Cal overall and CalOptima overall).

Three RFP responses were received by the June 29, 2016, deadline, and each potential vendor was interviewed between August 3, 2016, and August 11, 2016. The evaluation team selected Provencio Advisory Services on August 29, 2016, after reviewing best and final offers. Projected expenses of

$233,200, to audit CalOptima's thirteen (13) health networks during Fiscal Year (FY) 2016-17, is subject to final contract negotiation and execution by both parties.
Funding for a consultant to conduct an MLR audit was not included in the CalOptima FY 2016-17 Operating Budget approved by the Board on June 2, 2016. Management proposes to make an allocation of $233,200 from existing reserves to fund the recommended actions.

Fiscal Impact
The recommended action to contract with Provencio Advisory Services to conduct an MLR audit of contracted health networks participating in the Medi-Cal and OneCare Connect programs is an unbudgeted item. An allocation of $233,200 from existing reserves will fund this action.

Management will include expenses for the period of July 1, 2017 through October 10, 2019, related to the proposed contract in the CalOptima FY 2017-18 and FY 2018-19 Operating Budgets.

Rationale for Recommendation
The MLR audit of contracted health networks participating in the Medi-Cal and OneCare Connect programs will ensure CalOptima's compliance with federal and state MLR regulations, and health networks' compliance with contractual provisions.

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

Attachments
None

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

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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

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

Contact

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

Recommended Action

Approve recommended revisions to the adopted FY 2016-17 CalOptima Board of Directors Meeting Schedule to change the Board of Directors' Quality Assurance Committee meeting date and time through June 30, 2017.

Discussion

On June 2, 2016, the Board of Directors adopted the FY 2016-17 schedule of meetings for the Board of Directors, Board of Directors' Finance and Audit Committee, and Board of Directors' Quality Assurance Committee through June 30, 2017. As adopted, the Board of Directors' Quality Assurance Committee meeting schedule reflects quarterly meetings at 5:30 p.m. on the fourth Wednesday of the months of September, November, February and May.

At the Regular Board of Directors' Quality Assurance Committee (QAC) meeting held on September 21, 2016, the QAC considered modifying the meeting time for the remainder of the fiscal year, and the date of the May 2017 meeting due to conflicting Committee member schedules. The QAC recommends revising the Board of Directors' Quality Assurance Committee regular meeting schedule as follows:

- Change meeting time to 3:00 p.m. on the following scheduled meeting dates:
  - Wednesday, November 16, 2016;
  - Wednesday February 15, 2017; and
- Revise the date and time of the meeting scheduled on Wednesday May 17, 2017 to Wednesday, May 10, 2017 at 3:00 p.m.

Unless otherwise noticed, all QAC meetings will be held at CalOptima's offices located at 505 City Parkway West in Orange, California.

Fiscal Impact

None

Rationale for Recommendation

The recommended action will revise the Board of Directors' FY 2016-17 Meeting Schedule as required in Section 5.2 of the Bylaws.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
Proposed Revised FY 2016-17 Board of Directors' Meeting Schedule

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

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A Public Agency

CalOptima

Better. Together.

Proposed Revised

Board of Directors Meeting Schedule
July 1, 2016 – June 30, 2017

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: ~~5:30~~ 3:00 p.m.**
July 2016^		
August 4, 2016		
September 1, 2016	September 15, 2016	September 21, 2016
October 6, 2016		
November 3, 2016	November 17, 2016	November 16, 2016
December 1, 2016		
January 2017^		
February 2, 2017	February 16, 2017	February 15, 2017
March 2, 2017		
April 6, 2017		
May 4, 2017	May 18, 2017	May ~~17~~ 10, 2017
June 1, 2017[1]		

^No Regular meeting scheduled
[1] Organizational Meeting

Adopted June 2, 2016

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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

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

Contact

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

Recommended Action

Approve amendment to the 2016 Quality Improvement Program Description regarding cultural competency training required for federal requirements.

Background

Effective September 5, 2016, the Department of Health Care Services (DHCS) required health plans to provide cultural competency training in compliance with new federal requirements (CFR, Title 42, Section 438.206(c)(2)). The requirements stated that plans must have methods to promote access and delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency, diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identify.

To meet these requirements, MCP's were to include language in their written Quality Programs to ensure that all covered services are provided in a culturally and linguistically appropriate manner. This language was added to the 2016 QI Program on pages 12 and 47 of the attached.

Fiscal Impact

The recommended action is budget neutral.

Rationale for Recommendation

Regulatory compliance is a top priority for the organization; the inclusion of this language, and related implementation of the cultural competency training ensures that we have met this obligation.

Concurrence

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

Attachment

Revised 2016 Quality Improvement Program Description

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

09/29/2016 — **Date**

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2016

QUALITY IMPROVEMENT PROGRAM

REVISED 10/6/2016

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2016 QUALITY IMPROVEMENT PROGRAM SIGNATURE PAGE

Quality Improvement Committee Chair:

Richard Helmer, M.D. **Date**
Chief Medical Officer

Board of Directors' Quality Assurance Committee Chair:

~~**Viet Van Dang**~~**, Paul Yost, M.D.** **Date**

Board of Directors Chair:

Mark Refowitz **Date**

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WE ARE CALOPTIMA

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

Our Mission

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

The mission of CalOptima is the foundation of everything we do. It permeates every level of the organization. Our mission is focused on our members, and our members are the sole reason why CalOptima exists.

Our Vision

To be a model public agency and community health plan that provides an integrated and well-coordinated system of care to ensure optimal health outcomes for all of our members.

Our Values — CalOptima CARES

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

Accountability: We were created by the community, for the community, and are accountable to the community. Our Board of Directors, Member Advisory Committee and Provider Advisory Committee meetings are open to the public.

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

- We treat members with dignity in our words and actions
- We respect the privacy rights of our members
- We speak to our members in their languages
- We respect the cultural traditions of our members

We respect and care about our partners. We develop supportive working relationships with providers, community health centers and community stakeholders.

Excellence: We base our decisions and actions on evidence, data analysis and industry-recognized standards so our providers and community stakeholders deliver quality programs and services that meet our members' health needs. We embrace innovation and welcome differences of opinion and individual initiative. We take risks and seek new and practical solutions to meet health needs or solve challenges for our members.

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

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

WHAT IS CALOPTIMA?

Our Unique Dual Role
CalOptima is unique in that we must exhibit being the best of both a public agency upholding public trust, and a health plan seeking efficiency and member satisfaction.

As both, CalOptima must:

- Make the best use of our resources, funding and expertise
- Solicit stakeholder input
- Ensure transparency in our governance procedures
- Be accountable for the decisions we make

How We Became CalOptima
Orange County is unique in that it does not have county-run hospitals or clinics. By the mid-1990s, there was a coalescing crisis since not enough providers accepted Medi-Cal. This resulted in overcrowding in emergency rooms and delayed care, due to Medi-Cal recipients using emergency rooms across the county not only for acute care, but for primary care as well.

A dedicated coalition of local elected officials, hospitals, physicians and community advocates rallied and created a solution. The answer was to create CalOptima as a county organized health system (COHS) authorized by State and Federal law to administer Medi-Cal benefits in Orange County. CalOptima began serving members in 1995. Today, CalOptima is the largest of six COHS in the United States.

CalOptima is a public agency and has, as a COHS:

- Single-plan responsibility for providing Medi-Cal in the county
- Mandatory enrollment of all full-scope Medi-Cal beneficiaries, including dual eligibles
- Responsibility for almost all medical acute services and Long-Term Services and Supports (LTSS), including custodial long-term care.

In 2005, CalOptima became licensed to furnish a Medicare Advantage Special Needs Plan (MA SNP) through a competitive, risk-based contract with the Centers for Medicare and Medicaid Services (CMS). This plan, called OneCare (HMO SNP), allows

CalOptima to offer Medicare and Medi-Cal benefits under one umbrella to dual eligible individuals.

OneCare is also a Medicare Advantage Prescription Drug plan. OneCare operates exclusively as a "Zero Cost Share, Medicaid Subset Dual Special Needs Plan." OneCare only enrolls beneficiaries who qualify as a zero cost sharing Medicaid subset. To identify dual eligible members, OneCare imports daily member eligibility files from the State and Federal government with Medicaid and Medicare eligibility segments.

In July 2015, CalOptima launched OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan). This is a demonstration project in an effort by California and the Federal government to begin the process — through a single organized health care delivery system — of integrating medical, behavioral health, long-term care services and supports, and community-based services for dual eligible beneficiaries. The program's goal is to help members stay in their homes for as long as possible and shift services out of institutional settings and into the home and community. A key feature of CalOptima is identifying high-risk enrollees who need comprehensive care coordination, and assembling an appropriate care team to develop and track an individual care plan.

CalOptima was created as a public agency, operates like a private sector health plan and is accountable to stakeholders to build public trust.

WHAT WE OFFER:

Medi-Cal

In California, Medicaid is known as Medi-Cal. For more than 20 years, CalOptima has been serving Orange County's Medi-Cal population. Due to the implementation of the Affordable Care Act, membership in CalOptima from 2014–16 grew by 49 percent. More low-income children and adults qualified for Medi-Cal.

Medi-Cal covers low-income adults, families with children, seniors, people with disabilities, children in foster care as well as former foster youth up to age 26, pregnant women, and low-income people with specific diseases, such as tuberculosis, breast cancer or HIV/AIDS. A member must live in Orange County and be enrolled in Medi-Cal.

OneCare (HMO SNP)

OneCare (HMO SNP) means total care. Our members with Medicare and Medi-Cal benefits are covered in one single plan, making it easier for our members to get the health care they need. For more than a decade, CalOptima has been offering OneCare to low-income seniors and people with disabilities who quality for both Medicare and Medi-Cal**.** We have extensive experience serving the complex needs of the frail, disabled, dual eligible members in Orange County.

To be a member of OneCare, a person must live in Orange County and be enrolled in Medi-Cal and Medicare Parts A and B, and not be eligible for OneCare Connect.

OneCare Connect

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a new plan that launched in 2015 for people who qualify for both Medicare and Medi-Cal. OneCare Connect also integrates the Multipurpose Senior Services Program (MSSP), In-Home Supportive Services (IHSS) and Long-Term Care (LTC).

At no extra cost, our members also get vision care, taxi rides to medical appointments and enhanced dental benefits. Plus, our members get support so they can receive the services they need, when they need them. A Personal Care Coordinator works with our members and their doctors to create an individualized health care plan that fits our members' needs.

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

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

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

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

To be a PACE participant, members must be at least 55 years old, live in our Orange County service area, be determined as eligible for nursing facility services by the State of California, and be able to live safely at home or in a community setting with proper support.

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

WHO WE WORK WITH:

Contracted Health Networks/Contracted Network Providers

Providers have several options for participating in CalOptima's programs to provide health care to Orange County's Medi-Cal members. Providers can contract with a CalOptima health network, and/or participate through CalOptima Direct, and/or the CalOptima Community Network.

CalOptima members can choose one of 14 health networks, representing more than 7,500 practitioners.

CalOptima Community Network (CCN)

The CalOptima Community Network provides doctors with an alternate path to contract directly with CalOptima to serve our members. Currently, CalOptima contracts with 13 private health networks for Medi-Cal. CCN is administered internally by CalOptima and is the 14th network available for members to select, supplementing the existing health network delivery model and creating additional capacity for growth.

CalOptima Direct (COD)

CalOptima Direct is a self-directed program administered by CalOptima to serve Medi-Cal members in special situations, including foster children, dual-eligibles (those with both Medicare and Medi-Cal who elect not to participate in CalOptima's MA SNP), members in skilled nursing facilities, and share of cost members. COD also currently includes the following categories of vulnerable and complex/catastrophic care members: transplant, hemophilia, HIV, end-stage renal disease (ESRD), and seniors and persons with disabilities.

Not all CalOptima members are health network eligible. Members who are not eligible for enrollment in a health network may be assigned to CalOptima Direct based on the below criteria:

- Transitional members waiting to be assigned to a delegated health network
- Medi-Cal/Medicare members (Medi-Medi)
- Members who reside outside of Orange County
- Medi-Cal share of cost members
- Members residing in Fairview Developmental Center

Health Networks

CalOptima contracts with a variety of health networks to provide care to members. Since 2008, CalOptima has also included Health Maintenance Organizations (HMOs), Physician/Hospital Consortia (PHCs), Physician Medical Groups (PMGs) and Shared Risk Medical Groups (SRGs). CalOptima's HMOs, PHCs, PMGs and SRGs include more than 3,500 Primary Care Providers (PCPs) and 30 hospitals and clinics. New networks that demonstrate the ability to comply with CalOptima's delegated requirements are added as needed.

Health Network/Delegate No.	Medi-Cal	OneCare	OneCare Connect
AltaMed Health Services	SRG	PMG	SRG
AMVI Care Health Network	PHC	PMG	PHC
Arta Western Health Network	SRG	PMG	SRG
CHOC Health Alliance	PHC		
Family Choice Health Network	SRG	PMG	SRG
Heritage	HMO		HMO
Kaiser Permanente	HMO		
Monarch Family HealthCare	SRG	PMG	SRG
Noble Mid-Orange County	SRG	PMG	SRG
OC Advantage Medical Group	PHC		PHC
Prospect Medical Group	SRG		SRG
Talbert Medical Group	SRG	PMG	SRG
United Care Medical Group	SRG	PMG	SRG

Upon successful completion of audits, the health networks may be delegated for clinical and administrative functions, which may include:

- Utilization Management
- Case and Complex Case Management
- Claims (professional and institutional)
- Contracting
- Credentialing of practitioners
- Customer Services activities

BEHAVIORAL HEALTH SERVICES

Medi-Cal Ambulatory Behavioral Health Services

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

CalOptima delegates to College Health Independent Practice Association (CHIPA) for utilization management of the provider network. CHIPA subcontracts and delegates to Beacon Health Strategies LLC (Beacon) other functions that include credentialing the provider network, the Access Line and several quality improvement functions.

In addition, CalOptima covers behavioral health treatment (BHT) for members 20 years of age and younger with a diagnosis of Autism Spectrum Disorder (ASD).

Behavioral health services are also within the scope of practice for PCPs, including offering screening, brief intervention and referral to treatment (SBIRT) services to members 18 years of age and older who misuse alcohol. Providers in primary care settings also screen for alcohol misuse and provide people engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse and/or referral to mental health and/or alcohol use disorder services as medically necessary.

OneCare and OneCare Connect Behavioral Health Services

CalOptima has contracted with Windstone Behavioral Health for the behavioral health services portion of OneCare and OneCare Connect. CalOptima delegates utilization management (UM) to Windstone. Evidence-based MCG guidelines are used in the UM decision-making process.

OUR LINES OF BUSINESS:

MEDI-CAL

Scope of Services

Under our Medi-Cal program, CalOptima provides a comprehensive scope of acute and preventive care services for Orange County's Medi-Cal and dual eligible population.

These services include but are not limited to the following:

Adult preventive services	Hospital/inpatient care	Pediatric preventive services
Community-based adult services	Immunizations	Child health and disability prevention (CHDP)
Doctor visits	Laboratory services	Physical therapy
Durable medical equipment	Limited allied health services	Prenatal care
Emergency care	Medical supplies	Specialty care services
Emergency transportation	Medications	Speech therapy
Non-emergency medical transportation (NEMT)	Newborn care	Substance use disorder preventive services – limited
Hearing aid(s)	Nursing facility services	Vision care

Home health care	Occupational therapy	
Hospice care	Outpatient mental health services – limited	

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

- Specialty mental health services are administered by Orange County Health Care Agency (OC HCA).
- Substance use disorder services are administered by OC HCA.
- Dental services are provided through California's Denti-Cal program.

California Children's Services

Services for children with certain physical limitations, chronic health conditions or diseases are provided through California Children's Services (CCS), which is a statewide program. Currently, CCS authorizes and pays for specific medical services and equipment provided by CCS-approved specialists for CCS-eligible conditions. DHCS manages the CCS program and the Orange County Health Care Agency operates the program. CalOptima is responsible for coordinating care and services for all non-CCS related conditions. There is work underway to integrate CCS services as a benefit of CalOptima. This transition is planned for 2017.

Members With Special Health Care Needs

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

Additionally, CalOptima works with community programs to ensure that members with special health care needs (or with high risk or complex medical and developmental conditions) receive additional services that enhance their Medi-Cal benefits. These partnerships are established through special programs, such as the CalOptima Member Liaison program, and specific Memoranda of Understanding (MOU) with certain community agencies, including HCA, CCS and the Regional Center of Orange County (RCOC).

Medi-Cal Managed Long-Term Services and Supports

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

LTSS includes four programs:

- Community-Based Adult Services (CBAS)

- Nursing Facility Services for Long-Term Care
- Multipurpose Senior Services Program (MPSS)
- In-Home Supportive Services (IHSS)

ONECARE (HMO SNP)

Scope of Services

OneCare (HMO SNP) provides a comprehensive scope of services for the dual eligible members who are not eligible for OneCare Connect.

These services include but are not limited to the following:

Acupuncture and other alternative therapies	Foot care	Outpatient surgery
Ambulance	Hearing services	Prescription drugs
Chiropractic care	Home health care	Preventative care
Dental services – limited	Hospice	Prosthetic devices
Diabetes supplies and services	Inpatient hospital care	Renal dialysis
Diagnostic tests, lab and radiology services, and X-rays	Inpatient mental health care	Skilled nursing facility
Doctor visits	Mental health care	Transportation – limited
Durable medical equipment	Outpatient rehabilitation	Urgently needed services
Emergency care	Outpatient substance abuse	Vision services

ONECARE CONNECT

Scope of Services

Launched July 1, 2015, OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan offered by CalOptima to simplify and improve health care for low-income seniors and people with disabilities. OneCare Connect combines our members' Medicare and Medi-Cal benefits, adds supplemental benefits, and offers personalized support — all to ensure each member receives the right care in the right setting.

OneCare Connect 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 Medicare and Medi-Cal. These people 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, OneCare Connect delivers coordinated care. Care

coordination eliminates duplicated services and shifts services from more expensive institutions to home- and community-based settings.

OneCare Connect achieves these advancements via CalOptima's innovative Model of Care. Each member has a Personal Care Coordinator whose role is to help the member navigate the health care system and receive integrated medical, behavioral and supportive services. Addressing individual needs results in a better, more efficient health care experience for the member.

These services include but are not limited to the following:

Acupuncture (pregnant women)	Hearing screenings	Over-the-counter drugs – limited
Ambulance services	Incontinence supplies – limited	Radiology
Case management	In-Home Supportive Services (IHSS)	Rehabilitation services
Chiropractic services	Inpatient hospital care	Renal dialysis
Diabetes supplies and services	Inpatient mental health care	Screening tests
Disease self-management	Institutional care	Skilled nursing care
Doctor visits	Lab tests	Specialist care
Durable medical equipment	Medical equipment for home care	Substance abuse services
Emergency care	Mental or behavioral health services	Supplemental dental services
Eye exams	Multipurpose Senior Services Program (MSSP)	Transgender services
Foot care	Prescription drugs	Transportation to a doctor's office
Glasses or contacts – limited	Preventive care	Occupational, physical or speech therapy
Health education	Prosthetic devices	Urgent care
Hearing aids – limited	Outpatient care	"Welcome to Medicare" preventive visit

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY

Scope of Services

Launched August 1, 2013, CalOptima PACE is the only PACE center in Orange County. It is a community-based Medicare and Medi-Cal program that provides

coordinated and integrated health care services to frail elders to help them continue living independently in the community.

PACE provides all the acute and long-term care services covered by Medicare and Medi-Cal. The services are arranged for our participants, based on their needs as indicated by our Interdisciplinary Team.

Membership Demographics

CalOptima
A Public Agency
Better. Together.

Fast Facts: February 2016

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

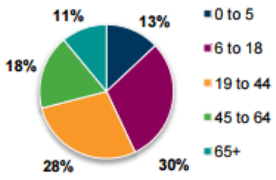
Membership Data as of December 31, 2015

Total CalOptima Membership
779,410

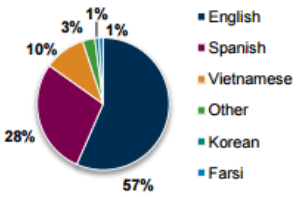
Program	Members
Medi-Cal	779,410
OneCare (HMO SNP)*	11,891
OneCare Connect*	4,437
Multipurpose Senior Services Program*	464
Program of All-Inclusive Care for the Elderly (PACE)*	129

*Membership already accounted for in total Medi-Cal membership

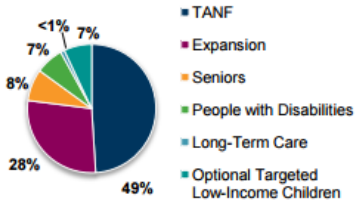
Member Age (All Programs)



Languages Spoken (All Programs)



Medi-Cal Aid Categories



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QUALITY IMPROVEMENT PROGRAM

CalOptima's Quality Improvement (QI) Program encompasses all clinical care, clinical services and organizational services provided to our members, which aligns with our vision to provide an integrated and well-coordinated system of care to ensure optimal health outcomes for all of our members.

CalOptima has developed programs using evidence-based guidelines that incorporate data and best practices tailored to our populations. Our focus extends across the health care continuum, from preventive care, closing gaps in care, care management, disease management and complex care management. Our approach uses support systems for our members with vulnerabilities, disabilities and chronic illnesses.

CalOptima's Quality Improvement Program includes processes and procedures designed to ensure that all medically necessary covered services are available and accessible to all members including those with limited English proficiency, diverse cultural and ethnic backgrounds, and regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, gender identity, health status, or disability, and that all covered services are provided in a culturally and linguistically appropriate manner.

AUTHORITY, ACCOUNTABILITY AND RESPONSIBILITY

Board of Directors

The CalOptima Board of Directors has ultimate accountability and responsibility for the quality of care and services provided to CalOptima members. The responsibility to oversee the program is delegated by the Board of Directors to the Board's Quality Assurance Committee — which oversees the functions of the Quality Improvement Committee described in CalOptima's State and Federal Contracts — and to CalOptima's Chief Executive Officer (CEO), as discussed below.

The Board holds the CEO and Chief Medical Officer (CMO) accountable and responsible for the quality of care and services provided to members. The Board of Directors promotes the separation of medical services from fiscal and administrative management to ensure that medical decisions will not be unduly influenced by financial considerations. The Board of Directors approves and evaluates the QI Program annually.

The QI Program is based on ongoing data analysis to identify the clinical needs, risk levels and appropriate interventions to make certain that the program meets the specific needs of members. The CMO is charged with identifying appropriate interventions and resources necessary to implement the QI Program. Such recommendations shall be aligned with Federal and State regulations, contractual obligations and fiscal parameters.

Quality Improvement Program, Role of CalOptima Officers

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

Chief Medical Officer (CMO) — or physician designee — chairs the QIC, which oversees and provides direction to CalOptima's QI activities, and supports efforts so that the QI Program objectives are coordinated, integrated and accomplished. At least quarterly, the CMO presents reports on QI activities to the Board of Directors' Quality Assurance Committee.

Deputy Chief Medical Officer (DCMO) along with the CMO, oversee strategies, programs, policies and procedures as they relate to CalOptima's medical care delivery system. The DCMO and CMO oversee Quality Analytics, Quality Management, Utilization Management, Case Management, Health Education & Disease Management, Pharmacy Management, and Long-Term Services and Supports.

Chief Network Officer (CNO) is responsible for developing and expanding CalOptima's programs by implementing strategies that achieve the established program objectives; leveraging the core competencies of CalOptima's existing administrative infrastructure to build an effective and efficient operational unit to serve CalOptima's networks; and making sure the delivery of accessible, cost-effective, quality health care services throughout the service delivery network. The CNO leads and directs the integrated operations of the networks, and must coordinate organizational efforts internally, as well as externally, with members, providers and community stakeholders.

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

Executive Director, Quality & Analytics (ED of QA) is responsible for facilitating the company-wide QI Program, driving improvements with Healthcare Effectiveness Data and Information Set (HEDIS), DHCS, CMS star measures and ratings, and facilitating compliance with NCQA. The ED of QA serves as a member of the executive team and with the CMO supports efforts to promote adherence to established quality improvement strategies and programs throughout the company. Reporting to the ED of QA is the Director of Quality Analytics, the Director of Health Education & Disease Management, and the Manager for Quality Improvement.

Executive Director of Clinical Operations (ED of CO) is responsible for oversight of all operational aspects of key Medical Affairs functions, including: Utilization, Case Management,

Long-Term Services and Supports, MSSP Services, along with new program implementation related to initiatives in these areas. The ED of CO serves as a member of the executive team, and, with the CMO, makes certain that Medical Affairs is aligned with CalOptima's strategic and operational priorities.

Executive Director of Public Affairs (ED of PA) serves as the State Liaison; oversees the development and amendment of CalOptima's policies and procedures to ensure adherence to State and Federal requirements; and the management, development and implementation of CalOptima's Communication plan, Issues Management and Legislative Advocacy. This position also oversees the integration of activities for the Community Relations Program. The QI department collaborates with Public Affairs to address specific developments or changes to policies and procedures that impact areas within the purview of QI.

Executive Director of Compliance (ED of C) is responsible to monitor and drive interventions so that CalOptima and its HMOs, PHCs, SRGs, MBHO and PMGs meet the requirements set forth by DHCS, CMS and DMHC. The Compliance staff works in collaboration with the CalOptima Audit & Oversight department to refer any potential sustained noncompliance issues or trends encountered during audits of health networks, provider medical groups, and other functional areas. The ED of C also oversees CalOptima's regulatory and compliance functions, including the development and amendment of CalOptima's policies and procedures to ensure adherence to State and Federal requirements.

QUALITY IMPROVEMENT PROGRAM PURPOSE

The purpose of the CalOptima QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members through CalOptima CCN and COD, as well as our contracted provider networks. Through the QI Program, and in collaboration with its providers, CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system.

The CalOptima QI Program incorporates continuous QI methodology of Plan-Do-Study-Act (PDSA) that focuses on the specific needs of CalOptima's multiple customers (members, health care providers, community-based organizations and government agencies):

- It is organized to identify and analyze significant opportunities for improvement in care and service.
- It fosters the development of improvement strategies, along with systematic tracking, to determine whether these strategies result in progress toward established benchmarks or goals.
- It is focused on QI activities carried out on an ongoing basis to promote efforts that support the identification and correction of quality of care issues.

Quality Improvement, Quality Analytics, Health Education & Disease Management departments, in conjunction with multiple Medical Directors support the organization's mission and strategic goals, and oversee the processes to monitor, evaluate and act on the quality of care and services that members receive.

QUALITY IMPROVEMENT DEPARTMENT

The Quality Improvement department supports the specific focus of monitoring quality of care issues and assuring the credentialing standards, policies and procedures are implemented to provide a qualified provider network for our members. QI fully aligns with the QI team to support the organizational mission, strategic goals, and processes to monitor and drive improvements to the quality of care and services, and that care and services are rendered appropriately and safely to all CalOptima members.

Quality Improvement department activities include:

- Monitor, evaluate and act to improve clinical outcomes for members
- Design, manage and improve work processes, clinical, service, access, member safety and quality related activities
  - Drive improvement of quality of care received
  - Minimize rework and unnecessary costs
  - Measure the member experience of accessing and getting needed care
  - Empower staff to be more effective
  - Coordinate and communicate organizational information, both division and department-specific as well as agencywide
- Support the maintenance of quality standards across the continuum of care and all lines of business
- Maintain agencywide practices that support accreditation by the National Commission for Quality Assurance (NCQA)

QUALITY ANALYTICS DEPARTMENT

The Quality Analytics department fully aligns with the QI team to support the organizational mission, strategic goals and processes to monitor and drive improvements to the quality of care and services, and ensure that care and services are rendered appropriately and safely to all CalOptima members.

The Quality Analytics department activities include design, implementation and evaluation of initiatives to:

- Monitor outcomes
- Drive solutions and interventions to improve quality of care, access to preventive care, and management of chronic conditions to clinical guidelines
- Support efforts to improve internal and external customer satisfaction
- Improve organizational quality improvement functions and processes to both internal and external customers
- Collect clear, accurate and appropriate data used to analyze problems and measure improvement

- Coordinate and communicate organizational information, both division and department specific, and agencywide
- Participate in various reviews through the QI Program such as the All Cause Readmission monitoring, access to care, availability of practitioners and other reviews
- Facilitate satisfaction surveys for members and practitioners
- Evaluate and monitor provider credentials
- Provide agencywide oversight of monitoring activities that are:
  - Balanced: Measures clinical quality of care and customer service
  - Comprehensive: Monitors all aspects of the delivery system
  - Positive: Provides incentive to continuously improve

In addition to working directly with the contracted health networks, data sources available for identification, monitoring and evaluating of opportunities for improvement and effectiveness of interventions include but are not limited to:

- Claims information/activity
- Encounter data
- Utilization data
- Case Management reports
- Pharmacy data
- STARS and HCC data
- Group Needs Assessments
- Results of Risk Stratification
- HEDIS Performance
- Member and Provider satisfaction
- Quality Improvement Projects (QIPs, PIPs and CCIPs)
- Health Risk Assessment data

HEALTH EDUCATION & DISEASE MANAGEMENT DEPARTMENT

The Health Education & Disease Management department is the third area in Quality that provides program development and implementation for the agencywide chronic condition improvement programs. Health Education & Disease Management (HE & DM) Programs provide for the identification, assessment, stratification and implementation of appropriate interventions for members with chronic diseases. Programs and materials use educational strategies and methods appropriate for member and designed to achieve behavioral change for improved health and are reviewed on an annual basis. Program topics covered include Asthma, Congestive Heart Failure, Diabetes, Exercise, Nutrition, Hyperlipidemia, Hypertension, Pediatric Weight Management and Tobacco Cessation.

Primary goals of the department are to achieve member wellness and autonomy through advocacy, communication, education, identification of services, resources and service facilitation throughout the continuum of care. Materials are written at the sixth grade reading level and are culturally and linguistically appropriate for our members.

Health Education & Disease Management supports CalOptima members with customized interventions, which may include:

- Healthy lifestyle management techniques and health education programs and services at no charge to members
- Medication education to ensure adherence to appropriate pharmacotherapy treatment plans
- Informational booklets for key conditions
- Referrals to community or external resources
- Execute and coordinate programs with Case Management, Utilization Management, Quality Analytics and our Health Network Providers.

RESOURCES TO DIRECTLY SUPPORT THE QUALITY IMPROVEMENT PROGRAM AND QUALITY IMPROVEMENT COMMITTEE

CalOptima's budgeting process includes personnel, IT resources and other administrative costs projected for the QI Program. The resources are revisited on a regular basis to promote adequate support for CalOptima's QI Program.

The QI staff directly impacts and influences the QI Committee and related committees through monitoring, evaluation and interventions, providing the various committees with outcomes and effectiveness of corrective actions.

The following staff positions provide direct support for organizational and operational QI Program functions and activities:

Medical Director, Quality
Appointed by the CMO, the Medical Director of Quality is responsible for the direction of the QI Program objectives to drive the organization's mission, strategic goals, and processes to monitor, evaluate and act on the quality of care and services delivered to members.

Manager, Quality Improvement
Responsibilities include assigned day-to day operations of the QI department, including Credentialing, Facility Site Reviews, Facility Physical Access Compliance and working with the ED of Quality. This position is also responsible for QI Program and Work Plan implementation.

- The following positions report to the QI Manager:
    - QI Nurse Specialists,
    - Data Analyst
    - Credentialing Coordinators,
    - Credentialing Program Assistant
    - Facility Site Review Master Trainer
    - Facility Site Review Nurse Reviewers

Director, Quality Analytics
Provides administrative and analytical direction to support quality measurement activities for the agencywide QI Program by managing, executing and coordinating QI activities and projects, aligned with the QI department supporting clinical operational aspects of quality management and improvement. Provides coordination and support to the QIC and other committees to support compliance with regulatory, and accreditation agencies.

- The following positions report to the Director of Quality Analytics:
    - Quality Analytics HEDIS Manager
    - Quality Analytics Medical Data Manager
    - Quality Analytics QI Initiatives Manager
    - Quality Analytics Analysts
    - Quality Analytics Project Managers
    - Quality Analytics Program Coordinators
    - Quality Analytics Program Specialists

Director, Health Education & Disease Management
Provides direction for program development and implementation for the agencywide health education and disease management initiatives. ensures linkages supporting a whole-person perspective to health and health care with Case Management, Care Management and Utilization Management. Also, supports the Model of Care implementation for members. Reports program progress and effectiveness to QIC and other committees to support compliance with regulatory and accreditation agencies.

- The following positions report to the Director, Health Education & Disease Management:
    - Disease Management Manager (Program Design)Disease Management Manager (Operations)
    - Health Education Manager
    - Health Education Supervisor
    - Disease Management Health Coaches
    - Senior Health Educator
    - Health Educators
    - Registered Dieticians
    - Program Specialists
    - Program Assistant

QUALITY IMPROVEMENT (QI) STRATEGIC GOALS

The purpose of the QI Program is to establish objective methods for systematically evaluating and improving the quality of care provided to CalOptima members. Through the QI Program, CalOptima strives to continuously improve the structure, processes and outcomes of its health care delivery system.

The QI Program incorporates continuous QI methodology that focuses on the specific needs of multiple stakeholders (members, health care providers and community and government agencies):

- It is organized to identify and analyze significant opportunities for improvement in care and service
- It fosters the development of quality improvement strategies, along with systematic tracking, to determine whether these strategies result in progress towards established benchmarks or goals
- It is focused on QI activities and projects carried out on an ongoing basis to monitor that quality of care issues are identified and corrected as needed

QI Goals and Objectives

QI goals and objectives are to monitor, evaluate and improve:

- The quality of clinical care and services provided by the health care delivery system in all settings, especially as it pertains to the unique needs of the population
- The important clinical and service issues facing the Medi-Cal population relevant to its demographics, high-risks, disease profiles for both acute and chronic illnesses, and preventive care
- The continuity and coordination of care between specialists and primary care practitioners, and between medical and behavioral health practitioners by annually acting on at least three identified opportunities
- The accessibility and availability of appropriate clinical care and to a network of providers with experience in providing care to the population
- The qualifications and practice patterns of all individual providers in the network to deliver quality care and service
- Member and provider satisfaction, including the timely resolution of complaints and grievances
- Risk prevention and risk management processes
- Compliance with regulatory agencies and accreditation standards
- Annual review and acceptance of the UM Program Description and Work Plan
- The effectiveness and efficiency of internal operations
- The effectiveness and efficiency of operations associated with functions delegated to the contracted medical groups
- The effectiveness of aligning ongoing quality initiatives and performance measurements with CalOptima's strategic direction in support of its mission, vision and values
- Compliance with Clinical Practice Guidelines and evidence-based medicine
- Compliance with regulatory agencies and accreditation standards (NCQA)
- Support of the agency's strategic quality and business goals by utilizing resources appropriately, effectively and efficiently
- Set expectations to develop plans to design, measure, assess, and improve the quality of the organization's governance, management and support processes
- Support the provision of a consistent level of high quality of care and service for members throughout the contracted network, as well as monitor utilization practice patterns of practitioners, contracted hospitals, contracted services, ancillary services and specialty providers

- Provide oversight of quality monitors from the contracted facilities to continuously assess that the care and service provided satisfactorily meet quality goals
- Make certain contracted facilities report outbreaks of conditions and/or diseases to the public health authority — Orange County Health Agency — which may include but are not limited to Methicillin resistant staphylococcus aureus (MRSA), staphylococcus aureus infections, scabies, Tuberculosis, etc. as reported by the health networks.
- Promote patient safety and minimize risk through the implementation of patient safety programs and early identification of issues that require intervention and/or education and work with appropriate committees, departments, staff, practitioners, provider medical groups, and other related health care delivery organizations (HDOs) to assure that steps are taken to resolve and prevent recurrences

QI Measureable Goals from the Model of Care

The Model of Care (MOC) is member-centric by design, and monitors, evaluates and acts upon the coordinated provisions of seamless access to individualized, quality health care. The MOC meets the needs of the special member populations through strategic activities and goals. Measureable goals are established and reported annually.

The MOC goals are:

- Improving access to essential services
- Improving access to affordable care
- Improving coordination of care through an identified point of contact
- Improving seamless transitions of care across health care settings, providers and health services
- Improving access to preventive health services
- Assuring appropriate utilization of services
- Improving integration of medical and behavioral health services
- Improving beneficiary health outcomes

A formal annual performance evaluation is conducted and strategies for continuous improvement for the coming year are established. These are reported to the QI Committee.

WORK PLAN

(SEE ATTACHMENT A — 2016 QI WORK PLAN)

The QI Work Plan outlines key activities for the upcoming year. It is reviewed and approved by the QIC. The QI Work Plan indicates objectives, scope, timeline, planned monitoring and accountable persons for each activity. Progress against the QI Work Plan is monitored throughout the year. QI Work Plan addendums may be established to address the unique needs of members in special needs plans or other health plan products as needed to capture the specific scope of the plan.

The QI Work Plan is the operational and functional component of the QI Program and is based on the most recent and trended HEDIS scores, physician quality measures, and other measures identified for attention, including any specific requirements mandated by the State or accreditation standards where these apply.

The QI Program guides the development and implementation of an annual QI Work Plan and a separate Utilization Management (UM) Work Plan that includes:

- Case Management
- Client Revisions
- LTSS
- Health Education & Disease Management, Health Assessments and related CCIP, QIP, PIPs
- Access and Availability to Care
- Member Experience and Service
- Patient Safety and Pharmacy Initiatives
- HEDIS/STARS Improvement
- Delegation Oversight
- Organizational Quality Projects
- QI Program scope
- Yearly objectives
- Yearly planned activities
- Time frame for each activity's completion
- Staff member responsible for each activity
- Monitoring of previously identified issues
- Annual evaluation of the QI Program
- Priorities for QI activities based on the specific needs of Cal Optima's organizational needs and specific needs of Cal Optima's populations for key areas or issues identified as opportunities for improvement
- Priorities for QI activities based on the specific needs of Cal Optima's populations, and on areas identified as key opportunities for improvement
- Ongoing review and evaluation of the quality of individual patient care to aid in the development of QI studies based on quality of care trends identified

The QI Work Plan supports the comprehensive annual evaluation and planning process that includes review and revision of the QI Program and applicable policies and procedures.

UTILIZATION MANAGEMENT

Coverage for health care services, treatment and supplies in all lines of business is based on the terms of the plan and subject to medical necessity. Contracts specify that medically necessary services are those which are established as safe and effective, consistent with symptoms and diagnosis and furnished in accordance with generally accepted professional standards to treat an illness, disease, or injury consistent with CalOptima medical policy, and not furnished primarily for the convenience of the patient, attending physician or other provider.

Use of evidence-based, industry-recognized criteria promotes efforts that medical decisions are not influenced by fiscal and administrative management considerations. As described in the 2016 Utilization Management (UM) Program all review staff are trained and audited in these principles. Clinical staff makes all medical necessity decisions and any denial is made only by a physician reviewer, including those decisions made by delegated health networks. Medical Directors actively engage subspecialty physicians as peer review consultants to assist in medical necessity determinations. Adherence to standards and evidence-based clinical criteria is obtained by cooperative educational efforts, personal contact with providers and monitoring through clinical studies.

BEHAVIORAL HEALTH

CalOptima focuses on the continuum of care for both medical and behavioral health services. Focusing on continuity and coordination of care, CalOptima monitors and works to improve the quality of behavioral health care and services provided to our members. The QI Program includes services for behavioral health and review of the quality and outcomes of those services delivered to the members within our network of practitioners and providers.

The quality of Behavioral Health services may be determined through but not limited to the following:

- Access to care
- Availability of practitioners
- Coordination of care
- Medical record and treatment record documentation
- Complaints and grievances
- Appeals
- Compliance with evidence-based clinical guidelines
- Language assistance
- HEDIS and STAR measurements

The Medical Director responsible for Behavioral Health services is involved in the behavioral aspects of the QI Program. The BH Medical Director is available for

assistance with member behavioral health complaints, development of behavioral health guidelines, recommendations on service and safety, provide behavioral health QI statistical data and follow-up on identified issues. The BH Medical Director shall serve as the chairperson of the BH QI Committee which is a subcommittee of the CalOptima QI Committee. The BH Medical Director also serves as a voting member of CalOptima's QI Committee.

CONFIDENTIALITY

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

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

CONFLICT OF INTEREST

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

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

STAFF ORIENTATION, TRAINING AND EDUCATION

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

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

- CalOptima New Employee Orientation
- HIPAA and Privacy/Corporate Compliance
- Use of technical equipment (phones, computers, printers, facsimile machines, etc.)
- Applicable Department Program, Policies & Procedures, etc.
- Appeals Process
- Seniors and Persons with Disabilities Awareness Training

CalOptima encourages and supports continuing education and training for employees, which increases competency in their present jobs and/or prepares them for career advancement within CalOptima. Each year, a specific budget is set for continuing education for each licensed employee.

MOC-related employees and contracted providers and practitioners network are trained at least annually on the Model of Care (MOC). The MOC training is a part of the comprehensive orientation process, and includes face-to-face, interactive and web-based platforms as well as paper format.

SAFETY PROGRAM

Member (Patient) safety is very important to CalOptima; it aligns with CalOptima's mission statement: *To provide members with access to quality health care services delivered in a cost-effective and compassionate manner*. By encouraging members and families to play an active role in making their care safe, medical errors will be reduced. Active, involved and informed patients and families are vital members of the health care team.

Member safety is integrated into all components of member enrollment and health care delivery organization continuum oversight and is a significant part of our quality and risk management functions. Our member safety endeavors are clearly articulated both internally and externally, and include strategic efforts specific to member safety.

This plan is based on a needs assessment and includes the following areas:

- Identification and prioritization of patient safety-related risks for all CalOptima members, regardless of line of business and contracted health care delivery organizations
- Operational objectives, roles and responsibilities, and targets based on the risk assessment
- Plans to conduct appropriate patient safety training and education are available to members, families and health care personnel/physicians
- Patient safety program and its outcomes, to be reviewed annually
- Health education and promotion
- Group Needs Assessment
- Over/Under utilization monitoring
- Medication Management
- Case Management/Disease Management
- Operational Aspects of Care and Service

Member Safety prevention, monitoring and evaluation include:

- Providing education and communication through the Group Needs Assessment to assess the member's comprehension through their language, cultural and diverse needs
- Distributing member information that improves their knowledge about clinical safety in their own care; (such as member brochures, which outline member concerns or questions that they should address with their practitioners for their care)
- Collaborating with Health Networks and practitioners in performing the following activities: improving medical record documentation and legibility, establishing timely follow-up for lab results; addressing and distributing data on adverse outcomes or polypharmacy issues by the Pharmacy & Therapeutics (P&T) Committee, and maintaining continuous quality improvement with pharmaceutical management practices to require safeguards to enhance patient safety
- Alerting the pharmacy to potential drug interactions and/or duplicate therapies, and discussing these potential problems with the prescribing physician(s), allows the opportunity for the practitioner to correct the amount of the appropriate drug is being delivered
- Improving continuity and coordination between sites of care, such as hospitals and skilled nursing facilities, to assure timely and accurate communication
- Utilizing facility site review, Physical Accessibility Review Survey (PARS) and medical record review results from practitioner and health care delivery organization at the time of credentialing to improve safe practices, and incorporating ADA (Americans with Disabilities Act) and SPD (Seniors and Persons with Disabilities) site review audits into the general facility site review process
- Tracking and trending of adverse event reporting to identify system issues that contribute to poor safety

Elements of the safety program address the environment of care and the safety of members, staff and others in a variety of settings. The focus of the program is to identify and remediate potential and actual safety issues, and to monitor ongoing staff education and training, including:

- Ambulatory setting
  - Adherence to ADA standards, including provisions for access and assistance in procuring appropriate equipment, such a electric exam tables
  - Annual blood-borne pathogen and hazardous material training
  - Preventative maintenance contracts to promote that equipment is kept in good working order
  - Fire, disaster, and evacuation plan, testing and annual training
- Institutional settings including Long-Term Care (LTC), CBAS and MSSP settings and Long-Term Services and Supports (LTSS) settings
  - Falls and other prevention programs
  - Identification and corrective action implemented to address post operative complications
  - Sentinel events identification and appropriate investigation and remedial action
  - Administration of flu/pneumonia vaccine
- Administrative offices
  - Fire, disaster, and evacuation plan, testing and annual training

COMMITTEE AND KEY GROUP STRUCTURES

(SEE PAGE 52 — COMMITTEE ORGANIZATION STRUCTURE DIAGRAM)

Board of Directors' Quality Assurance Committee

The Board of Directors appoints the Quality Assurance Committee (QAC) to review and accept the overall QI Program and annual evaluation, and routinely receives progress reports from the QIC describing improvement actions taken, progress in meeting objectives, and improvements achieved. The QAC shall also make recommendations for annual modifications of the QI program and actions to be taken when objectives are not met. CalOptima is required under California's open meeting law, the Ralph M. Brown Act, Government Code §54950 *et seq.*, to hold public meetings except under specific circumstances described in the Act. CalOptima's QAC meetings are open to the public.

Member Advisory Committee

The Member Advisory Committee (MAC) is composed of representatives of the population CalOptima serves. The MAC ensures that CalOptima members' values and needs are integrated into the design, implementation, operation, and evaluation of the overall QI program. The MAC provides advice and recommendations on community outreach, cultural and linguistic needs and needs assessment, member survey results, access to health care, preventative services and contracting. The MAC meets on a bi-monthly basis and reports directly to the CalOptima Board of Directors. MAC meetings are open to the public.

The MAC membership is composed of representatives from the following constituencies:

- Adult beneficiaries
- Children
- Consumer
- Family Support
- Foster Children
- Long-Term Care
- Medi-Cal beneficiaries
- Medically indigent persons
- Orange County Health Care Agency
- Orange County Social Services Agency
- Persons with disabilities
- Persons with mental illnesses
- Persons with Special Needs
- Recipients of CalWORKs
- Seniors

Provider Advisory Committee

The Provider Advisory Committee (PAC) is composed of representatives from the following constituencies:

- Health Networks
- Hospitals
- Physicians
- Nurses
- Allied Health Services
- Community Clinics
- The Orange County Health Care Agency (HCA)
- Long-Term Services and Supports including (LTC Facilities and CBAS)
- Mid-Level Practitioners
- Behavioral/mental health

Quality Improvement Committee (QIC)

The QIC is the foundation of the QI program. The QIC assists the CMO in overseeing, maintaining, and supporting the QI Program and QI Work Plan activities.

The purpose of the QIC is to assure that all QI activities are performed, integrated, and communicated internally and to the contracted HMOs, PHCs, SRGs, MBHO, and PMGs to achieve the end result of improved care and services for members. The QIC oversees the performance of delegated functions by its HMOs, PHCs, SRGs, MBHO, and PMGs and contracted provider and practitioner partners. The composition of the QIC includes a participating Behavioral Health Practitioner to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review as needed, and identification of opportunities to improve care.

The QIC provides overall direction for the continuous improvement process and evaluates whether activities are consistent with CalOptima's strategic goals and priorities. It supports efforts that an interdisciplinary and interdepartmental approach is taken and adequate resources are committed to the program. It monitors compliance with regulatory and accrediting body standards relating to Quality Improvement Projects (QIP), activities, and initiatives. In addition, and most importantly, it makes certain that members are provided optimal quality of care. HEDIS activities and interventions are reviewed, approved, processed, monitored and reported through the QIC.

Responsibilities of the QI Committee include the following:

- Recommends policy decisions
- Analyzes and evaluates policy decisions
- Makes certain that there is practitioner participation in the QI Program through planning, design, implementation and review
- Identifies needed actions and interventions
- Makes certain that there is follow-up as necessary

Practice patterns of providers, practitioners, HMOs, PHCs, SRGs, MBHO, and PMGs are evaluated, and recommendations are made to promote practices that all members receive medical care that meets CalOptima standards.

The QIC oversees and coordinates member outcome-related quality improvement actions. Member outcome-related QI actions consist of well-defined, planned QI Projects by which the plan addresses and achieves improvement in major focus areas of clinical and non-clinical services.

The QIC also recommends strategies for dissemination of all study results to CalOptima-contracted providers and practitioners, HMOs, PHCs, SRGs, MBHO, and PMGs.

The QI Projects themselves consist of four (4) cycles:

- **Plan** — detailed description and goals
- **Do** — Implementation of the plan
- **Study** — data and collection
- **Act** — analyze data and develop conclusions

The goal of the QI Program is to improve the health outcomes of members through systematic and ongoing monitoring of specific focus areas and development and implementation of QI Projects and interventions designed to improve provider and practitioner and system performance.

The QIC provides overall direction for the continuous improvement process and monitors that activities are consistent with CalOptima's strategic goals and priorities. It promotes efforts that an interdisciplinary and interdepartmental approach is taken, and adequate resources are committed to the program and drives actions when opportunities for improvement are identified.

The composition of the QIC is defined in the QIC Charter and includes, but may not be limited to the following:

Voting Members:

- Four (4) participating physicians or practitioners, with no more than two (2) administrative medical directors
- CalOptima CMO/DCMO
- CalOptima Medical Director, Quality (Chair)
- CalOptima Medical Director also representing the UM Committee
- CalOptima Medical Director, Behavioral Health also representing the BH QI Committee
- Executive Director Clinical Operations
- Director of Network Management
- Director Business Integration

The QIC is supported by:

Executive Director, Quality Improvement
Manager, Quality Improvement
Director, Quality Analytics
Director, Health Education & Disease Management
Committee Recording Secretary as assigned

Quorum

A quorum consists of a majority of the voting members (at least six) of which at least four are physicians or practitioners. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by phone.

The QIC meets no less than eight times per year, and reports to the Board QAC no less than quarterly.

QIC and all quality improvement subcommittee reports and proceedings are covered under California Welfare & Institution Code § 14087.58(b), Health and Safety Code § 1370, and California Evidence Code §1157. Section 14087.58(b) renders records of QI proceedings, including peer review and quality assessment records, exempt from disclosure under the Public Records Act.

Minutes of the Quality Improvement Committee (QIC)

Contemporaneous minutes reflect all Committee decisions and actions. These minutes are dated and signed by the Committee Chair to demonstrate that they are representative of the official findings of the committee.

Minutes of the QIC meeting include, but are not limited to goals and objectives outlined in the QI Charter and which include but are not limited to:

- Active discussion and analysis of quality issues analysis

- Credentialing or re-credentialing issues, as appropriate
- Establishment or approval of clinical practice guidelines
- Reports from various committees and subcommittees
- Recommendations, actions and follow-up actions
- Plans to disseminate Quality Management/Improvement information to network providers and practitioners
- Tracking of work plan activities

All agendas, minutes, reports, and documents presented to the QIC are maintained in a confidential manner. Minutes are maintained in an electronic format and not reproduced (except for Quality Profile documentation) in order to maintain confidentiality, privilege and protection.

The following are committees and subcommittees of the QIC:

Credentialing and Peer Review Committee (CPRC)

The CPRC provides guidance and peer input into the CalOptima practitioner and provider selection process, and determines corrective actions as necessary to support that all practitioners and providers that serve CalOptima members meet generally accepted standards for their profession or industry. The CPRC reviews, investigates, and evaluates the credentials of all internal CalOptima medical staff for membership, and maintains a continuing review of the qualifications and performance of all external medical staff. The CPRC's review and findings are reported to the QIC, with recommendations for approval/denial of credentialing. All approved providers and practitioners are presented to QAC on a quarterly basis as part of the CMO's report.

The goals of the CPRC include:

1. Maintain a peer review and credentialing program that aligns with regulatory (DHCS, DMHCS, CMS) and accreditation (NCQA) standards.
2. Promote continuous improvement of the quality of health care provided by providers in CalOptima Direct/CalOptima Community Network and its delegated health networks.
3. Conduct peer-level review and evaluation of provider performance and credentialing information against CalOptima requirements and appropriate clinical standards.
4. Investigate patient care outcomes that raise quality and safety concerns for corrective actions, as appropriate.

CPRC primary responsibilities include:

1. Provide peer review and credentialing functions for CalOptima.
2. Review reports submitted by internal departments including but not limited to Audit & Oversight, Quality Improvement (PQI issues), GARS (complaints) and take action on credentialing or quality issues, as appropriate.
3. Provide guidance and peer participation in the CalOptima credentialing and recredentialing processes to ensure that all providers that serve CalOptima members meet generally accepted standards for their profession or industry.

4. Make final determinations regarding the eligibility of providers to participate in the CalOptima program based on CalOptima policies and applicable standards.
5. Review, investigate, and evaluate the credentials of CalOptima Direct/CalOptima Community Network practitioners and internal CalOptima medical staff.
6. Review facility site review results and oversee all related actions.
7. Investigate, review and evaluate quality of care matters referred by CalOptima's functional departments (including, without limitation, Customer Service, Grievance and Appeals Resolution Services, Utilization Management, Case Management and Pharmacy) and/or the CMO or his/her physician designee related to CalOptima Direct/CalOptima Care Network or its delegated Health Networks.
8. Initiate and monitor imposed provider corrective actions and make adverse action recommendations, as necessary and appropriate.

In addition, as a part of CalOptima's Patient Safety Program, and utilizing the full range of methods and tools of that program, CalOptima conducts Sentinel Event monitoring. A Sentinel Event is defined as "an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof." The phrase "or risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome.

Sentinel Event monitoring includes patient safety monitoring across the entire continuum of CalOptima's contracted providers: HMOs, PHCs, SRGs, MBHO, PMGs, and health care delivery organizations. The presence of a Sentinel Event is an indication of possible quality issues, and the monitoring of such events will increase the likelihood of early detection of developing quality issues so that they can be addressed as early as possible. Sentinel Event monitoring serves as an independent source of information on possible quality problems, supplementing the existing Patient Safety Program's consumer-complaint-oriented system.

All medically related cases are reviewed by the CPRC to determine the appropriate course of action and/or evaluate the actions recommended by an HMO, PHC, SRG, MBHO, or PMG delegate. Board certified peer-matched specialists are available to review complex cases as needed. Results of peer review are used at the reappointment cycle, or upon need, to review the results of peer review and determine the competency of the provider. This is accomplished through routine reporting of peer review activity to HMOs, PHCs, SRGs, MBHO and PMGs for incorporation in their re-credentialing process.

The CPRC shall consist of a minimum of five physicians selected on a basis that will provide representation of active physicians from the CalOptima Direct network and/or the Health Networks. Physician participants shall represent various specialties including but not limited to general surgery, OB/ GYN and primary care. In addition, the Chairperson and CalOptima's CMO or DCMO are considered part of the Committee and, as such, are voting members. The CPRC provides reports to CalOptima QI Committee at least quarterly.

Grievance and Appeals Resolution Services Subcommittee (GARS)
The Grievance and Appeals Resolution Services subcommittee serves to protect the rights of our members, and to promote the provision of quality health care services and enforces that the policies of CalOptima are consistently applied to resolve member complaints in an equitable and compassionate manner through oversight and monitoring. The GARS subcommittee serves to provide a mechanism to resolve provider and practitioner complaints and appeals expeditiously. It protects the rights of practitioners and providers by providing a multilevel process that is fair and progressive in nature, leading to the resolution of provider complaints. The GARS subcommittee meets at least quarterly and reports to the QIC.

Pharmacy & Therapeutics Subcommittee
The Pharmacy & Therapeutics (P&T) Subcommittee is a forum for an evidence-based formulary review process. The P&T promotes clinically sound and cost effective pharmaceutical care for all CalOptima members and reviews anticipated and actual drug utilization trends, parameters, and results on the basis of specific categories of drugs and formulary initiatives, as well as the overall program. In addition, the P&T reviews and evaluates current pharmacy-related issues that are interdisciplinary, involving interface between medicine, pharmacy and other practitioners involved in the delivery of health care to CalOptima's members. The P&T includes practicing physicians and the contracted provider networks. A majority of the members of the P&T are physicians (including both CalOptima employee physicians and participating provider physicians), and the membership represents a cross section of clinical specialties and clinical pharmacists in order to adequately represent the needs and interests of all plan members. The P&T provides written decisions regarding all formulary development and revisions. The P&T meets at least quarterly, and reports to the UM subcommittee.

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

The UM subcommittee monitors the utilization of health care services by CalOptima Direct and through the delegated HMOs, PHCs, SRGs, MBHO, and PMGs to identify areas of under or over utilization that may adversely impact member care. The UM subcommittee oversees Inter-rater Reliability testing to support consistency of application in criteria for making determinations, as well as development of Evidence Based Clinical Practice Guidelines and completes an annual review and updates the clinical practice guidelines to make certain they are in accordance with recognized clinical organizations, are evidence-based, and comply with regulatory and other agency standards. The UM subcommittee meets quarterly and reports to the QIC.

The UM subcommittee includes a minimum of four (4) practicing physician representatives, reflecting CalOptima's HMO, PHC, SRG, MBHO, and PMG composition, and is appointed by the CMO. The composition includes a participating Behavioral Health practitioner* to specifically address integration of behavioral and physical health, appropriate utilization of recognized criteria, development of policies and procedures, and case review, as needed.

The UM subcommittee is supported by:
Medical Director, Concurrent Review
Director, Utilization Management
Director, Pharmacy
Director, Enterprise Analytics
Manager, Referral/Prior Authorization
Manager, Concurrent Review

Quorum:
A quorum consists of fifty percent (50%) plus one of voting member participation and of the eleven, the minimum quorum must include three committee participants from the community. Once a quorum is attained, the meeting may proceed and any vote will be considered official, even if the quorum is not maintained. Participation is defined as attendance in person or participation by telephone.

** Behavioral Health practitioner is defined as medical director, clinical director or participating practitioner from the organization.*

Long-Term Services and Supports Subcommittee (LTSS)
The LTSS subcommittee is composed of representatives from the Long-Term Care (LTC), Community-Based Adult Services (CBAS), and Multipurpose Senior Services Program (MSSP) communities, which may include administrators, directors of nursing, facility Medical Directors, and pharmacy consultants, along with appropriate CalOptima staff. Previously, the CBAS Quality Advisory Subcommittee was integrated into the LTSS Quality Subcommittee. The LTSS subcommittee members serve as specialists to assist CalOptima in the development, implementation, and evaluation of establishing criteria and methodologies to measure and report quality standards with Home and Community Based Services (HCBS) and in LTC facilities where CalOptima members reside. The LTSS subcommittee also serves to identify "best practices" and partner with facilities to share the information as it is identified. The LTSS subcommittee meets quarterly and reports to the QIC.

Benefit Management Subcommittee (BMSC)
The purpose of the Benefit Management Subcommittee is to oversee, coordinate, and maintain a consistent benefit system as it relates to CalOptima's responsibilities for administration of all its program lines of business benefits, prior authorization, and

financial responsibility requirements for the administration of benefits. The subcommittee shall also see to it that benefit updates are implemented, and communicated accordingly, to internal CalOptima staff, and that updates are provided to contracted HMOs, PHCs, SRGs, MBHO, and PMGs. The Government Affairs department provides the technical support to the subcommittee, which includes, but is not limited to, analyzing regulations and guidance that impacts the benefit sets and CalOptima's authorization rules.

Behavioral Health Quality Improvement Committee (BHQIC)

The Behavioral Health Quality Improvement Committee was established in 2011 to ensure members receive timely and satisfactory behavioral health care services, enhancing continuity and coordination between physical health and behavioral health care providers, monitoring key areas of services to members and providers, identifying areas of improvement and guiding CalOptima towards the vision of bi-directional behavioral health care integration.

The BHQIC responsibilities are to:

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

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

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

- Medical Director, Behavioral Health Integration (Chair)
- Chief Medical Officer/Deputy Medical Officer
- Medical Director, Quality and Analytics
- Executive Director, Clinical Operations
- Executive Director, Quality Analytics
- Medical Director, Utilization Management
- Director, Behavioral Health Integration

- Clinical Pharmacist
- Medical Director, Orange County Health Care Agency
- Medical Director, Medi-Cal MBHO
- Chief Clinical Officer, Medi-Medi MBHO
- Medical Director, Health Network
- Medical Director, Regional Center of Orange County
- Contracting Behavioral Health Care Practitioners

The BHQI shall meet, at a minimum, on a quarterly basis, or more often as needed.

METHODOLOGY

QI Project Selections and Focus Areas

Performance and outcome improvement projects will be selected from the following areas:

- Areas for improvement identified through continuous HMO, PHC, SRG, PMG, and internal monitoring activities, including, but not limited to, (a) potential quality concern (PQI) review processes, (b) provider and facility reviews, (c) preventive care audits, (d) access to care studies, (e) satisfaction surveys, (f) HEDIS results, and (g) other subcommittee unfavorable outcomes
- Measures required by regulators such as DHCS and CMS

The QI Project methodology described below will be used to continuously review, evaluate, and improve the following aspects of clinical care: preventive services, perinatal care, primary care, specialty care, emergency services, inpatient services, long-term care, and ancillary care services

- Access to and availability of services, including appointment availability, as described in the Utilization Management Program and in policy and procedure
- Coordination and continuity of care for seniors and persons with disabilities
- Provisions of chronic, complex care management and case management services
- Access to and provision of preventive services

Improvements in work processes, quality of care, and service are derived from all levels of the organization.

- Staff, administration, and physicians provide vital information necessary to support continuous performance is occurring at all levels of the organization
- Individuals and administrators initiate improvement projects within their area of authority, which support the strategic goals of the organization
- Other prioritization criteria include the expected impact on performance, (if the performance gap or potential of risk for non-performance is so great as to make it a priority), and items deemed to be high risk, high volume, or problem-prone processes

- Project coordination occurs through the various leadership structures: Board of Directors, Management, QI and UM Committees, etc., based upon the scope of work and impact of the effort
- These improvement efforts are often cross functional, and require dedicated resources to assist in data collection, analysis, and implementation. Improvement activity outcomes are shared through communication that occurs within the previously identified groups

QI Project Quality Indicators

Each QI Project will have at least one (and frequently more) quality indicator(s). While at least one quality indicator must be identified at the start of a project, more may be identified after analysis of baseline measurement or re-measurement. Quality indicators will measure changes in health status, functional status, member satisfaction, and provider/staff, HMO, PHC, SRG, MBHO, PMG, or system performance. Quality indicators will be clearly defined and objectively measurable. Standard indicators from HEDIS & STARS measures are acceptable.

Quality indicators may be either outcome measures or process measures where there is strong clinical evidence of the correlation between the process and member outcome. This evidence must be cited in the project description.

QI Project Measurement Methodology

Methods for identification of target populations will be clearly defined. Data sources may include encounter data, authorization/claims data, or pharmacy data. To prevent exclusion of specific member populations, data from the Clinical Data Warehouse will be utilized. See explanation of Clinical Data Warehouse below.

For studies/measures that require data from sources other than administrative data (e.g., medical records), sample sizes will be a minimum of 411 (with 5 to 10% over sampling), so as to allow performance of statistically significant tests on any changes. Exceptions are studies for which the target population total is less than 411, and for certain HEDIS studies whose sample size is reduced from 411 based on CalOptima's previous year's score. Measures that rely exclusively on administrative data utilize the entire target population as a denominator.

CalOptima also uses a variety of QI methodologies dependent on the type of opportunity for improvement identified. The Plan/Do/Study/Act model is the overall framework for continuous process improvement. This includes:

Plan 1) Identify opportunities for improvement
2) Define baseline
3) Describe root cause(s)
4) Develop an action plan

Do 5) Communicate change/plan
6) Implement change plan

Study 7) Review and evaluate result of change
8) Communicate progress

Act 9) Reflect and act on learning
10) Standardize process and celebrate success

CARE OF MEMBERS WITH COMPLEX NEEDS

CalOptima is committed to serving the needs of all members assigned, and places additional emphasis on the management and coordination of care of the most vulnerable populations and members with complex health needs. Our goal is promotion of the delivery of effective, quality health care to members with special health care needs, including, but not limited to, physical and developmental disabilities, multiple chronic conditions, and complex behavioral health and social issues through:

- Standardized mechanisms for member identification through use of data
- Documented process to assess the needs of member population
- Multiple avenues for referral to case management and disease management programs
- Management of transitions of care across the continuum of health care from outpatient or ambulatory to inpatient or institutionalized care, and back to ambulatory
- Ability of member to opt-out
- Targeted promotion of the use of recommended preventive health care services for members with chronic conditions (e.g. diabetes, asthma) through health education and member incentive programs
- Use of evidenced based guidelines distributed to members and practitioners that are relevant to chronic conditions prevalent in the member population (e.g. COPD, asthma, diabetes, ADHD)
- Development of individualized care plans that include input from member, care giver, primary care provider, specialists, social worker, and providers involved in care management, as necessary
- Coordinating services for members for appropriate levels of care and resources
- Documenting all findings
- Monitoring, reassessing, and modifying the plan of care to drive appropriate quality, timeliness, and effectiveness of services
- Ongoing assessment of outcomes

CalOptima's case management program includes three care management levels that reflect the health risk status of members. All members are stratified using a plan-developed stratification tool that utilizes information from data sources such as acute hospital/emergency department utilization, severe and chronic conditions, and pharmacy. The members are stratified into complex, care coordination and basic care management levels.

The Interdisciplinary Care Team (ICT) for low risk members — is basic — and occurs at the PCP level. Moderate and high risk members are managed by an ICT at the Medical Group level for delegated groups or at the plan level in the instance of the Community Network.

The members of the ICT always includes the member (and caregivers or an authorized representative with member approval or appropriate authorization to act on behalf of a member) and PCP. For members with more needs, other disciplines are included, but not limited to a Medical Director, specialist(s), case management team, behavioral health specialist, pharmacist, social worker, dietician, and/or long-term care manager. The teams are designed to see that members' needs are identified and managed by an appropriately composed team.

The Interdisciplinary Care Teams process includes:

- Basic ICT for Low-Risk Members — Basic Team at PCP level
  - Team Composition: member, caregiver or authorized representative, PCP, PCP support staff (nurse, etc.)
    - Roles and responsibilities of this team:
      - Basic case management, including advanced care planning
      - Medication reconciliation
      - Identification of member at risk of planned and unplanned transitions
      - Referral and coordination with specialists
      - Development and implementation of an ICP
      - Communication with members or their representatives, vendors, and medical group
      - Review and update the ICP at least annually, and when there is a change in the members health status
      - Referral to the primary ICT, as needed

- Primary ICT for Moderate to High-Risk Members — ICT at the Physician Medical Group (PMG) level or the Health Plan for Community Network
  - ICT Composition (appropriate to identified needs): member, caregiver, or authorized representative, PMG Medical Director, PCP and/or specialist, ambulatory case manager (CM), hospitalist, hospital CM and/or discharge planners, PMG Utilization Management staff, behavioral health specialist and social worker
    - Roles and responsibilities of this team:
      - Identification and management of planned transitions
      - Case management of high risk members
      - Coordination of ICPs for high risk members
      - Facilitating member, PCP and specialists, and vendor communication
      - Meets as frequent as is necessary to coordinate and care and stabilize member's medical condition

- Complex ICT for High-Risk Members — ICT at the Physician Medical Group (PMG) level or Health Plan for Community Network
    - Team Composition (As appropriate for identified needs): member, caregiver, or authorized representative, PMG Medical Director, CalOptima clinical/PMG case manager, PCP and/or specialist, social worker, and behavioral health specialist
        - Roles and responsibilities of this team:
            - Consultative for the PCP and PMG teams
            - Encourages member engagement and participation in the IDT process
            - Coordinating the management of members with complex transition needs and development of ICP
            - Providing support for implementation of the ICP by the PMG
            - Tracks and trends the activities of the IDTs
            - Analyze data from different data sources in the plan to evaluate the management of transitions and the activities of the IDTs to identify areas for improvement
            - Oversight of the activities of all transition activities at all levels of the delivery system
            - Meets as often as needed until member's condition is stabilized

Dual Eligible Special Needs Plan (SNP)/OneCare and OneCare Connect

The goal of D-SNPs is to provide health care and services to those who can benefit the most from the special expertise of CalOptima providers and focused care management. Care management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet the comprehensive medical, behavioral health, and psychosocial needs of an individual and the individual's family, while promoting quality and cost-effective outcomes.

The goal of care management is to help patients regain optimum health or improved functional capability, cost-effectively and in the right setting. It involves comprehensive assessment of the patient's condition, determining benefits and resources, and developing and implementing a care management plan that includes performance goals, monitoring and follow-up.

CalOptima's D-SNP care management program includes, but is not limited to:

- Complex case management program aimed at a subset of patients whose critical event or diagnosis requires extensive use of resources, and who need help navigating the system to facilitate appropriate delivery of care and services
- Transitional case management program focused on evaluating and coordinating transition needs for patients who may be at risk of re hospitalization
- High-risk and high-utilization program aimed at patients who frequently use emergency department (ED) services or have frequent hospitalizations, and at high-risk individuals (e.g., patients dually eligible for Medicare and Medicaid or patients who are institutionalized)

- Hospital case management program designed to coordinate care for patients during an inpatient admission and discharge planning
- Care management program focused on patient-specific activities and the coordination of services identified in members' care plans. Care management performs these activities and coordinates services for members to optimize their health status and quality of life

CalOptima's goals for 2016 are:

- Continue with the comprehensive assessment strategy
- Measure and assess the quality of care CalOptima provides
- Evaluate how CalOptima addresses the special needs of our beneficiaries
- Drive interventions and actions when opportunities for improvement are identified

Please reference the 2016 Case Management Program Description for further details and program plans.

DISEASE MANAGEMENT PROGRAM

The Disease Management (DM) Program is a targeted program for the management, coordination, and intervention for a highly vulnerable patient population. CalOptima assumes responsibility for the Disease Management program for all of its lines of business, therefore the management for Disease Management is non-delegated to the PHCs, SRGs, and PMGs. The contracted PHCs, SRGs, and PMGs must participate collaboratively with interventions necessary to produce compliant quality outcomes. The DM program is a comprehensive system of caring for members with chronic illnesses. A system-wide, multidisciplinary approach is utilized that entails the formation of a partnership between the patient, the healthcare practitioner and CalOptima. The DM program coordinates care for members across time, locates and provides services and resources, and supports the members as they learn to care for themselves.

A detailed description of the Disease Management Program is contained in the Disease Management Program Description document. The DM Program is evaluated on an annual basis.

CLINICAL DATA WAREHOUSE

The Clinical Data Warehouse aggregates data from CalOptima's core business systems and processes, such as member eligibility, provider, encounters, claims, and pharmacy. The clinical data warehouse allows staff to apply evidence-based clinical practice guidelines to analyze data for quality purposes, such as disease management population identification, risk stratification, process measures and outcomes measures. CalOptima staff creates and maintains the data base with quarterly data updates.

Based upon evidence-based practice guidelines built into the system, the clinical data warehouse can assess the following:

- Identify and stratify members with certain disease states
- Identify over/under utilization of services
- Identify missing preventive care services
- Identify members for targeted interventions

Identification/Stratification of Members
Using clinical business rules, the database identifies members with a specific chronic disease condition, such as Asthma, Diabetes, or Congestive Heart Failure. It then categorizes the degree of certainty the member has the condition as being probable or definitive. Once the member has been identified with a specific disease condition, the database is designed to detect treatment failure, complications and co-morbidities, noncompliance, or exacerbation of illness to determine if the member requires medical care, and recommends an appropriate level of intervention.

Identify Over/Under Utilization of Services
Using clinical business rules, the database can identify if a member or provider is over or under utilizing medical services. In analyzing claims and pharmacy data, the data warehouse can identify if a member did not refill their prescription for maintenance medication, such as high blood pressure medicines. The database can also identify over utilization or poor management by providers. For example, the system can list all members who have exceeded the specified timeframe for using a certain medication, such as persistent use of antibiotics greater than 61 days.

Identify Missing Preventive Care Services
The data warehouse can identify members who are missing preventative care services, such as an annual exam, an influenza vaccination for members over 65, a mammogram for women for over 50 or a retinal eye exam for a diabetic.

Identify Members for Targeted Interventions
The rules for identifying members and initiating the intervention are customizable to CalOptima to fit our unique needs. By using the standard clinical rules and customizing CalOptima specific rules, the database is the primary conduit for targeting and prioritizing heath education, disease management and HEDIS-related interventions.

By analyzing data that CalOptima currently receives (i.e. claims data, pharmacy data, and encounter data) the data warehouse can identify the members for quality improvement and access to care interventions, which will allow us to improve our HEDIS measures. This information will guide CalOptima in not only targeting the members, but also the HMOs, PHCs, SRGs, MBHO, PMGs, and providers who need additional assistance.

Medical Record Review
Wherever possible, administrative data is utilized to obtain measurement for some or all project quality indicators. Medical record review may be utilized as appropriate to augment administrative data findings. In cases where medical record abstraction is used, appropriately trained and qualified individuals are utilized. Training for each data element (quality indicator) is accompanied by clear guidelines for interpretation. Validation will be done through a minimum 10% sampling of abstracted data for rate to standard reliability, and will be conducted by the Director, Quality Analytics or designee. If validation is not achieved on all records samples, a further 25% sample will be reviewed. If validation is not achieved, all records completed by the individual will be re-abstracted by another staff member.

Where medical record review is utilized, the abstractor will obtain copies of the relevant section of the record. Medical record copies, as well as completed data abstraction tools, are maintained for a minimum period, in accordance with applicable law and contractual requirements.

Interventions
For each QI Project, specific interventions to achieve stated goals and objectives are developed and implemented. Interventions for each project must:

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

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

Improvement Standards

A. **Demonstrated Improvement**
Each project is expected to demonstrate improvement over baseline measurement on the specific quality indicators selected. In subsequent measurements, evidence of significant improvement over the initial performance to the indicator(s) must be sustained over time.

B. **Sustained Improvement**
Sustained improvement is documented through the continued re-measurement of quality indicators for at least one year after the improved performance has been achieved.

Once the requirement has been met for both significant and sustained improvement on any given project; there is no other regulatory reporting requirement related to that project. CalOptima may internally choose to continue the project or to go on to another topic.

Documentation of QI Projects
Documentation of all aspects of each QI Project is required. Documentation includes (but is not necessarily limited to):

- Project description, including relevance, literature review (as appropriate), source and overall project goal.
- Description of target population
- Description of data sources and evaluation of their accuracy and completeness
- Description of sampling methodology and methods for obtaining data
- List of data elements (quality indicators). Where data elements are process indicators, there must be documentation that the process indication is a valid proxy for the desired clinical outcome
- Baseline data collection and analysis timelines
- Data abstraction tools and guidelines
- Documentation of training for chart abstraction
- Rater to standard validation review results
- Measurable objectives for each quality indicator
- Description of all interventions including timelines and responsibility
- Description of benchmarks
- Re-measurement sampling, data sources, data collection, and analysis timelines
- Evaluation of re-measurement performance on each quality indicator

KEY BUSINESS PROCESSES, FUNCTIONS, IMPORTANT ASPECTS OF CARE AND SERVICE

CalOptima provides comprehensive acute and preventive care services, which are based on the philosophy of a medical "home" for each member. The primary care practitioner is this medical "home" for members who previously found it difficult to access services within their community. The Institute of Medicine describes the concepts of primary care and community oriented primary care, which apply to the CalOptima model:

- Primary Care, by definition, is accessible, comprehensive, coordinated, and continual care delivered by accountable providers of personal health services.

- Community Oriented Primary Care is the provision of primary care to a defined community, coupled with systematic efforts to identify and address the major health problems of that community.

The important aspects of care and service around which key business processes are designed include:

Clinical Care and Service:

- Access and availability
- Continuity and coordination of care
- Preventive care, including:
  - Initial Health Assessment
  - Initial Health Education
  - Behavioral Assessment
- Patient diagnosis, care and treatment of acute and chronic conditions
- Complex Case Management: CalOptima coordinates services for members with multiple and/or complex conditions to obtain access to care and services via the Utilization and Case Management department, which details this process in its UM/CM Program and other related policies and procedures.
- Drug utilization
- Health education and promotion
- Over/under utilization
- Disease management

Administrative Oversight:

- Delegation oversight
- Member rights and responsibilities
- Organizational ethics
- Effective utilization of resources
- Management of information
- Financial management
- Management of human resources
- Regulatory and contract compliance
- Customer satisfaction
- Fraud and abuse* as it relates to quality of care

* CalOptima has a zero tolerance policy for fraud and abuse, as required by applicable laws and its regulatory contracts. The detection of fraud and abuse is a key function of the CalOptima program.

DELEGATED AND NON-DELEGATED ACTIVITIES

CalOptima delegates certain functions and/or processes to HMO, PHC, SRG, MBHO, and PMG contractors who are required to meet all contractual, statutory, and regulatory requirements, accreditation standards, CalOptima policies, and other guidelines applicable to the delegated functions.

Delegation Oversight
Participating entities are required to meet CalOptima's QI standards and to participate in CalOptima's QI Program. CalOptima has a comprehensive interdisciplinary team that is assembled for evaluating any new potential delegate for ability to perform its contractual scope of responsibilities. Predelegation review is conducted through the Audit and Oversight department and overseen by the Delegation Oversight Committee reporting to the Compliance Committee. (See Attachment B for the 2016 Delegation Grid.)

Non-Delegated Activities
The following activities are not delegated, and remain the responsibility of CalOptima:

- Quality Improvement, as delineated in the Contract for Health Care Services
- QI Program for all lines of business, HMOs, PHCs, SRGs, MBHO, and PMGs must comply with all quality related operational, regulatory and accreditation standards
- Disease Management Program, may otherwise be referred to as Chronic Care Improvement Program
- Health Education (as applicable)
- Grievance and Appeals process for all lines of business, peer review process on specific, referred cases
- Development of system-wide indicators, thresholds and standards
- Satisfaction surveys of members, practitioners and providers
- Survey for Annual Access and Availability
- Access and availability oversight and monitoring
- Second level review of provider grievances
- Development of credentialing and re-credentialing standards for both practitioners and healthcare delivery organizations (HDOs)
- Credentialing and re-credentialing of HDOs
- Development of Utilization Management and Case Management standards
- Development of QI standards
- Management of Perinatal Support Services (PSS)
- Risk management
- Pharmacy and drug utilization review as it relates to quality of care
- Interfacing with State and Federal agencies, medical boards, insurance companies, and other managed care entities and health care organizations

PEER REVIEW PROCESS

Peer Review is coordinated through the QI Department. Medical staff triage potential quality of care issues and conduct reviews of suspected physician and ancillary quality of care issues. All closed cases are presented to CPRC to assess if documentation is complete, and no further action is required. The QI department also tracks, monitors, and trends, service and access issues to determine if there is an opportunity to improve care and service. Results of Quality of Care reviews and tracking and trending of service and access issues are reported to the CPRC at time of re-credentialing. Quality of care case

referral to the QI department are based on referrals to the QI department originated from multiple areas, which include, but are not limited to, the following: prior authorization, concurrent review, case management, legal, compliance, customer service, pharmacy, or grievances and appeals resolution.

CULTURAL & LINGUISTIC SERVICES

CalOptima serves a large and culturally diverse population. The five most common languages spoken for all CalOptima programs are: English at 57 percent, Spanish at 28 percent, Vietnamese at 10 percent, Farsi at one percent, Korean at one percent, Chinese at one percent, Arabic at one percent and all others at three percent, combined. CalOptima provides member materials in:

- Medi-Cal member materials are provided in seven languages: English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic
- OneCare member materials are provided in three languages: English, Spanish and Vietnamese
- OneCare Connect member materials are provided in five languages: English, Spanish, Vietnamese, Korean and Farsi.
- PACE participant materials are provided in four languages: English, Spanish, Vietnamese and Korean.

CalOptima is committed to Member Centric care that recognizes the beliefs, traditions, customs and individual differences of the diverse population we serve. Beginning with identification of needs through a Group Needs Assessment, programs are developed to address the specific education, treatment and cultural norms of the population impacting the overall wellness of the community we serve. Identified needs and planned interventions involve member input and are vetted through the Member and Provider Advisory Committees prior to full implementation. See CalOptima Policy DD. 2002 – Cultural and Linguistic Services for a detailed description of the program.

Objectives for serving a culturally and linguistically diverse membership include:

- Analyze significant health care disparities in clinical areas
- Use practitioner and provider medical record reviews to understand the differences in care provided and outcomes achieved
- Consider outcomes of member grievances and complaints
- Conduct patient-focused interventions with culturally competent outreach materials that focus on race/ethnicity/language or gender specific risks
- Identify and reduce a specific health care disparity with culture, race, gender
- Provide information, training and tools to staff and practitioners to support culturally competent communication

COMPREHENSIVE CREDENTIALING PROGRAM STANDARDS

The comprehensive credentialing process is designed to provide ongoing verification of the practitioner's ability to render specific patient care and treatment within limits defined by licensure, education, experience, health status and judgment, thus ensuring the competency of practitioners working within the CalOptima contracted delivery system. Practitioners are credentialed and re-credentialed according to regulatory and accreditation standards (DHCS, DMHC, CMS and NCQA). The scope of the credentialing program includes all licensed M.D.s, D.O.s, allied health and midlevel practitioners, which include, but are not limited to: behavioral health practitioners, certified nurse midwives, nurse practitioners, optometrist, etc., both in the delegated and CalOptima direct environments.

Health Care Delivery Organizations
CalOptima performs credentialing and re-credentialing of ancillary providers and HDOs (these include, but are not limited to, acute care hospitals, home health agencies, skilled nursing facilities, free standing surgery centers, dialysis centers, etc.) upon initial contracting, and every three years thereafter. The intent of this process is to assess that these entities meet standards for quality of care and are in good standing with State and Federal regulatory agencies.

Use of Quality Improvement Activities in the Re-credentialing Process
Findings from quality improvement activities are included in the re-credentialing process.

Monitoring for Sanctions and Complaints
CalOptima has adopted policies and procedures for ongoing monitoring of sanctions, which include, but are not limited to, State or Federal sanctions, restrictions on licensure, or limitations on scope of practice, Medicare and Medicaid sanctions, potential quality concerns and member complaints between re-credentialing periods.

FACILITY SITE REVIEW, MEDICAL RECORD AND PHYSICAL ACCESSIBILITY REVIEW SURVEY

CalOptima does not delegate Primary Care Practitioner (PCP) site and medical records review to its contracted HMOs, PHCs, SRGs, MBHO, and PMGs. CalOptima does, however, delegate this function to designated health plans in accordance with standards set forth by MMCD Policy Letter 02-02. CalOptima assumes responsibility and conducts and coordinates FSR/MRR for the non-delegated SRGs and PMGs. CalOptima retains coordination, maintenance, and oversight of the FSR/MRR process. CalOptima collaborates with the SRGs and PMGs to coordinate the FSR/MRR process, minimize the duplication of site reviews, and support consistency in PCP site reviews for shared PCPs.

Site reviews are completed as part of the initial credentialing process, except in those cases where the requirement is waived because the provider received a passing score on

another full scope site review performed by another health plan in the last three years, in accordance with MMCD Policy Letter 02-02 and CalOptima policies. Medical records of new providers shall be reviewed within ninety calendar days of the date on which members are first assigned to the provider. An additional extension of ninety calendar days may be allowed only if the provider does not have sufficient assigned members to complete review of the required number of medical records.

Physical Accessibility Review Survey for Seniors and Persons with Disabilities (SPD)
CalOptima conducts an additional DHCS-required facility audit for American with Disabilities Act compliance for seniors and persons with disabilities (SPD) members, which includes access evaluation criteria to determine compliance with ADA requirements.

- Parking
- Exterior ramps
- Exterior stairways
- Entrances
- Interior circulation
- Interior doors
- Interior ramps
- Interior stairways
- Elevators
- Controls
- Sanitary facilities
- Reception and waiting areas
- Diagnostic and treatment areas

Medical Record Documentation Standards
CalOptima requires that its contracted HMOs, PHCs, SRGs, MBHO, and PMGs make certain that each member medical record is maintained in a accurate and timely manner that is current, detailed, organized and easily accessible to treating practitioners. All patient data should be filed in the medical record in a timely manner (i.e., lab, x-ray, consultation notes, etc). The medical record should also promote timely access by members to information that pertains to them.

The medical record should provide appropriate documentation of the member's medical care, in such a way that it facilitates communication, coordination, continuity of care, and promotes efficiency and effectiveness of treatment. All medical records should, at a minimum, include all information required by State and Federal laws and regulations, and the requirements of CalOptima's contracts with CMS, DHCS, and MRMIB.

The medical record should be protected in that medical information is released only in accordance with applicable Federal and/or State law.

CORRECTIVE ACTION PLAN(S) TO IMPROVE CARE, SERVICE

When monitoring by either CalOptima Quality Improvement Department or Audit & Oversight Department identifies an opportunity for improvement, the delegated or functional areas will determine the appropriate action(s) to be taken to correct the problem. Those activities specific to delegated entities will be conducted at the direction of the Audit and Oversight Department as overseen by the Delegation Oversight Committee, reporting to the Compliance Committee. Those activities specific to CalOptima's functional areas will be overseen by the Quality Improvement Department as overseen by and reported to QIC. Actions for either delegates or functional areas may include the following:

- Development of cross-departmental teams utilizing continuous improvement tools to identify root causes, develop and implement solutions, and develop quality control mechanisms to maintain improvements.
- Discussion of the data/problem with the involved practitioner, either in the respective committee or by a Medical Director.
- Further observation of performance via the appropriate clinical monitor. (This process shall determine if follow up action has resolved the original problem.)
- Discussion of the results of clinical monitoring. (The committee/functional area may refer an unresolved matter to the appropriate committee/functional area for evaluation and, if necessary, action.)
- Intensified evaluation when a trigger for evaluation is attained, or when further study needs to be designed to gather more specific data, i.e. when the current data is insufficient to fully define the problem.
- Changes in policies and procedures: the monitoring and evaluation results may indicate a problem, which can be corrected by changing policy or procedure.
- Prescribed continuing education
- Intensive monitoring and oversight
- De-delegation
- Contract termination

Performance Improvement Evaluation Criteria for Effectiveness

The effectiveness of actions taken and documentation of improvements made are reviewed through the monitoring and evaluation process. Additional analysis and action will be required when the desired state of performance is not achieved. Analysis will include use of the statistical control process, use of comparative data, and benchmarking when appropriate.

COMMUNICATION OF QUALITY IMPROVEMENT ACTIVITIES

Results of performance improvement activities will be communicated to the appropriate department, multidisciplinary committee or administrative team as determined by the nature of the issue. The frequency will be determined by the receiving groups, and be reflected on the work plan or calendar. The QI Subcommittees will report their summarized information to the QIC quarterly in order to facilitate communication along the continuum of care. The QIC reports activities to the Board of Directors, and/or the QAC, through the CMO or designee, on a quarterly basis. QIC participants are responsible for communicating pertinent, non-confidential QI issues to all members of CalOptima staff. Communication of QI trends to CalOptima's contracted entities and practitioners and providers is through the following:

- Practitioner participation in the QIC and its subcommittees
- Health Network Forums, Medical Director meeting, and other ongoing ad-hoc meetings
- Annual synopsized QI report (both web-site and hardcopy availability for both practitioners and members) shall be posted on CalOptima's website, in addition to the annual article in both practitioner and member newsletter. The information includes a QI Program Executive Summary or outline of highlights applicable to the Quality Program, its goals, processes and outcomes as they relate to member care and service. Notification on how to obtain a paper copy of QI Program information is posted on the web, and is made available upon request
- Annual PCP pamphlet

ANNUAL PROGRAM EVALUATION

The objectives, scope, organization and effectiveness of CalOptima's QI Program are reviewed and evaluated annually by the QIC, QAC, and approved by the Board of Directors, as reflected on the QI Work Plan. Results of the written annual evaluation are used as the basis for formulating the next year's initiatives and incorporated into the QI Work Plan and reported to DHCS & CMS on an annual basis. In the evaluation, the following are reviewed:

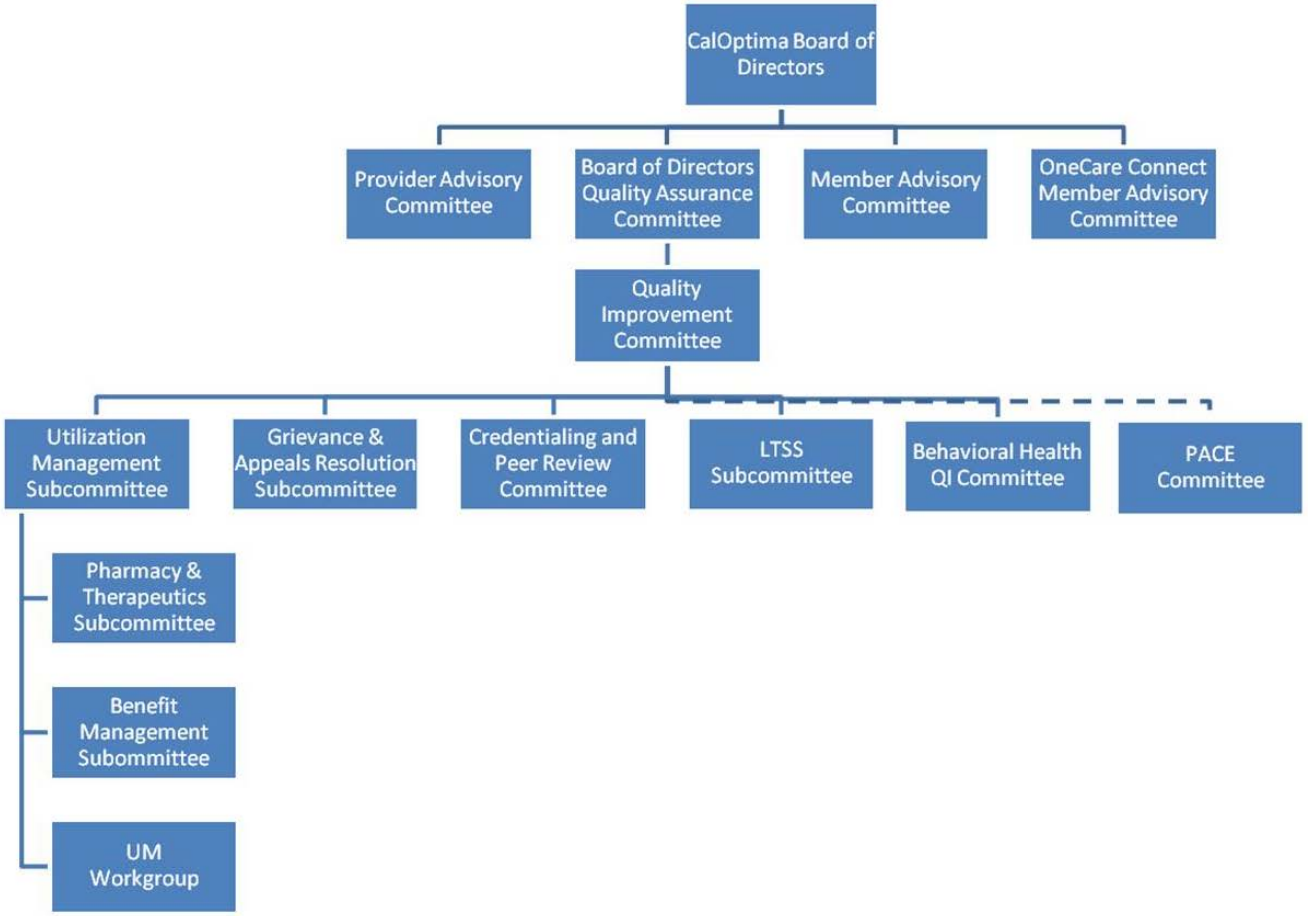
- A description of completed and ongoing QI activities that address quality and safety of clinical care and quality of services, including the achievement or progress towards goals, as outlined in the QI Work Plan, and identification of opportunities for improvement
- Trending of measures to assess performance in the quality and safety of clinical care and quality of service, including aggregate data on utilization,
- An assessment of the accomplishments from the previous year, as well as identification of the barriers encountered in implementing the annual plan through root cause and barrier analyses, to prepare for new interventions
- An evaluation of each QI Activity, including Quality Improvement Projects (QIPs), with any area showing improvements in care or service as a result of QI activities receiving continued interventions to sustain improvement

- An evaluation of member satisfaction surveys and initiatives
- A report to the QIC and QAC of a summary of all quality indicators and identification of significant trends
- A critical review of the organizational resources involved in the QI Program through the CalOptima strategic planning process
- The recommended changes, included in the revised QI Program Description for the subsequent year, for QIC, QAC, and the Board of Directors for review and approval

IN SUMMARY

As stated earlier, we cannot achieve our mission and our vision alone. We must work together with providers, community health centers, county agencies, State and Federal agencies and other community stakeholders to provide quality health care to our members. Together, we can be innovative in developing solutions that meet our diverse members' health care needs. We are truly "Better. Together."

QUALITY IMPROVEMENT COMMITTEE STRUCTURE – 2016



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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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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 October 6, 2016
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

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

Contact

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

Recommended Actions

1. Approve distribution of 30-day all cause (non maternity related) avoidable readmission reduction program for Medi-Cal incentive payments to the highest performing health networks and hospitals; and
2. Recommend discontinuing Readmission Program.

Background

At its March 6, 2014 meeting, the CalOptima Board of Directors heard and approved staff's recommendation for a 30 day all cause (non maternity related) avoidable readmission reduction program for Medi-Cal. The following program parameters and payment methodology were included in the initial request.

Measurement Periods and Criteria for Reimbursement

The first year measurement period for this project began July 1, 2014 and ended June 30, 2015. The second year measurement period began July 1, 2015 and ended June 30, 2016. The proposed hospital and health network performance incentive, if paid, will be paid in October following the respective measurement period.

For a hospital to be eligible the hospital must be contracted with CalOptima through the respective measurement and payment distribution period with the performance parameters discussed below.

For a health network to be eligible they must also be in good standing with CalOptima, be contracted with CalOptima through the respective measurement and distribution period with the performance parameters described below, and be without changes in risk assignment (e.g., Shared risk group changing to HMO or PHC arrangement). Current HMO and PHC exclusions include Kaiser, CHOC, AMVI and Family Choice).

Provider Performance Incentives

A proposed distribution was presented at the February 19, 2014 Quality Assurance Committee meeting and is presented again below for reference.

- 100,000 for health network with lowest readmission rate (dependent on statistically significant sample size)
- $100,000 for hospital with lowest readmission rate (dependent on statistically significant sample)
- $50,000 for most improved health network (representing the greatest readmission rate improvement with a statistically significant sample size)

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- $50,000 for most improved hospital (representing the greatest readmission rate improvement with a statistically significant sample size)

As noted in the March 6, 2014 staff report, actual payment and methodology were to be finalized after the end of the first year, based on funds available and review of performance by the Health Networks and hospitals. Currently, there is $442,874 remaining in IGT 1 for this program; therefore the payments will be adjusted accordingly.

Discussion

Given the variation in member demographics and the populations served by each of the health networks and hospitals, staff concluded that the best approach to calculate a more accurate relative performance representation between the health networks and hospitals was to segment the population into three main member demographic categories:

- SPD>18,
- TANF<18,
- TANF>18

A significant sample size was determined to be 500 admissions for each hospital and health network (HN) for each incentive year.

As proposed, payment will occur as follows:

HN:	$242,874	SPD	TANF >18	TANF <18
	Top performer:	$50,958	$50,958	$50,958
	Most improved:	$30,000	$30,000	$30,000
Facilities: $200,000				
	Top performer:	$40,000	$40,000	$40,000
	Most improved	$20,000	$20,000	$20,000

Health Network Performance (Total award: $242,874)

HEALTH NETWORKS		
	Top Performer	**Most Improved**
SPD> 18	United Care	United Care
TANF <= 18	AltaMed	Monarch
TANF > 18	Arta Western	Monarch

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Hospital Performance (Total Award: $200,000)

FACILITIES		
	Top Performer	**Most Improved**
SPD> 18	Fountain Valley Regional Hospital & Medical Center	Orange Coast Memorial Medical Center
TANF > 18	Anaheim Regional Medical Center	UCI Medical Center
TANF <= 18	Fountain Valley Regional Hospital & Medical Center	Fountain Valley Regional Hospital & Medical Center

The rollout of the CPT codes for post discharge and care coordination follow-up showed very little uptake (see presentation to Utilization Management Committee, May 5, 2015). Only 181 claims were received from 45 unique providers and the average reimbursement was $214 per claim. In addition, only one provider with previous high readmission rates participated in the incentive. Due to these results, staff recommends that this component of the overall readmissions program be discontinued.

Fiscal Impact
The recommended action to distribute a total of $442,874 in IGT 1 funds for Medi-Cal incentive payments for the 30 day All Cause (Non Maternity Related) Avoidable Readmission Reduction Program is budget neutral. 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
The proposed readmission reduction incentive program was expected to guide CalOptima in constructing a long term reduction readmission strategy and improving health outcomes for members discharged from inpatient care by incentivizing post-hospital visits. With payout of remaining funds, this initiative will be discontinued and restructured to meet CalOptima's long term goal of a sustainable reduction in readmissions.

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

Attachments
1. Board Action dated March 6, 2014, Approve Provider Payments to Support Initiatives to Reduce 30-Day All Cause (Non Maternity Related) Avoidable Hospital Readmissions for Medi-Cal
2. May 5, 2015 presentation to Utilization Management Committee

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2014
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

V. A. Approve Provider Payments to Support Initiatives to Reduce 30-Day All Cause (Non Maternity Related) Avoidable Hospital Readmissions for Medi-Cal

Contact

Roberto Madrid, M.D., Medical Director, Quality and Analytics, (714) 246-8400

Recommended Action

Approve provider payments to support initiatives to reduce 30-day All Cause (Non Maternity Related) Avoidable Readmission Reduction Program for Medi-Cal to begin during Fiscal Year 2014-15.

Background

Managing all cause 30-day hospital readmission rates is critical to the viability of any health plan. CalOptima's inpatient costs for calendar year 2012 exceeded $348 million, making this the highest driver of medical costs. Of these inpatient costs, approximately $32.6 million were the result of readmissions. Although CalOptima has experienced a reduction in hospital costs during the past two years, this is not expected to be a long-term trend in the absence of interventions that successfully target readmission rates.

Reasons for readmission vary greatly by provider and according to geography, patient demographics, and patient diagnoses. According to a February 2013 Robert Wood Johnson Foundation report, a significant portion of readmissions for Medicare are avoidable. The medical literature also shows that reductions in readmission rates can be achieved through improved discharge planning, care coordination, and post discharge follow-up by primary care providers, particularly when providers are reimbursed for these services and/or educated to achieve performance targets.

CalOptima currently has multiple programs that target readmission reductions, but prior to 2013 did not have the ability to reimburse post discharge care coordination and follow-up. Effective January 1, 2013, Medicare pays for two CPT codes (99495 and 99496) that are used to report care management services for patients discharged following a hospital or skilled nursing facility stay, outpatient observation, or partial hospitalization. Given that these codes are already being reimbursed for Medicare members, One Care post discharge visits are excluded from this program. Currently these codes are not reimbursed by the Medi-Cal program, and if at any time during the 2-year program Medi-Cal should begin to pay for these services, the program will cease. Payments to providers will be made up to dates of service prior to Medi-Cal adopting these new codes. Any payments made to contracted hospitals and or Health Networks will also reflect dates of service prior to Medi-Cal adoption of the new codes and take into account a modified measurement period. To qualify for reimbursement, services must be rendered by a physician or qualifying non-physician practitioner within a 7 to 14-day post discharge period, depending on severity and continue to 30 days post discharge for non-maternity related diagnoses.

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CalOptima's proposed program will employ a two-pronged approach to the reduction of readmission rates: 1) Promote physicians' appropriate use of the post discharge visit for care coordination and follow-up care by educating providers about newly available reimbursement for these services; and 2) Leverage current Health Network and hospital's readmission reduction efforts by providing performance supplements to those organizations that demonstrate lowest readmission rates and or most significant decrease in readmission rates if additional funds are available after fee-for-services visits are paid.

Discussion

Reimbursement for Post Discharge Follow-up

The first year measurement period for this project will start July 1, 2014 and end June 30, 2015. The second year measurement period will follow and start July 1, 2015 and end June 30, 2016. The individual provider payments for this program will be paid consistent with other Medi-Cal payment parameters 90 days from receipt of the measurement period claim. The proposed hospital and Health Network performance supplement, if paid, will be paid in the October time frame following the respective measurement period. To be eligible an individual provider must be contracted through the measurement period and distribution period with CalOptima, both directly or through at least one Health Network, and be in good standing with CalOptima. For a hospital to be eligible the hospital must be contracted with CalOptima through the respective measurement and payment distribution period with the performance parameters discussed below. For a Health Network to be eligible they must also be in good standing with CalOptima, be contracted with CalOptima through the respective measurement and distribution period with the performance parameters described below, and be without changes in risk assignment (e.g., Shared Risk group changing to HMO or PHC arrangement).

It is estimated that primary care providers will claim $1 million for post discharge care during the first year of the program. Given the lack of historical data for the two CPT codes that physicians can now use to bill for these services, CalOptima's analyzed all cause hospital admissions for a 36-month period, excluding maternity-related diagnoses. Staff also factored in assumptions regarding providers' rate of adoption of new behaviors, as well as estimations of the percentage of claims that are likely to be submitted for moderate severity diagnoses, as compared with claims for high severity diagnoses. Based on this analysis, staff anticipates that 40% of the new post discharge claims will be for Medi-Cal, and 50% will be for One Care and that 75% of claims for these codes will be for moderate severity diagnoses, and 25% will be for high severity.

A new claims monitoring process will track each provider's transitional care management claims activity. Over or under utilization of the two CPT codes will trigger a focused audit process to validate the results. Providers demonstrating over utilization and potential abuse of this program will be referred to the Office of Compliance for appropriate action. Providers demonstrating underutilization will be further educated about the program and its goals.

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Provider Performance Incentives

Health Networks and hospitals will eligible to receive performance incentives if additional funds are available after payment for fee-for-service Transition Codes. A proposed distribution approach is presented below. However, actual payment and methodology will be finalized after the end of the first year based on funds available and review of performance by the Health Networks and hospitals. This item will be brought back to the Quality Assurance Committee and the Board of Directors for final approval ahead of payment distribution. Sample performance incentives:

- $100,000 for Health Network with lowest readmission rate (dependent on statistically significant sample size);
- $100,000 for hospital with lowest readmission rate (dependent on statistically significant sample);
- $50,000 for most improved Health Network (representing the greatest readmission rate improvement with a statistically significant sample size); and
- $50,000 for most improved hospital (representing the greatest readmission rate improvement with a statistically significant sample size).

Fiscal Impact

CalOptima's program to reduce avoidable readmissions will begin in July 2014 and will be funded by funds set aside from an Intergovernmental Transfer (IGT) funds for this purpose. Initially, the program was budgeted at $1 million for its first year and $2 million for the second year. To align more accurately with the timeline and scope of the program, and given the potential to generate early and significant savings from a successful program, CalOptima proposes a reallocation of IGT funds approved by the Board of Directors in March 2013, so as to provide $1.5 million for the first year and $1.5 million for the second year.

Rationale for Recommendation

The proposed readmission reduction incentive program is expected to guide CalOptima in constructing a long term reduction readmission strategy and improving health outcomes for members discharged from inpatient care.

Concurrence

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

Attachments

None

/s/ Michael Schrader — *2/28/2014*
Authorized Signature — **Date**

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A Public Agency

CalOptima

Better. Together.

Medi-Cal Readmissions

Utilization Management Committee

May 5, 2015

Roberto Madrid, MD

Medical Director, Quality and Analytics

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Readmission Reduction

- On July 1, 2014, CalOptima implemented a 2-year initiative aimed at lowering avoidable hospital readmissions for Medi-Cal members by extending payment for post-discharge care management services to Primary Care Providers (PCP's)
- CalOptima and the health networks will reimburse PCP's on a fee-for-service basis at 100% of the current Medicare rate for codes 99495 and 99496 (30-day transitional care management)
- The health networks will be reimbursed by CalOptima based on paid encounter submissions (beginning October 2014)

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Incentive Statistics

- For Dates of Service (DOS) from 7/14 through 4/15
- 181 claims were received
- Over $38,600 reimbursed to providers
- Average reimbursement has been $214 per claim
- 45 unique providers have sent in a claim for transitional care management
- Significant opportunity to increase utilization of this program

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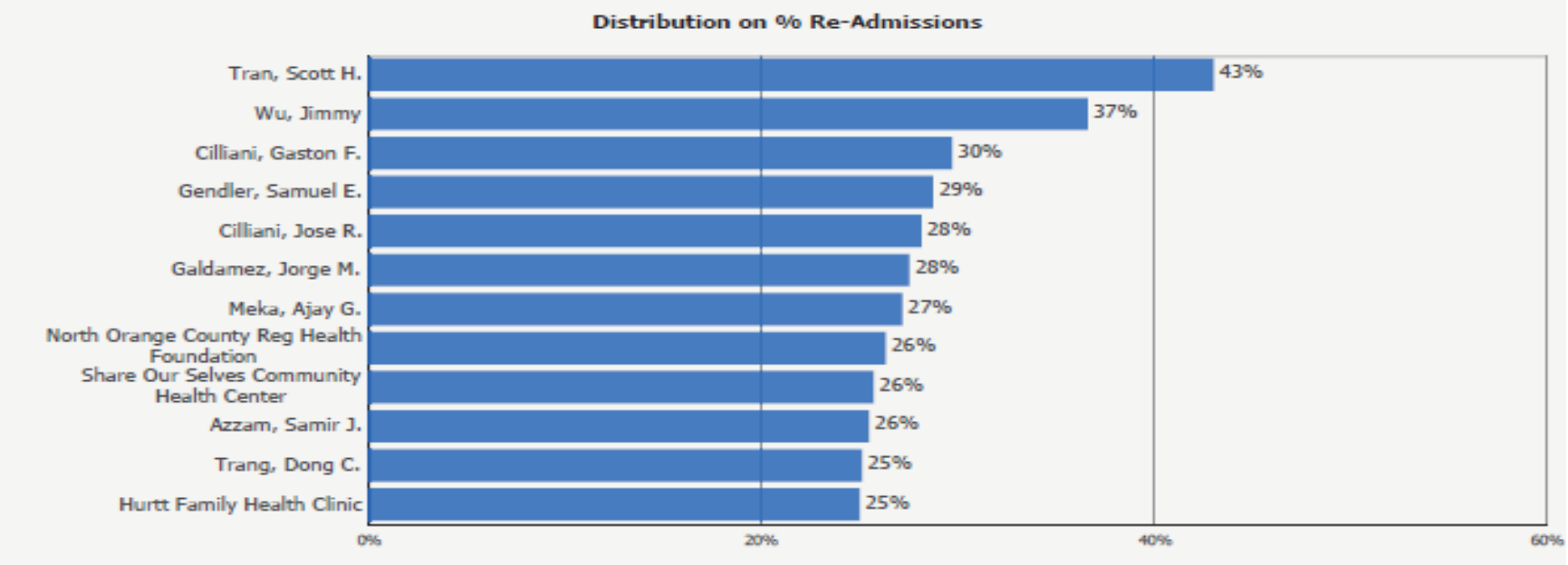
Readmissions



- Data is for 2014 + Q1 of 2015
- % readmission= # of 30 day all cause readmissions/ total admissions
- 540 readmissions by 238 unique members
- 45 average readmissions per provider

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Incentive

- Number of providers who are on the list of providers with the highest readmission rates and have utilized the readmission reduction incentive
  - One
- Significant room to increase awareness and utilization of this program

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Intervention

- Work with Provider Relations to provide feedback
  - Letters have been composed for each of the providers with the highest readmission rates
  - Attached to letters will be the list of members that were readmitted over the measurement period
  - The provider relations team will hand deliver letters to the targeted providers
- Monitor and re-measure readmission rates
- Cross reference with incentive utilization

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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

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

Contact

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

Recommended Actions

Authorize:

1. The expenditure of $500,000 in Intergovernmental Transfer (IGT) 1 funds to expand the child and adolescent component of the Shape Your Life weight management program for CalOptima Medi-Cal members, which includes, subject to regulatory approval as applicable, member and provider incentives; and
2. The Chief Executive Officer to contract with the vendor(s) selected through an RFP process to provide group-based child and adolescent Shape Your Life program interventions.

Background

Childhood obesity is a growing national epidemic that has more than doubled in children and quadrupled in adolescents in the past 30 years. Overweight and obesity in childhood are known to have significant impact on both physical and psychosocial heath. In 2014, an average of 33% of Orange County students in 5th, 7th, and 9th grades were overweight or obese, compared to 38% statewide. In 2011-2012, 32% of Orange County adults were overweight, in addition to23% identified as obese. Weight status has worsened in Orange County, decreasing from 50% of adults with a healthy weight in 2001 to only 43% in 2011-2012.

Discussion

CalOptima's takes a population management approach towards addressing obesity. Clinical practice guidelines serve as the foundation of the program. These guidelines provide direction for medically-based prevention and treatment protocols within the program. The child and adolescent component of the Shape Your Life program has adopted the clinical practice guidelines entitled "Prevention, Assessment and Treatment of Childhood Obesity: Recommendations from the AMA Expert Committee on Childhood Obesity, June 2007". The main tenet of these guidelines is that a staged approach should be used in the treatment of childhood obesity. This incremental approach begins with health education and moves to structured weight management programs.

Staff has completed a comprehensive evaluation of CalOptima's program and identified many opportunities for improvement, including revising the program's structured weight management interventions for children due to the interventions' high costs, low member penetration and limited geographical access. As a result, staff has redesigned the child and adolescent evidenced-based core

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curriculum for our community, group-based weight management interventions, refined our risk stratification and rebranded our entire obesity program "Shape Your Life." The program currently provides health education materials to all its members and has outreached to all CalOptima primary care physicians (PCPs) to share the evidenced-based treatment recommendations, as well as tools to aid in the office-based treatment of childhood and adult obesity.

The Board allocated $500,000 of IGT 1 funds for high risk children programs at its March 6, 2014, meeting. Of these allocated funds, none have been expended to date. Staff believes these funds are best used to expand the child and adolescent components of the redesigned Shape Your Life program.

Staff proposes to use $150,000 on the group-based weight management childhood obesity interventions, $100,000 for member and provider incentives and up to $250,000 over two years to hire new staff to manage this expansion.

Child and Adolescent Group-Based Interventions: $150,000
For the proposed child and adolescent group-based weight management interventions, staff plans to use the RFP process to find and contract with vendors who can provide these services countywide to our child and adolescent Medi-Cal members. The proposed intervention will be 6-8 group-based visits with nutritional, exercise and healthy habit components.

Incentives: $100,000
A proposed distribution approach for the member and provider incentives are presented below. However, actual payment and methodology will be finalized based on funds available, DHCS approval of member incentive plan and participant engagement. Member incentive goals will be established by CalOptima. The goals will be based on completing 6-8 group-based visits, completing a pre and post-program PCP assessment and behavior modification achievements as measured by a validated questionnaire. Provide incentives will be established by CalOptima and will be based on program referrals, pre-intervention program assessments and post-intervention assessments.

Member
- $50 for achievement of program process and outcome goals.
- $25 for post-program office visit.

Provider
- $25 for program referral and member assessment.
- $50 for post-program office visit and reassessment.

Staffing: $250,000
Staff proposes the use of up to $250,000 over two years to hire one new project manager that will help in the expansion of the child and adolescent components of the Shape Your Life program. As proposed, the staff duties will include:
1. Evaluating the vendors who respond to the RFP
2. Developing rates for the community, group-based child and adolescent weight management interventions

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3. Providing technical assistance to vendors across the county as needed
4. Developing, managing and evaluating the child and adolescent "Shape Your Life" member and provider incentives
5. Continuously evaluate the vendors, interventions and the incentive programs

At the conclusion of the two years, staff will transition the remaining ongoing duties of the project manager to budgeted staff positions.

Fiscal Impact

The recommended action to authorize use of $500,000 in currently available IGT 1 funds to expand CalOptima's Shape Your Life program is budget neutral. 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

Childhood obesity is a growing epidemic that affects more than 48,000 children enrolled in CalOptima's Medi-Cal program. Although health plans are not the only stakeholder in this national epidemic, CalOptima recognizes that it plays a critical role in combating this important issue.

Early intervention can assist children in achieving and maintaining appropriate BMI levels. These interventions may prevent complications such as hyperlipidemia, hypertension, diabetes, and other chronic conditions associated with obesity. The IGT funds will be used to expand the newly redesigned child and adolescent components of the CalOptima Shape Your Life program with a focus on evidence-based interventions and outcomes.

Concurrence

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

Attachments

1. Power Point Presentation, Shape Your Life Expansion
2. Board Action dated March 6, 2014, Approve Final Expenditure Plan for Use of FY 2010-11 IGT Funds; Approve Expenditure Plan for Use of FY 2011-12 IGT Funds; Authorize the CEO to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

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

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“Shape Your Life” Expansion

Board of Directors Meeting

October 6, 2016

Dr. Miles Masatsugu, Medical Director

Pshyra Jones, Director, Health Education & Disease Management

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Roadmap

- Completed a comprehensive assessment of our obesity programs
- Redesigned our entire obesity program
  - Rebranded the program “Shape Your Life”
  - Refined our obesity risk stratification
  - Developed an evidenced-based core curriculum for our obesity interventions
  - Refined our evidence-based outcome metrics for our obesity interventions
- Expansion
- Evaluation and further refinement

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Assessment Findings

- Evidence **is not yet conclusive** on the long term benefits of intensive short term interventions.
- However, evidence-based recommendations on the prevention and treatment of childhood obesity have been made and endorsed by the CDC, AAP and AMA
- Limited provider understanding of evidence-based recommendations
- Providers and members alike would like to know what resources exist in the community and what is offered through CalOptima
- Access is an issue for our members due to limited intervention sites and lack of knowledge of the interventions offered by CalOptima by both its providers and members.

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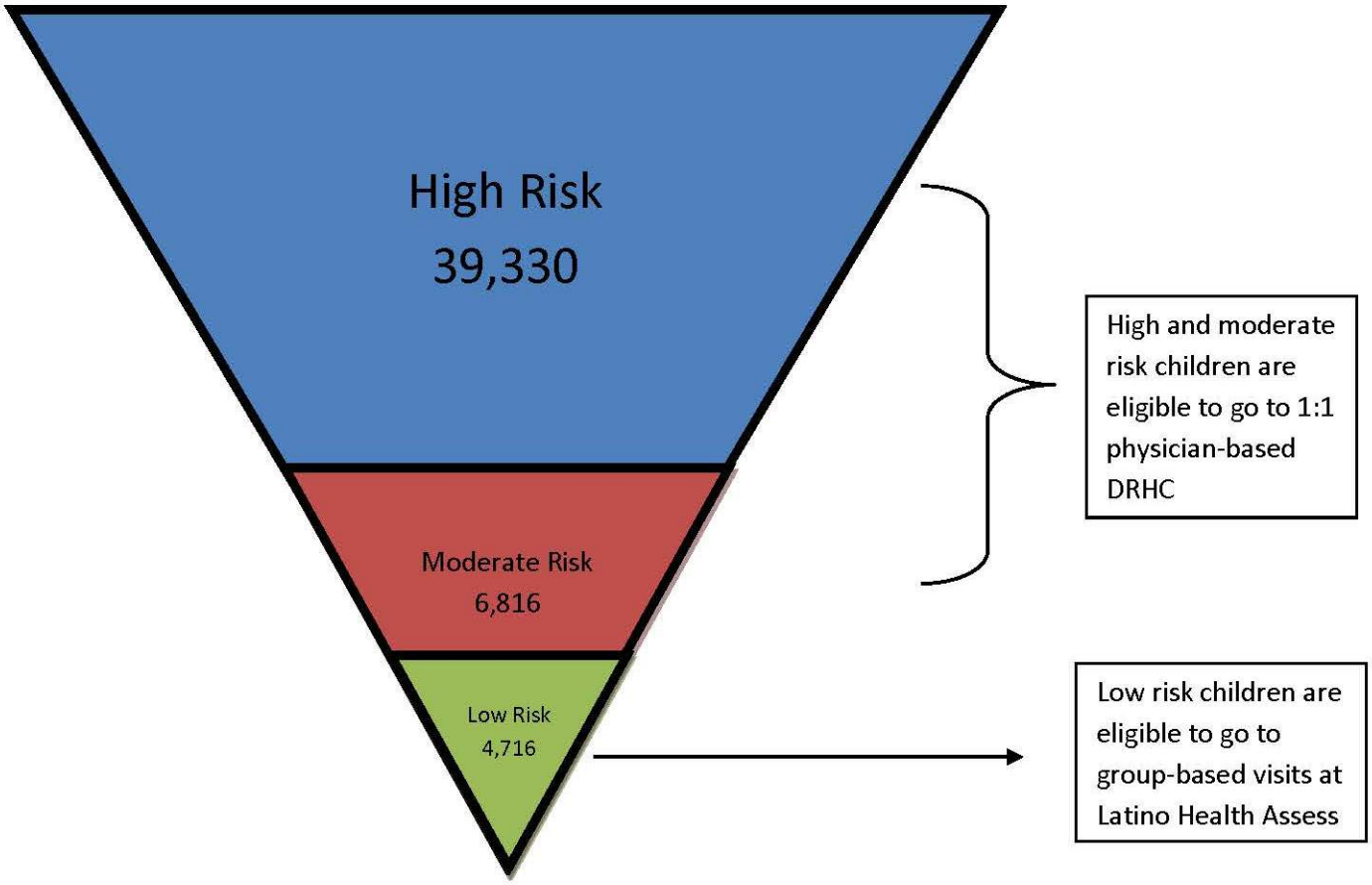
Assessment Findings: Risk Stratification Data Upside Down



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Assessment Findings: Penetration Low and Costs High

		2012-2013	2013-2014	% Increase Year Over Year
Dr. Riba's Health Club	Members	361	666	84%
Medium and High Risk	Visits	1,165	2,325	99.6%
Members	Costs	$130,020	$263,200	102.4%
	Cost per Member	$364.20	$395.13	7.8%
		2012-2013	2013-2014	% Increase
Latino Health Access	Members	100	115	15%
Low Risk	Visits	764	843	10.3%
Members	Costs	$76,472	$85,788	12.1%
	Costs per Member	$764.72	$745.98	-2.5%

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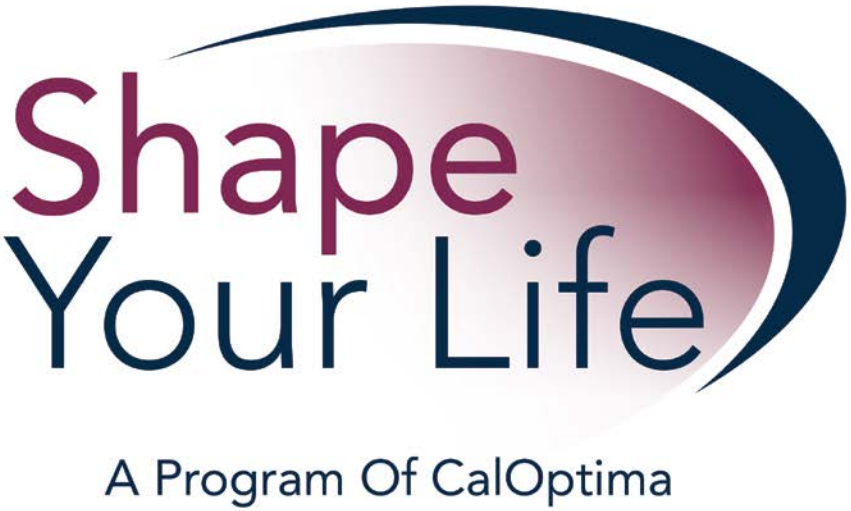
Rebranded Obesity Program



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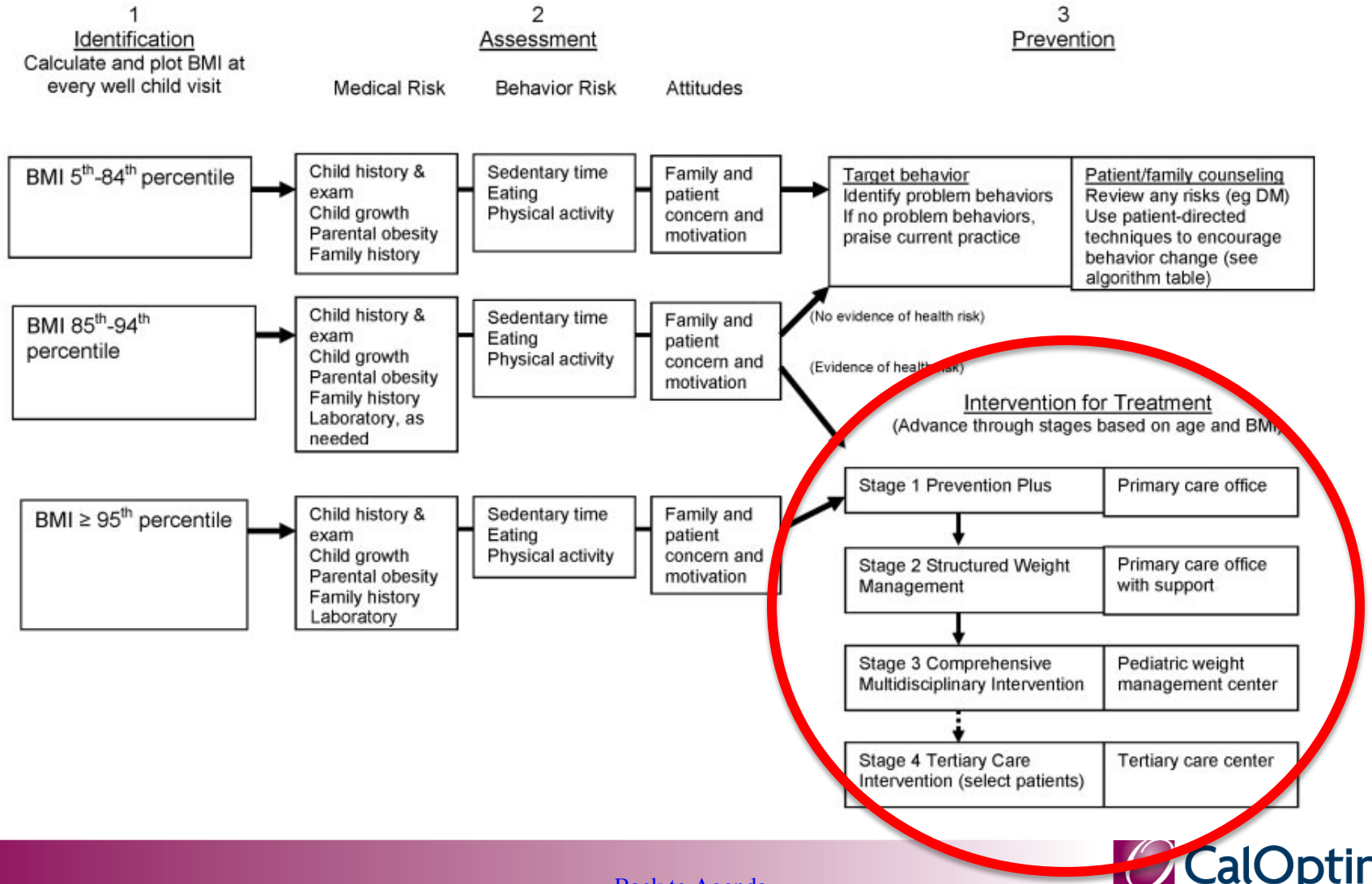
Adopted the Expert Committee Recommendations for the Assessment, Prevention, and Treatment of Childhood Obesity by Childhood Obesity Action Network (COAN) Evidenced-Based Recommendations



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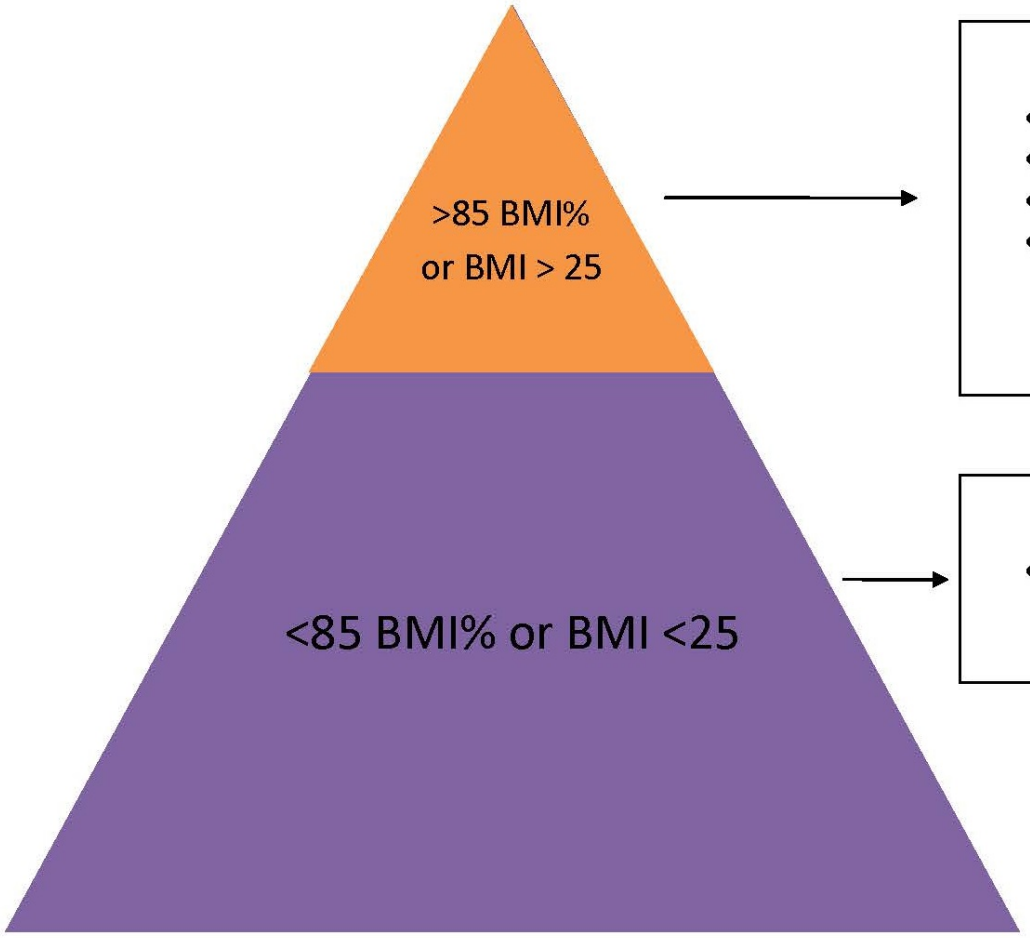
Refined New Risk Stratification



Structured Weight Management

- w/PCP
- Group-based interventions
- Member and Provider Incentives
- Telephonic counseling from CalOptima Health Education Department

Prevention

- Regular newsletters & mailed educational material

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Redesigned Interventions (Implemented)

- Entire Population
  - Healthy Alert
    - Quarterly newsletter w/healthy recipes, tips for parents, teens and children, informed about other services for eligible members
- Group-Based Interventions
  - Assessing member readiness for behavior modification prior to authorization
  - Streamlined referral process
  - Supportive tools and local resources mailed to members to support group-based education intervention model
  - Evaluated existing vendor contracts

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Redesigned Interventions (Not Implemented)

- Member incentives to improve children's participation in group-based interventions and reaching outcome goals
- Provider incentives to improve the assessments, referrals and post-program reassessments of overweight and obese children
- Expand the group-based educational intervention for children countywide

Back to Agenda

Proposed Next Steps

- Request Board authorization to expend the $500,000 in allocated IGT funds
- Request for Proposal (RFP) to find vendors who can provide the group-based intervention
- Hire project manager
- Develop Member and Provider Incentives
- Contract with vendors and expand intervention countywide
- Ongoing evaluation of interventions and incentive programs

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Project Manager Duties

- Evaluate the vendors who respond to the RFP
- Provide technical assistance to vendors as needed
- Develop, manage and evaluate the child and adolescent “Shape Your Life” member and provider incentives
- Develop, manage and evaluate the child and adolescent “Shape Your Life” group-based interventions

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Proposed Member and Provider Incentives

Member

- $50 for achievement of program process and outcome goals*
- $25 for post-program office visit*

Provider

- $25 for program referral and member assessment*
- $50 for post-program office visit and reassessment*

*Actual payment and methodology will be finalized based on funds available, DHCS approval of member incentive plan and participation engagement

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Proposed IGT Expenditures to Expand “Shape Your Life”

- Use up to $250,000 to add a new staff member for up to two years to implement and manage the program expansion
- $100,000 to support member & provider incentives
- $150,000 to pay new vendors for group-based intervention services

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Recommended Board Action

- Recommend Board of Directors' authorize the expenditure of $500,000 in Intergovernmental Transfer (IGT) 1 funds to expand the child and adolescent component of the Shape Your Life program for CalOptima Medi-Cal members.
- Recommend authorizing the CEO to contract with the vendors selected through the RFP process to provide the group-based child and adolescent Shape Your Life program interventions.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 6, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. C. Approve Final Expenditure Plan for Use of FY 2010-11 Intergovernmental Transfer (IGT) Funds; Approve Expenditure Plan for Use of FY 2011-12 Intergovernmental Transfer (IGT) Funds; Authorize the Chief Executive Officer (CEO) to Initiate Required Process for FY 2012-13 IGT Funds and Execute the Standard Required Application Documents

Contact

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

Recommended Actions

1. Approve final expenditure plan for $12.4 Million in FY 2010-11 Intergovernmental Transfer (IGT) funds;
2. Approve expenditure plan for $7.4 Million in FY 2011-12 IGT funds;
3. Authorize the CEO to initiate the required process for FY 2012-13 IGT and execute the required application documents consistent with Board approved terms.

Background

CalOptima has partnered with the Regents of the University of California/University of California, Irvine (UCI) to secure two IGTs to date. The two transactions are summarized below:

- IGT 1 was authorized by the CalOptima Board on March 3, 2011, and covers the claiming period of Fiscal Year (FY) 2010-11. CalOptima retained $12.4 Million, UCI retained $8.4 Million, and the state disbursed the funds in August 2012.
- IGT 2 was authorized by the CalOptima Board on March 7, 2013 for the FY 2011-12 claiming period. CalOptima retained $7.4 million, UCI retained $4.8 Million, and the state disbursed the funds in June 2013.

IGTs are transfers of public funds between governmental entities. The revenue generated through the CalOptima /UCI IGTs must be used to finance improvements in services for Medi-Cal beneficiaries. Funds are potentially non-recurring, since there is no guarantee of future IGT agreements. Thus, these funds are best suited for one-time investments or as seed capital for new services or initiatives for Medi-Cal beneficiaries.

The present item seeks: 1) authorization to adjust the expenditure plan for IGT 1 to reflect the final funding distribution needed to fully implement the approved uses; 2) approval of the proposed expenditure plan for IGT 2; and 3) authorization to initiate the process to secure a third IGT.

Discussion

Final Expenditure Plan for IGT 1

On March 7, 2013, the CalOptima Board approved the following expenditure plan for IGT 1:

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Table 1. Approved Expenditure Plan for IGT 1	**Budget**
Complex Case Management – Part 1 • Case management for high-risk members across various care settings	Year 1: $5.1M Year 2: $4.2M
Complex Case Management – Part 2 • Improved health network documentation of clinical needs	Year 1: $1.8M Year 2: $200K
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

As reported at the February 2014 CalOptima Board meeting, recent data analyses indicate that the need for improved health network documentation of clinical needs (i.e., Complex Case Management – Part 2 in the above table) is not consistent among the networks, and thus will not require the entire budgeted amount. At the same time, full implementation of the uses proposed under Complex Case Management – Part 1, including reimbursement of health networks for enhanced care coordination, requires more funding than originally budgeted. To allow for greater efficiency and ensure that funds are used most effectively, staff recommends merging the two Complex Case Management budget categories, as reflected in Table 2 below.

Table 2. Final Expenditure Plan for IGT 1	**Budget**
Complex Case Management • Case management for high-risk members across various care settings, including improved documentation of clinical risk	Year 1: $6.9M Year 2: $4.4M
Expanded Access Pilots • Pilot selected strategies with documented Return on Investment, such as e-consults, telemonitoring and alternative access points	Year 1: $450K Year 2: $650K
Total Budget	**$12.4 M**

Proposed Expenditure Plan for IGT 2
As previously stated, CalOptima retained $7.4 million from the second IGT. Per the state's agreement with the Centers for Medicare and Medi-Cal (CMS), funds must be used for any of three Board-approved general purposes:

1. Enhance CalOptima's core data systems and information technology infrastructure to facilitate improved member care;
2. Continue and/or expand on services and initiatives developed with FY 2010-11 IGT funds; and/or
3. Provide wraparound services and optional benefits for members in order to address critical gaps in care, including, but not limited to, behavioral health, preventive dental services and supplies, and incentives to encourage members to participate in preventive health programs.

Based on an analysis of current and emerging priorities, staff proposes the budget allocation plan presented in the attached presentation and summarized below:

Table 3. Proposed Expenditure Plan for IGT 2	**Budget**
Enhancement of Core Data Systems	$3.0 M
Continuation/Expansion of IGT 1 Initiatives	$3.0 M
Wraparound Services/Optional Benefits to Address Critical Gaps	$1.4 M
Total Budget	**$7.4 M**

Proposed FY 2012-13 IGT

UCI has notified CalOptima of its interest to secure a third IGT for FY 2012-13. The Department of Health Care Services (DHCS) is in the process of calculating the amount of funds that would be available for this transaction. Authorization is requested to begin working with UCI to determine feasibility of securing a third IGT under the same general terms as the prior two IGTs, and to initiate the process. If IGT 3 is secured, funds will be applied to uses consistent with the categories outlined in Table 3 above.

Fiscal Impact

The recommended action is to be funded from DHCS capitation receipts which are currently reserved. Expenditure of IGT funds is for restricted, one-time purposes and does not commit CalOptima to future budget allocations. It should be noted that the proposed expenditures under IGTs 1 and 2 are aligned with many of the system improvements required in response to the recent CMS audit.

Rationale for Recommendation

The recommendations above are expected to generate the most positive impact on members, CalOptima and its delegated networks while also providing a sustainable return on investment for the future.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

2/28/2014 — **Date**

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Intergovernmental Transfers (IGT)

Board of Directors Meeting
March 6, 2014

Ilia Rolon
Director, Strategic Development

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Background

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About IGTs

- Intergovernmental Transfers (IGTs) are transfers of public funds between governmental entities
- Extensive precedent of IGTs among managed care plans in California
- California managed care plans have historically saved state/federal governments millions in health care costs
  - Federal Medical Assistance Percentage (FMAP): Amount of federal match for states' expenditures on social, medical services
    - California: 50%
    - Mississipi: 73%
- IGTs are a means of leveling the field and ensuring continued investment in our healthcare systems

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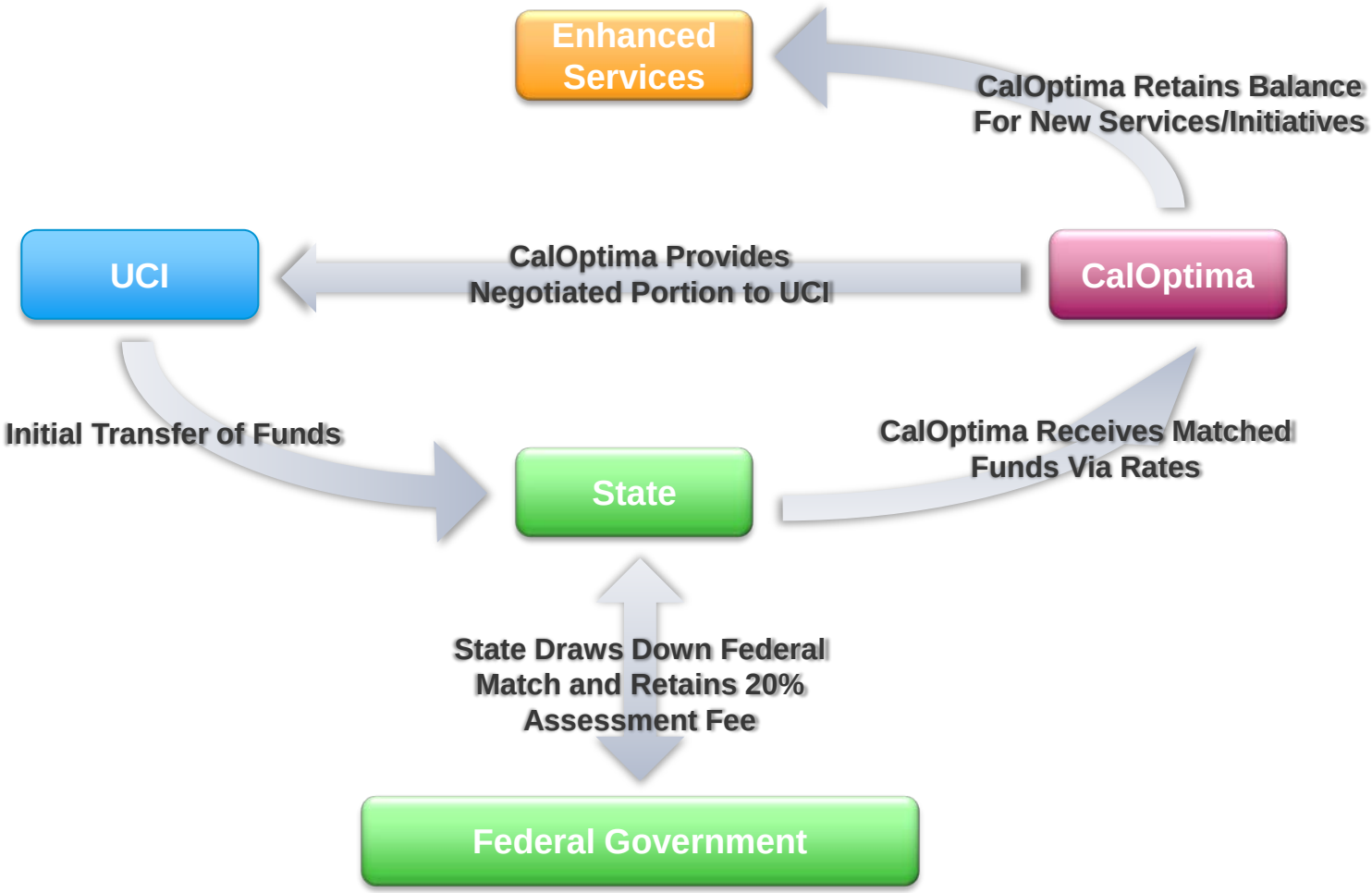
IGT Transaction Overview



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Use of Funds

- Revenue must be used to finance improvements in services for Medi-Cal beneficiaries
- No guarantee of future IGT agreements -- thus funds are best suited for one-time investments or as seed capital for new services or initiatives
- Budgeted uses for current IGTs are consistent with system improvements that will support successful response to OneCare audit
- Agreements are silent on deadline for use of funds

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IGTs Received to Date

Funding Source	Claim Year	Year Received	CalOptima Amount	UCI Amount	State Amount	Total
IGT 1	FY 10-11	2012	**$12.4 M**	**$8.4 M***	$3.1 M	$23.9 M
IGT 2	FY 11-12	2013	**$7.4 M**	**$4.8 M**	$5.4 M	$17.6 M
Total Funds			**$19.8 M**	**$13.2 M**	$8.5 M	$41.5 M

- IGT 1 included a one-year community vetting process; proposed uses for IGTs 2 and 3 are consistent with results of this earlier process
- Status of IGT Year 1 expenditures: $2 M contract award for new case management system; agreements with health networks for approximately $2 M in funding for personal care coordinators pending

* UCI's net revenue was $3.4 Million due to exclusion from approximately $5.0 million in state disproportionate share (DSH) payments

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Proposal

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IGT 1 Expenditure Plan

Proposed Uses	Year 1	Year 2	Impacted Programs	Timing	Description
Complex Case Management I	$5.1 M	$4.2 M	–	–	
Personal Care Coordinators	$1.85 M	$1.95 M	CMC	CY 14	Additional PMPM line item payment to networks
Case Management System	$2.0 M	$0	All	CY 14	Replace existing case management system
Strategies to Reduce Readmission	$1.0 M	$2.0 M	MC, CMC OneCare	CY 14	Post-discharge follow up; transitions of care
Program for High-Risk Children	$250 K	$250 K	MC	FY 14/15	Services for children affected by both obesity and asthma
Complex Case Management II	**$1.8 M**	**$200,000**	**N/A**	**N/A**	**Merge this category with CCM 1**
Access Strategies	$450,000	$650,000	–	–	
e-Referral/ Telemedicine	TBD	TBD	All	CY 14	Dermatology project in development
Total Funds	$7.35 M	$5.05 M			

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Proposed IGT 2 Expenditure Plan

CMS and CalOptima Board Approved Categories	Proposed Allocation
Enhanced Core Systems • Facets system upgrade and reconfiguration • Provider network management solution • Security audit remediation • Funding to continue COREC services for two years	**$3.0 M**
Continued / Expanded IGT 1 Services •Personal care coordinators •Strategies to reduce hospital readmissions	**$3.0 M**
Wraparound Services & Optional Benefits • To be developed further. • May include: school-based vision and dental services for children; recuperative care for homeless members discharged from hospital; and/or backfilling Medi-Cal cuts to payments and/or benefits.	**$1.4 M**
Total Funds	**$7.4 M**

60% for direct services

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Next Steps

- Execute approved expenditure plan for IGT 1
- Begin implementation of IGT 2 funded activities
- Initiate process to explore feasibility of securing third IGT
- Periodic Board updates on progress

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Maintain current rates paid to Full Risk Health Network(s) for Medi-Cal Expansion Members through June 30, 2017; and
2. Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an amendment to extend the Heritage Provider Network Medi-Cal Full-Risk Health Network Contract through June 30, 2017 on the same terms and conditions.

Background

At its May 5, 2016 meeting, the CalOptima Board of Director authorized the extension of CalOptima's contracts with Full-Risk health network Heritage Provider Network (Heritage) from July 1, 2016 to December 31, 2016. The contract was extended.

At the May 5, 2016 meeting, staff had recommended extension of all health network contracts through June 30, 2017. Due to lower than anticipated utilization (and corresponding rate reductions from the state), staff also had recommended reducing the capitation rates paid to health networks for the Medi-Cal Expansion (MCE) members by 15% for the FY2016-17 fiscal year. However, based in part on stakeholder input, the Board approved the rate reduction, but only for a six-month period – effective July 1, 2016 through December 31, 2016 – for the health networks. The Board Chair established a Board ad hoc committee to evaluate the financial impact of the rate reduction for the MCE members to CalOptima and the health networks and make recommendations for the second half of the 2016-17 fiscal year.

Discussion

Following appointment by the Board Chair, the members of the ad hoc met to review member utilization levels and discuss and evaluate the financial impact of the reduction in rates on CalOptima and the health networks, with the final recommendation to: 1) maintain the current capitation rates for the Full-Risk health network for the remainder of the fiscal year; and 2) extend the current health network contract term through June 30, 2017.

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *09/29/2016*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Maintain current rates paid to contracted Shared Risk Health Network for Medi-Cal Expansion Members through June 30, 2017; and
2. Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into amendments to extend the Arta Western Health Network, Monarch Family HealthCare, Noble Mid-Orange County, Prospect Medical Group, Talbert Medical Group, United Care Medical Network and Alta Med Health Services Medi-Cal Shared-Risk Health Network Contracts through June 30, 2017 on the same terms and conditions.

Background

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

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

Discussion

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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Continued to the November 3, 2016 Board Meeting

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

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

Background

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

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

Discussion

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

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

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

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

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize and direct the Chief Executive Officer (CEO) to implement a process to ensure that rates for LTC facilities and Hospice agencies are paid in accordance with both interim and final annual changes to the California Department of Health Care Services (DHCS) rates within 90 days of notification from DHCS, subject to reconciliation of interim payments to final rates and retroactive adjustments, as appropriate; and
2. Authorize the CEO, with the assistance of legal counsel, to amend LTC contracts to allow CalOptima to offset overpayments from future payments to LTC facilities should the retroactive adjustments result in overpayments, or allow the CEO to establish a repayment plan for up to six months should recoupment of the overpayment result in a financial burden to the LTC facility.

Background

CalOptima has administered the Medi-Cal LTC facility benefit since 1998. This benefit was included in the agreement between DHCS and CalOptima with the understanding that CalOptima would receive funding for this benefit on a "pass-through" basis. Specifically, CalOptima understands that capitation rates received from DHCS are based on the actuarial equivalent amount of Medi-Cal fee-for-service (FFS) funding for covered LTC facility services furnished to CalOptima members. CalOptima also understands that it is required to pay LTC facilities at the same per diem amount that Medi-Cal FFS would pay for covered Medi-Cal services. The current agreement between DHCS and CalOptima specifies that CalOptima's capitation rates shall be adjusted for any enacted increase or decrease in LTC payment rates. Consistent with this understanding, on November 1, 2005, the CalOptima Board authorized the "passing through" of funding to LTC facilities. The Board specified that CalOptima would pass through the payments to the LTC facilities when, and to the extent, that CalOptima received funding for the payments from the state. This "pass through" approach has been consistently followed since that time.

LTC and hospice rate changes have historically been effective August 1 of each year. DHCS typically notifies CalOptima of the revised rates via Operating Instruction Letter (OIL). Although revised rates are effective August 1 of each year, the OIL is usually released (retroactively) sometime after August 1st. Moreover, revisions to the rates are not uncommon, and notice of which could occur as late as a year later. To address these timing challenges, on July 10, 2007, the Board authorized the

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implementation of a standardized process to update LTC facility rates. While the Board committed to implementation of rate changes within 90 days after notification from the state, the Board also specified that such payments would be made by CalOptima only after CalOptima's full and timely receipt of state funding of such rates. This process is consistent with the "pass through" nature of the LTC facility rate payments.

Since that time, DHCS has begun to publicly post LTC Facility FFS Medi-Cal rates on its website. In addition to the annual rate revisions effective in August, DHCS has also begun publishing "Interim" rates from time to time for certain LTC facilities. DHCS has informed Plans, including CalOptima, that when it releases interim FFS rates, these rates are considered effective at the time the DHCS Medi-Cal FFS rates are posted. DHCS has instructed Plans to pay LTC facilities no less than the DHCS Medi-Cal FFS interim rates when the rates are in effect for FFS reimbursement.

In the case of hospice, Medi-Cal guidelines provide that when a member who resides in an LTC facility elects hospice, payments go to the hospice agency (rather than the LTC) for the room and board. In such situations, Plans are obligated to factor in the current rate (whether interim or final) for the LTC in which the member resides when calculating the appropriate payment to the hospice agency. The hospice agency is then responsible for reimbursing the LTC facility, as appropriate. Because of this payment arrangement, hospice agencies are also impacted by any changes to LTC Facility FFS Medi-Cal annual and interim rates.

Discussion

In light of this background information and DHCS' instruction to CalOptima to develop a mechanism to ensure timely payment of interim LTC Facility Medi-Cal rates, Management recommends that the Board authorize modification of the existing process for updating LTC Facility rates. Instead of updating these rates only once annually, and upon notification of the rate finalization, Management plans to develop a process to ensure timely payment of the interim LTC rates on behalf of eligible recipients, subject to reconciliation of interim payments to final rates and retroactive adjustments, as appropriate.

Consistent with CalOptima's previous processes for updating LTC Facility rates, Management recommends that the Board authorize development of a process to promptly update and pay rates in accordance with both final annual and interim changes to the DHCS rates for LTC facilities and hospice agencies within 90 days of notification from DHCS, subject to reconciliation of interim payments to final rates and retroactive adjustments, as appropriate.

In the event the payment reconciliation process results in a recoupment, Management recommends that the Board authorize amendment of the LTC contracts allowing CalOptima to offset future claims payments by the amount of the deficit. If an LTC facility demonstrates to CalOptima that the lump-sum recoupment would result in a financial burden, Management will develop a repayment plan of up

to six months which will be implemented upon execution of a repayment agreement by both CalOptima and LTC facility.

Fiscal Impact
Management has included projected expenses associated with LTC services in the CalOptima Fiscal Year (FY) 2016-17 Operating Budget approved by the Board on June 2, 2016. The Operating Budget included assumptions related to expected adjustments to the LTC facility rates. The anticipated Medi-Cal revenue for FY 2016-17 is projected to be sufficient to cover the costs associated with providing LTC and hospice services to members.

Rationale for Recommendation
Management recommends approval of the proposed change to ensure that CalOptima's payments to LTC Facility rates and Hospice services providers are in line with DHCS requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to extend the existing CalOptima Program of All-Inclusive Care for the Elderly (PACE) transportation contract with vendor Secure Transportation for six months, with an option for the CEO to extend the contract for an additional six months.

Background/Discussion
PACE is a managed care service delivery model for the frail elderly and integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants.

The CalOptima PACE center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide necessary services to ensure the proper continuum of care. The current vendor Secure Transportation, provides transportation for program participants from their homes to and from the PACE center and to medical appointments.

On November 3, 2011, the Board of Directors authorized the CEO to enter into vendor contracts for the PACE center. The current transportation contracted vendor was selected through a Request for Proposal (RFP) process. The transportation contract was executed in November 2012 for a 3-year term and expired in November 2015. Management was satisfied with this vendor's performance at that time, and based on the Board's authorization of a one year extension at its September 3, 2015 meeting, the contract was extended through November 2016. At its September 3, 2015 meeting, the Board also directed staff to complete a RFP process in accordance with CalOptima's Board-approved Purchasing Policy.

Since this time, issues with Secure Transportation's performance have surfaced despite PACE Management's efforts to improve the quality of the transportation services the vendor is providing. Per the Board's direction, a RFP was issued; however, the only bidder was Secure Transportation.

Based on this limited response, staff would like to withdraw the current RFP for PACE transportation without awarding the contract, and issue a Request for Information (RFI) to assist management in identifying other potential transportation vendors and options for meeting the transportation needs of PACE participants. As this process continues, management proposes to continue to contract with Secure Transportation to provide this service. Following the RFI, another RFP will be issued to select

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vendor(s) for transportation services at PACE, and staff will return to the Board with further recommendations.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2016-17 Operating Budget approved by the Board on June 2, 2016, included forecasted PACE transportation service expenses that were consistent with current rates and utilization levels. Staff included approximately $1 million annually or $435.29 per member per month in the budget for PACE transportation services.

Assuming continuance of the terms of the current contract and no overlap between the current and future vendor, the recommended action to execute a contract amendment to extend the terms of the contract for PACE transportation services from November 2016 through May 2017 is a budgeted item with no additional anticipated fiscal impact.

Rationale for Recommendation

CalOptima staff recommends that the Board authorize a six month extension through May 2017, with an option to extend for an additional six months if no other vendors have been identified, to existing contract with Secure Transportation to ensure that PACE members continue to have access to these covered services.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Board Action dated September 3, 2015, Authorize Amendments of Existing Meals and Transportation Contracts for CalOptima Program of All Inclusive Care for the Elderly (PACE) to Add Extension Options

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

09/29/2016 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

VII. B. Authorize the Extension of Existing Meals and Transportation Contracts for CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

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

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to extend existing meals and transportation contracts with vendors for additional three (3)-year terms, through November 30, 2018.

Background/Discussion

PACE is a managed care service delivery model for the frail elderly and integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants.

The PACE center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. In addition, PACE must provide necessary services to ensure the proper continuum of care. Vendors providing meals and transportation services are:

- Secure Transportation – Transportation to and from the PACE center and to medical appointments
- Community SeniorServ – Meals at the PACE center
- LifeSpring Nutrition – Home-delivered meals

On November 3, 2011, the Board of Directors authorized the CEO to enter into new vendor contracts for the PACE center. The new transportation and meals contracted vendors were selected through RFP processes. The transportation and meals contracts were executed in November 2012 for a 3-year term and expire in November 2015. Management is satisfied with the performance of these three vendors as they continue to provide services to the PACE center.

Fiscal Impact

Based on forecasted PACE enrollment, the fiscal impact for FY 2015-16 to extend the existing meals and transportation contracts is approximately $1.2 million or $795 per member per month. The recommended actions are budgeted items under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015.

Rationale for Recommendation

CalOptima staff recommends that the Board authorize three-year extensions through November 2018, to existing contracts with meals and transportation vendors to ensure that PACE members continue to have access to these covered services.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader *8/28/2015*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to contract with a Risk Adjusted Factor (RAF) vendor selected in accordance with CalOptima's Board-approved purchasing policy for the purpose of assisting staff in appropriately capturing PACE member medical information; and
2. Authorize expenditures of up to $75,000 of unbudgeted dollars to pay the consultant for work performed under the contract.

Background/Discussion

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

The Risk Adjusted Factor (RAF) score for Dual Eligible participants determines the reimbursement CalOptima receives from Medicare for the provision of member care. A higher RAF score indicates higher participant acuity and therefore yields a greater reimbursement. According to benchmarking data, the average Risk Adjusted Factor for the PACE population was 2.5 in 2015. CalOptima PACE providers do not appear to be capturing all appropriate medical information in the Electronic Medical Record which has a negative impact on the RAF, and leads to lower reimbursement.

As proposed the consultant will establish a baseline for our RAF by conducting an internal audit of PACE participant medical records and data analysis to determine what the Risk Adjusted Factor is for CalOptima PACE at the start of the contract. This will be used as the basis for measuring improvement in documentation achieved with the assistance of the vendor's services. The vendor will also provide our physicians and nurse practitioners with training on proper documentation, assist in submitting encounters to the Centers for Medicare & Medicaid Services, and monitor continual quality improvement.

The consulting contract will assist CalOptima in more closely reaching the full reimbursement potential by properly documenting participants' medical conditions in the medical records. The selected consultant for this project will focus on assisting staff in managing risk adjustment processes to match the specific needs of CalOptima's PACE program, and will have the expertise to navigate and extract data from PACE Care Online (PCO) and TruChart, the PACE-specific EMR systems utilized by CalOptima PACE.

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PACE Management has been working with the CalOptima Coding department to educate our providers on proper documentation. They have also been conducting regular audits of medical charting. This practice has led to RAF scores more accurately reflecting the acuity of CalOptima PACE members (2.3 at Mid-Year reforecast).

Fiscal Impact
The recommended action to authorize expenditure of an additional $75,000 to fund consulting services for PACE is an unbudgeted item. Management is requesting Board approval to authorize an additional $75,000 in administrative expenses to fund the cost of the consulting services.

Rationale for Recommendation
Management recommends engaging a consultant selected in accordance with CalOptima's Board-approved Purchasing Policy. The chosen consultant will provide additional training, beyond what CalOptima coding department is able to provide for our providers. The vendor will also assist with auditing PACE medical records so that we may continue to improve our documentation of participants' acuity at PACE. Management also recommends that the Board authorize additional administrative expenses to cover the cost of this consulting engagement.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

Recommended Actions
1. Adopt Resolution Approving CalOptima's Updated Human Resources Policy GA.8058: Salary Schedule; and
2. Approve proposed market adjustments for various positions.

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

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

The following table lists an existing Human Resources policy that has been updated and is being presented for review and approval.

	Policy No./Name	Summary of Changes	Reason for Change
1.	GA. 8058: Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment 1 – Salary Schedule, has been revised in order to reflect recent changes to the Salary Schedule, including changes to, and the addition and deletion of	- Pursuant to CalPERS requirement, 2 CCR §570.5, CalOptima periodically updates the salary schedule to reflect current job titles and pay rates for each job position. - There are changes to 3 positions indicated on the

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	Policy No./Name	Summary of Changes	Reason for Change
		positions. A summary of the changes to the Salary Schedule is included for reference.	attached revised Salary Schedule. New Position: Creation of a new Job Title typically due to a change in the scope of a current position or the addition of a new level in a job family. (1 position) Remove Position: Elimination of a Job Title typically due to a change in the scope of a current position or the elimination of position in a job family. (2 positions)

Market Adjustments

Staff recommends salary adjustments for 21 positions effective on or after the pay period ending October 15, 2016. This impacts employees in the following departments: six 6 in Accounting; two 2 in Finance; four in Budget & Vendor Management; three in Financial Analysis; and six in Pharmacy Management. The recommended increases are to attract and retain qualified staff. Pursuant to the Compensation Administration Guidelines adopted as part of CalOptima Policy GA. 8057: Compensation Program, approval by the Board of Directors is required as part of the process for market adjustments, which are not part of the regular merit process. Recommendations are made based on extensive research by the Human Resources Department and review by CalOptima's Resources Workgroup consistent with the market adjustment process to ensure that CalOptima remains competitive with market trends and meets its ongoing obligation to provide structure and clarity on employment matters, consistent with applicable federal, state, and local laws and regulations.

Fiscal Impact

The fiscal impact of this recommended action is budget neutral. Unspent budgeted funds for salaries and benefits approved in the CalOptima FY 2016-17 Operating Budget on June 2, 2016, will fund the market adjustments for various positions. The total cost for the market adjustments effective on or after the pay period ending October 15, 2016 through June 30, 2017, is $65,251.96. The estimated annual cost is $89,292.16.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Resolution No. 16-1006, Approve Updated Human Resources Policies
2. Revised CalOptima Policy GA.8058: Salary Schedule (redlined and clean versions) – with revised Attachment
3. Summary of Changes to the Salary Schedule, Market Adjustments

/s/ Michael Schrader — *09/29/2016*

Authorized Signature — **Date**

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RESOLUTION NO. 16-1006

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

APPROVE UPDATED HUMAN RESOURCES POLICY

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policy GA.8058: Salary Schedule.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 6th day of October, 2016.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	~~09~~10/~~01~~0
Last Revised Date:	6/16 ~~09~~10/~~01~~0 6/16

~~*Board Approved Policy*~~

I. PURPOSE

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

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

II. POLICY

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

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

2. Identification of position titles for every employee position;

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

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

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

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

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

and

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

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

III. PROCEDURE

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

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

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

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

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of ~~09/01~~10/06/16)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

Not Applicable

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

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

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

IX. GLOSSARY

Not Applicable

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

I. PURPOSE

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

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

II. POLICY

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

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

2. Identification of position titles for every employee position;

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

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

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

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

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

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

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

III. PROCEDURE

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

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

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

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

IV. ATTACHMENTS

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

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

Not Applicable

VII. BOARD ACTIONS

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

VIII. REVIEW/REVISION HISTORY

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

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IX. GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised October 6, 2016
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Accountant	K	39	$47,112	$61,360	$75,504	
	Accountant Int	L	TBD	$54,288	$70,512	$86,736	
	Accountant Sr	M	68	$62,400	$81,120	$99,840	
	Accounting Clerk	I	334	$37,128	$46,384	$55,640	
	Actuarial Analyst	L	558	$54,288	$70,512	$86,736	
	Actuarial Analyst Sr	M	559	$62,400	$81,120	$99,840	
	Actuary	O	357	$82,576	$107,328	$131,976	
	Administrative Assistant	H	19	$33,696	$42,224	$50,648	
	Analyst	K	562	$47,112	$61,360	$75,504	
	Analyst Int	L	563	$54,288	$70,512	$86,736	
	Analyst Sr	M	564	$62,400	$81,120	$99,840	
	Applications Analyst	K	232	$47,112	$61,360	$75,504	
	Applications Analyst Int	L	233	$54,288	$70,512	$86,736	
	Applications Analyst Sr	M	298	$62,400	$81,120	$99,840	
	Associate Director Customer Service	O	593	$82,576	$107,328	$131,976	
	Associate Director Information Services	Q	557	$114,400	$154,440	$194,480	
	Auditor	K	565	$47,112	$61,360	$75,504	
	Auditor Sr	L	566	$54,288	$70,512	$86,736	
	Behavioral Health Manager	N	383	$71,760	$93,184	$114,712	
	Biostatistics Manager	N	418	$71,760	$93,184	$114,712	
	Board Services Specialist	J	435	$40,976	$53,352	$65,624	
	Business Analyst	J	40	$40,976	$53,352	$65,624	
	Business Analyst Sr	M	611	$62,400	$81,120	$99,840	
	Business Systems Analyst Sr	M	69	$62,400	$81,120	$99,840	
	Buyer	J	29	$40,976	$53,352	$65,624	
	Buyer Int	K	49	$47,112	$61,360	$75,504	
	Buyer Sr	L	67	$54,288	$70,512	$86,736	
	Care Transition Intervention Coach (RN)	N	417	$71,760	$93,184	$114,712	
	Certified Coder	K	399	$47,112	$61,360	$75,504	
	Change Control Administrator	L	499	$54,288	$70,512	$86,736	
	Change Control Administrator Int	M	500	$62,400	$81,120	$99,840	
	Change Management Analyst Sr	N	465	$71,760	$93,184	$114,712	
**	Chief Counsel	T	132	$197,704	$266,968	$336,024	
**	Chief Executive Officer	V	138	$319,740	$431,600	$543,600	
**	Chief Financial Officer	U	134	$237,224	$320,216	$403,312	
**	Chief Information Officer	T	131	$197,704	$266,968	$336,024	
**	Chief Medical Officer	U	137	$237,224	$320,216	$403,312	
**	Chief Operating Officer	U	136	$237,224	$320,216	$403,312	
	Claims - Lead	J	574	$40,976	$53,352	$65,624	
	Claims Examiner	H	9	$33,696	$42,224	$50,648	
	Claims Examiner - Lead	J	236	$40,976	$53,352	$65,624	
	Claims Examiner Sr	I	20	$37,128	$46,384	$55,640	
	Claims QA Analyst	I	28	$37,128	$46,384	$55,640	
	Claims QA Analyst Sr.	J	540	$40,976	$53,352	$65,624	

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	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Claims Recovery Specialist	I	283	$37,128	$46,384	$55,640	
	Claims Resolution Specialist	I	262	$37,128	$46,384	$55,640	
	Clerk of the Board	O	59	$82,576	$107,328	$131,976	
	Clinical Auditor	M	567	$62,400	$81,120	$99,840	
	Clinical Auditor Sr	N	568	$71,760	$93,184	$114,712	
	Clinical Pharmacist	P	297	$95,264	$128,752	$162,032	
	Clinical Systems Administrator	M	607	$62,400	$81,120	$99,840	
	Clinician (Behavioral Health)	M	513	$62,400	$81,120	$99,840	
	Communications Specialist	J	188	$40,976	$53,352	$65,624	
	Community Partner	K	575	$47,112	$61,360	$75,504	
	Community Partner Sr	L	612	$54,288	$70,512	$86,736	
	Community Relations Specialist	J	288	$40,976	$53,352	$65,624	
	Compliance Claims Auditor	K	222	$47,112	$61,360	$75,504	
	Compliance Claims Auditor Sr	L	279	$54,288	$70,512	$86,736	
	Contract Administrator	M	385	$62,400	$81,120	$99,840	
	Contracts Manager	N	207	$71,760	$93,184	$114,712	
	Contracts Specialist	K	257	$47,112	$61,360	$75,504	
	Contracts Specialist Int	L	469	$54,288	$70,512	$86,736	
	Contracts Specialist Sr	M	331	$62,400	$81,120	$99,840	
*	Controller	Q	464	$114,400	$154,440	$194,480	
	Credentialing Coordinator	J	41	$40,976	$53,352	$65,624	
	Credentialing Coordinator - Lead	J	510	$40,976	$53,352	$65,624	
	Customer Service Coordinator	J	182	$40,976	$53,352	$65,624	
	Customer Service Rep	H	5	$33,696	$42,224	$50,648	
	Customer Service Rep - Lead	J	482	$40,976	$53,352	$65,624	
	Customer Service Rep Sr	I	481	$37,128	$46,384	$55,640	
	Data Analyst	K	337	$47,112	$61,360	$75,504	
	Data Analyst Int	L	341	$54,288	$70,512	$86,736	
	Data Analyst Sr	M	342	$62,400	$81,120	$99,840	
	Data and Reporting Analyst - Lead	O	TBD	$82,576	$107,328	$131,976	
	Data Entry Tech	F	3	$27,872	$34,840	$41,808	
	Data Warehouse Architect	O	363	$82,576	$107,328	$131,976	
	Data Warehouse Programmer/Analyst	O	364	$82,576	$107,328	$131,976	
	Data Warehouse Project Manager	O	362	$82,576	$107,328	$131,976	
	Data Warehouse Reporting Analyst	N	412	$71,760	$93,184	$114,712	
	Data Warehouse Reporting Analyst Sr	O	522	$82,576	$107,328	$131,976	
	Database Administrator	M	90	$62,400	$81,120	$99,840	
	Database Administrator Sr	O	179	$82,576	$107,328	$131,976	
**	Deputy Chief Counsel	S	160	$164,736	$222,352	$280,072	
**	Deputy Chief Medical Officer	T	561	$197,704	$266,968	$336,024	
*	Director Accounting	P	122	$95,264	$128,752	$162,032	
*	Director Applications Management	R	170	$137,280	$185,328	$233,376	
*	Director Audit & Oversight	Q	546	$114,400	$154,440	$194,480	
*	Director Behavioral Health Services	P	392	$95,264	$128,752	$162,032	

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* Director Budget and Procurement	Q	527	$114,400	$154,440	$194,480	
* Director Business Development	P	351	$95,264	$128,752	$162,032	
* Director Business Integration	Q	543	$114,400	$154,440	$194,480	
* Director Case Management	Q	318	$114,400	$154,440	$194,480	
* Director Claims Administration	P	112	$95,264	$128,752	$162,032	
* Director Clinical Outcomes	Q	602	$114,400	$154,440	$194,480	
* Director Clinical Pharmacy	R	129	$137,280	$185,328	$233,376	
* Director Coding Initiatives	P	375	$95,264	$128,752	$162,032	
* Director Communications	P	361	$95,264	$128,752	$162,032	
* Director Community Relations	P	292	$95,264	$128,752	$162,032	
* Director Configuration & Coding	Q	596	$114,400	$154,440	$194,480	
* Director Contracting	P	184	$95,264	$128,752	$162,032	
* Director COREC	Q	369	$114,400	$154,440	$194,480	
* Director Customer Service	P	118	$95,264	$128,752	$162,032	
* Director Electronic Business	P	358	$95,264	$128,752	$162,032	
* Director Enterprise Analytics	Q	520	$114,400	$154,440	$194,480	
* Director Facilities	P	428	$95,264	$128,752	$162,032	
* Director Finance & Procurement	P	157	$95,264	$128,752	$162,032	
* Director Financial Analysis	R	374	$137,280	$185,328	$233,376	
* Director Financial Compliance	P	460	$95,264	$128,752	$162,032	
* Director Fraud Waste & Abuse and Privacy	Q	581	$114,400	$154,440	$194,480	
* Director Government Affairs	P	277	$95,264	$128,752	$162,032	
* Director Grievance & Appeals	P	528	$95,264	$128,752	$162,032	
* Director Health Education & Disease Management	Q	150	$114,400	$154,440	$194,480	
* Director Health Services	Q	328	$114,400	$154,440	$194,480	
* Director Human Resources	Q	322	$114,400	$154,440	$194,480	
* Director Information Services	R	547	$137,280	$185,328	$233,376	
* Director Long Term Support Services	Q	128	$114,400	$154,440	$194,480	
* Director Medi-Cal Plan Operations	P	370	$95,264	$128,752	$162,032	
* Director Network Management	P	125	$95,264	$128,752	$162,032	
* Director OneCare Operations	P	425	$95,264	$128,752	$162,032	
* Director Organizational Training & Education	P	579	$95,264	$128,752	$162,032	
* Director PACE Program	Q	449	$114,400	$154,440	$194,480	
* Director Process Excellence	Q	447	$114,400	$154,440	$194,480	
* Director Program Implementation	Q	489	$114,400	$154,440	$194,480	
* Director Project Management	Q	447	$114,400	$154,440	$194,480	
* Director Provider Data Quality	Q	TBD	$114,400	$154,440	$194,480	
* Director Provider Services	P	597	$95,264	$128,752	$162,032	
* Director Public Policy	P	459	$95,264	$128,752	$162,032	
* Director Quality (LTSS)	Q	613	$114,400	$154,440	$194,480	
* Director Quality Analytics	Q	591	$114,400	$154,440	$194,480	
* Director Quality Improvement	Q	172	$114,400	$154,440	$194,480	
* Director Regulatory Affairs and Compliance	Q	625	$114,400	$154,440	$194,480	
* Director Strategic Development	P	121	$95,264	$128,752	$162,032	

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*	Director Systems Development	R	169	$137,280	$185,328	$233,376	
*	Director Utilization Management	Q	265	$114,400	$154,440	$194,480	
	Disease Management Coordinator	M	70	$62,400	$81,120	$99,840	
	Disease Management Coordinator - Lead	M	472	$62,400	$81,120	$99,840	
	EDI Project Manager	O	403	$82,576	$107,328	$131,976	
	Enrollment Coordinator (PACE)	K	441	$47,112	$61,360	$75,504	
	Enterprise Analytics Manager	P	582	$95,264	$128,752	$162,032	
	Executive Assistant	K	339	$47,112	$61,360	$75,504	
	Executive Assistant to CEO	L	261	$54,288	$70,512	$86,736	
**	Executive Director, Behavioral Health Integration	S	614	$164,736	$222,352	$280,072	
**	Executive Director Clinical Operations	S	501	$164,736	$222,352	$280,072	
**	Executive Director Compliance	S	493	$164,736	$222,352	$280,072	
**	Executive Director Human Resources	S	494	$164,736	$222,352	$280,072	
**	Executive Director Network Operations	S	632	$164,736	$222,352	$280,072	
**	Executive Director Operations	S	276	$164,736	$222,352	$280,072	
**	Executive Director Program Implementation	S	490	$164,736	$222,352	$280,072	
**	Executive Director Public Affairs	S	290	$164,736	$222,352	$280,072	
**	Executive Director Quality Analytics	S	601	$164,736	$222,352	$280,072	
	Facilities & Support Services Coord - Lead	J	631	$40,976	$53,352	$65,624	
	Facilities & Support Services Coordinator	J	10	$40,976	$53,352	$65,624	
	Facilities Coordinator	J	438	$40,976	$53,352	$65,624	
	Financial Analyst	L	51	$54,288	$70,512	$86,736	
	Financial Analyst Sr	M	84	$62,400	$81,120	$99,840	
	Financial Reporting Analyst	L	475	$54,288	$70,512	$86,736	
	Gerontology Resource Coordinator	M	204	$62,400	$81,120	$99,840	
	Graphic Designer	M	387	$62,400	$81,120	$99,840	
	Grievance & Appeals Nurse Specialist	N	226	$71,760	$93,184	$114,712	
	Grievance Resolution Specialist	J	42	$40,976	$53,352	$65,624	
	Grievance Resolution Specialist - Lead	L	590	$54,288	$70,512	$86,736	
	Grievance Resolution Specialist Sr	K	589	$47,112	$61,360	$75,504	
	HCC Coding Specialist	K	405	$47,112	$61,360	$75,504	
	HCC Coding Specialist Sr	L	615	$54,288	$70,512	$86,736	
	Health Coach	M	556	$62,400	$81,120	$99,840	
	Health Educator	K	47	$47,112	$61,360	$75,504	
	Health Educator Sr	L	355	$54,288	$70,512	$86,736	
	Health Network Liaison Specialist (RN)	N	524	$71,760	$93,184	$114,712	
	Health Network Oversight Specialist	M	323	$62,400	$81,120	$99,840	
	HEDIS Case Manager	N	443	$71,760	$93,184	$114,712	
	HEDIS Case Manager (LVN)	M	552	$62,400	$81,120	$99,840	
	Help Desk Technician	J	571	$40,976	$53,352	$65,624	
	Help Desk Technician Sr	K	573	$47,112	$61,360	$75,504	
	HR Assistant	I	181	$37,128	$46,384	$55,640	
	HR Business Partner	M	584	$62,400	$81,120	$99,840	
	HR Coordinator	J	316	$40,976	$53,352	$65,624	

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HR Representative	L	278	$54,288	$70,512	$86,736	
HR Representative Sr	M	350	$62,400	$81,120	$99,840	
HR Specialist	K	505	$47,112	$61,360	$75,504	
HR Specialist Sr	L	608	$54,288	$70,512	$86,736	
HRIS Analyst Sr	M	468	$62,400	$81,120	$99,840	
ICD-10 Project Manager	O	411	$82,576	$107,328	$131,976	
Infrastructure Systems Administrator	J	541	$40,976	$53,352	$65,624	
Infrastructure Systems Administrator Int	K	542	$47,112	$61,360	$75,504	
Intern	E	237	$25,272	$31,720	$37,960	
Investigator Sr	L	553	$54,288	$70,512	$86,736	
IS Coordinator	J	365	$40,976	$53,352	$65,624	
IS Project Manager	O	424	$82,576	$107,328	$131,976	
IS Project Manager Sr	P	509	$95,264	$128,752	$162,032	
IS Project Specialist	M	549	$62,400	$81,120	$99,840	
IS Project Specialist Sr	N	550	$71,760	$93,184	$114,712	
Kitchen Assistant	E	585	$25,272	$31,720	$37,960	
Legislative Program Manager	N	330	$71,760	$93,184	$114,712	
Licensed Clinical Social Worker	L	598	$54,288	$70,512	$86,736	
Litigation Support Specialist	M	588	$62,400	$81,120	$99,840	
LVN (PACE)	M	533	$62,400	$81,120	$99,840	
Mailroom Clerk	E	1	$25,272	$31,720	$37,960	
Manager Accounting	N	98	$71,760	$93,184	$114,712	
Manager Actuary	P	453	$95,264	$128,752	$162,032	
Manager Applications Management	P	271	$95,264	$128,752	$162,032	
Manager Audit & Oversight	O	539	$82,576	$107,328	$131,976	
Manager Behavioral Health	O	633	$82,576	$107,328	$131,976	
Manager Business Integration	O	544	$82,576	$107,328	$131,976	
Manager Case Management	O	270	$82,576	$107,328	$131,976	
Manager Claims	N	92	$71,760	$93,184	$114,712	
Manager Clinic Operations	O	551	$82,576	$107,328	$131,976	
Manager Clinical Pharmacist	Q	296	$114,400	$154,440	$194,480	
Manager Coding Quality	N	382	$71,760	$93,184	$114,712	
Manager Communications	N	398	$71,760	$93,184	$114,712	
Manager Community Relations	M	384	$62,400	$81,120	$99,840	
~~Manager Concurrent Review~~	~~O~~	~~320~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Job
Manager Contracting	O	329	$82,576	$107,328	$131,976	
Manager Creative Branding	N	430	$71,760	$93,184	$114,712	
Manager Cultural & Linguistic	N	349	$71,760	$93,184	$114,712	
Manager Customer Service	N	94	$71,760	$93,184	$114,712	
Manager Decision Support	O	454	$82,576	$107,328	$131,976	
Manager Disease Management	O	372	$82,576	$107,328	$131,976	
Manager Electronic Business	O	422	$82,576	$107,328	$131,976	
Manager Employment Services	N	420	$71,760	$93,184	$114,712	
Manager Encounters	N	516	$71,760	$93,184	$114,712	

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Manager Environmental Health & Safety	N	495	$71,760	$93,184	$114,712	
Manager Facilities	N	209	$71,760	$93,184	$114,712	
Manager Finance	N	148	$71,760	$93,184	$114,712	
Manager Financial Analysis	O	356	$82,576	$107,328	$131,976	
Manager Government Affairs	N	437	$71,760	$93,184	$114,712	
Manager Grievance & Appeals	N	426	$71,760	$93,184	$114,712	
Manager Health Education	N	173	$71,760	$93,184	$114,712	
Manager HEDIS	O	427	$82,576	$107,328	$131,976	
Manager Human Resources	O	526	$82,576	$107,328	$131,976	
Manager Information Services	P	560	$95,264	$128,752	$162,032	
Manager Information Technology	P	110	$95,264	$128,752	$162,032	
Manager Integration Government Liaison	N	455	$71,760	$93,184	$114,712	
Manager Long Term Support Services	O	200	$82,576	$107,328	$131,976	
Manager Marketing & Enrollment (PACE)	O	414	$82,576	$107,328	$131,976	
Manager Medical Data Management	O	519	$82,576	$107,328	$131,976	
Manager Medi-Cal Program Operations	N	483	$71,760	$93,184	$114,712	
Manager Member Liaison Program	N	354	$71,760	$93,184	$114,712	
Manager Member Outreach & Education	N	616	$71,760	$93,184	$114,712	
Manager Member Outreach Education & Provider Relations	O	576	$82,576	$107,328	$131,976	
Manager MSSP	O	393	$82,576	$107,328	$131,976	
Manager OneCare Clinical	O	359	$82,576	$107,328	$131,976	
Manager OneCare Customer Service	N	429	$71,760	$93,184	$114,712	
Manager OneCare Regulatory	N	197	$71,760	$93,184	$114,712	
Manager OneCare Sales	O	248	$82,576	$107,328	$131,976	
Manager Outreach & Enrollment	N	477	$71,760	$93,184	$114,712	
Manager PACE Center	O	432	$82,576	$107,328	$131,976	
Manager Payroll & Benefits	N	144	$71,760	$93,184	$114,712	
Manager Pharmacy Operations	N	396	$71,760	$93,184	$114,712	
~~Manager Prior Authorizations~~	~~O~~	~~269~~	~~$82,576~~	~~$107,328~~	~~$131,976~~	Remove Job
Manager Process Excellence	O	622	$82,576	$107,328	$131,976	
Manager Program Implementation	O	488	$82,576	$107,328	$131,976	
Manager Project Management	O	532	$82,576	$107,328	$131,976	
Manager Provider Data Management Services	N	TBD	$71,760	$93,184	$114,712	
Manager Provider Network	O	191	$82,576	$107,328	$131,976	
Manager Provider Relations	N	171	$71,760	$93,184	$114,712	
Manager Provider Services	O	TBD	$82,576	$107,328	$131,976	
Manager Purchasing	N	275	$71,760	$93,184	$114,712	
Manager QI Initiatives	N	433	$71,760	$93,184	$114,712	
Manager Quality Analytics	O	617	$82,576	$107,328	$131,976	
Manager Quality Improvement	O	104	$82,576	$107,328	$131,976	
Manager Regulatory Affairs and Compliance	O	626	$82,576	$107,328	$131,976	
Manager Reporting & Financial Compliance	O	572	$82,576	$107,328	$131,976	
Manager Strategic Development	O	603	$82,576	$107,328	$131,976	
Manager Strategic Operations	N	446	$71,760	$93,184	$114,712	

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	Manager Systems Development	P	515	$95,264	$128,752	$162,032	
	Manager Utilization Management	O	250	$82,576	$107,328	$131,976	
	Marketing and Outreach Specialist	J	496	$40,976	$53,352	$65,624	
	Medical Assistant	H	535	$33,696	$42,224	$50,648	
	Medical Authorization Asst	H	11	$33,696	$42,224	$50,648	
	Medical Case Manager	N	72	$71,760	$93,184	$114,712	
	Medical Case Manager (LVN)	L	444	$54,288	$70,512	$86,736	
*	Medical Director	S	306	$164,736	$222,352	$280,072	
	Medical Records & Health Plan Assistant	G	548	$30,576	$38,272	$45,968	
	Medical Records Clerk	E	523	$25,272	$31,720	$37,960	
	Medical Services Case Manager	K	54	$47,112	$61,360	$75,504	
	Member Liaison Specialist	I	353	$37,128	$46,384	$55,640	
	MMS Program Coordinator	K	360	$47,112	$61,360	$75,504	
	Nurse Practitioner (PACE)	P	TBD	$95,264	$128,752	$162,032	
	Occupational Therapist	N	531	$71,760	$93,184	$114,712	
	Occupational Therapist Assistant	M	623	$62,400	$81,120	$99,840	
	Office Clerk	C	335	$21,008	$26,208	$31,408	
	OneCare Operations Manager	O	461	$82,576	$107,328	$131,976	
	OneCare Partner - Sales	K	230	$47,112	$61,360	$75,504	
	OneCare Partner - Sales (Lead)	K	537	$47,112	$61,360	$75,504	
	OneCare Partner - Service	I	231	$37,128	$46,384	$55,640	
	OneCare Partner (Inside Sales)	J	371	$40,976	$53,352	$65,624	
	Outreach Specialist	I	218	$37,128	$46,384	$55,640	
	Paralegal/Legal Secretary	K	376	$47,112	$61,360	$75,504	
	Payroll Specialist	J	554	$40,976	$53,352	$65,624	
	Performance Analyst	L	538	$54,288	$70,512	$86,736	
	Personal Care Attendant	C	485	$21,008	$26,208	$31,408	
	Personal Care Attendant - Lead	E	498	$25,272	$31,720	$37,960	
	Personal Care Coordinator	I	525	$37,128	$46,384	$55,640	
	Pharmacy Resident	K	379	$47,112	$61,360	$75,504	
	Pharmacy Services Specialist	I	23	$37,128	$46,384	$55,640	
	Pharmacy Services Specialist Int	J	35	$40,976	$53,352	$65,624	
	Pharmacy Services Specialist Sr	K	507	$47,112	$61,360	$75,504	
	Physical Therapist	N	530	$71,760	$93,184	$114,712	
	Physical Therapist Assistant	M	624	$62,400	$81,120	$99,840	
	Policy Advisor Sr	O	580	$82,576	$107,328	$131,976	
	Privacy Manager	N	536	$71,760	$93,184	$114,712	
	Process Excellence Manager	O	529	$82,576	$107,328	$131,976	
	Program Assistant	I	24	$37,128	$46,384	$55,640	
	Program Coordinator	I	284	$37,128	$46,384	$55,640	
	Program Development Analyst Sr	M	492	$62,400	$81,120	$99,840	
	Program Manager	M	421	$62,400	$81,120	$99,840	
	Program Manager Sr	O	594	$82,576	$107,328	$131,976	

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	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Program Specialist	J	36	$40,976	$53,352	$65,624	
	Program Specialist Int	K	61	$47,112	$61,360	$75,504	
	Program Specialist Sr	L	508	$54,288	$70,512	$86,736	
	Program/Policy Analyst	K	56	$47,112	$61,360	$75,504	
	Program/Policy Analyst Sr	M	85	$62,400	$81,120	$99,840	
	Programmer	L	43	$54,288	$70,512	$86,736	
	Programmer Int	N	74	$71,760	$93,184	$114,712	
	Programmer Sr	O	80	$82,576	$107,328	$131,976	
	Project Manager	M	81	$62,400	$81,120	$99,840	
	Project Manager - Lead	M	467	$62,400	$81,120	$99,840	
	Project Manager Sr	O	105	$82,576	$107,328	$131,976	
	Project Specialist	K	291	$47,112	$61,360	$75,504	
	Project Specialist Sr	L	503	$54,288	$70,512	$86,736	
	Projects Analyst	K	254	$47,112	$61,360	$75,504	
	Provider Enrollment Data Coordinator	I	12	$37,128	$46,384	$55,640	
	Provider Enrollment Data Coordinator Sr	J	586	$40,976	$53,352	$65,624	
	Provider Enrollment Manager	K	190	$47,112	$61,360	$75,504	
	Provider Network Rep Sr	L	391	$54,288	$70,512	$86,736	
	Provider Network Specialist	K	44	$47,112	$61,360	$75,504	
	Provider Network Specialist Sr	L	595	$54,288	$70,512	$86,736	
	Provider Office Education Manager	L	300	$54,288	$70,512	$86,736	
	Provider Relations Rep	K	205	$47,112	$61,360	$75,504	
	Provider Relations Rep Sr	L	285	$54,288	$70,512	$86,736	
	Publications Coordinator	J	293	$40,976	$53,352	$65,624	
	QA Analyst	L	486	$54,288	$70,512	$86,736	
	QA Analyst Sr	N	380	$71,760	$93,184	$114,712	
	QI Nurse Specialist	N	82	$71,760	$93,184	$114,712	
	QI Nurse Specialist (LVN)	M	445	$62,400	$81,120	$99,840	
	Receptionist	F	140	$27,872	$34,840	$41,808	
	Recreational Therapist	L	487	$54,288	$70,512	$86,736	
	Recruiter	L	406	$54,288	$70,512	$86,736	
	Recruiter Sr	M	497	$62,400	$81,120	$99,840	
	Registered Dietitian	L	57	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Analyst	K	628	$47,112	$61,360	$75,504	
	Regulatory Affairs and Compliance Analyst Sr	L	629	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Lead	M	630	$62,400	$81,120	$99,840	
	RN (PACE)	N	480	$71,760	$93,184	$114,712	
	Security Analyst Int	N	534	$71,760	$93,184	$114,712	
	Security Analyst Sr	O	474	$82,576	$107,328	$131,976	
	Security Officer	F	311	$27,872	$34,840	$41,808	
	SharePoint Developer/Administrator Sr	O	397	$82,576	$107,328	$131,976	
	Social Worker	K	463	$47,112	$61,360	$75,504	
*	Special Counsel	R	317	$137,280	$185,328	$233,376	
	Sr Manager Government Affairs	O	451	$82,576	$107,328	$131,976	

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Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Staff Attorney	P	195	$95,264	$128,752	$162,032	
Supervisor Accounting	M	434	$62,400	$81,120	$99,840	
Supervisor Audit and Oversight	N	618	$71,760	$93,184	$114,712	
Supervisor Budgeting	M	466	$62,400	$81,120	$99,840	
Supervisor Case Management	N	86	$71,760	$93,184	$114,712	
Supervisor Claims	K	219	$47,112	$61,360	$75,504	
Supervisor Coding Initiatives	M	502	$62,400	$81,120	$99,840	
Supervisor Customer Service	K	34	$47,112	$61,360	$75,504	
Supervisor Data Entry	K	192	$47,112	$61,360	$75,504	
Supervisor Day Center (PACE)	K	619	$47,112	$61,360	$75,504	
Supervisor Encounters	L	253	$54,288	$70,512	$86,736	
Supervisor Facilities	L	162	$54,288	$70,512	$86,736	
Supervisor Finance	N	419	$71,760	$93,184	$114,712	
Supervisor Grievance and Appeals	M	620	$62,400	$81,120	$99,840	
Supervisor Health Education	M	381	$62,400	$81,120	$99,840	
Supervisor Health Services	N	506	$71,760	$93,184	$114,712	
Supervisor Information Services	N	457	$71,760	$93,184	$114,712	
Supervisor Long Term Support Services	N	587	$71,760	$93,184	$114,712	
Supervisor Member Outreach and Education	L	592	$54,288	$70,512	$86,736	
Supervisor MSSP	N	348	$71,760	$93,184	$114,712	
Supervisor OneCare Customer Service	K	408	$47,112	$61,360	$75,504	
Supervisor Payroll	M	517	$62,400	$81,120	$99,840	
Supervisor Pharmacy Services	K	146	$47,112	$61,360	$75,504	
Supervisor Pharmacist	P	610	$95,264	$128,752	$162,032	
Supervisor Provider Enrollment	K	439	$47,112	$61,360	$75,504	
Supervisor Regulatory Affairs and Compliance	N	627	$71,760	$93,184	$114,712	
Supervisor Social Work (PACE)	L	TBD	$54,288	$70,512	$86,736	
Supervisor Systems Development	O	456	$82,576	$107,328	$131,976	
Supervisor Therapy Services (PACE)	N	TBD	$71,760	$93,184	$114,712	
Supervisor Utilization Management	N	TBD	$71,760	$93,184	$114,712	New Job
Supervisor Quality Analytics	M	609	$62,400	$81,120	$99,840	
Supervisor Quality Improvement	N	600	$71,760	$93,184	$114,712	
Systems Manager	N	512	$71,760	$93,184	$114,712	
Systems Network Administrator Int	M	63	$62,400	$81,120	$99,840	
Systems Network Administrator Sr	N	89	$71,760	$93,184	$114,712	
Systems Operations Analyst	J	32	$40,976	$53,352	$65,624	
Systems Operations Analyst Int	K	45	$47,112	$61,360	$75,504	
Technical Analyst Int	L	64	$54,288	$70,512	$86,736	
Technical Analyst Sr	M	75	$62,400	$81,120	$99,840	
Technical Writer	L	247	$54,288	$70,512	$86,736	
Technical Writer Sr	M	470	$62,400	$81,120	$99,840	
Therapy Aide	J	521	$40,976	$53,352	$65,624	
Training Administrator	L	621	$54,288	$70,512	$86,736	
Training Program Coordinator	K	471	$47,112	$61,360	$75,504	

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Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Translation Specialist	G	241	$30,576	$38,272	$45,968	
Web Architect	O	366	$82,576	$107,328	$131,976	

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

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

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

Summary of Changes to Salary Schedule

For October 2016 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Manager Concurrent Review	O	N/A	Remove title from salary schedule. Position is consolidated with Manager Utilization Management.	N/A	October 2016
Manager Prior Authorizations	O	N/A	Remove title from salary schedule. Position is consolidated with Manager Utilization Management.	N/A	October 2016
Supervisor Utilization Management	N/A	TBD / N	The "Supervisor Utilization Management" job title will replace the "Supervisor Health Services" title. Will be responsible for monitoring and overseeing the Prior Authorization work activities related to CalOptima's policies and procedures including regulatory requirements governing authorization processing.	N/A	October 2016

Summary of Market Adjustment Changes

For October 2016 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Accountant	K	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties.	2 Accountants will receive a 3% adjustment. The total impact for the current fiscal year is $2,790.75 or $3,818.92 annualized.	October 2016
Accounting Clerk	I	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties.	3 Accounting Clerks will receive a 4% adjustment. The total impact for the current fiscal year is $3,977.27 or $5,442.58 annualized.	October 2016
Actuarial Analyst Sr	M	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties.	2 Actuarial Analyst Srs will receive between 3.6% and 9.0% adjustment. The total impact for the current fiscal year is $7,820.63 or $10,701.92 annualized.	October 2016
Buyer Sr	L	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties.	1 Buyer Sr will receive a 2% adjustment. The	October 2016

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
				total impact for the current fiscal year is $1,096.15 or $1,500 annualized.	
Clinical Pharmacist	P	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties.	5 Clinical Pharmacists will receive between 1% and 4.67% adjustment. The total impact for the current fiscal year is $10,647.17 or $14,569.81 annualized.	
Controller	Q	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties.	1 Controller will receive a 4.48% adjustment. The total impact for the current fiscal year is $5,111.00 or $6,994.00 annualized.	October 2016
Data Analyst Sr	M	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties.	1 Data Analyst Sr will receive a 4.39% adjustment. The total impact for the current fiscal year is $2,305.80 or $3,155.31 annualized.	October 2016
Director Budget and Procurement	Q	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties.	1 Director Budget and Procurement will receive a 6.8%	October 2016

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
				adjustment. The total impact for the current fiscal year is $6,283.45 or $8,598.40 annualized.	
Director Financial Analysis	R	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties.	1 Director Financial Analysis will receive a 5.19% adjustment. The total impact for the current fiscal year is $5,880.47 or $8,046.95 annualized.	October 2016
Director Financial Compliance	P	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties.	1 Director Financial Compliance will receive a 7.18% adjustment. The total impact for the current fiscal year is $6,612.00 or $9,048.00 annualized.	October 2016
Financial Analyst Sr	M	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties.	1 Financial Analyst Sr will receive a 9.49% adjustment. The total impact for the current fiscal year is $5,828.81 or $7,976.27 annualized.	October 2016
Manager Clinical Pharmacist	Q	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in	1 Manager Clinical Pharmacist will	October 2016

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
			aspects of job duties.	receive a 3% adjustment. The total impact for the current fiscal year is $3,273.85 or $4,480.00 annualized.	
Manager Purchasing	N	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties.	1 Manager Purchasing will receive a 5.7% adjustment. The total impact for the current fiscal year is $3,624.62 or $4,960.00 annualized.	October 2016

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

Katia Taylor, Interim Director Human Resources (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to enter into contracts and/or amendments to provide group health insurance policies, including medical, dental, and vision, for CalOptima employees and retirees, and basic employee life insurance and accidental death and dismemberment, short-term and long-term disability, employee assistance program, and flexible spending accounts, for CalOptima employees, effective January 1, 2017, for a total amount for calendar year 2017 not to exceed $14,523,005;
2. Authorize an increase to employer contributions (based on % of premium, employer pays for each plan) to absorb the entire increase to premium rates, thereby maintaining employee contributions at current levels and increasing costs to CalOptima for calendar year 2017 of an amount not to exceed $321,608 for the increase to premium rates for the benefits package, as well as an additional amount of up to $11,512 for the cost of realigning Medicare-eligible retiree contributions to be consistent with Policy GA. 8055: Retiree Health Benefit for calendar year 2017; and
3. Direct staff to revise Policy GA.8055: Retiree Health Benefit to allow for the payment of a stipend in lieu of dependent insurance coverage in situations in which CalOptima is unable to obtain reasonable medical coverage for a Medicare-eligible retiree's spouse and/or dependents who are not Medicare eligible, and return to the Board with the revised policy at the November 2016 Board Meeting.

Background

California Government Code section 53201 provides that local public agencies including CalOptima have the option of providing health and welfare benefits for the benefit of their officers, employees, and retired employees, who elect to accept the benefits and who authorize the local agencies to deduct the premiums, dues or other charges from their compensation. Government Code section 53200 provides that health and welfare benefits may include hospital, medical, surgical, dental, disability, group life, legal expense, and income protection insurance or benefits. And while CalOptima previously contracted with the California Public Employees Retirement System (CalPERS) to provide these benefits, on August 5, 2003, the Board of Directors approved the cancellation of CalOptima's contract with CalPERS for employee health insurance coverage effective January 1, 2004, and opted to contract directly with Aetna and Kaiser for plan year 2004 and has offered such benefits from commercial insurers since that time. CalOptima has been purchasing group health insurance through Ascension, an insurance broker, since 2014 on a year-to-year basis. CalOptima currently contracts with both Kaiser and Cigna to provide group health insurance coverage for all benefited employees and retirees.

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By statute, the Board may authorize payment of all, or such portion as it may elect, of premiums for these health and welfare benefits. CalOptima currently pays a portion of the premiums for health and welfare benefits for officers, employees, and eligible retired employees. In plan year 2015, there was no increase to the employee contributions because CalOptima received a rate decrease, which in effect decreased CalOptima's contributions towards the premiums. In plan year 2016, there was an increase in premium rates, wherein CalOptima shared in the costs of premium rate increases, paying a small portion and passing along the remaining increase to employees, averaging roughly 3% to 4% to employee contributions for Kaiser HMO, Cigna HMO, Cigna HDHP, Cigna PPO and Cigna Dental PPO.

On October 5, 2005, the CalOptima Board of Directors approved retiree health benefits for eligible employees who were hired prior to January 1, 2004, and met other eligibility criteria. CalOptima last adopted revisions to CalOptima Policy GA. 8055: Retiree Health Benefits on June 2, 2016, to update the Policy to be consistent with prior Board of Director's action. The effect of this change was to provide Medicare Supplemental Coverage for Retirees who are Medicare eligible. In addition, because supplemental insurance coverage is different than CalOptima's basic health insurance coverage offered to active employees, the language governing premium costs for Medicare-eligible retirees needed to be updated to reflect the difference.

Discussion

Ascension marketed the group health benefits on behalf of CalOptima for the renewal of CalOptima's health benefit insurance policies, and the total group health benefit insurance package cost results in an annual increase of 2.27% for calendar year 2017, totaling $321,608. The proposed increase falls below the regional average increase range of 8% - 15%. These recommended changes are summarized below:

Benefit Plan	CY 2016	CY 2017	$ Change
Medical	$12,269,714	$12,644,506	$320,606
Dental	$1,012,150	$1,012,150	$0
Vision	$168,793	$168,793	$0
Basic Employee Life & AD&D	$59,079	$59,079	$0
Short Term Disability	$383,109	$383,109	$0
Long Term Disability	$202,726	$202,726	$0
Employee Assistance Program	$31,000	$31,000	$0
Flexible Spending Accounts	$20,640	$21,642	$1,002
Total	**$14,147,211**	**$14,523,005**	**$321,608**

Medical

For CY 2017:

Cigna: Cigna negotiated a proposed rate pass for the HMO and a 3.0% increase to the PPO, for active employees and eligible retirees.

Kaiser: Kaiser negotiated an annual increase of 6.0% for active employees / eligible early retirees and 5.6% for Medicare eligible retirees.

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Eligible Medicare Retirees: CalOptima currently offers: (1) a Medicare Supplemental plan (Kaiser Sr. Advantage plan) for retirees residing within the State of California; and (2) a secondary insurance PPO plan for retirees residing within and outside of California. Pursuant to the 2005 Board action, which is reflected in the updates to CalOptima Policy GA. 8055: Retiree Health Benefits, last adopted on June 2, 2016, a true Medicare Supplemental PPO plan is now being proposed alongside Kaiser Sr. Advantage plan to eligible Medicare retirees *only*. The Medicare Retirees plan is offered through AmWINS Group Medicare Plans and provides two plan options for CalOptima to select from as further described in the attached renewal option summary documents. The cost impact to CalOptima to realign the Medicare retiree plans to be consistent with Policy GA. 8055: Retiree Health Benefit for calendar year 2017 is estimated at $11,512.

In prior years, an eligible retiree's spouse and/or dependents, who are not yet Medicare eligible, could be enrolled in the secondary insurance PPO plan. However, in moving to a Medicare Supplemental PPO plan provided by AmWINS Group Medicare Plans, non-Medicare eligible spouses and dependents cannot be enrolled in the plan. Accordingly, staff proposes to revise CalOptima Policy GA. 8055: Retiree Health Benefits to indicate that if CalOptima is unable to obtain coverage for an eligible retiree's spouse and/or dependents who are not Medicare eligible, CalOptima may provide a stipend to Medicare retirees' spouse and/or dependents below age 65 in the following amounts:

- Spouse/Domestic Partner –77.9% of Gold PPO plan (most closely analogous to active employee health insurance coverage)
- Dependents –76% of Gold PPO plan (most closely analogous active employee health insurance coverage)

Dental
For CY 2017:

Cigna Dental: Rate pass (no proposed rate increase) to the DHMO and PPO for Active employees and Retirees.

Other Ancillary Plans
For CY 2017:

Cigna Life & Disability: Rate pass.

Employee Assistance Program: Rate pass.

Hyatt Legal: Rate pass.

Flexible Spending Accounts: A 4.9% increase is proposed due to increased administrative costs, with adding the $500 carryover feature at no additional cost. Beginning in plan year 2017, flexible spending health care account participants can carry remaining balances of between $50 and $500 at the end of the plan year (12/31/17) to the next plan year. This is in lieu of the grace period we have today. Any amount carried over will be in addition to the $2,550 annual maximum contribution limit set by the IRS.

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CalOptima's and the employee's share of the premiums differ depending on the employee's elections. As set forth in the attached presentation, employer contributions for full time employees range from 76.0% to 94.3%. The methodology used to calculate the employer and employee contributions is to attract and retain talent. CalOptima's group health benefits insurance are comparable to the County of Orange with an average of 89% employer contribution rate for CalOptima's employee only coverage, in comparison to the County's 90% employer contribution rate. However, CalOptima's employer contribution for employees with dependents is higher at an average of 85% employer contribution rate compared to the County's 75% employer contribution rate.

Recommendations are made based on a thorough review by CalOptima's Human Resources Department to ensure that CalOptima remains competitive with market trends and meets its ongoing obligation to provide a comprehensive benefits package to attract and retain talent.

Fiscal Impact

The employer cost to absorb the increased premiums and realign the Medicare-eligible retiree contributions consistent with Board-approved policy totals $333,120 for calendar year 2017, or $166,560 for the remainder of FY 2016-2017 covering the period of January 1, 2017-June 30, 2017. The recommended actions to provide group health insurance policies for calendar year 2017, increase the employer contribution to absorb increases in premium costs in order to retain current employee contributions and realign Medicare-eligible retirees contributions are included in the CalOptima FY 2016-17 Operating Budget approved by the Board on June 2, 2016. Funding for the group health insurance benefits will also be included in the Fiscal Year 2017-18 budget.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. CalOptima Renewal Executive Summary
2. Board Action dated June 2, 2016, Consider Adoption of Resolution Approving Updated CalOptima Policy GA.8055, Retiree Health Benefits

/s/ Michael Schrader — *09/29/2016*

Authorized Signature — **Date**

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CalOptima
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2017 Benefits Executive Summary

October 6, 2016

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Ascension Benefits & Insurance Solutions
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Renewal Executive Summary

Total benefits package cost results in an annual increase of 2.27% or $321,608. CalOptima's proposed increase falls well below the regional average increase range of 8-15%

MEDICAL

Cigna – Negotiated a proposed rate pass and 3.0% increase to the HMO and PPO, respectively, for Actives and Retirees; mandatory legislative plan change to Choice Fund plan

Kaiser – Negotiated renewal is an annual increase of 6.0% and 5.6% for Actives/Early Retirees and Medicare Retirees, respectively

Medicare Retirees – Currently being offered a Medicare Supplemental plan (Kaiser Sr. Advantage plan) for eligible retirees residing within state of CA and a PPO plan for eligible retirees residing inside or outside of CA. Recommendation is to offer a true Medicare Supplemental PPO plan along side Kaiser Sr. Advantage plan to Medicare retirees ***only***.

Option for CalOptima to provide a stipend to Medicare-eligible retirees' spouse and/or dependents below age 65. Stipend recommendation of:

- Spouse/Domestic Partner – 77.9% of Gold PPO plan (most closely analogous active employee health insurance coverage)
- Dependents – 76% of Gold PPO plan (most closely analogous active employee health insurance coverage)

(Pricing example through Covered CA – Spouse, age 64, resides in Orange County, Anthem PPO Gold plan = $883/month)

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Renewal Executive Summary

DENTAL

Cigna Dental – Negotiated a proposed rate pass to the DHMO and PPO for Actives and Retirees

OTHER ANCILLARY PLANS

Cigna Life & Disability – Negotiated a proposed rate pass

ACI EAP - Renewal is a rate pass

Hyatt Legal - Renewal is a rate pass

WageWorks FSA – Proposed a 4.9% increase; adding the carryover feature of $500 at no additional cost

EMPLOYEE CONTRIBUTIONS

Recommendation is to retain employees' current contributions by increasing employer contributions to absorb premium rate increases and realign Medicare-eligible retirees' contributions consistent with Board-approved policy. Overall annual cost impact to CalOptima is $333,120 increase

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Total Cost Summary

Total Cost Summary

		2016 Current	2017 Renewal	$ Change	% Change
All Medical	**1016**	**$12,269,714**	**$12,590,320**	**$320,606**	**2.61%**
Kaiser HMO Actives	505	$5,193,351	$5,504,530	$311,178	5.99%
Kaiser HMO Early Retirees	11	$169,489	$181,315	$11,826	6.98%
Kaiser HMO Medicare Retirees	12	$75,426	$79,616	$4,190	5.56%
Cigna HMO Actives & Early Retirees	357	$5,152,440	$5,152,440	$0	0.00%
Cigna PPO Actives & Early Retirees	47	$833,306	$858,212	$24,906	2.99%
Cigna PPO Medicare Retirees	23	$207,405		($207,405)	
Amwins PPO Medicare Retirees	23		$159,417	$159,417	
Cigna HDHP Actives	38	$558,544	$575,238	$16,694	2.99%
HSA Administration	38	$2,253	$2,052	($201)	-8.91%
HSA Funding ($1,250 single / $2,500 with deps)	38	$77,500	$77,500	$0	0.00%
All Ancillary		**$1,877,497**	**$1,878,499**	**$1,002**	**0.05%**
Cigna Dental PPO Actives & Retirees	741	$894,680	$894,680	$0	0.00%
Cigna Dental HMO Actives & Retirees	349	$117,470	$117,470	$0	0.00%
VSP Vision Actives & Retirees	1,100	$168,793	$168,793	$0	0.00%
Basic Employee Life & AD&D	1,088	$59,079	$59,079	$0	0.00%
Short Term Disability	1,090	$383,109	$383,109	$0	0.00%
Long Term Disability	1,090	$202,726	$202,726	$0	0.00%
Employee Assistance Program	1,090	$31,000	$31,000	$0	0.00%
Flexible Spending Accounts	334	$20,640	$21,642	$1,002	4.85%
Premiums					
Monthly - Estimated		**$1,178,934**	**$1,205,735**		
Annual - Estimated		**$14,147,212**	**$14,468,819**		
Differences					
Versus Current - $			**$321,608**		
Versus Current - %			**2.27%**		

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Medical Contributions – No increase to employee contributions

2016 Employer vs. Employee Contributions

FULL TIME ACTIVES & EARLY RETIREES	Enrollment	2016 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Early Retirees		**Cigna HMO**				
Employee	107	$560.83	$31.83	5.7%	$529.00	94.3%
Employee + One	83	$1,177.74	$80.34	6.8%	$1,097.40	93.2%
Employee + Family	166	$1,626.40	$116.31	7.2%	$1,510.09	92.8%
MONTHLY TOTAL	356	$427,744	$29,381		$398,362	
Actives & Early Retirees		**Cigna PPO**				
Employee	24	$873.49	$170.19	19.5%	$703.30	80.5%
Employee + One	14	$1,834.31	$405.22	22.1%	$1,429.09	77.9%
Employee + Family	9	$2,533.12	$607.85	24.0%	$1,925.27	76.0%
MONTHLY TOTAL	47	$69,442	$15,228		$54,214	
Actives		**Cigna HDHP**				
Employee	14	$661.73	$92.94	14.0%	$568.79	86.0%
Employee + One	13	$1,404.62	$250.72	17.8%	$1,153.90	82.2%
Employee + Family	11	$1,729.19	$453.34	26.2%	$1,275.85	73.8%
MONTHLY TOTAL	38	$46,545	$9,547		$36,998	
Actives		**Kaiser HMO**				
Employee	205	$476.84	$31.83	6.7%	$445.01	93.3%
Employee + One	120	$953.68	$80.34	8.4%	$873.34	91.6%
Employee + Family	173	$1,239.78	$116.31	9.4%	$1,123.47	90.6%
MONTHLY TOTAL	498	$426,676	$36,288		$390,388	
Early Retirees		**Kaiser HMO**				
Employee	4	$713.34	$31.83	4.5%	$681.51	95.5%
Employee + One	4	$1,426.68	$80.34	5.6%	$1,346.34	94.4%
Employee + Family	3	$1,854.66	$116.31	6.3%	$1,738.35	93.7%
MONTHLY TOTAL	11	$14,124	$798		$13,326	
PART TIME ACTIVES	**Enrollment**	**2016 RATES**	**EE Contributions**	**EE Contribution % of Premium**	**CalOptima Contributions**	**CalOptima % of Premium**
		Cigna HMO				
Employee	0	$560.83	$63.67	11.4%	$497.16	88.6%
Employee + One	0	$1,177.74	$160.68	13.6%	$1,017.06	86.4%
Employee + Family	1	$1,626.40	$232.62	14.3%	$1,393.78	85.7%
MONTHLY TOTAL	1	$1,626	$233		$1,394	
		Cigna PPO				
Employee	0	$873.49	$340.37	39.0%	$533.12	61.0%
Employee + One	0	$1,834.31	$810.45	44.2%	$1,023.86	55.8%
Employee + Family	0	$2,533.12	$1,215.70	48.0%	$1,317.42	52.0%
MONTHLY TOTAL	0	$0	$0		$0	
		Cigna HDHP				
Employee	0	$661.73	$185.87	28.1%	$475.86	71.9%
Employee + One	0	$1,404.62	$501.44	35.7%	$903.18	64.3%
Employee + Family	0	$1,729.19	$906.69	52.4%	$822.50	47.6%
MONTHLY TOTAL	0	$0	$0		$0	
		Kaiser HMO				
Employee	3	$476.84	$63.67	13.4%	$413.17	86.6%
Employee + One	1	$953.68	$160.68	16.8%	$793.00	83.2%
Employee + Family	3	$1,239.78	$232.62	18.8%	$1,007.16	81.2%
MONTHLY TOTAL	7	$6,104	$1,050		$5,054	
		$11,907,131	$1,110,293		$10,796,838	

2017 Employer vs. Employee Contributions

FULL TIME ACTIVES & EARLY RETIREES	Enrollment	2017 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Early Retirees		**Cigna HMO**				
Employee	107	$560.83	$31.83	5.7%	$529.00	94.3%
Employee + One	83	$1,177.74	$80.34	6.8%	$1,097.40	93.2%
Employee + Family	166	$1,626.40	$116.31	7.2%	$1,510.09	92.8%
MONTHLY TOTAL	356	$427,744	$29,381		$398,362	
Actives & Early Retirees		**Cigna PPO**				
Employee	24	$899.60	$170.19	18.9%	$729.41	81.1%
Employee + One	14	$1,889.13	$405.22	21.5%	$1,483.91	78.5%
Employee + Family	9	$2,608.83	$607.85	23.3%	$2,000.98	76.7%
MONTHLY TOTAL	47	$71,518	$15,228		$56,289	
Actives		**Cigna HDHP**				
Employee	14	$681.51	$92.94	13.6%	$588.57	86.4%
Employee + One	13	$1,446.60	$250.72	17.3%	$1,195.88	82.7%
Employee + Family	11	$1,780.87	$453.34	25.5%	$1,327.53	74.5%
MONTHLY TOTAL	38	$47,937	$9,547		$38,389	
Actives		**Kaiser HMO**				
Employee	205	$505.41	$31.83	6.3%	$473.58	93.7%
Employee + One	120	$1,010.82	$80.34	7.9%	$930.48	92.1%
Employee + Family	173	$1,314.07	$116.31	8.9%	$1,197.76	91.1%
MONTHLY TOTAL	498	$452,242	$36,288		$415,954	
Early Retirees		**Kaiser HMO**				
Employee	4	$763.11	$31.83	4.2%	$731.28	95.8%
Employee + One	4	$1,526.22	$80.34	5.3%	$1,445.88	94.7%
Employee + Family	3	$1,984.08	$116.31	5.9%	$1,867.77	94.1%
MONTHLY TOTAL	11	$15,110	$798		$14,312	
PART TIME ACTIVES	**Enrollment**	**2017 RATES**	**EE Contributions**	**EE Contribution % of Premium**	**CalOptima Contributions**	**CalOptima % of Premium**
		Cigna HMO				
Employee	0	$560.83	$63.67	11.4%	$497.16	88.6%
Employee + One	0	$1,177.74	$160.68	13.6%	$1,017.06	86.4%
Employee + Family	1	$1,626.40	$232.62	14.3%	$1,393.78	85.7%
MONTHLY TOTAL	1	$1,626	$233		$1,394	
		Cigna PPO				
Employee	0	$899.60	$340.37	37.8%	$559.23	62.2%
Employee + One	0	$1,889.13	$810.45	42.9%	$1,078.68	57.1%
Employee + Family	0	$2,608.83	$1,215.70	46.6%	$1,393.13	53.4%
MONTHLY TOTAL	0	$0	$0		$0	
		Cigna HDHP				
Employee	0	$681.51	$185.87	27.3%	$495.64	72.7%
Employee + One	0	$1,446.60	$501.44	34.7%	$945.16	65.3%
Employee + Family	0	$1,780.87	$906.69	50.9%	$874.18	49.1%
MONTHLY TOTAL	0	$0	$0		$0	
		Kaiser HMO				
Employee	3	$505.41	$63.67	12.6%	$441.74	87.4%
Employee + One	1	$1,010.82	$160.68	15.9%	$850.14	84.1%
Employee + Family	3	$1,314.07	$232.62	17.7%	$1,081.45	82.3%
MONTHLY TOTAL	7	$6,469	$1,050		$5,420	
		$12,271,735	$1,110,293		$11,161,443	

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Medical Contributions – No increase to employee contributions

MEDICARE RETIREES	Enrollment	2016 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Cigna PPO						
Retiree (Medicare)	10	$463.33	$90.49	19.5%	$372.84	80.5%
Retiree + 1 (1 Medicare)	0	$973.11	$215.24	22.1%	$757.87	77.9%
Retiree + 1 (2 Medicare)	13	$973.11	$215.24	22.1%	$757.87	77.9%
Retiree + Family	0	$1,343.67	$322.50	24.0%	$1,021.17	76.0%
MONTHLY TOTAL	23	$17,284	$3,703		$13,581	
Kaiser HMO						
Retiree (Medicare)	7	$190.90	$13.27	7.0%	$177.63	93.0%
Retiree + 1 (1 Medicare)	4	$904.24	$79.39	8.8%	$824.85	91.2%
Retiree + 1 (2 Medicare)	0	$381.80	$33.52	8.8%	$348.28	91.2%
Retiree + Family (1 Medic	1	$1,332.22	$122.44	9.8%	$1,209.78	90.8%
Retiree + Family (2 Medic	0	$809.78	$79.12	9.8%	$730.66	90.2%
MONTHLY TOTAL	12	$6,285	$533		$5,753	
		$282,831	$50,831		$232,000	

DENTAL & VISION	Enrollment	2016 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Retirees		**Dental PPO**				
Employee	293	$47.48	$5.17	10.9%	$42.31	89.1%
Employee + One	199	$96.74	$15.72	16.2%	$81.02	83.8%
Employee + Family	249	$166.24	$31.54	19.0%	$134.70	81.0%
MONTHLY TOTAL	741	$74,557	$12,497		$62,060	
Actives & Retirees		**Dental HMO**				
Employee	105	$12.00	$0.00	0.0%	$12.00	100.0%
Employee + One	90	$24.10	$0.00	0.0%	$24.10	100.0%
Employee + Family	154	$41.30	$0.00	0.0%	$41.30	100.0%
MONTHLY TOTAL	349	$9,789	$0		$9,789	
Actives & Retirees		**VSP Vision**				
Employee	482	$7.96	$0.00	0.0%	$7.96	100.0%
Employee + One	261	$12.37	$1.00	8.1%	$11.37	91.9%
Employee + Family	357	$19.61	$2.00	10.2%	$17.61	89.8%
MONTHLY TOTAL	1,100	$14,066	$975		$13,091	
		$1,180,943	$161,659		$1,019,284	

ANNUAL TOTAL	$13,370,905	$1,322,782	$12,048,122

MEDICARE RETIREES	Enrollment	2017 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Amwins PPO						
Retiree (Medicare)	10	$369.02	$69.74	18.9%	$299.28	81.1%
Retiree + 1 (2 Medicare)	13	$738.04	$158.68	21.5%	$579.36	78.5%
MONTHLY TOTAL	23	$13,285	$2,760		$10,524	
Kaiser HMO						
Retiree (Medicare)	7	$196.77	$12.40	6.3%	$184.37	93.7%
Retiree + 1 (1 Medicare)	4	$959.88	$75.83	7.9%	$884.05	92.1%
Retiree + 1 (2 Medicare)	0	$393.54	$31.09	7.9%	$362.45	92.1%
Retiree + Family (1 Medicare)	1	$1,417.74	$126.18	8.9%	$1,291.56	91.1%
Retiree + Family (2 Medicare)	0	$851.40	$75.77	8.9%	$775.63	91.1%
MONTHLY TOTAL	12	$6,635	$516		$6,118	
		$239,032	$39,319		$199,714	

DENTAL & VISION	Enrollment	2017 RATES	EE Contributions	EE Contribution % of Premium	CalOptima Contributions	CalOptima % of Premium
Actives & Retirees		**Dental PPO**				
Employee	293	$47.48	$5.17	10.9%	$42.31	89.1%
Employee + One	199	$96.74	$15.72	16.2%	$81.02	83.8%
Employee + Family	249	$166.24	$31.54	19.0%	$134.70	81.0%
MONTHLY TOTAL	741	$74,557	$12,497		$62,060	
Actives & Retirees		**Dental HMO**				
Employee	105	$12.00	$0.00	0.0%	$12.00	100.0%
Employee + One	90	$24.10	$0.00	0.0%	$24.10	100.0%
Employee + Family	154	$41.30	$0.00	0.0%	$41.30	100.0%
MONTHLY TOTAL	349	$9,789	$0		$9,789	
Actives & Retirees		**VSP Vision**				
Employee	482	$7.96	$0.00	0.0%	$7.96	100.0%
Employee + One	261	$12.37	$1.00	8.1%	$11.37	91.9%
Employee + Family	357	$19.61	$2.00	10.2%	$17.61	89.8%
MONTHLY TOTAL	1,100	$14,066	$975		$13,091	
		$1,180,943	$161,659		$1,019,284	

ANNUAL TOTAL	$13,691,711	$1,311,270	$12,380,441
$ Difference From Current	$320,806	($11,512)	$332,319

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Retiree Coverage

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MEDICARE ELIGIBLE RETIREES OPTION

Cigna members – Move to AmWINS group medicare plans

- Plan has similar benefits to current PPO plan; Annual savings of $54,187 from renewal (assumes same enrollment as renewal; savings already accounted for in totals; spouses < 65 years old not eligible for plan). Members would enroll in Medicare Part A & B

Kaiser members – Remain on CalOptima Kaiser Medicare plan

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Open Enrollment Calendar

- October
  - October 6th - All decisions must be made in order to provide rates, contributions & benefits to Dayforce for system update for Open Enrollment
  - October 6th – October 24th:
    - Communications developed & distributed
    - Dayforce system updated, tested, ready for Open Enrollment
    - Required notices/documentation prepared & distributed
    - Carriers notified of decisions
  - October 24th – November 4th – Open Enrollment
- November
  - Carriers update systems with new elections, produce & distribute new ID cards as needed

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 2, 2016
Regular Meeting of the CalOptima Board of Directors

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

Contact
Ron Santos, Executive Director, Human Resources, (714) 246-8400

Recommended Action
Adopt Resolution No. 16-0602-03, approving updated CalOptima Policy GA.8055, Retiree Health Benefits.

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.

As part of a review of existing processes and current policies and procedures, language was identified in a Human Resources Policy that needed to be updated to align with a prior Board of Director's action. The update involves revisions to Human Resources Policy GA. 8055: Retiree Health Benefits to reflect the Board action from October 5, 2005, to provide Medicare Supplemental Coverage for Retirees who are Medicare eligible. In addition, because supplemental insurance coverage is different than CalOptima's basic health insurance coverage offered to active employees, the language governing premium costs for Medicare-eligible retirees needed to be updated to reflect this difference. Implementation of this change will be reflected during CalOptima's next open enrollment period for coverage to begin on January 1, 2017.

The following table lists the existing Human Resources policy that has been updated and is presented for review and approval:

	Policy No./Name	Summary of Changes	Reason for Change
1.	GA. 8055: Retiree Health Benefits	• To reflect Medicare Supplemental Coverage for Retirees who are Medicare eligible. • To clarify the language applicable to premiums for Medicare-eligible retirees.	- To align the policy with the Board of Director's action from October 4, 2005, to provide Medicare Supplemental Coverage for Retirees who are Medicare eligible.

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	Policy No./Name	Summary of Changes	Reason for Change
		• Moved definitions to the beginning of the Policy.	

Fiscal Impact
The recommended action to revise CalOptima Policy GA.8055: Retiree Health Benefits is budget neutral.

Rationale for Recommendation
Approval is recommended of the updated Human Resources Policy 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 and to align the policy with the prior Board of Director's action.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 16-0602-03, A Resolution Approving CalOptima's Updated Human Resources Policy
2. Revised CalOptima Policy:
   a. GA.8055: Retiree Health Benefit (redlined and clean copies)

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

5/26/2016 — **Date**

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RESOLUTION NO. 16-0602-03

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

APPROVE UPDATED HUMAN RESOURCES POLICY

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

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

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policy GA.8055, Retiree Health Benefits.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of June, 2016.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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Policy #:	GA.8055
Title:	**Retiree Health Benefit ~~Policy~~**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	~~08/7/14~~
Last Revision Date:	~~N/A~~06/02/16 06/02/16

I. PURPOSE

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

II. DEFINITIONS

~~A. Current Retiree: Former employee of CalOptima who:~~

~~1. Was hired before January 1, 2004;~~

~~2. Completed at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS); and~~

~~3. Was already receiving retiree health benefits from CalOptima on January 1, 2014.~~

~~B. Eligible Dependent: The current spouse, registered domestic partner, dependent child up to age 26, and/or certified disabled dependent child over age 26, of a Current Retiree, Retired Eligible Employee, or Reinstated Eligible Retiree, who:~~

~~1. Meets the definition of a dependent who is eligible for coverage under the employee health plan then maintained by CalOptima for its active employees; and~~

~~2. Has been timely enrolled for coverage under this retiree health policy by the Eligible Retiree.~~

~~C. Eligible Employee: A current active employee of CalOptima meeting the following criteria:~~

~~1. The most recent date of hire was before January 1, 2004, or whose initial date of hire was before January 1, 2004, and whose most recent rehire date was on or before December 31, 2013;~~

~~2. Completes at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS).~~

~~D. Eligible Retiree: Current Retiree, Retired Eligible Employee, Reinstated Eligible Retiree or Eligible Survivor Dependent.~~

~~E. Eligible Survivor Dependent: A Survivor Dependent who timely enrolls for Survivor Dependent health coverage within sixty (60) days of the death of the Eligible Retiree.~~

~~F. Reinstated Eligible Retiree: A Current Retiree or Retired Eligible Employee whose CalPERS retirement annuity and benefits under this Policy ended due to a reinstatement from retirement as defined in Government Code §§ 22838 and 21190 et.seq., or successor sections, and who (i) subsequently terminates employment from another state employer who does not provide retiree health benefits with a retiree share premium that is less than or equal to that being charged by CalOptima under this Policy; (ii) once again begins collecting retirement annuity payments from CalPERS within 120 days of such subsequent separation from employment; and (iii) timely enrolls for resumption of coverage under this Policy.~~

~~G. Retired Eligible Employee: Eligible Employee who:~~

~~1. Retires within 120 days of such Eligible Employee's separation from employment with CalOptima and receives a monthly retirement allowance from CalPERS; and~~

~~2. Timely applies for retiree health benefits in accordance with this policy on and after January 1, 2014.~~

~~H. Retirement Date: Date Eligible Employee becomes an annuitant with CalPERS within 120 days of such Eligible Employee's separation from employment with CalOptima.~~

~~I. Subsequent Retirement Date: Date Reinstated Eligible Retiree again begins collecting retirement annuity payments from CalPERS within 120 days of separating from employment with the subsequent state employer described in that definition.~~

~~J. Survivor Dependent: Eligible Dependent who:~~

~~1. Survives an Eligible Retiree; and~~

~~Is collecting monthly survivor benefits from CalPERS that is attributable to a deceased Current Retiree, Retired Eligible Employee, or Reinstated Eligible Employee.~~

Term	**Definition**
Current Retiree~~:~~	Former employee of CalOptima who: 1. Was hired before January 1, 2004; 2. Completed at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS); and ~~—~~Was already receiving retiree health benefits from CalOptima on January 1, 2014. 3.
Eligible Dependent~~:~~	The current spouse, registered domestic partner, dependent child up to age 26, and/or certified disabled dependent child over age 26, of a Current Retiree, Retired Eligible Employee, or Reinstated Eligible Retiree, who:

Term	Definition
	1. Meets the definition of a dependent who is eligible for coverage under the employee health plan then maintained by CalOptima for its active employees; and 2. Has been timely enrolled for coverage under this retiree health policy by the Eligible Retiree.
Eligible Employee~~:~~	A current active employee of CalOptima meeting the following criteria: 1. The most recent date of hire was before January 1, 2004, or whose initial date of hire was before January 1, 2004, and whose most recent rehire date was on or before December 31, 2013; 2. Completes at least five years of pensionable service (with CalOptima and/or combined with other service with a public agency that participates in CalPERS).
Eligible Retiree~~:~~	Current Retiree, Retired Eligible Employee, Reinstated Eligible Retiree or Eligible Survivor Dependent.
Eligible Survivor Dependent~~:~~	A Survivor Dependent who timely enrolls for Survivor Dependent health coverage within sixty (60) days of the death of the Eligible Retiree.
Reinstated Eligible Retiree~~:~~	A Current Retiree or Retired Eligible Employee whose CalPERS retirement annuity and benefits under this Policy ended due to a reinstatement from retirement as defined in Government Code §§ 22838 and 21190 et.seq., or successor sections, and who (i) subsequently terminates employment from another state employer who does not provide retiree health benefits with a retiree share premium that is less than or equal to that being charged by CalOptima under this Policy; (ii) once again begins collecting retirement annuity payments from CalPERS within 120 days of such subsequent separation from employment; and (iii) timely enrolls for resumption of coverage under this Policy.
Retired Eligible Employee~~:~~	Eligible Employee who: 1. Retires within 120 days of such Eligible Employee's separation from employment with CalOptima and receives a monthly retirement allowance from CalPERS; and ~~—~~Timely applies for retiree health benefits in accordance with this policy on and after January 1, 2014. 2.
Retirement Date~~:~~	Date Eligible Employee becomes an annuitant with CalPERS within 120 days of such Eligible Employee's separation from employment with CalOptima.
Subsequent Retirement Date~~:~~	Date Reinstated Eligible Retiree again begins collecting retirement annuity payments from CalPERS within 120 days of separating from employment with the subsequent state employer described in that definition.

Term	Definition
Survivor Dependent~~:~~	Eligible Dependent who: 1. Survives an Eligible Retiree; and ~~—~~Is collecting monthly survivor benefits from CalPERS that is attributable to a deceased Current Retiree, Retired Eligible Employee, or Reinstated Eligible Employee. 2.

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~~2.———~~

III. POLICY

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

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

1. ***Not Medicare Eligible***: If the Eligible Retiree and/or the Eligible Dependent(s) is/are not yet eligible for Medicare, then the Eligible Retiree and/or the Eligible Dependent(s) will receive the same health insurance coverage as active employees and their dependents. The Eligible Retiree's share of premiums will be the same as those paid by active employees for similar coverage.

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

premium will be calculated based on the same proportional amount ~~as~~ active employees ~~are required to~~ pay for the most closely analogous active employee health insurance coverage for the active employee and their dependents.

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

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

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

IV. PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

Not Applicable

VII. REGULATORY APPROVALS ~~OR~~

None to Date

~~VII.~~VIII. BOARD ACTIONS

A. 06/02/16: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 08/07/14: Regular Meeting of the CalOptima Board of Directors ~~Standard Meeting~~

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

~~Not Applicable~~

Version	Date	Policy Number	Policy Title
Original	05/01/2014	GA.8055	Retiree Health Benefit Policy
Revised	08/07/2014	GA.8055	Retiree Health Benefit Policy
Revised	06/02/2016	GA. 8055	Retiree Health Benefit

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

CEO Approval: Michael Schrader

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

I. PURPOSE

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

II. DEFINITIONS

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

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

III. POLICY

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

1. ***Not Medicare Eligible***: If the Eligible Retiree and/or the Eligible Dependent(s) is/are not yet eligible for Medicare, then the Eligible Retiree and/or the Eligible Dependent(s) will receive the same health insurance coverage as active employees and their dependents. The Eligible Retiree's share of premiums will be the same as those paid by active employees for similar coverage.

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

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

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

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IV. PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. ATTACHMENTS

Not Applicable

VI. REFERENCES

Not Applicable

VII. REGULATORY APPROVALS

None to Date

VIII. BOARD ACTIONS

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

IX. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title
Original	05/01/2014	GA.8055	Retiree Health Benefit Policy
Revised	08/07/2014	GA.8055	Retiree Health Benefit Policy
Revised	06/02/2016	GA. 8055	Retiree Health Benefit

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

The OCC MAC recommends:

1. Appointment of Patty Mouton, Home and Community-Based Services (HCBS) Representative Serving Seniors, as the Chair of the OCC MAC for the remainder of Fiscal Year 2016-17; and
2. Appointment of Gio Corzo, Community Based Adult Services (CBAS) Provider Representative, as the Vice Chair of the OCC MAC for the remainder of Fiscal Year 2016-17.

The PAC recommends:

1. Appointment of Teri Miranti, Health Network Representative, as the Chair of the PAC for the remainder of Fiscal Year 2016-17; and
2. Appointment of Suzanne Richards, Hospital Representative, as the Vice Chair of the PAC for the remainder of Fiscal Year 2016-17.

Background

The CalOptima Board of Directors established the OCC MAC on February 5, 2015 and the PAC on February 14, 1995 to provide input to the Board. Per CalOptima policies MA.1219b and CMC.1007, OCC MAC and PAC Chair and Vice Chair will serve two consecutive one year terms. Furthermore, the CalOptima Board is responsible for the appointment of all advisory committee members.

Discussion

At its August 4, 2016 meeting, the CalOptima Board of Directors adopted Resolution No. 16-0804-01, adding Vice Chair positions to the Board of Directors' Member Advisory Committee (MAC), OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) and Provider Advisory Committee (PAC) and directed the MAC, OCC MAC and PAC to revisit their nominations processes to fill the chair and vice chair positions to ensure proper coverage in both positions before presenting recommendations to the Board for approval. OCC MAC and PAC have revisited their nominations and put forth the recommended candidates for approval. These candidates were vetted at the September 8, 2016 PAC meeting and at the September 22, 2016 OCC MAC meeting. The MAC, which did not have a quorum at its September 8, 2016 meeting, will consider Chair and Vice Chair nominations at its November 10, 2016 meeting, with MAC chair and vice chair recommendations to be presented to the Board at a subsequent meeting.

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The slates of candidates for OCC MAC and PAC are as follows:

OCC MAC Chair

Patty Mouton, Home and Community-Based Services Representative Serving Seniors
Ms. Mouton is the Vice President of Outreach and Advocacy at Alzheimer's Orange County, and has more than 30 years of experience in health care. She oversees professional and clinical activities and events, provides community education programs, and coordinates the legislative advocacy and public policy forming activities. Ms. Mouton is active in the community, speaking on issues of medical coverage, such as Medicare and Medi-Cal and defining the continuum of care, and has served as OCC MAC Chair since 2015.

OCC MAC Vice Chair

Gio Corzo, Community Based Adult Services (CBAS) Provider Representative
Mr. Corzo is the Vice President of Home & Care Services for SeniorServ. He has over sixteen years of 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 Adult Day Health Care (ADHC) to CBAS transition and has been a member of OCC MAC since 2015.

PAC Chair

Teri Miranti, Health Network Representative
Ms. Miranti is Director of Government Programs at Monarch HealthCare Irvine. She has over 21 years of health care experience in Orange County focused on government sponsored programs. She worked at CalOptima as the Director of Provider Network Management in 1998 before joining Monarch in 2004. She has been a member of the California Association of Physician Groups (CAPG) State Programs Committee since 2004 and has been a member of the PAC since 2015.

PAC Vice Chair

Suzanne Richards, RN, MBA, FACHE - Hospital Representative
Ms. Richards has served on the PAC since October 2014. She currently serves as the Chief Executive Officer for KPC Healthcare, Inc., as well as the CEO, Orange County Global Medical Centers in Anaheim and Santa Ana. In addition to her duties as a corporate CEO and hospital CEO, Ms. Richards is an active surveyor for the Joint Commission and has conducted accreditation surveys of healthcare entities throughout the United States since 2005.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The OCC MAC and PAC forward their respective recommended slates of candidates for committee chair and vice chair positions to the Board of Directors for consideration.

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Concurrence
OCC MAC Advisory Committee
PAC Advisory Committee
Gary Crockett, Chief Counsel

Attachment
Resolution No. 16-0804-01

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

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RESOLUTION NO. 16-0804-01

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

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

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

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

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

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

AYES: Bartlett, Berger, DiLuigi, Do, Khatibi, Nguyen, Penrose, Schoeffel, Yost

NOES: None

ABSENT: None

ABSTAIN: None

Original signed by Mark A. Refowitz
Title: Chair, Board of Directors
Printed Name and Title: Mark A. Refowitz, Chair, CalOptima Board of Directors

Attest:

Original signed by Suzanne Turf
Suzanne Turf, Clerk of the Board

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the expenditure for CalOptima's participation in the following event:
    a. Up to $2,000 for the VPASC Foundation's Free Health Fair on Sunday, October 23, 2016 in Westminster.
2. Make a finding that such expenditure is 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 expenditure.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners, providers and key stakeholders.

Requests for participation are considered based on several factors, including: the number of people the activity/event will reach; the marketing benefits accrued to CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and available budget.

Discussion

Staff recommends the authorization of the expenditure for participation in the VPASC Foundation's Free Health Fair to strengthen CalOptima's relationship with Vietnamese healthcare professionals including physicians, specialists and others serving our members. The health fair will provide free health care services to community members, which is in line with CalOptima's mission. The event will also provide CalOptima an opportunity to conduct outreach and education about our programs and services to Vietnamese-speaking members, who comprise approximately twelve percent of our total membership. A $2,000 financial commitment for the VPASC Foundation Health Fair includes: Resource table at the health fair, a 5'x2' CalOptima banner display, and CalOptima brochures in each attendee's gift bag. Employee time will be used to participate in this event. Employees will have an opportunity to interact

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with current and potential members to share information about CalOptima's programs and services, potentially increasing awareness of programs, and utilization of primary and preventive care services. The VPASC is a non-profit organization established to improve the quality of health care to the underserved communities of Orange County by providing free public education seminars and free annual health fairs. The health fair brings together hundreds of healthcare professionals including doctors, dentists, pharmacists, nurses and dental assistants to provide free medical services. These services will include flu shots, health screenings for blood pressure, blood glucose screening, vision, hepatitis B/C, and breast and colon cancer. Dental services will include dental exams, fillings, and extractions. Volunteer physicians will be on-site to provide health education on topics which include management of coronary artery disease, hypertension, strokes, high cholesterol, diabetes and hepatitis B. During last year's health fair, over five hundred (500) individuals were served. VPASC is estimating that this year's event will serve over seven (700) hundred individuals. The event is open to the public and all services including medical, dental and health education will be provided at no cost.

CalOptima staff has reviewed the request and it meets the consideration for participation including the following:

1. The number of people 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;
4. Past participation;
5. Staff availability;
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations department. The Community Relations department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended actions of up to $2,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2016-17 Operating Budget approved by the CalOptima Board of Directors on June 2, 2016.

Rationale for Recommendation

Staff recommends approval of the recommended 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, and promotes collaboration with our Vietnamese healthcare professionals to provide medical services for our community.

Concurrence

Gary Crockett, Chief Counsel

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Attachment
VPASC Request Letter and Sponsorship Information

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

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Vietnamese Physician Association of Southern California (VPASC) Foundation

a 501(c)(3) nonprofit organization
Tax ID # 45-3844398
64 Bridgeport Road, Newport Coast, CA 92657
E-mail: info@vpasc.org

September 19, 2016

Dear Business Leaders:

"I can do things you cannot, you can do things I cannot;
together we can do great things." Mother Teresa

Thank you for giving our group this opportunity to work with you. Together we can create a healthier community.

The Vietnamese Physician Association of Southern California (VPASC) Foundation is a California 501(c)(3) nonprofit organization originally incorporated in 2011. Our primary mission is to improve the quality of health care in the underserved communities of Orange County through free public education seminars and free annual health fairs.

Each year at our VPASC Free Health Fair, our group brings together hundreds of health care professionals (doctors, dentists, pharmacists, nurses, dental assistants), students, volunteers, and community businesses to provide much-needed medical screenings, dental treatments, and preventative health education free of charge to the medically underserved population.

This year, our VPASC Free Health Fair will be held on Sunday October 23rd, 2016 from 9am-3pm at the Boys & Girls Club of Westminster.

Among the free medical services that will be available are free flu shots, blood pressure check for hypertension, blood glucose check for diabetes, vision check for glaucoma, and screenings for hepatitis B/C, breast cancer, and colon cancer. Dental services will include dental exam, fillings, and extractions. Health education lectures will be given by our volunteer physician members on important topics such as management of coronary artery disease, hypertension, strokes, high cholesterol, diabetes, and hepatitis B.

Our health fairs have always been very successful and well attended. Last year, we served over 500 patients. We expect to increase our attendance this year to over 700 (+) . **Our health fair is open to the public.** These public service activities are made possible by the generous donation, sponsorship, and support of distinguished businesses in the community such as yours.

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The projected budget for our health fair this year is $15,000.00 (fifteen thousand dollars) to be expended as follow:

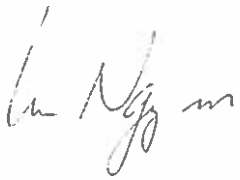
- $1,600.00 for facility rental
- $500.00 for newspaper, radio, and television advertising
- $1,200.00 for supplies, banners, tables and chairs
- $1,500.00 for T-shirts, food, and refreshment for the volunteers
- $2,000.00 for flu vaccines
- $2,000.00 for hepatitis B screening (blood test)
- $1,300 for medical supplies (diabetes and high cholesterol screening)
- $5,000 for dental equipment and supplies.

Grand total $15,000

We hope that you are as passionate about bringing medical health services to the community as we are. We would appreciate if your institution will help us fund the 2016 VPASC Health Fair. Attached you will find the preliminary health fair flyer and the sponsorship level proposal.

We thank you for your time and consideration.

Sincerely,



Luan Nguyen, M.D.
Chairman of Health Fair Planning Committee
Vietnamese Physician Association of Southern California Foundation

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TITLE SPONSORSHIP $5000

Radio and TV advertising as Official/Title Sponsor of The VPASC Health Fair

Allowance for a booth near entrance of Health Fair

Allowance for large banner 12'x3' and products display inside

Business cards and brochure in attendee gift bag

PLATINUM SPONSORSHIP $3000

Allowance for booth near entrance of Health Fair

Allowance of banner 8'x3' and products displayed inside building

Business cards and brochure in attendee gift bag

GOLD SPONSORSHIP $2000

Allowance of booth at the Health Fair

Allowance of banner 5'x2' with products displayed inside building

Business cards and brochure in attendee gift bag

SILVER SPONSORSHIP $1000

Allowance of booth at the Health Fair

Business cards and brochure in attendee gift bag

Radio and TV advertisements to be done within the first three weeks of October 2016

All sponsors provide own banners, business cards and brochures

Please make checks payable to VPASC Foundation (501(c)(3) Tax ID#: 45-3844398)

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Vietnamese **P**hysician **A**ssociation of **S**outhern **C**alifornia

FOUNDATION

"One life to share. One family to love. One community to serve."

FREE HEALTH FAIR

Hội Chợ Y Tế Miễn Phí - Do Bác Sĩ Tổ Chức

SUNDAY, October 23, 2016
9 AM – 3 PM

Boys & Girls Club – Westminster
14400 Chestnut Street, Westminster, CA 92683

MEDICAL SERVICES:

FLU SHOT/ Chích Ngừa Cúm **(while supplies last)**
Blood Pressure Check / Đo Huyết Áp
Blood Cholesterol Check / Đo Lượng Mỡ Trong Máu
Blood Glucose Check/ Đo Lượng Đường Trong Máu
HEPATITIS B/C SCREENING / Truy Tầm Viêm Gan B/C (**9am-1pm only**)
Vision and GLAUCOMA Testing / Khám Mắt & Đo Áp Suất Mắt
Osteoporosis / BONE DENSITY TESTING/ Đo Rỗng Xương
Hearing Screening / Khám Thính Lực
Heart / Cardiovascular Diseases / Tham Khảo Bệnh Tim/ EKG
Breast Cancer Screening Consultation/ Tham Khảo & Truy Tầm Ung Thư
Colon Cancer Consultation / Tham Khảo Ung Thư Ruột Kết

DENTAL SERVICES:
Exam, filling, extraction / Khám, Trám và Nhổ Răng

EDUCATIONAL CLASSES / Thuyết Trình Về Bệnh Viêm Gan B,
Cao Huyết Áp, Tiểu Đường, Đau Nhức

Tham Khảo & Chữa Trị Miễn Phí

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

Recommended Actions
1. Approve the reforecasted CalOptima Fiscal Year (FY) 2016-17 Operating Budget, as detailed on the attachments; and
2. Authorize the expenditures and appropriate the funds for items listed in the Revised Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy.

Background
At the June 2, 2016, meeting, the CalOptima Board of Directors (Board) approved the CalOptima FY 2016-17 Operating Budget.

Section II.F. of CalOptima Policy GA.5003: Budget and Operations Forecasting, provides that CalOptima shall reforecast revenue and expenditures periodically throughout the year.

Discussion
When Staff prepared the CalOptima FY 2016-17 Operating Budget, it applied a budgeting methodology and used current actual run-rate assumptions to allocate funds to various categories, departments and lines of business. Upon further review, Staff discovered that certain areas within the budget were under budgeted or allocated differently amongst budget areas. In particular, the attachments highlight that operating expenses for OneCare Connect were underbudgeted.

Management recommends the following changes in budgeted annual operating expenses to address reforecasted projected expenses, as detailed in the following attachments:
- Attachment 1: Revised Attachment A, Consolidated Budgeted Statement of Revenues and Expenses;
- Attachment 2: Revised Attachment B, Administrative Budget Details; and
- Attachment 3: List of Proposed Budget Changes.

Attachment A Summary: Change in Net Assets

	Approved Budget (As of 6/2/16)			Proposed Reforecasted Budget (As of 8/31/16)		
Line of Business	**Change in Net Assets**	**MLR**	**ALR**	**Change in Net Assets ****	**MLR**	**ALR**
Medi-Cal	$7,178,249	95.90%	3.84%	$7,965,341	95.89%	3.83%
OneCare	$395,561	90.50%	7.14%	$365,020	90.58%	7.25%
OneCare	$2,095,516	94.51%	5.10%	$1,016,356	94.57%	5.24%

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	Approved Budget (As of 6/2/16)			Proposed Reforecasted Budget (As of 8/31/16)		
Line of Business	**Change in Net Assets**	**MLR**	**ALR**	**Change in Net Assets ****	**MLR**	**ALR**
Connect						
PACE	($2,389,250)	107.06%	9.37%	($2,389,250)	107.06%	9.37%
Facilities	($781,000)			($781,000)		
Other	$2,500,000			$2,500,000		
Consolidated	**$8,999,075***	**95.7%**	**4.11%**	**$8,676,468***	**95.7%**	**4.12%***

* Board Approved changes to Change in Net Assets:
- Board action on 4/7/16: Carry forward $300,000 for ICD-10
  Board action on 8/4/16: $22,602 for Development Rights

** Refer to Attachment 3: List of Proposed Budget Changes

Fiscal Impact
The fiscal impact for the recommended action is budget neutral.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Revised Attachment A, Consolidated Budgeted Statement of Revenues and Expenses
2. Revised Attachment B, Administrative Budget Details for Medi-Cal, OneCare and OneCare Connect
3. List of Proposed Budget Changes

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

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Attachment 1
Revised Attachment A

CalOptima Fiscal Year 2016-17 Budget
Budgeted Statement of Revenue & Expenses
By Line of Business

	Medi-Cal (Classic)	Medi-Cal (Expansion)	Total	OneCare	OCC	PACE	Facilities	Other	Consolidated
Member Months	6,691,301	2,686,236	9,377,537	14,227	261,930	2,310	-		**9,656,004**
Avg Members	557,608	223,853	781,461	1,186	21,828	193	-		**804,667**
Revenues									
Capitation revenue	$ 1,599,051,456	$ 1,221,965,048	2,821,016,503	$ 16,771,979	$ 533,118,659	$ 14,540,515	$ 255,419		**$ 3,385,703,075**
Total	1,599,051,456	1,221,965,048	2,821,016,503	16,771,979	533,118,659	14,540,515	255,419		**$ 3,385,703,075**
Medical Costs									
1 Provider capitation	$ 408,068,316	$ 491,225,981	899,294,297	$ 4,660,772	$ 118,185,631	$ -	$ -		**$ 1,022,140,700**
2 Claims Payments	$ 453,082,246	$ 437,591,284	890,673,530	$ 4,577,281	$ 143,270,454	$ -	$ -		**$ 1,038,521,266**
3 LTC/Skilled Nursing Facilities	$ 425,107,202	$ 19,931,662	445,038,864	$ -	$ 123,723,434	$ -	$ -		**$ 568,762,298**
4 Prescription Drugs	$ 221,228,415	$ 191,351,662	412,580,077	$ 5,436,158	$ 96,469,980	$ 1,598,041	$ -		**$ 516,084,256**
5 Case Mgmt & Oth Medical	$ 27,330,329	$ 30,120,073	57,450,402	$ 517,526	$ 22,524,183	$ 13,969,728	$ -		**$ 94,461,840**
Total	$ 1,534,816,508	$ 1,170,220,663	$ 2,705,037,171	$ 15,191,738	$ 504,173,683	$ 15,567,769	$ -		**$ 3,239,970,360**
MLR	***95.98%***	***95.77%***	***95.89%***	***90.58%***	***94.57%***	***107.06%***	***0.00%***	*	***95.70%***
Gross Margin	$ 64,234,948	$ 51,744,385	$ 115,979,333	$ 1,580,241	$ 28,944,976	$ (1,027,254)	$ 255,419		**$ 145,732,715**
Administrative Expenses									
Salaries, Wages, & Employee Benefits			$ 80,880,170	$ 257,952	$ 11,405,360	$ 1,115,205	$ -		**$ 93,658,686**
Professional Fees			$ 3,594,718	$ 160,000	$ 958,646	$ 40,000	$ 25,020		**$ 4,778,384**
Purchased services			$ 8,704,037	$ 292,580	$ 2,159,607	$ 12,000	$ 268,857		**$ 11,437,081**
Printing & Postage			$ 3,719,580	$ 149,703	$ 1,619,979	$ 20,738	$ 0		**$ 5,510,000**
Depreciation & Amortization			$ 4,596,733	$ -	$ -	$ 24,674	$ 2,521,689		**$ 7,143,096**
Other Operating Expenses			$ 13,024,868	$ 1,063	$ 535,140	$ 137,106	$ 2,446,051		**$ 16,144,229**
Indirect Cost Allocation, Occupancy Expense			$ (6,506,114)	$ 353,923	$ 11,249,888	$ 12,273	$ (4,225,198)		**$ 884,772**
Total			$ 108,013,992	$ 1,215,220	$ 27,928,620	$ 1,361,996	$ 1,036,419		**$ 139,556,248**
ALR			***3.83%***	***7.25%***	***5.24%***	***9.37%***		*	***4.12%***
Operating Income/(Loss)			$ 7,965,341	$ 365,020	$ 1,016,356	$ (2,389,250)	$ (781,000)	$ -	**$ 6,176,468**
Investment Income								$ 2,500,000	$ 2,500,000
MCO Tax Revenue			$ 106,277,305						$ 106,277,305
MCO Tax Expense			$ (106,277,305)						$ (106,277,305)
CHANGE IN NET ASSETS			**$ 7,965,341**	**$ 365,020**	**$ 1,016,356**	**$ (2,389,250)**	**$ (781,000)**	**$ 2,500,000**	**$ 8,676,468**

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Attachment 2
Revised Attachment B

	Medi-Cal: Professional Fees			
Specific Type	Objective - of the Item Proposed	Budget FY2017 Input	Authorization	Appropriation
Legal	Programmatic And General Legal Fees	578,650	x	x
Legal	Adversarial Legal Fees	361,656	x	x
Consulting	Executive Office Consulting Services	246,666	x	x
Professional Fees	Professional Services Required For Corporate Applications And Systems	216,592	x	x
Consulting	Government Affairs Contract And Management Of State And Federal Lobbyists	185,000	x	x
Audit Fees	Financial Audit Annual Contract	150,000	x	x
Training	Professional Services For An Enterprise Identity Access Management	143,585	x	x
Consulting*, **	Services For Core Application To Support Configurations And Interface Analytics	142,000	x	x
Consulting	Marketing And Advertising Consulting Fees To Support CalOptima's Public Affairs Division With Outreach And Marketing Efforts, And To Acquire Data To Help Inform Strategic Direction For All Lines Of Business	94,660	x	x
Consulting	Communications Consulting Fees To Support CalOptima's Public Affairs Division	94,660	x	x
Consulting**	Rebasing And Network Support	89,919	x	x
Consulting	Compliance - Health Insurance Portability And Accountability Act (HIPAA) Security	86,151	x	x
Consulting	Investment Advisory Annual Contract	80,000	x	x
Professional Fees	Executive Coaching	75,000	x	x
Consulting	Consultant For Medi-Cal Mock Audit	75,000	x	x
Consulting	Consultant For Mock Audit For Department of Managed Health Care (DMHC) Audit	75,000	x	x
Professional Fees	Project Management Consulting Services To Implement The Data Warehousing And Analytics Maturity Model	74,935	x	x
Legal	Peer Review - Credentialing	72,331	x	x
Consulting	Semi-Annual Chronic Illness and Disability Payment System (CDPS) Risk Adjustment	61,279	x	x
Consulting	Virtualization Architecture Assessment	57,434	x	x
Consulting	Professional Services For Network Access Control Health Check And Remediation	57,434	x	x
Consulting	Public Relations And Strategic Development Consulting Fees To Support CalOptima's Public Affairs Division With Outreach And Marketing Efforts, And To Acquire Data To Help Inform Strategic Direction For All Lines Of Business	56,796	x	x
Consulting	Research And Evaluation Consulting For New CalOptima 3-Year Strategic Development	55,000	x	x
Professional Fees**	Salary And Compensation Research	54,284	x	x
Consulting	Chronic Illness And Disability Payment System	45,959	x	x
Consulting	Consulting fees for Vietnamese & Spanish Community Liasons	41,140	x	x
Professional Fees	Reporting Software Review And Data Transfer	35,651	x	x
Audit Fees	Fair Labor Standards Act Audit	35,000	x	x
Consulting	New Programs: Health Homes, California Children's Services (CCS) Integration, Whole Person Care Model; Transplant Network Management	35,000	x	x
Consulting**	Real Estate Consultant	30,000	x	x
Consulting	457B Plan Review	20,000	x	x
Actuary	Full Actuarial Review	19,099	x	x
Professional Fees	Professional Services To Support The Accounting Application and Finance Systems	15,736	x	x

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Attachment 2
Revised Attachment B

	Medi-Cal: Professional Fees			
Specific Type	**Objective - of the Item Proposed**	**Budget FY2017 Input**	**Authorization**	**Appropriation**
Consulting	Annual IBNR Certification Review	15,320	x	x
Consulting*	Software Updates And Changes To Support Changes Required By The Department Of Health Care Services	15,000	x	x
Professional Fees	Miscellaneous Consulting/Professional Services At The CalOptima Data Center	14,358	x	x
Consulting	General Consulting Services	12,330	x	x
Consulting*, **	Provider And Physician Credentialing	12,000	x	x
Consulting*	Analytic Services And Support For Financial And Historical Claims Analysis	12,000	x	x
Consulting	Required Annual A-133 Audit	10,000	X	X
Consulting	New Learning Management System; Host Implementation And Consulting Services	10,000	x	x
Training	Consultant For Accounting Reporting Software Training	7,799	x	x
Consulting	Accounting System New Version Features Review	6,685	x	x
Professional Fees	Professional Fees To Enhance The Use Of The HR Application	6,161	x	x
Professional Fees	Professional Services For Ad-Hoc Updates Request By Customer Service For Phone Surveys	2,872	x	x
Professional Fees	Consulting Resources To Ensure Implementation Of New Programs And Program Readiness And Validations	2,171	x	x
Professional Fees	Community Relations Professional Fees	1,350	x	x
Professional Fees	Vendor Management Purchasing Professional Fees	1,200	x	x
Professional Fees	Budgeting Software Professional Fees	1,200	x	x
Professional Fees	Contract Management Professional Fees	1,200	x	x
Professional Fees	Miscellaneous Accounting Projects Professional Fees	955	x	x
Consulting	Behavioral Health Professional Fees	500	x	x
Consulting*	Core System (Facets) Upgrade Consultation Support	0	x	x
Consulting*	Software Application Configurations	0	x	x
	Total Professional Fees	**3,594,718**		

*** Budget Reforecast**
**** Prior Approved Budget Reallocation**

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Attachment 2
Revised Attachment B

Medi-Cal: Purchased Services				
Specific Type	**Objective - of the Item Proposed**	**Budget FY2017 Input**	**Authorization**	**Appropriation**
Purchased Services	Pharmacy Benefits Management (PBM) Fees (70% Administrative)	2,900,000	X	X
Claims Review	Claims Editing Software Services	631,190	X	X
EDI Claims Clearinghouse	Electronic Data Interchange Institutional Claims	569,495	X	X
Purchased Services**	Integration Of Claim Editing Software To Enhance Claims Reporting Capabilities And Inventory Management Forecasting	567,223	X	X
Claims Review	Claims Web Based Fraud, Waste, And Abuse Services	545,766	X	X
Claims Review	Coordination Of Benefits (COB) Project	398,646	X	X
Purchased Services	Conversion Of Temporary Assistance To Needy Families (TANF) To Supplemental Security Income (SSI)	350,000	X	X
Claims Review	Forensic And Diagnosis Related Groupings (DRG) Validation Review Services	284,747	X	X
Imaging Services	Claims Imaging And Indexing Vendor	284,747	X	X
Purchased Services*, **	Healthcare Productivity Automation Services	231,000	X	X
Purchased Services*, **	Disaster Recovery Technology Services	230,729	X	X
Interpretive Services**	Language Interpreter Services (Telephonic And In-Person)	165,511	X	X
Purchased Services**	Third Party Check Printing And Mailing Fees	131,205	X	X
Purchased Services	Retiree Benefit Administration	107,000	X	X
Claims Review**	Long-Term Care Rate Adjustments	98,000	X	X
Advertising	Support And Help Elevate The CalOptima Brand In The Community	83,329	X	X
Advertising**	Online Career Site For Recruitment Advertisement And Sourcing	80,000	X	X
Broker Services	Insurance Broker Services	79,000	X	X
Purchased Services	Retained Search, Conversion Fees And Recruitment Expenses	75,000	X	X
Purchased Services	Website Compliance For Provider Directories, 2017 Plan Year Materials And Other Documents	64,855	X	X
Bank Fees	Business Bank Fees	63,007	X	X
Bank Fees	Custodial Bank Fees	60,000	X	X
Purchased Services	Talent Network/Recruitment Fees Including Market Monitoring And Employee Network And Contacts	56,508	X	X
Advertising	Radio, Television, Print, Outdoor and Digital Advertising to Promote And Support Enrollment And Participation	55,814	X	X
Purchased Services*	Offsite Backup Tape Storage And Services	45,000	X	X
Purchased Services**	Restacking Services	45,000	X	X
Purchased Services*	Initial Programming To Support The Set Up To Bring On Additional Image Archives For Quality Improvement Dept, Regulatory Affairs Dept, And Quality Analytics Dept	40,000	X	X
Purchased Services	Temporary Outsource Service	35,000	X	X
Purchased Services*	Claims Pricing Automation Enhancements	35,000	X	X
Imaging Services	Correspondence Imaging Services	31,322	X	X
Employee Benefits	Flexible Spending Accounts (FSA)/ Consolidated Omnibus Budget Reconciliation Act (COBRA)	31,000	X	X

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Attachment 2
Revised Attachment B

	Medi-Cal: Purchased Services			
Specific Type	**Objective - of the Item Proposed**	**Budget FY2017 Input**	**Authorization**	**Appropriation**
Advertising	Recruitment For New Departments And Initiatives	30,000	X	X
Imaging Services**	Imaging Of Provider Cases	26,731	X	X
Employee Engagement	Leave Of Absence Administration	25,000	X	X
Purchased Services	Employee Assistance Program (EAP)	25,000	X	X
Purchased Services	Website Redesign Services	19,653	X	X
License fees	Compensation System Subscription Fee	18,000	X	X
Purchased Services**	Internal Member Survey, Reporting Fees, Benefits Guides, Video Interpreting, Publications And Other General Purchased Services	16,439	X	X
Purchased Services	Flu Shots	16,000	X	X
Purchased Services	Photography Services And Stock Photograph Purchases For Use In Member, Provider, Marketing, Outreach And Other Community Oriented Materials	15,722	X	X
Wellness Program	Background Screening	15,600	X	X
Translation Services	Language Translation Services Of Written Materials	14,197	X	X
Purchased Services**	Direct Hire/Placement Fees	12,600	X	X
Purchased Services	Recruitment Job Posting System	10,200	X	X
Purchased Services	Salary Survey	10,000	X	X
Purchased Services	Drug Screens And Video Interview	8,750	X	X
Purchased Services	Graphic Design To Support CalOptima Programs	7,861	X	X
Purchased Services	Imaging Services	7,798	X	X
Purchased Services**	Telephone On-Hold Music/Audio Add-On	6,500	X	X
Purchased Services	OCSD (Orange County Sheriff Department) Armed Security Services For Board And Other Meetings	6,082	X	X
Purchased Services	Tax Form Processing Fees	5,834	X	X
Purchased Services	Tuberculosis (TB) Tests	5,655	X	X
Purchased Services	Waived Services Including Home Care, Meal Deliveries And Taxi Services	5,000	X	X
Purchased Services**	Miscellaneous Purchased Services to Support Department's Needs	5,000	X	X
Purchased Services	Marketing Services And Material	5,000	X	X
Purchased Services	Emission Credits/Fees In Which CalOptima Is Required To Pay By The State Of California For Not Meeting Our Average Vehicle Rider (AVR) Target / Ride Sharing Program	4,161	X	X
Purchased Services	Advertising Services For Provider Relations And Customer Services	4,020	X	X
Purchased Services	Employee Recognition And Retention For Gars And Customer Service Departments	2,140	X	X
Purchased Services*	Application Security Testing To Reduce Chance Of Loss Of Restricted Data	-	X	X
Purchased Services*	Destruction Of Electronic Media	-	X	X
	Total Purchased Services	**8,704,037**		

*** Budget Reforecast**
**** Prior Approved Budget Reallocation**

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Attachment 2
Revised Attachment B

	Medi-Cal: Printing & Postage			
Specific Type	**Objective - of the Item Proposed**	**Budget FY2017 Input**	**Authorization**	**Appropriation**
Printing	Print Fulfillment And Postage For All Regular Monthly Mailings	2,132,083	x	x
Postage	General Postage For Outgoing Mail	436,759	x	x
Printing	Print Fulfillment And Postage For New Member/Enrollment Packages	331,696	x	x
Printing	Print Fulfillment And Postage For Quarterly Newsletters	254,853	x	x
Printing	Printing And Postage For Qualified Medicare Beneficiary (QMB) Outreach & Healthy You (HY) Monthly Mailings	208,987	x	x
Printing	Print Fulfillment And Postage For All Communication Of Health Network Changes To Members And Reprogramming Cost Changes	155,223	x	x
Printing	Printing And Postage For Programming Changes	45,427	x	x
Courier	Mail Services Charges	39,308	x	x
Printing	Printing Services For Facilities Projects/Events Such As Business Continuity Plan (BCP), Safety & Security, And Other CalOptima Departments Printing Needs	27,297	x	x
Printing	Printing Of The Annual Report To The Community, Holiday Cards, CalOptima Brochures, Pace Marketing Materials, Ad Hoc Materials, And Provider Press Mailings	26,849	x	x
Printing	Environment Health & Safety (EHS) Printing For Ergonomics, Business Emergency Response, Business Continuity, Workplace Violence, And Other Related Functions	13,649	x	x
Printing*	Printing Expenses/Items Needed for Community Events	10,000	x	x
Member Communication	Printing Of Miscellaneous Member Materials	8,528	x	x
Printing**	Printing Expenses And Supplies For Claims, Accounting, And Office Of Compliance	7,845	x	x
Postage	Postage Expenses For Provider Relations, Contracting, Behavioral Health Integration	4,833	x	x
Printing	Client Brochures In Multiple Languages	4,000	X	X
Courier**	Courier/Delivery Of Materials	3,743	X	X
Printing & Postage	Member Materials	3,500	x	x
Printing**	Printing Expenses and Supplies for Community Relations	2,500	x	x
Printing**	Printing Expenses and Supplies for GARS	2,500	X	X
	Total Printing and postage	**3,719,580**		

*** Budget Reforecast**
**** Prior Approved Budget Reallocation**

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Attachment 2
Revised Attachment B

	Medi-Cal: Other			
Specific Type	**Objective - of the Item Proposed**	**Budget FY2017 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	1,531,934	X	X
Maintenance*	Facets Core System (Enrollment, Claims, Authorizations, And Other Modules) License Renewal And Maintenance	1,473,434	X	X
Equipment*, **	Telecommunications And Network Connectivity Expenses	1,339,968	X	X
Maintenance*	Network Connectivity Maintenance And Support For CalOptima Sites Including Network Monitoring Tools, Web Filters, All Main Distribution Frame & Intermediate Distribution Frame Batteries, Internet Optimizers, Routers, Wireless Application Protocol Devices, And Other Tools	1,287,918	X	X
Maintenance*	Server Connectivity Maintenance And Support For Server Equipments Such As Servers, Storage, Virtual Machine Licenses, Backup Software	671,345	X	X
Maintenance*, **	Corporate Software Maintenance (Provider Sanctioning And Analytics, Member Population Health And Wellness, Data Warehouse Cleansing, Analytics, Business Application Workflow, Website Content Management, And Compliance Applications)	593,561	X	X
Maintenance*	Additional Software Licensing/True-Up Costs For Operating Systems And Office Software Suite	451,732	X	X
Maintenance*	Operating Systems And Office Software Suite License Costs And Upgrades To Support Entire Organization	416,895	X	X
Professional Dues	Association Membership Dues (Provide Advocacy, Program Support, Technical Support Regarding State And Federal Regulatory Issues)	407,122	X	X
Office Supplies	Office Supplies Such As Paper, Toner, Batteries, Mouse Pads, Keyboards, And Others Miscellaneous Items For Company-Wide Usage	274,942	X	X
Maintenance**	Human Resources Corporate Application Software Maintenance (Training, Recruitment, Performance Evaluation, HR Benefits, Employee Time And Attendance And Payroll)	260,224	X	X
Training & Seminar**	Various Training, Seminars, And Conferences For Professional Development And Education	257,300	X	X
Maintenance*	Maintenance And Support Annual Renewal For The Telecommunications Network Systems	243,828	X	X
Repair & Maintenance	Minor Office Construction, Maintenance For Carpet Cleaning, Refreshment, Doors, Moveable Partitions, Cable And Electrical Work	231,523	X	X
Equipment	Purchases And Installation Of Office Furniture For Adds, Moves, Furniture, Fixture And Equipment, And Various Other Articles Of Minor Equipment	212,861	X	X
Equipment	Encrypted Security Tokens And Desktop Hardware Replacement	199,550	X	X
Maintenance*	Maintenance And Support For The Production/Development Citrix Operating System/Software Environments	185,576	X	X
Maintenance*	24/7 Support To Assist Cal optima's Operating Systems And Office Software Suite Related Questions And Issues	181,999	X	X
Maintenance*	Software Maintenance True-Up For Facets Projects	174,027	X	X
Maintenance*	Maintenance And License Renewal For Auto Pricing All Patient Refined/Diagnosis Related Group And Associated Royalty Fees	169,000	X	X
Maintenance*	Finance Corporate Applications Software Maintenance (Accounting And Finance, Procurement, Bids, Accounting, Administrative Contract Management, And Budget Systems)	152,109	X	X
Subscriptions*	Healthcare Information Research And Analysis Subscription Renewal	144,743	X	X
Maintenance*	Database Administrator License Renewals, Maintenance, And Support	139,686	X	X
Maintenance*	Application Software Maintenance - IT Development Tools (Data Modeling, Architecture, Technical Libraries, Documentation, Technical Frameworks, Electronic Data Interchange, And Software Development Testing)	111,782	X	X
Equipment**	Laptops, Desktops, Flat Panel Monitors, Printers For New Employees And Other Minor/Miscellaneous Equipments	104,997	X	X
Equipment*	Business Telephones And Accessories Such As Desk Phones, Headsets, And Tablets Accessories	99,067	X	X

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	Medi-Cal: Other			
Specific Type	Objective - of the Item Proposed	Budget FY2017 Input	Appropriation	Authorization
Assessments	California Department Of Aging - OneCare Membership Assessment, California Department Of Managed Health Care Assessments	85,000	X	X
Maintenance*	Provider And Physician Credentialing System Maintenance & License Renewal	74,500	X	X
Office Supplies**	Office Supplies For Various Departments Needed For Everyday Operations	72,583	X	X
Public Activities	Promotional/Marketing And Outreach Activities To Help Elevate The CalOptima Brand In The Community To Support Enrollment And Participation In PACE	68,969	X	X
Travel**	Travel Allowance For Various Departments As Required By Their Job Function	68,609	X	X
Training	Board Training And Development	63,146	X	X
Public Activities	Cost For Rental And Reservations, Sponsorship And Registration Fees For New And Anticipated Community And Health Fairs	62,117	X	X
Maintenance*	Security Maintenance And Support For CalOptima Security Systems	53,960	X	X
Maintenance	Project Management Fees From Capital Projects Completed In FY2017	52,843	X	X
Food Services / Supplies**	Food Services Allowances As Needed For Sponsoring Member & Provider Meetings And Conferences	52,152	X	X
Maintenance*	Information Services Corporate Software Maintenance - Enterprise Help Desk Management Application	46,800	X	X
Education**	Tuition Reimbursement For Staff Development	45,655	X	X
Maintenance	Subscription Renewal For Standard Medical Coding Schedules And Multiple User Licenses	42,718	X	X
Software	Desktop Software	39,582	X	X
Software License	Annual Maintenance For MSSP Software License	35,000	X	X
Maintenance*	License And Maintenance Support For Purchases Associated With Capital Projects Completed In FY2017	33,000	X	X
Equipment	Laptops, Desktops, Flat Panel Monitors, Printers, Software And Other Miscellaneous Equipments	32,657	X	X
Travel	Travel Expenses For Association Meetings And Meetings With State And Federal Legislators And Regulators	30,000	X	X
Public Activities**	Public Activities For Various Outreach, Community Events, Sponsorships And Health Fairs	29,939	X	X
Maintenance	Software Maintenance And Renewal For Budgeting Software	27,588	X	X
Training & Seminar**	Human Resources Conferences And Training Supplies For Staff	25,366	X	X
Travel	Mileage Reimbursement For Staff Travel Expenses	25,200	X	X
Telephone Expense	Field Staff Cell Phone Service	25,000	X	X
Travel	Travel For Board Meetings, Legal And Regulatory, And State Program Meetings	24,760	X	X
Training & Seminar	Outsource Health Insurance Portability And Accountability Act, Sexual Harassment, Safety And Skill Building And Online Content Library For Training	24,634	X	X
Maintenance**	Maintenance And Support For Fax Application That Sends Faxes Via Email	21,369	X	X
Education	Organizational Development Programs Such As CalOptima Special Speakers, Trainers, Computer Classes, And Other Training Events	21,342	X	X
Travel	Travel Expenses For Federal And State Regulatory Meetings	20,801	X	X
Comp Supply/Minor Equip**	Licenses for Electronic Signature Software, Cloud Services, Software to Help Identify Security Issues	20,400	X	X
Incentives	Promotional Items Provided During Meetings With Physicians	20,003	X	X
Professional Dues**	Professional Membership Fees	19,511	X	X
Maintenance	Software Maintenance And Renewal For Procurement Software	19,311	X	X
Maintenance*	Information Security Data Loss Prevention Solution Annual Maintenance	15,937	X	X
Maintenance*, **	Maintenance And Support For Printers	15,426	X	X
Public Activities	Physician Forums For California Children's Services (CCS) Transition	15,000	X	X
Travel	Staff Mileage To And From Clients' Homes. Airfare, Hotel Reimbursement For Sacramento Legislation Policy And Procedure Meetings Three Times Per Year	15,000	X	X
Subscriptions**	Subscriptions Fees For Various Databases And Licenses	14,217	X	X
Food Services/Supplies	Food Services For Quarterly Legislative Luncheon Events	14,000	X	X

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	Medi-Cal: Other			
Specific Type	**Objective - of the Item Proposed**	**Budget FY2017 Input**	**Appropriation**	**Authorization**
Training & Seminar	Training & Seminar For Certified Fraud Examiner Certifications And Compliance Related Conferences	14,000	X	X
Office Supplies	Environmental Health And Safety Supplies For Employee Health & Safety, Disaster Recovery, Earthquake Preparedness, And Security & Safety Week Promotion	13,304	X	X
Training & Seminar**	Training & Seminars For Professional Development And Education	13,000	X	X
Training & Seminar	Training, Seminars And Conferences For Staff Development And New Initiatives/Programs	12,944	X	X
Training & Seminar	Seminar & Conferences And Professional Development For Staff	12,418	X	X
Travel	Travel Expenses For State Mandated Initiatives Including Health Homes, California Children's Services Carve In, Whole Person Care, Palliative Care	11,326	X	X
Subscriptions	Subscription Fees For Both Clinical And Programmatic Support As Well As Normal Maintenance Of Certification Licensure	11,326	X	X
Travel	Travel Expenses (Transportation, Mileage, And Food) For Annual Audits And Conferences	10,957	X	X
Travel	Mileage Reimbursement For Travel To Community Presentations, Provider Offices, And Member Enrollment	10,737	X	X
Food Services/Supplies	Floor Warden Meetings, Earthquake Response Team, Triage Team Training	10,643	X	X
Training & Seminar	Environmental Health And Safety Training For Ergonomics, Business Emergency Response, Business Continuity, Workplace Violence, Cardio-Pulmonary Resuscitation (CPR)	10,643	X	X
Subscriptions	Subscriptions For Annual User Group, Publishing Software, Cloud-Based Software	10,366	X	X
Maintenance*	Operations Software License Tools Maintenance And Support	10,084	X	X
Food Services/Supplies	Stakeholder Community Meetings, International Forums, Department Training, Refreshments For Other Public Activities	9,535	X	X
Equipment	Replacement For Laptops & Or Desktops	9,000	X	X
Training & Seminar	Accounting & Reporting Software Upgrade And Miscellaneous Training	8,776	X	X
Maintenance	Accounting Software Annual Maintenance	8,310	X	X
Food Services/Supplies	Food Services And Miscellaneous Supplies/Items For Board Meetings	8,168	X	X
Travel	Travel For State Meetings, Conferences/Seminars, And Association Meetings	8,125	X	X
Education	Supplemental Training For Human Resources Payroll Software	8,003	X	X
Subscriptions	Professional Education Subscription Fees For Various Organizations And Institutes	7,814	X	X
Food Services/Supplies	Food Services For Department/Organization Community Health Initiatives, Community And Health Fairs, Committee And Coalition Meetings	7,537	X	X
Training & Seminar	Training, Seminars And Various Conferences Including University Of California, Irvine Health Care Forecast Conference, Annual California Association Of Health Plans Conference And Other Conferences	7,429	X	X
Allowances	Board Stipends	7,429	X	X
Training & Seminar	Professional Development And Education Related To Department Functions Such As Staff Training, Conferences, Professional Certifications, And Additional Development Opportunities	7,328	X	X
Food Services/Supplies	Food Services For Provider Advisory Committee And CalOptima Community Network Lunch & Learn Events	7,200	X	X
Training & Seminar	Rapid Process Improvement Training & Personnel Development	6,657	X	X
Maintenance	Software Subscription Fees For Related Graphic Design Software	6,568	X	X
Professional Dues	Medical Licenses And Required Certifications	6,472	X	X
Travel	Travel And Mileage For Leadership And Staff For Meetings Related To Regulatory Issues, Legislative Issues, Marketing, Outreach And Strategic Development	6,182	X	X
Subscriptions	Subscription Fees For Various Organizations And Associations	6,155	X	X
Training & Seminar	Conference & Seminar And Professional Development For Staff	6,002	X	X
Training & Seminar	Training For Facilities Staff In Ergonomics, International Facilities Management (IFM) Classes, Real Estate Management Classes Provided By The Institute Of Real Estate Management (IREM) And Other Training Courses	5,322	X	X

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	Medi-Cal: Other			
Specific Type	**Objective - of the Item Proposed**	**Budget FY2017 Input**	**Appropriation**	**Authorization**
Training & Seminar	Seminars, Ongoing Training, And Continuing Legal Education For Staff Development	5,173	X	X
Food Services/Supplies	Food Services For Meetings And Other Events Such As CalOptima Informational Series	5,023	X	X
Training & Seminar	Training And Conferences And Professional Certifications For Professional Development And Education	5,000	X	X
Other Expenses	Miscellaneous Telephone, Certification/Continued Education, Maintenance Expenses	4,214	X	X
Office Supplies	Office Supplies Needed For Everyday Operations	4,026	X	X
Professional Dues	Professional Dues For Various Professional Associations	3,976	X	X
Other Expenses	Other Expenses For Minor Equipment, Subscriptions And Maintenance.	2,500	X	X
Comp Supply/Minor Equip**	Tableau License	2,000	X	X
Equipment**	Performance Management Software Subscriptions And User Licenses	1,500	X	X
Telephone Expense	Web Cards	480	X	X
Maintenance*	Maintenance And Support For Batch Scheduler System	0	X	X
	Total Other Operating Expenses	**13,024,868**		

*** Budget Reforecast**
**** Prior Approved Budget Reallocation**

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OneCare: Professional Fees

Specific Type	Objective - of the Item Proposed	Budget FY2017 Input	Appropriation	Authorization
Consulting	Annual Contract Bid For Calendar Year 2017	150,000	X	X
Consulting	Healthcare Coding Consulting	10,000	X	X
	Total Professional Fees	**160,000**		

OneCare: Purchased Services

Specific Type	Objective - of the Item Proposed	Budget FY2017 Input	Appropriation	Authorization
Purchased Services	IT Infrastructure, Enterprise Application And Business Process Outsourcing Services	180,000	X	X
Purchased Services	Pharmacy Benefits Management	67,000	X	X
Advertising	Advertising And Media Buys Including Newspaper, Magazine, Radio, Bus Shelter And Other Media	30,000	X	X
Interpreter services	Telephonic Language Interpretation And Translation Of Member Materials	13,800	X	X
Purchased Services	Document Imaging Services	1,400	X	X
Purchased Services	Reminder Communications, Patient Surveys And Marketing Solutions	380	X	X
	Total Purchased Services	**292,580**		

OneCare: Printing & Postage

Specific Type	Objective - of the Item Proposed	Budget FY2017 Input	Appropriation	Authorization
Printing & Postage	Maintenance Of Membership Packets: Print, Fulfillment And Postage	80,494	X	X
Printing & Postage	Required Member Routine Annual & Quarterly Mailings	37,814	X	X
Printing*	Required Member Materials	17,400	X	X
Printing	Health Risk Assessment Mailings	11,290	X	X
Imaging	Imaging Of Records Fees	1,769	X	X
Printing & Postage	New Member Enrollment Packets	936	X	X
	Total Printing and postage	**149,703**		

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	OneCare: Other			
Specific Type	**Objective - of the Item Proposed**	**Budget FY2017 Input**	**Appropriation**	**Authorization**
Travel	Travel Allowance For Various Departments As Required By Their Job Functions	375	X	X
Computer/Minor Equipment	Computer Supply/Minor Equipment	261	X	X
Office Supplies	Office Supplies For Various Departments Needed For Everyday Operations	209	X	X
Training & Seminars	Training, Conferences And Professional Certifications For Professional Development And Education	131	X	X
Food Services	Food Services Allowances As Needed For Sponsoring Member & Provider Meetings And Conferences	87	X	X
	Total Other Operating Expenses	**1,063**		

*** Budget Reforecast**

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Revised Attachment B

OneCare Connect: Professional Fees

Specific Type	Objective - of the Item Proposed	Budget FY2017 Input	Appropriation	Authorization
Consulting*, **	Annual Mock Audit Using Centers for Medicare and Medicaid Services (CMS) Audit Protocols	524,646	X	X
Consulting	Internal And Health Network Financial Planning	175,000	X	X
Consulting**	Department of Managed Health Care (DMHC) Annual Mock Audit	69,000	X	X
Consulting	Review And Recalculation Of The Health Network Capitation Rates	60,000	X	X
Consulting*	Professional Consultant Resources to Develop Additional Integration for Automation of Claims Pricing	60,000		
Consulting	New Or Revised Risk Adjustment Data Validation (RADV) Regulatory Requirements	50,000	X	X
Actuary	Chronic Illness And Disability Payment System (CDPS)	20,000	X	X
Consulting**	Annual Compliance Program Effectiveness (CPE) Audit	0	X	X
	Total Professional Fees	**958,646**		

OneCare Connect: Purchased Services

Specific Type	Objective - of the Item Proposed	Budget FY2017 Input	Appropriation	Authorization
Purchased Services	Pharmacy Benefits Management Services	1,200,000	X	X
Data Transmission*	Data Submission To And From Centers For Medicare And Medicaid Services (CMS) For Enrollment And Regulatory Reporting. Hierarchical Condition Category (HCC) Scores Analytics	340,359	X	X
Advertising	Advertising And Media Buys Including Newspapers, Magazines, Radio, Bus Shelter And Other Media	333,803	X	X
Data Transmission*	Claims Processing Through Automation Data Flow	160,700	X	X
Translation Services	Translator For Written Materials	87,454	X	X
Interpreter Services	Telephonic Language Interpretation As Well As Written Member Materials	33,353	X	X
Advertising	Advertising For Community Outreach Events/Activities And Member Awards	2,498	X	X
Purchased Services	General Purchase Services For Customer Services	1,440	X	X
	Total Purchased Services	**2,159,607**		

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OneCare Connect: Printing & Postage

Specific Type	Objective - of the Item Proposed	Budget FY2017 Input	Appropriation	Authorization
Member Communications	Post Enrollment Member Materials For Maintenance Of Enrolled Members	1,039,943	X	X
Member Communications	Annual Mailings	263,640	X	X
Member Communications	Printing Programming Service And Ad Hoc Mailings	151,820	X	X
Member Communications	New Member Packets	64,811	X	X
Member Communications*	Required Member Materials	32,800	X	X
Printing & Postage	Marketing Materials Including Sales Brochures, Posters, Handouts And Other Member And Provider Oriented Materials And Postage	29,221	X	X
Member Communications	Imaging Of Materials With Member Information For Record Retention Purpose	27,734	X	X
Printing**	Printing of Enrollment Materials	5,000	X	X
Printing	Printing Of Onsite Materials	2,235	X	X
Printing**	Printing of Envelops	1,500	X	X
Printing	Provider Mailing Materials	1,117	X	X
Courier/Delivery	Courier/Delivery Of Materials	158	X	X
	Total Printing and Postage	**1,619,979**		

OneCare Connect: Other

Specific Type	Objective - of the Item Proposed	Budget FY2017 Input	Appropriation	Authorization
Maintenance*	User Licenses For Claims Medicare Pricing Automation	375,000	X	X
Public Activities*	Cost For Rental And Reservations, Sponsorship And Registration Fees For New And Anticipated Community And Health Fairs	40,000	X	X
Marketing	Marketing And Outreach Activities	38,250	X	X
Travel*	Travel Expenses (Transportation, Mileage, And Food) For Annual Audits And Conferences	37,600	X	X
Travel	Mileage For Visits To Provider Offices, Presentations, Health Fairs And Community Events	11,000	X	X
Public Activities	Promotional Items Provided During Meetings With Physicians	5,000	X	X
Travel	Travel Allowance For Staff As Required By Their Job Functions	6,490	X	X
Equipment	Printers, Monitors, Desktops, Laptops And Other Minor Equipment	5,800	X	X
Office Supplies	Office Supplies Needed For Everyday Department Operations	5,620	X	X
Training & Seminars	Training & Seminars For Professional Development And Education	4,750	X	X
Public Activities	Public Activities For Various Outreach, Community Events, Sponsorships And Health Fairs	4,500	X	X
Subscriptions	Subscriptions & Professional Dues	650	X	X
Food Services	Food Services Allowances As Needed For Sponsoring Member & Provider Meetings And Conferences And Other Events	480	X	X
	Total Other operating expenses	**535,140**		

*** Budget Reforecast**
**** Prior Approved Budget Reallocation**

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Attachment 3
List of Proposed Budget Changes

	FY 2016-17 Operating Budget	Additional Funds Needed	Reforecast FY 2016-17 Budget
Medi-Cal: IS-Application Development, Other Operating Expenses - Maintenance for Unlimited Innovation (PMPM base)	$989,786	$542,149	$1,531,935
Medi-Cal: IS - Application Management, Medical Management, Milliman Care Guideline	$320,000	$321,300	$641,300
OneCare Connect: Audit & Oversight, Other Operating Expenses - Travel and Training for audits	$0	$37,600	$37,600
OneCare Connect: Office of Compliance, Professional Fees, Mock Audit and Annual Compliance Program Effectiveness Audit	$196,646	$97,000	$293,646
OneCare Connect: Community Relations, Other Operating Expenses - Food Services & Public Activities for events for senior community/members	$0	$40,000	$40,000
OneCare Connect: Sales & Marketing, Printing & Postage, Required Member Materials	$0	$32,800	$32,800
OneCare Connect: Quality Analytics, Other Operating Expenses, AWARE toolkits, Physician office after hour initiatives, Transportation initiative, Provider incentives Timely Access Study, Physician Satisfaction Survey and other related public activities	$45,700	$219,400	$265,100
OneCare Connect: Quality Analytics, Printing & Postage, Wellness campaign, Provider outreach, and other Member and Provider mailings	$140,000	$71,000	$211,000
OneCare Connect: Quality Analytics, Purchased Services, Advent Advisory Group (HEDIS Audit for OCC)	$455,000	$6,000	$461,000
OneCare Connect: Pharmacy Management, Other Operating Expenses, Training & Subscription	$15,250	$15,250	$30,500
OneCare Connect: Pharmacy Management, Printing & Postage, Required mailings for Medication Therapy Management (MTM) based on membership	$24,250	$24,250	$48,500

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	FY 2016-17 Operating Budget	Additional Funds Needed	Reforecast FY 2016-17 Budget
OneCare Connect: Pharmacy Management, Professional Fees, MTM services	$2,000	$2,000	$4,000
OneCare: Sales & Marketing, Printing & Postage, Required Member Materials	$0	$17,400	$17,400
OneCare: Quality Analytics, Other Operating Expenses, Annual Required Training	$6,210	$12,140	$18,350
OneCare: Pharmacy Management, Professional Fees, MTM services	$0	$1,000	$1,000
OneCare Connect: IS-Application Management, Purchased Services, InfoCrossing & Optuminsight	$180,911	$159,448	$340,359
OneCare Connect: IS-Application Management, Purchased Services, Burgess Reimbursement System	$36,988	$123,712	$160,700

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

Recommended Action
Receive and file the Fiscal Year (FY) 2016 CalOptima consolidated audited financial statements as submitted by Moss-Adams, LLP.

Background
At the May 19, 2016 Finance and Audit Committee (FAC) meeting, CalOptima's contracted financial auditor, Moss-Adams, LLP presented on the 2016 Audit Plan. The plan included performing the mandatory annual consolidated financial statement audit, and drafting of the consolidated financial statements for the year ending June 30, 2016.

Discussion
Moss-Adams, LLP performed the interim audit from May 23, 2016, through May 27, 2016, and the on-site audit from July 25, 2016, through August 12, 2016. The significant audit areas that Moss-Adams, LLP reviewed included:

- Internal Control;
- Capitation revenue, receivables and unearned revenue;
- Cash and cash equivalents;
- Investments; and
- Medical claims liability, capitation payable and payable to Sate of California.

CalOptima Consolidated Financial Statement Summary
The following table shows key operating indicators and CalOptima's financial position, including CalOptima Foundation, for the fiscal years ended June 30, 2016 and 2015.

Key Financial Indicators	FY 2015-16	FY 2014-15
Average member months	782,577	712,385
Operating revenues (in millions)	$3,164	$3,117
Operating expenses (in millions)		
Medical expenses	3,038	2,801
Administrative expenses	107	88
Operating Income (in millions)	$19	$228
Medical Loss Ratio	*96%*	*90%*

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Key Financial Indicators	FY 2015-16	FY 2014-15
Administrative Loss Ratio	*3%*	*3%*
Financial Position (in millions)		
Total assets and deferred outflows of resources	$2,308	$1,869
Total liabilities and deferred inflows of resources	$1,645	$1,240
Net position*	$662	$630

*Figures may not total due to rounding

FY 2016 Audit Results

Results from CalOptima's FY 2016 Audit were very positive. The auditor made no changes in CalOptima's approach to applying the critical accounting policies. They did not encounter any significant difficulties during the audit. And, there were no material misstatements identified by the auditor. As such, Management recommends the Board to accept the CalOptima Fiscal 2016 audited financial statements as presented.

Fiscal Impact

There is no fiscal impact related to this recommended action.

Concurrence

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

Attachments

1. FY 2016 CalOptima Audited Financial Statements
2. Presentation by Moss-Adams, LLP

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

09/29/2016 — **Date**

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Report of Independent Auditors
and Consolidated Financial Statements
with Supplementary Information for

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/ dba CalOptima

June 30, 2016 and 2015

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

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ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA
MANAGEMENT'S DISCUSSION AND ANALYSIS

The intent of management's discussion and analysis of CalOptima's consolidated financial performance is to provide readers with an overview of the agency's financial activities for the fiscal years ended June 30, 2016 and 2015. Readers should review this summation in conjunction with CalOptima's consolidated financial statements and accompanying notes to the consolidated financial statements to enhance their understanding of CalOptima's financial performance.

Key Operating Indicators

The table below compares key operating indicators for CalOptima for the fiscal years ended June 30, 2016, 2015 and 2014:

Key Operating Indicators	2016	2015	2014 (as restated)
Members (at end of fiscal period):			
Medi-Cal program	$ 776,713	$ 739,567	$ 603,623
OneCare	1,174	12,951	15,121
OneCare Connect	29,416	-	-
PACE	168	95	40
Average member months			
Medi-Cal program	765,938	698,718	542,487
OneCare	6,879	13,595	15,764
OneCare Connect	9,626	-	-
PACE	135	71	17
Operating revenues (in millions)	$ 3,164	$ 3,117	$ 1,908
Operating expenses (in millions)			
Medical expenses	3,038	2,801	1,638
Administrative expenses	107	88	87
Operating income (in millions)	$ 19	$ 228	$ 183
Operating revenues PMPM (per member per month)	$ 337	$ 365	$ 285
Operating expenses PMPM			
Medical expenses PMPM	323	328	244
Administative expenses PMPM	11	10	12
Opeating income (loss) PMPM	$ 3	$ 27	$ 29
Medical loss ratio	96%	90%	86%
Administrative expenses ratio	3%	3%	4%
Premium tax revenue and expenses not included above			
Operating revenues (in millions)	$ 114	$ 125	$ 102
Administrative expenses (in millions)	114	125	103

Overview of the Consolidated Financial Statements

This annual report consists of consolidated financial statements and notes to those statements, which reflect CalOptima's financial position and results of its operations for the fiscal years ended June 30, 2016 and 2015. The consolidated financial statements of CalOptima, including the consolidated statements of net position, statements of revenues, expenses and changes in net position, and statements of cash flows, represent the consolidated accounts and transactions of the five (5) programs – Medi-Cal, OneCare, OneCare Connect, Program of All-inclusive Care for the Elderly (PACE), and CalOptima Foundation.

- The consolidated statements of net position include all of CalOptima's assets, deferred outflows of resources, liabilities, and deferred inflows of resources, using the accrual basis of accounting, as well as an indication about which assets and deferred outflows of resources are utilized to fund obligations to providers and which are restricted as a matter of Board of Directors' policy.
- The consolidated statements of revenues, expenses and changes in net position present the results of operating activities during the fiscal year and the resulting increase or decrease in net position.
- The consolidated statements of cash flows report the net cash provided by or used in operating activities, as well as other sources and uses of cash from investing and capital and related financing activities.

The following discussion and analysis addresses CalOptima's overall program activities. CalOptima's Medi-Cal program accounted for 89.4 percent, 93.8 percent, and 88.7 percent of its annual revenues during fiscal years 2016, 2015, and 2014, respectively. CalOptima's OneCare accounted for 3.3 percent, 6.0 percent, and 11.2 percent of its annual revenues during fiscal years 2016, 2015, and 2014, respectively. CalOptima's new OneCare Connect program accounted for 7.0 percent of its annual revenues during fiscal year 2016. All other programs consolidated accounted for 0.3 percent, 0.4 percent, and 0.1 percent of CalOptima's annual revenues during fiscal years 2016, 2015, and 2014, respectively.

CalOptima Foundation (the Foundation) was formed as a not-for-profit benefit corporation in 2010 and is dedicated to the betterment of public health care services in Orange County. The activities of the Foundation are included in the consolidated financial statements of CalOptima.

2016 and 2015 Financial Highlights

As of June 30, 2016 and 2015, total assets and deferred outflows of resources were approximately $2,307.8 million and $1,869.5 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $662.5 million and $629.9 million, respectively.

Net position increased by approximately $32.5 million, or 5.2 percent, during fiscal year 2016 and increased by approximately $231.0 million, or 57.9 percent, during fiscal year 2015.

Table 1a: Condensed Consolidated Statements of Net Position as of June 30,

(Dollars in Thousands)

Financial Position	2016	2015	Change From 2015 Amount	Change From 2015 Percentage
Assets				
Current assets	$ 1,771,671	$ 1,350,744	$ 420,927	31.2%
Board-designated assets and restricted cash	476,146	460,449	15,697	3.4%
Capital assets, net	54,996	53,349	1,647	3.1%
Total assets	$ 2,302,813	$ 1,864,542	$ 438,271	23.5%
Deferred outflows of resources	$ 5,003	$ 4,951	$ 52	1.1%
Total assets and deferred outflows of resources	$ 2,307,816	$ 1,869,493	$ 438,323	23.4%
Liabilities				
Current liabilities	$ 1,609,330	$ 1,206,097	$ 403,233	33.4%
Other liabilities	33,864	27,861	6,003	21.5%
Total liabilities	$ 1,643,194	$ 1,233,958	$ 409,236	33.2%
Deferred inflows of resources	$ 2,155	$ 5,581	$ (3,426)	-
Net posiition				
Net investment in capital assets	$ 54,995	$ 53,349	$ 1,646	3.1%
Restricted	89,284	86,144	3,140	3.6%
Unrestricted	518,188	490,461	27,727	5.7%
Total net position	$ 662,467	$ 629,954	$ 32,513	5.2%
Total liabilities, deferred inflows of resources and net position	$ 2,307,816	$ 1,869,493	$ 438,323	23.4%

Current assets increased $420.9 million from $1,350.7 million in 2015 to $1,771.7 million in 2016. The increase in current assets is primarily due to the delay of Medi-Cal Expansion capitation rate recoupment in fiscal 2016 that resulted in increased cash and investments. Current liabilities increased $ 403.2 million from $1,206.1 million in 2015 to $1,608.9 million in 2016. Current liabilities increased in unearned revenue category from the above Medi-Cal Expansion rate changes. Moreover, additional payables to the health networks of approximately $163.1 million were recorded for shared risk payout estimate in 2016. Deferred outflows of resources – pension contributions and deferred inflows of resources – excess earnings were added since 2015 consolidated statement of net position related to GASB 68 reporting requirements. Refer to Note 6 for additional information.

2016 and 2015 Financial Highlights (continued)

Board-designated assets and restricted cash increased by $15.7 million and $305.4 million in fiscal years 2016 and 2015, respectively. The Board of Directors' policy is to augment Board-designated assets to provide a desired level of funds between 1.4 months and 2 months of capitation revenue to meet future contingencies. CalOptima reserve level as of June 30, 2016 is at 1.8 times of monthly capitation revenue. CalOptima is also required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975.

2015 and 2014 Financial Highlights

As of June 30, 2015 and 2014, total assets were $1,869.5 million and $1,036.9 million, respectively, and exceeded liabilities by $629.9 million and $398.9 million, respectively.

Net position increased by $231.0 million, or 57.9 percent, during fiscal year 2015 and increased by $187.0 million, or 88.2 percent, during fiscal year 2014.

Financial Position	2015	2014 (as restated)	Change From 2014 Amount	Change From 2014 Percentage
Assets				
Current assets	$ 1,350,744	$ 826,076	$ 524,668	63.5%
Board-designated assets and restricted cash	460,449	156,212	304,237	194.8%
Capital assets, net	53,349	51,523	1,826	3.5%
Total assets	$ 1,864,542	$ 1,033,811	$ 830,731	80.4%
Deferred outflows of resources - pension contributions	$ 4,951	$ 3,120	$ 1,831	58.7%
Total assets and deferred outflows of resources	$ 1,869,493	$ 1,036,931	$ 832,562	80.3%
Liabilities				
Current liabilities	$ 1,206,097	$ 605,702	$ 600,395	99.1%
Other liabilities	27,861	32,302	(4,441)	-13.7%
Total liabilities	$ 1,233,958	$ 638,004	$ 595,954	93.4%
Deferred inflows of resources - excess earnings	$ 5,581	$ -	$ 5,581	-
Net posiition				
Net investment in capital assets	$ 53,349	$ 51,523	$ 1,826	3.5%
Restricted	86,144	53,728	32,416	60.3%
Unrestricted	490,461	293,676	196,785	67.0%
Total net position	$ 629,954	$ 398,927	$ 231,027	57.9%
Total liabilities, deferred inflows of resources and net position	$ 1,869,493	$ 1,036,931	$ 832,562	80.3%

2015 and 2014 Financial Highlights (continued)

Current assets increased $524.7 million from $826.1 million in 2014 to $1,350.7 million in 2015. The increase in current assets is primarily due to the timing of retroactive capitation rate increases received for fiscal 2014 and capitation rate increases in 2015 that resulted in increased cash and accounts receivable. Current liabilities increased $600.4 million from $605.7 million in 2014 to $1,206.1 million in 2015. Current liabilities increased from the above retroactive rate changes received late in fiscal 2015 and population increases. Payables to the State of California of approximately $201.3 million were recorded for newly enrolled Medi-Cal Expansion members in 2015 to meet the 85 percent medical loss ratio requirement.

2016 and 2015 Results of Operations

CalOptima's fiscal year 2016 operations and nonoperating revenues resulted in a $32.5 million increase in net position, $198.5 million lower compared to a $231.0 million increase in fiscal year 2015. The following table shows the changes in revenues and expenses for 2016 compared to 2015:

Table 2a: Consolidated Revenues, Expenses and Changes in Net Position for Fiscal Years Ended June 30 (Dollars in Thousands)

Results of Operations	2016	2015	Change From 2015 Amount	Change From 2015 Percentage
Capitation revenues	$ 3,163,753	$ 3,111,945	$ 51,808	1.7%
Other income	305	5,233	(4,928)	-94.2%
Total operating revenues	3,164,058	3,117,178	46,880	1.5%
Medical expenses	3,037,911	2,801,158	236,753	8.5%
Administative expenses	107,182	88,382	18,800	21.3%
Total opeating expenses	3,145,093	2,889,540	255,553	8.8%
Operating income	18,965	227,638	(208,673)	-91.7%
Nonoperating revenues and expenses	13,548	3,389	10,159	299.8%
Increase in net position	32,513	231,027	(198,514)	-85.9%
Net position, beginning of year	629,954	398,927	231,027	57.9%
Net position, end of year	$ 662,467	$ 629,954	$ 32,513	5.2%

2016 and 2015 Operating Revenues

The increase in consolidated operating revenues of $ 46.9 million in fiscal year 2016 is attributable to additional revenue from the new IHSS benefit; and continued growth in Medi-Cal Expansion program; offset by rate reduction from DHCS for the Medi-Cal Expansion population. $40.8 million revenue was recorded for Hepatitis C drug reimbursement in fiscal year 2016.

2016 and 2015 Medical Expenses

Overall medical expenses increased by 8.5 percent in fiscal year 2016, totaling $3,037.9 million, compared to $ 2,801.2 million in fiscal year 2015. CalOptima's medical loss ratio, or medical expenses as a percentage of operating revenues, was 96.0 percent in fiscal year 2016, compared to 89.9 percent in fiscal year 2015.

Medi-Cal Provider capitation, comprising capitation payments to CalOptima's contracted health networks, increased by 9.2 percent from fiscal year 2015 to fiscal year 2016 due to an overall increase in enrollment and Affordable Care Act new rates in Medi-Cal. Capitated member enrollment accounted for approximately 80.0 percent of CalOptima's enrollment, averaging members 612,704 during fiscal year 2016, and 79.3 percent of CalOptima's enrollment, averaging 554,271 members during fiscal year 2015. Included in the capitated environment are 342,498 or 44.7 percent and 306,847, or 43.9 percent members in a Shared Risk Network for fiscal years 2016 and 2015, respectively. Shared Risk Networks receive capitation for professional services and are claim-based for hospital services.

The overall Medi-Cal capitation payments totaled $935.4 million in fiscal year 2016, compared to $856.4 million in fiscal year 2015, which reflects the increased enrollment in capitated networks.

Medi-Cal Claim payments to providers and facilities, including LTC facilities increased by 10.7 percent from fiscal year 2015 to fiscal year 2016. This increase is mainly attributable to new IHSS benefits starting July 1, 2015.

Pharmacy costs increased by 30.3 percent in fiscal year 2016, compared to fiscal year 2015. Results from fiscal year 2016 reflect higher enrollment.

Other medical expenses decreased by $187.1 million during fiscal year 2016. This was mainly attributable to less contingency payables to the State to meet the 85 percent medical loss ratio in fiscal year 2016, compared to fiscal year 2015.

CalOptima did not recognize a premium deficiency reserve in fiscal years 2016 and 2015.

2016 and 2015 Administrative Expenses

Total administrative expenses were $107.2 million in 2016. Overall administrative expenses increased by 21.2 percent, due to additional administrative expenses related to higher enrollment and new program implementation costs related to OneCare Connect program. During fiscal years 2016 and 2015, respectively, CalOptima's administrative expenses were 3.4 percent and 2.8 percent of operating revenues.

2015 and 2014 Results of Operations

CalOptima's fiscal year 2015 operations and nonoperating revenues results in a $231.0 million increase in net position, compared to a $187.0 million increase in fiscal year 2014. The following table shows the changes in revenues and expenses for 2015 compared to 2014:

Table 2b: Consolidated Revenues, Expenses and Changes in Net Position for Fiscal Years Ended June 30
(Dollars in Thousands)

Results of Operations	2015	2014 (as restated)	Change From 2014 Amount	Change From 2014 Percentage
Capitation revenues	$ 3,111,945	$ 1,899,208	$ 1,212,737	63.9%
Other income	5,233	8,672	(3,439)	-39.7%
Total operating revenues	3,117,178	1,907,880	1,209,298	63.4%
Medical expenses	2,801,158	1,638,183	1,162,975	71.0%
Administative expenses	88,382	86,782	1,600	1.8%
Total opeating expenses	2,889,540	1,724,965	1,164,575	67.5%
Operating income	227,638	182,915	44,723	24.5%
Nonoperating revenues and expenses	3,389	4,080	(691)	-16.9%
Increase in net position	231,027	186,995	44,032	23.5%
Net position, beginning of year	398,927	211,932	186,995	88.2%
Net position, end of year	$ 629,954	$ 398,927	$ 231,027	57.9%

2015 and 2014 Operating Revenues

The increase in consolidated operating revenues of $1,209.3 million in fiscal year 2015 is attributable to the new Medi-Cal Expansion program that started January 1, 2014; $42.0 million retroactive capitation rate amendment received in fiscal year 2015 for prior years.

2015 and 2014 Medical Expenses

Overall medical expenses increased by 71.0 percent in fiscal year 2015, totaling $2,801.2 million, compared to $1,638.2 million in fiscal year 2014. CalOptima's medical loss ratio, or medical expenses as a percentage of operating revenues, was 89.9 percent in fiscal year 2015, compared to 86.0 percent in fiscal year 2014.

2015 and 2014 Medical Expenses (continued)

Medi-Cal Provider capitation increased by 141.4 percent from fiscal year 2014 to fiscal year 2015 due to an overall increase in enrollment and Affordable Care Act new rates in Medi-Cal. Capitated member enrollment accounted for approximately 79.3 percent of CalOptima's enrollment, averaging 554,271 members during fiscal year 2015, and 83.1 percent of CalOptima's enrollment, averaging 388,724 members during fiscal year 2014. The overall capitation payments totaled 856.4 million in fiscal year 2015, compared to $381.9 million in fiscal year 2014, which reflects the increased enrollment and higher capitation rates for Medi-Cal Expansion members.

Claim payments to providers and facilities increased by 61.1 percent from fiscal year 2014 to fiscal year 2015. Similar to provider capitation expenses, this increase is due to higher overall enrollment and the launch of the new Medi-Cal Expansion program starting Jan 1, 2014

In addition to the above Medi-Cal revenues and claims payment in fiscal year 2015, Quality Assurance Fee (QAF) payments received and passed through to hospitals were $ 107.3 million and $48.4 million during fiscal years 2014 and 2015, respectively. These receipts and payments are not included in the consolidated statements of revenues, expenses and changes in net position.

Pharmacy costs increased by 48.6 percent in fiscal year 2015, compared to fiscal year 2014. Results from fiscal year 2015 reflect new Hepatitis C drugs introduced to the market this year.

Other medical expenses increased by $232.4 million during fiscal year 2015. This was mainly attributable to contingency payables to the State to meet 85 percent medical loss ratio for Medi-Cal Expansion members. Moreover, additional medical costs directly related to enrollment increase, such as reinsurance and other high cost items. Also, additional labor and G&A costs had been incurred in fiscal year 2015 to manage the higher membership, which impacted medical management expenses.

CalOptima did not recognize a premium deficiency in fiscal years 2015 and 2014.

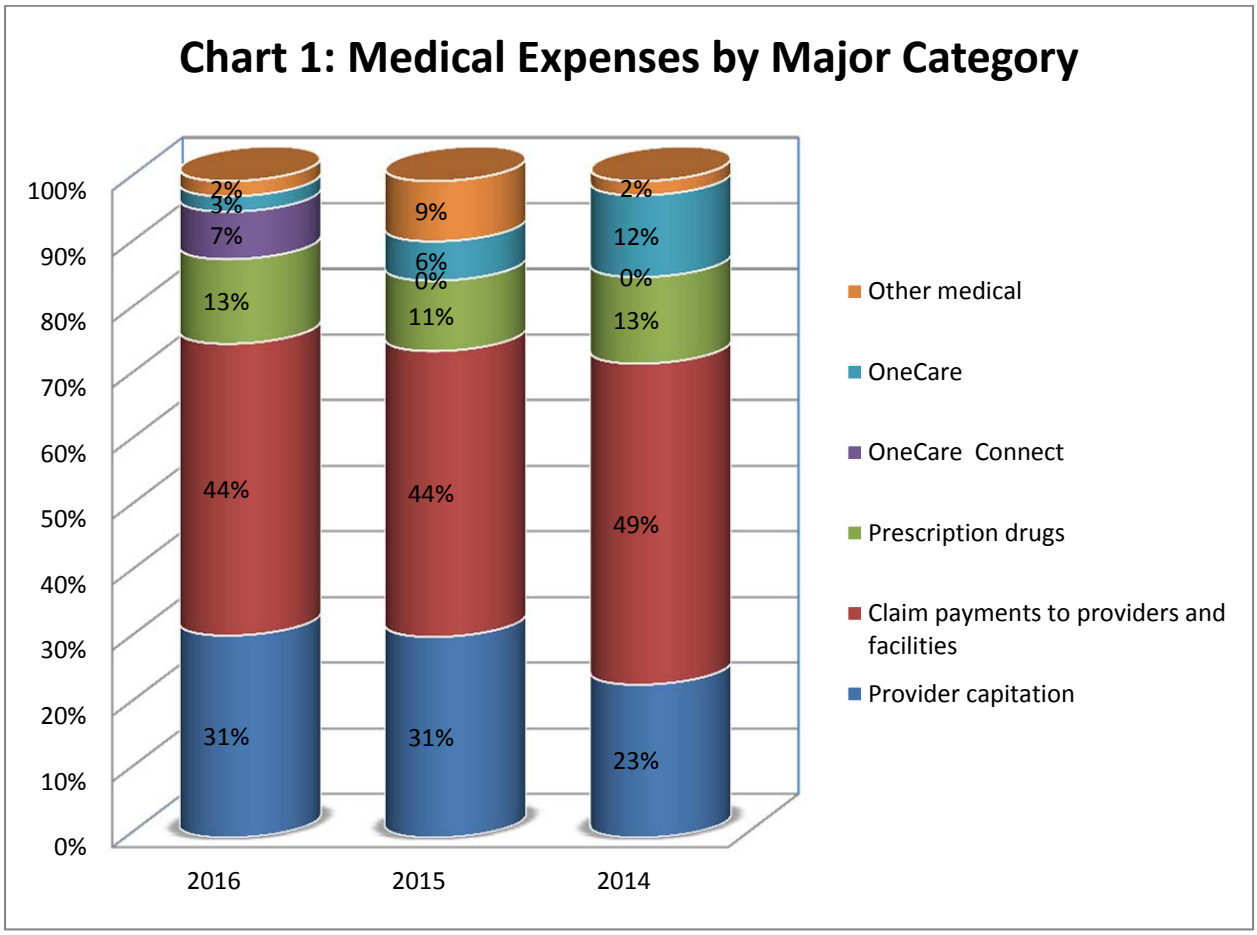
2015 and 2014 Administrative Expenses

Total administrative expenses were $88.4 million in 2015, compared to $86.8 million in 2014, for a net decrease of $1.6 million, or 1.8 percent. During fiscal years 2015 and 2014, respectively, Cal Optima's administrative expenses were 2.8 percent and 4.2 percent of operating revenues, respectively.

During fiscal year 2015, CalOptima had passed the audit from Centers for Medicare & Medicaid Services (CMS) and the medical review from California Department of Health Care Services (DHCS). CMS sanction had been lifted during fiscal year 2015. Other than administrative expenses, CMS and DHCS findings had no other financial impact in fiscal year 2015.

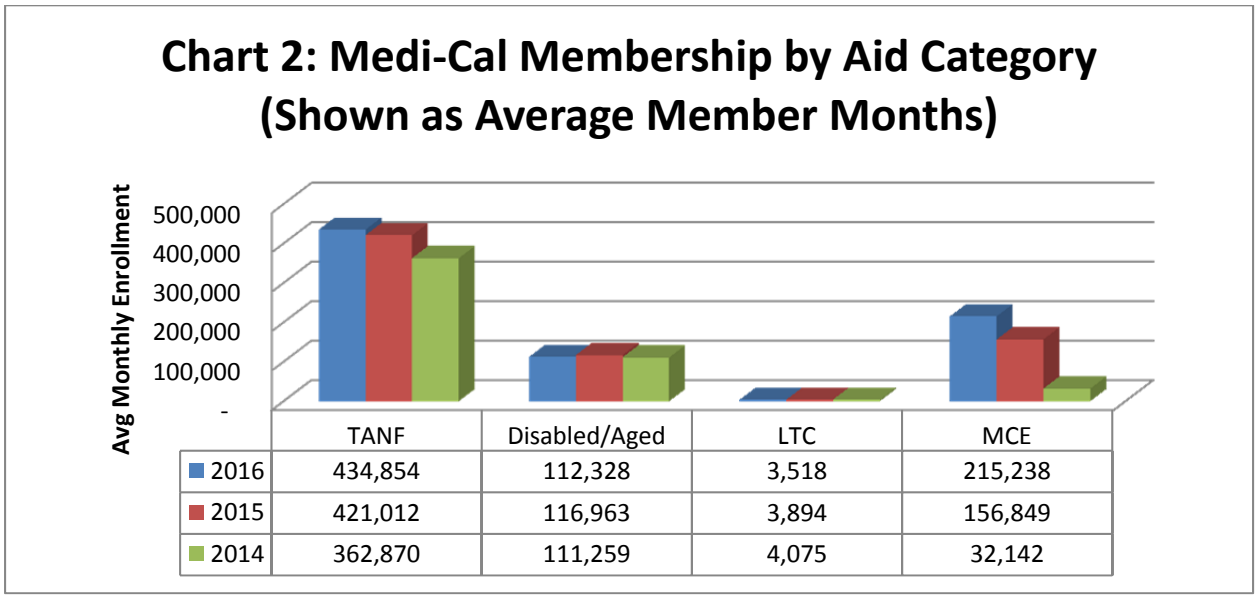
2016, 2015 and 2014 Medical Expenses by Major Category

Below is a comparison chart of medical expenses by major category and their respective percentages of the overall medical expenditures by fiscal year.



2016, 2015 and 2014 Enrollment

During fiscal year 2016, CalOptima served an average of 765,938 Medi-Cal members per month compared to an average of 698,718 members per month in 2015, and 510,345 members per month in 2014. The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2016, 2015, and 2014:



	TANF	Disabled/Aged	LTC	MCE
2016	434,854	112,328	3,518	215,238
2015	421,012	116,963	3,894	156,849
2014	362,870	111,259	4,075	32,142

Significant aid categories are defines as follows:

Temporary Assistance to Needy Families (TANF) includes families, children and poverty-level members who qualify for the TANF federal welfare program, which provides cash aid and job-search assistance to poor families. TANF also includes members who migrated from CalOptima, Health Net and Kaiser Healthy Family programs.

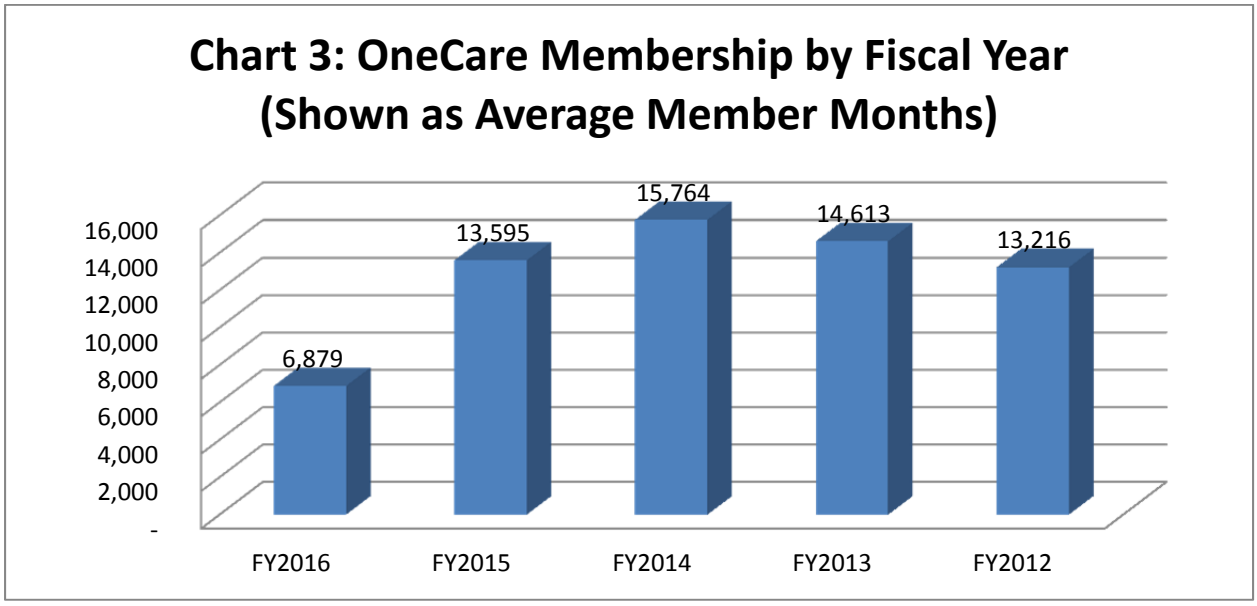
Disabled and Aged includes individuals who have met the criteria for disability set by the Social Security Administration, and individuals of 65 years of age and older who receive supplemental security income (SSI) checks, or are medically needy, or have an income of 100 percent or less of the federal poverty level.

Long Term Care (LTC) includes frail elderly, nonelderly adults with disabilities and children with developmental disabilities and other disabling conditions requiring long-term care services.

Medi-Cal Expansion program (MCX and MSI) includes adults without children, ages 19-64, qualified based upon income, as required by the Patient Protection and Affordable Care Act (ACA).

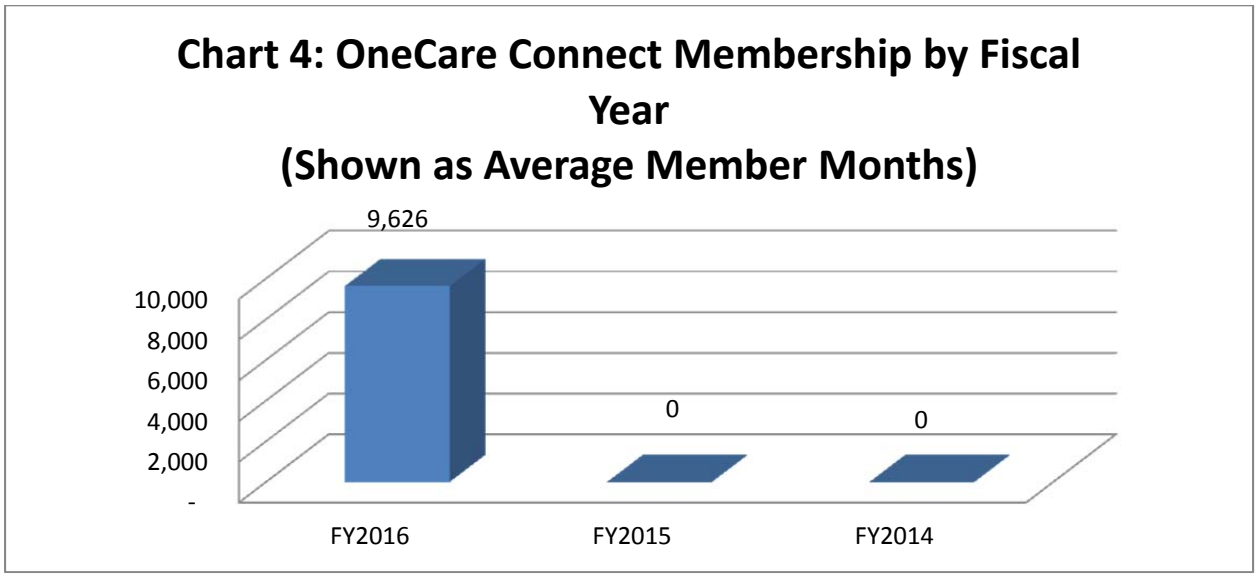
2016, 2015 and 2014 Enrollment (continued)

OneCare was introduced in fiscal year 2006 to service the unique Medicare Advantage Special Needs Plan. It provides a full range of health care services to average member months of 6,879, 13,595, and 15,764 for the years ended June 30, 2016, 2015, and 2014, respectively. Members are eligible for both the Medicare and Medi-Cal programs. The membership decrease in 2016 was primarily due to more than 10,000 OneCare members transitioned to CalOptima's new OneCare Connect program on January 1, 2016. The chart below displays the average member months for the past five years.



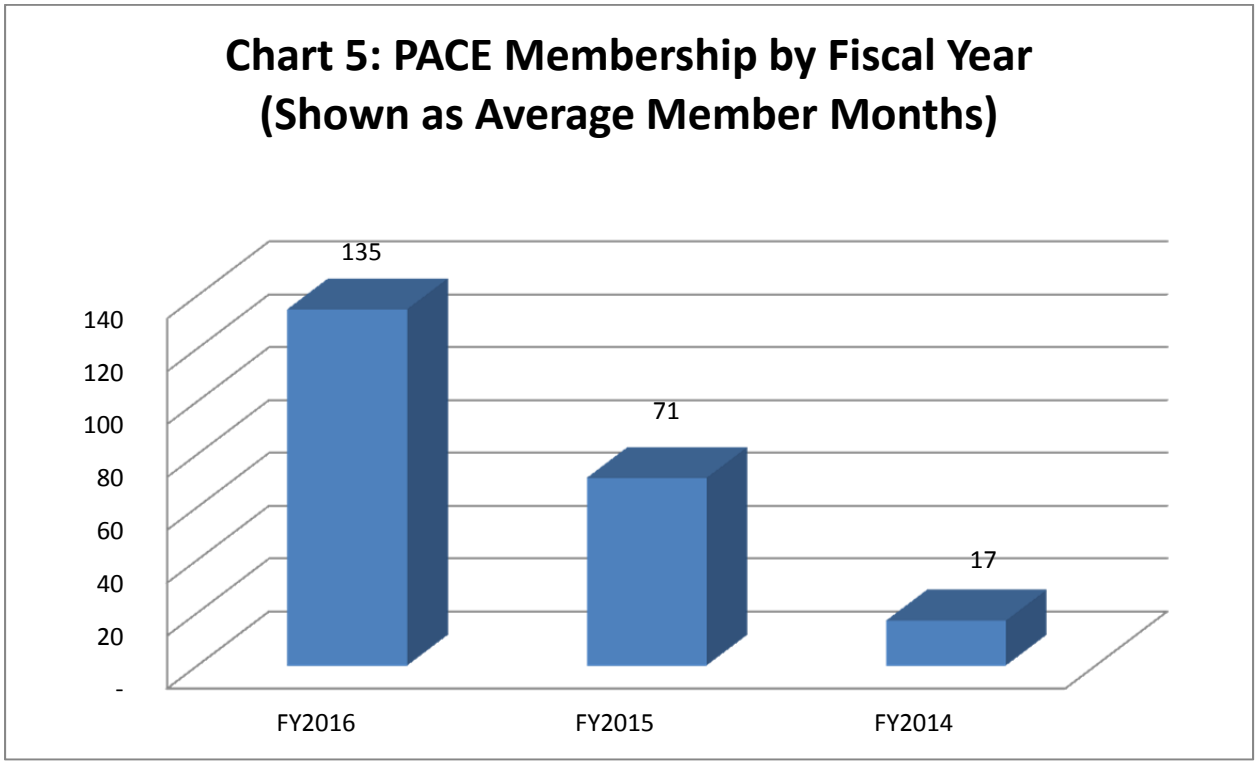
2016, 2015 and 2014 Enrollment (continued)

CalOptima launched OneCare Connect (OCC) program to serve dual eligible members in Orange County on July 1, 2015. This new program combines members' Medicare and Medi-Cal coverage and adds other benefits and supports. Average member month was 9,626 in fiscal year 2016. The chart below displays the average member months for the current fiscal year.



2016, 2015 and 2014 Enrollment (continued)

PACE (Program of All-Inclusive Care for the Elderly) started operation in October 2013. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community. It provides a full range of health care services to average member months of 135, 71, and 17 for the years ended June 30, 2016, 2015, and 2014, respectively. The chart below displays the average member months for the past three years.



Economic Factors and the State's Fiscal Year 2017 Budget

On June 27, 2016, Governor Jerry Brown signed the state's FY2016-17 budget into law. The budget is consistent with his overall focus on ensuring the state is prepared for a potential economic slowdown. The budget transfers $2 billion more than the required amount into the State's Rainy Day Fund and pays down some existing debts and liabilities. As a reflection of the State's current financial health, the budget increases funding for education and programs that address homelessness and poverty.

Related to health care, Medi-Cal spending has increased marginally to account for additional items included in the budget, such as the limitation of Medi-Cal estate recovery and the restoration of acupuncture as a Medi-Cal benefit.

The Governor's FY2016-17 State Budget assumes a $122.6 billion General Fund, representing a 5.6% increase over the 2015-16 General Fund. The budget proposes a $19.6 billion expenditure for the Medi-Cal program, representing an 8% increase over last fiscal year. The two main factors contributing to the increase in Medi-Cal funding include the State's anticipated increase in Medi-Cal enrollment and the State's obligation for the $3.5 million Medi-Cal Expansion (MCE) members. In accordance with the Affordable Care Act, in which the Federal government fully funded the MCE cost obligation for the first three years of implementation, the State would incur this obligation beginning in 2017. The State estimates its cost share burden at $740 million.

Requests for Information

This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of CalOptima's operations. If the reader has questions or would like additional information about CalOptima Foundation, please direct the requests to CalOptima, 505 City Parkway West, Orange, CA 92868 or call 714.347.3237.

REPORT OF INDEPENDENT AUDITORS

The Board of Directors
Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Report on Financial Statements

We have audited the accompanying consolidated financial statements of Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") (a discrete component unit of the County of Orange, California), as of and for the years ended June 30, 2016 and 2015, and the related notes to the consolidated financial statements, which collectively comprise CalOptima's basic consolidated financial statements, as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

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We believe that the audit evidence obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CalOptima as of June 30, 2016 and 2015, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis, schedules of changes in net pension liability and related ratios, schedule of plan contributions, and schedule of funding progress for the postemployment health-care plan, as listed in the table of contents, be presented to supplement the basic consolidated financial statements. Such information, although not a part of the basic consolidated financial statements, is required by the Governmental Accounting Standards Board, which considers it to be an essential part of financial reporting for placing the basic consolidated financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods or preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic consolidated financial statements, and other knowledge we obtained during our audit of the basic consolidated financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Information

Our audit was conducted for the purpose of forming an opinion on the consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards as required by Title 2 U.S. *Code of Federal Regulations (CFR)* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* is presented for purpose of additional analysis and is not a required part of the basic consolidated financial statements. The supplementary information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic consolidated financial statements or to the basic consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In

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our opinion, the information is fairly stated, in all material respects, in relation to the basic consolidated financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated September 16, 2016 on our consideration of the CalOptima's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering CalOptima's internal control over financial reporting and compliance.

Moss Adams LLP

Irvine, California
September 16, 2016

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA
CONSOLIDATED STATEMENTS OF NET POSITION

	JUNE 30, 2016	JUNE 30, 2015
Current Assets		
Cash and cash equivalents	$ 258,846,237	$ 25,430,975
Investments	1,019,264,632	745,792,608
Capitation receivable from the State of California	470,263,571	559,110,130
Prepaid expenses and other	23,296,446	20,410,563
Total current assets	1,771,670,886	1,350,744,276
Board-Designated Assets and Restricted Cash		
Cash and cash equivalents	10,132,014	866,365
Investments	465,713,886	459,282,739
Restricted deposit	300,000	300,000
	476,145,900	460,449,104
Capital Assets, net	54,995,566	53,349,391
Total assets	2,302,812,352	1,864,542,771
Deferred Outflows of Resources	5,003,017	4,950,911
Total assets and deferred outflows of resources	$ 2,307,815,369	$ 1,869,493,682

See accompanying notes.

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ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA
CONSOLIDATED STATEMENTS OF NET POSITION (CONTINUED)

	JUNE 30, 2016	JUNE 30, 2015
Current Liabilities		
Medical claims liability and capitation payable		
Medical claims liability	$ 593,810,057	$ 640,921,119
Capitation and withholds	401,826,300	290,632,911
Accrued insurance costs	4,884,800	29,412,181
Payable to State of California and the Centers for Medicare & Medicaid Services (CMS)	179,113	17,705,126
Unearned revenue	586,185,868	207,946,164
	1,586,886,138	1,186,617,501
Accounts payable and other	10,606,638	10,247,107
Accrued payroll and employee benefits and other	11,837,190	9,232,081
Total current liabilities	1,609,329,966	1,206,096,689
Postemployment health-care plan	27,327,000	26,802,492
Net pension liability	6,536,809	1,059,495
Total Liabilities	1,643,193,775	1,233,958,676
Deferred Inflows of Resources	2,154,540	5,580,552
Net position		
Net investment in capital assets, net of related debt	54,995,566	53,349,391
Restricted - required tangible net equity and restricted deposit	89,283,747	86,144,291
Unrestricted	518,187,741	490,460,772
Total net position	662,467,054	629,954,454
Total liabilities, deferred inflows of resources and net position	$ 2,307,815,369	$ 1,869,493,682

See accompanying notes.
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ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA

CONSOLIDATED STATEMENTS OF REVENUES, EXPENSES AND CHANGE IN NET POSITION

	YEARS ENDED JUNE 30,	
	2016	2015
REVENUES:		
Capitation revenues	$ 3,163,753,022	$ 3,111,945,148
Other income	304,591	5,232,786
Total operating revenues	3,164,057,613	3,117,177,934
OPERATING EXPENSES:		
Medical expenses		
Provider capitation	935,360,536	856,409,999
Claim payments to providers and facilities	1,349,950,877	1,219,710,161
Prescription drugs	391,480,137	300,408,516
OneCare	86,724,744	167,697,672
OneCare Connect	205,122,734	-
Other medical	69,272,018	256,931,809
Total medical expenses	3,037,911,046	2,801,158,157
Administrative expenses		
Salaries, wages and employee benefits	64,666,948	54,367,612
Professional fees	4,368,357	4,688,952
Purchased services	10,032,627	6,943,850
Supplies, occupancy, insurance and other	24,972,237	19,266,874
Depreciation	3,142,262	3,114,714
Total administrative expenses	107,182,431	88,382,002
Total operating expenses	3,145,093,477	2,889,540,159
OPERATING INCOME	18,964,136	227,637,775
NON-OPERATING REVENUES (EXPENSES):		
Investment income	13,880,954	3,255,038
Rental income, net of related expenses	(332,490)	134,078
Total non-operating revenues and expenses	13,548,464	3,389,116
Increase in net position	32,512,600	231,026,891
Net position, beginning of year	629,954,454	398,927,563
Net position, end of year	$ 662,467,054	$ 629,954,454

See accompanying notes.

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ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA
CONSOLIDATED STATEMENTS OF CASH FLOWS

	2016	2015
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation payments received and other	$ 3,631,143,876	$ 3,224,316,944
Payment to providers and facilities	(3,015,522,582)	(2,388,753,456)
Payments to vendors	(42,259,104)	(35,492,101)
Payments of premium tax	-	-
Payments to employees	(59,538,135)	(53,928,304)
Net cash provided by operating activities	513,824,055	746,143,083
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(4,788,437)	(4,940,747)
Net cash used in capital and related financing activities	(4,788,437)	(4,940,747)
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment income received	10,003,777	25,380,546
Purchases of securities	(435,633,131)	(7,998,645,037)
Sales of securities	150,008,998	7,203,413,969
Net cash used in investing activities	(275,620,356)	(769,850,522)
Net increase (decrease) in cash and cash equivalents	233,415,262	(28,648,186)
CASH AND CASH EQUIVALENTS, beginning of year	25,430,975	54,079,161
CASH AND CASH EQUIVALENTS, end of year	$ 258,846,237	$ 25,430,975
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 18,964,136	$ 227,637,775
ADJUSTMENT TO RECONCILE OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Depreciation	3,142,262	3,114,714
Changes in assets and liabilities		
Capitation receivable from the State of California	88,846,559	(79,721,547)
Prepaid expenses and other assets	(2,885,883)	(4,592,425)
Medical claims liability	(47,111,062)	326,157,461
Payable to the State of California and CMS	(17,526,013)	(67,599,283)
Unearned revenue	378,239,704	186,860,557
Capitation and withholds	111,193,389	198,481,000
Accounts payable and other	359,531	(71,647,765)
Accrued payroll and employee benefits and other	2,605,109	1,129,797
Accrued insurance costs	(24,527,381)	27,013,288
Postemployment health-care plan	524,508	2,002,604
Net pension obligation	1,999,196	(2,693,093)
Net cash provided by operating activities	$ 513,824,055	$ 746,143,083
SUPPLEMENTAL SCHEDULE OF NON-CASH OPERATING AND INVESTING ACTIVITIES		
Change in unrealized appreciation on investments	$ 3,007,940	$ 170,914

See accompanying notes.

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Note 1 – Organization

Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") is a county-organized health system ("COHS") serving primarily Medi-Cal beneficiaries in Orange County, California. Pursuant to the California Welfare and Institutions Code, CalOptima was formed by the Orange County Board of Supervisors as a public/private partnership through the adoption of Ordinance NO. 3896 in August 1992. The agency began operations in October 1995.

As a COHS, CalOptima maintains an exclusive contract with the State of California Department of Health Care Services ("DHCS") to arrange for the provision of health-care services to Orange County's approximately 777,000 and 740,000 Medi-Cal beneficiaries for the years ended June 30, 2016 and 2015, respectively. CalOptima also offers OneCare, a Medicare Advantage Special Needs Plan, via a contract with the Centers for Medicare, and Medicaid Services ("CMS"). In January 2016, CalOptima began transferring subscribers from OneCare to the OneCare Connect Cal MediConnect Plan. OneCare serves approximately 1,000 and 13,000 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2016 and 2015, respectively. In January 2016, CalOptima began offering OneCare Connect Cal MediConnect Plan ("OCC"), a Medicare-Medicaid Plan, via a contract with CMS. OCC serves approximately 29,000 members eligible for both Medicare and Medi-Cal for the year ended June 30, 2016. CalOptima also contracts with the California Department of Aging to provide case management of social and health-care services to approximately 500 Medi-Cal eligible seniors under California's Multipurpose Senior Services program. The Program of All-inclusive Care for the Elderly ("PACE") provides services to 55 years of age or older members who reside in the PACE service area and meet California nursing facility level of care requirements. The program receives Medicare and Medi-Cal funding.

CalOptima in turn subcontracts the delivery of health-care services through health maintenance organizations and provider-sponsored organizations, known as Physician/Hospital Consortia, and Shared Risk Groups. Additionally, CalOptima has direct contracts with hospitals and providers for its fee-for service network.

CalOptima is licensed by the State of California as Health Care Service Plans pursuant to the Knox-Keene Health Care Services Act of 1975 (the "Act"), as amended. As such, CalOptima is subject to the regulatory requirements of the Department of Managed Health Care under Section 1300, Title 28 of the California Administrative Code, including minimum requirements of Tangible Net Equity, which CalOptima exceeded as of June 30, 2016 and 2015.

CalOptima Foundation (the "Foundation") was formed as a not-for-profit benefit corporation in 2010 and is dedicated to the betterment of public health-care services in Orange County.

Note 2 – Summary of Significant Accounting Policies

Basis of presentation – CalOptima is a county-organized health system governed by an 11-member Board of Directors appointed by the Orange County Board of Supervisors. The CalOptima Board of Directors also serves as the Board of Directors of the Foundation. Effective for the fiscal year ended June 30, 2014, CalOptima began reporting as a discrete component unit of the County of Orange, California. The County made this determination based on the County Board of Supervisors having the right to elect 100 percent of the CalOptima Board of Directors.

Principle of consolidation – The consolidated financial statements include the accounts of CalOptima and the Foundation (collectively referred to herein as the "Organization").

Basis of accounting – CalOptima uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. The accompanying consolidated financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board ("GASB").

Use of estimates – The preparation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and cash equivalents – The Organization considers all highly liquid investments with original maturities of three months or less to be cash and cash equivalents.

Investments – Investments are stated at fair value in accordance with GASB Codification Section 150. The fair value of investments is estimated based on quoted market prices, when available. For debt securities not actively traded, fair values are estimated using values obtained from external pricing services or are estimated by discounting the expected future cash flows, using current market rates applicable to the coupon rate, credit and maturity of the investments.

All investments with an original maturity of one year or less when purchased are recorded as current investments, unless designated or restricted.

Board-designated assets and restricted cash – CalOptima's Board of Directors designated the establishment of certain reserve funds for contingencies. According to policy, the desired level for these funds is between 1.4 months and 2 months of capitation revenues. CalOptima is required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975 (see Note 9).

Note 2 – Summary of Significant Accounting Policies (continued)

Capital assets – Capital assets are stated at cost at the date of acquisition. The costs of normal maintenance, repairs and minor replacements are charged to expense when incurred.

Depreciation and amortization are calculated using the straight-line method over the estimated useful lives of the assets. Long-lived assets are periodically reviewed for impairment. The following estimated useful lives are used:

	Years
Furniture	5 years
Vehicles	5 years
Computers and software	3 years
Leasehold improvements	15 years or life of lease, whichever is less
Building	40 years
Building components	10 to 30 years
Land improvements	8 to 25 years
Tenant improvements	7 years or life oflease, whichever is less

Fair value of financial instruments – The consolidated financial statements include financial instruments for which the fair market value may differ from amounts reflected on a historical basis. Financial instruments of the Organization consist of cash deposits, investments, capitation receivable, accounts payable, and certain accrued liabilities. The Organization's other financial instruments generally approximate fair market value based on the relatively short period of time between origination of the instruments and their expected realization.

Medical claims liability and expenses – CalOptima establishes a claims liability based on estimates of the ultimate cost of claims in process and a provision for incurred but not yet reported ("IBNR") claims, which is actuarially determined based on historical claim payment experience and other statistics. Such estimates are continually monitored and analyzed with any adjustments made as necessary in the period the adjustment is determined. CalOptima retains an outside actuary to perform an annual review of the actuarial projections. Amounts for claims payment incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled.

Note 2 – Summary of Significant Accounting Policies (continued)

Effective with the enrollment of the Medi-Cal Expansion Population per the Affordable Care Act ("ACA") CalOptima is subject to DHCS requirements to meet the minimum 85% medical loss ratio for this population. Specifically, CalOptima will be required to expend at least 85% of the Medi-Cal capitation revenue received for this population on allowable medical expenses as defined by DHCS. In the event CalOptima expends less than the 85% requirement, CalOptima will be required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. Approximately $15,493,000 and $201,290,000 for the years ended June 30, 2016 and 2015, respectively, is included in other medical expenses in the consolidated statements of revenues, expenses, and changes in net position to meet the 85% requirement. As of June 30, 2016 and 2015, approximately $299,654,000 and $284,160,000, respectively, were accrued. This liability is presented in the Medical Claims Liability line item in the accompanying consolidated statements of net position.

Capitation and withholds – CalOptima has provider services agreements with several health networks in Orange County, whereby the health networks provide care directly to covered members or through subcontracts with other health-care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network. CalOptima withholds amounts from providers at an agreed upon percentage of capitation payments made to ensure the financial solvency of each contract. CalOptima also records a liability related to quality incentive payments and risk-share provisions. The quality incentive liability is estimated based on member months and rates agreed upon by the Board of Directors. For the risk-share provision liability, management allocates surplus or deficits, multiplied by a contractual rate, with the shared-risk groups. Estimated amounts due to health networks pertaining to risk-share provisions are approximately $359,800,000 and $196,700,000 as of June 30, 2016 and 2015, respectively. During the years ended June 30, 2016 and 2015, CalOptima incurred approximately $973,118,000 and $921,933,000, respectively, of capitation expense relating to health-care services provided by health networks. The Capitation expense is included in the provider capitation and OneCare line items in the consolidated statements of revenues, expenses and changes in net position. Estimated amounts due to health networks as of June 30, 2016 and 2015, related to the capitation withhold arrangements, quality incentive payments, and risk-share provisions are approximately $401,823,000 and $290,633,000, respectively.

Premium deficiency reserves – CalOptima performs periodic analyses of its expected future health care costs and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is accrued. Investment income is not included in the calculation to estimate premium deficiency reserves. CalOptima's management determined that no premium deficiency reserves were necessary as of June 30, 2016 and 2015.

Note 2 – Summary of Significant Accounting Policies (continued)

Accrued compensated absences – CalOptima's policy permits employees who are regularly scheduled to work more than 20 hours per week to accrue 18 days of paid time off (PTO) (23 days for exempt employees) based on their years of continuous service, with an additional week of accrual after three years of service and another after 10 years of service. Unused PTO may be carried over into subsequent years, not to exceed two and a half times the annual accrual. If an employee reaches his/her PTO maximum accrual, a portion of the accrued PTO equal to half of the employees' annual PTO accruals will be automatically paid out to the employees. Accumulated PTO will be paid to the employees upon separation from service with CalOptima. All compensated absences are accrued and recorded in accordance with GASB Codification Section C60, and are included in accrued payroll and employee benefits.

Net position – Net position is reported in three categories, defined as follows:

- **Net investment in capital assets** – This component of net position consists of capital assets, including restricted capital assets, net of accumulated depreciation, and is reduced by the outstanding balances of any bonds, notes or other borrowings that are attributable (if any) to the acquisition, construction or improvement of those assets.

- **Restricted** – This component of net position consists of external constraints placed on net asset use by creditors (such as through debt covenants), grantors, contributors, or the law or regulations of other governments. It also pertains to constraints imposed by law or constitutional provisions or enabling legislation (see also Note 9).

- **Unrestricted** – This component of net position consists of net position that does not meet the definition of "restricted" or "net investment in capital assets, net of related debt."

- **Restricted resources** – When CalOptima has both restricted an unrestricted resources available to finance a particular program, it is CalOptima's policy to use restricted resources before unrestricted resources.

Operating revenues and expenses – CalOptima's consolidated statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with arranging for the provision of health-care services. Operating expenses are all expenses incurred to arrange for the provision of health-care services as well as the costs of administration. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in operating expenses. Non-exchange revenues and expenses are reported as nonoperating revenues and expenses.

Note 2 – Summary of Significant Accounting Policies (continued)

Revenue recognition and receivable from the State of California and CMS – Capitation revenue is recognized in the period the members are eligible to receive healthcare services. Capitation revenue is generally received from the State of California (the "State") each month following the month of coverage based on estimated enrollment and capitation rates as provided for in the State contract. As such, capitation revenue includes an estimate for amounts receivable from or refundable to the State for these retrospective adjustments. These estimates are continually monitored and analyzed, with any adjustments recognized in the period when determined. OneCare capitation revenue is generally received from CMS each month for the month of coverage. Premiums received in advance are recorded in unearned revenue on the consolidated statements of net position. CalOptima recognized a decrease to capitation revenue in the amount of approximately $1,000,000 and an increase of approximately $42,000,000 related to retroactive capitation rate adjustments during the years ended June 30, 2016 and 2015, respectively.

Capitation revenue and related net receivables as a percent of the totals were as follows:

	Years Ended June 30,			
	2016		2015	
Revenue	Revenue	%	Revenue	%
Medi-Cal	$ 2,829,513,864	89.4%	$ 2,918,762,758	93.8%
OneCare	104,201,695	3.3%	188,307,271	6.1%
OneCare Connect	220,185,400	7.0%	-	0.0%
PACE	9,852,063	0.3%	4,875,119	0.1%
	$ 3,163,753,022	100.0%	$ 3,111,945,148	100.0%

	As of June 30,			
	2016		2015	
Receivables	Receivables	%	Receivables	%
Medi-Cal	$ 447,869,626	95.2%	$ 555,594,348	99.4%
OneCare	-	0.0%	1,923,428	0.3%
OneCare Connect	21,241,317	0.0%	-	0.0%
PACE	1,152,628	0.2%	1,592,354	0.3%
	$ 470,263,571	100.0%	$ 559,110,130	100.0%

Administrative services contract – CalOptima previously contracted with a specialty managed mental health-care organization to arrange, coordinate and manage mental health outpatient services for its Mental Health Program. Revenue was recognized based on contractual terms, which could not exceed a prescribed budgeted administrative rate. The contract ended June 30, 2015. Revenue of approximately $4,984,000 is included in other income during the year ended June 30, 2015. Medical expenses of approximately $4,679,000 is included in other medical for the year ended June30, 2015.

Note 2 – Summary of Significant Accounting Policies (continued)

Intergovernmental transfer – CalOptima entered into an agreement with DHCS and the University of California, Irvine ("UCI") to receive an intergovernmental transfer ("IGT") through a capitation rate increase of approximately $30,457,000 and $25,200,000 during the years ended June 30, 2016 and 2015, respectively. Under the agreement, approximately $23,500,000 of the funds that were received from the IGT passed through to UCI. Under GASB, the amounts that will be passed through to UCI are not reported in the consolidated statements of revenues, expenses, and changes in net position or the consolidated statements of net position. CalOptima accounts for the IGT transfer for CalOptima purposes as an exchange transaction requiring funds to be expended prior to revenue recognition. The funds were not yet expended for the required purpose during the years ended June 30, 2016 or 2015 as the revenue recognition criteria had not been met. CalOptima retains a portion of the IGT, which must be used to enhance provider reimbursement rates and strengthen the delivery system. A retainer in the amount of approximately $6,996,000 and $4,881,000 as of June 30, 2016 and 2015, respectively, is included in unearned revenues in the consolidated statements of net position.

Medicare Part D – CalOptima covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments CalOptima receives monthly from CMS and members, which are determined from its annual bid, represent amounts for providing prescription drug insurance coverage. CalOptima recognizes premiums for providing this insurance coverage ratably over the term of its annual contract. CalOptima's CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies, as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which CalOptima is not at risk.

The risk corridor provisions compare costs targeted in CalOptima's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to CalOptima or require CalOptima to refund to CMS a portion of the premiums CalOptima received. The Company estimates and recognizes an adjustment to premiums revenue related to these risk corridor provisions based upon pharmacy claims experience to date as if the annual contract were to terminate at the end of the reporting period. Accordingly, this estimate provides no consideration to future pharmacy claims experience. CalOptima records a receivable or payable at the contract level and classifies the amount as current or long-term in the accompanying consolidated statements of net position based on the timing of expected settlement.

Grant revenue recognition – The Foundation recognized approximately $653,323 and $484,761 in grant revenues during the years ended June 30, 2016 and 2015, respectively. Grant revenue is recognized when all eligibility requirements are met, and is included in other income in the consolidated statements of revenues, expenses, and changes in net position.

Note 2 – Summary of Significant Accounting Policies (continued)

Income taxes – CalOptima operates under the purview of the Internal Revenue Code, Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, CalOptima is not subject to federal or state taxes on related income. The Foundation is operated as a tax-exempt organization under Section 501(c)(3) of the federal Internal Revenue Code and applicable sections of the California statutes. Accordingly, no provision for income tax has been recorded in the accompanying consolidated financial statements.

Premium taxes – California passed Senate Bill 78 *Public health: Medi-Cal managed care plan taxes* (SB 78) pursuant of Section 1 Article V of the Revenue and Taxation Code. Effective July 1, 2013, SB 78 levies a tax on all sellers of Medi-Cal managed care plans for the privilege of selling Medi-Cal health care services at retail at a rate of 3.94 percent of gross receipts. CalOptima recognized premium tax expense of $113,654,434 and $124,649,170 in the consolidated statements of revenue, expenses, and change in net position for the years ended June 30, 2016 and 2015, respectively.

Pensions – For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions, and pension expense, information about the fiduciary net position of CalOptima's California Public Employees' Retirement System Plan (the "CalPERS Plan") and additions to/deductions from the Plan's fiduciary net position have been determined on the same basis as they are reported by CalPERS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Reclassifications – Certain accounts in the prior-year financial statements have been reclassified for comparative purposes to conform with the presentation in the current-year financial statements.

Recent accounting pronouncements – In February 2015, GASB issued Statement No. 72, *Fair Value Measurement and Application, ("GASB 72")* which is effective for periods beginning after June 15, 2015. GASB 72 addresses accounting and financial reporting issues related to fair value measurements. GASB 72 provides guidance for determining a fair value measurement for financial reporting purposes as well as guidance for applying fair value to certain investments and disclosures related to all fair value measurements. The Organization has adopted GASB 72 effective July 1, 2015.

Note 2 – Summary of Significant Accounting Policies (continued)

In June 2015, GASB issued Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions* ("GASB No. 75"), which is effective for periods beginning after June 15, 2017. GASB No. 75 replaces requirements of GASB Statement No. 45, *Accounting and Financial Reporting by Employers for Postemployment Benefits Other than Pensions,* as amended, and GASB Statement No. 57, *OPEB Measurements by Agent Employers and Agent Multiple-Employer Plans***,** for OPEB. This statement establishes standards for recognizing and measuring liabilities, deferred outflows of resources, deferred inflows of resources, and expense/expenditures. GASB No. 75 also lays out requirements for methods and assumptions that are required to be used to project benefit payments, discount projected benefit payments to their actuarial present value and attribute that present value to periods of employee service for defined benefit OPEB. Note disclosure and required supplementary information requirements about defined benefit OPEB also are addressed. In addition, GASB 75 includes the recognition and disclosure requirements for employers with payables to defined benefit OPEB plans that are administered through trusts that meet the specified criteria and for employers whose employees are provided with defined contribution OPEB. This Statement also addresses certain circumstances in which a non-employer entity provides financial support for OPEB of employees of another entity. The Organization is currently evaluating the impact of the adoption of GASB No. 75 for the year ending June 30, 2017.

In June 2015, GASB also issued Statement No. 76, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments* ("GASB No. 76"), which is effective for periods beginning after June 15, 2015. The objective of GASB No. 76 is to identify the hierarchy of generally accepted accounting principles ("GAAP") in the context of the current governmental financial reporting environment. The Statement reduces GAAP hierarchy to two categories of authoritative GAAP and addresses the use of authoritative and non-authoritative literature in the event that the accounting treatment for a transaction or other event is not specific within a source of authoritative GAAP. The Organization has adopted GASB No. 76 effective July 1, 2015.

In December 2015, GASB issued Statement No. 79, *Certain External Investment Pools and Pool Participants* ("GASB No. 79"), which is effective for periods beginning after June 15, 2015, except for certain provisions on portfolio quality, custodial credit risk, and shadow pricing. Those provisions are effective for reporting periods beginning after December 15, 2015. The objective of GASB No. 79 is to address for certain external investment pools and their participants the accounting and financial reporting implications that result from changes in the regulatory provisions referenced by previous accounting and financial reporting standards. Those provisions were based on the Investment Company Act of 1940, Rule 2a7. The Organization has adopted GASB No. 79 effective July 1, 2015.

Note 3 – Cash and Investments

The Organization categorizes its fair value investments within the fair value hierarchy established by GAAP. The hierarchy for fair value measurements is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date.

Level 1 Quoted prices in active markets for identical assets or liabilities

Level 2 Inputs other than quoted prices included within Level 1 that are observable for an asset or liability, either directly or indirectly

Level 3 Significant unobservable inputs

The following is a description of the valuation methodologies used for instruments at fair value on a recurring basis and recognized in the accompanying consolidated statements of net position, as well as the general classification of such instruments pursuant to the valuation hierarchy.

Marketable securities – Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows. These securities are classified within Level 2 of the valuation hierarchy. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy.

Note 3 – Cash and Investments (continued)

The following table presents the fair value measurements of assets recognized in the accompanying consolidated statements of net position measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall:

	Investment Assets at Fair Value as of June 30, 2016			
	Level 1	Level 2	Level 3	Total
U.S. treasury notes	$ 594,011,051	$ -	$ -	$ 594,011,051
Money market funds	14,231,723	34,971,635	-	49,203,358
Government	7,576,010	72,625,568	-	80,201,578
U.S. agencies	-	202,911,440	-	202,911,440
Asset-backed securities	-	115,567,448	-	115,567,448
Corporate bonds	-	332,854,276	-	332,854,276
Mortgage-backed securities	-	39,116,801	-	39,116,801
Municipal bonds	-	67,822,241	-	67,822,241
Tax exempt	-	70,000	-	70,000
	$ 615,818,784	$ 865,939,409	$ -	$ 1,481,758,193

	Investment Assets at Fair Value as of June 30, 2015			
	Level 1	Level 2	Level 3	Total
U.S. treasury notes	$ 332,526,432	$ -	$ -	$ 332,526,432
Money market funds	49,905,643	161,248,377	-	211,154,020
Government	-	2,698,727	-	2,698,727
U.S. agencies	-	50,937,353	-	50,937,353
Asset-backed securities	-	111,541,227	-	111,541,227
Corporate bonds	-	339,824,175	-	339,824,175
Mortgage-backed securities	-	63,675,293	-	63,675,293
Municipal bonds	-	63,109,279	-	63,109,279
Tax exempt	-	27,064,882	-	27,064,882
	$ 382,432,075	$ 820,099,313	$ -	$ 1,202,531,388

Note 3 – Cash and Investments (continued)

Cash and investments are reported in the June 30 consolidated statements of net position as follows:

	June 30, 2016	June 30, 2015
Current assets:		
Cash and cash equivalents	$ 258,846,237	$ 25,430,975
Investments	1,019,264,632	745,792,608
Board-designated assets and restricted cash:		
Cash and cash equivalents	10,132,014	866,365
Investments	465,713,886	459,282,739
Restricted deposit	300,000	300,000
	$ 1,754,256,769	$ 1,231,672,687

Custodial credit risk-deposits – Custodial credit risk is the risk that in the event of a bank failure the Organization may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. At June 30, 2016 and 2015, no deposits were exposed to custodial credit risk, as CalOptima has pledged collateral to cover the amounts.

Investments – CalOptima invests in obligations of the U.S. Treasury, other U.S. government agencies and instrumentalities, state obligations, corporate securities, money market funds, and mortgage or asset-backed securities.

Note 3 – Cash and Investments (continued)

Interest rate risk – In accordance with its Annual Investment Policy ("investment policy"), CalOptima manages its exposure to decline in fair value from increasing interest rates by matching maturity dates to the extent possible with CalOptima's expected cash flow draws. Its investment policy limits maturities to five years, while also staggering maturities. CalOptima maintains a low-duration strategy, targeting a portfolio duration of three years or less, with the intent of reducing interest rate risk. Portfolios with low duration are less volatile because they are less sensitive to interest rate changes. As of June 30, 2016 and 2015, CalOptima's investments, including cash equivalents, had the following modified duration:

	June 30, 2016			
		Investment Maturities (In Years)		
Investment Type	Fair Value	Less Than 1	1-5	More Than 5
U.S. agencies	$ 207,911,621	$ 134,250,313	$ 73,661,308	$ -
Asset-backed securities	115,567,448	33,757,195	81,810,253	-
Corporate bonds	342,562,050	182,151,144	160,410,906	-
Government	103,571,333	86,462,088	17,109,245	-
Money market funds	49,203,359	49,203,359	-	-
Mortgage-backed securities	39,116,803	4,571,701	34,545,102	-
Municipal bonds	74,647,560	38,093,490	36,554,070	-
Tax exempt	70,000	70,000	-	-
U.S. treasury notes	609,519,716	443,005,155	166,514,561	-
Cash equivalents	145,777,389	102,544,320	43,233,069	-
Cash	2,434,995	2,434,995	-	-
		$ 1,076,543,760	$ 613,838,514	$ -
Accrued interest receivable	3,544,687			
	$ 1,693,926,961			

Note 3 – Cash and Investments (continued)

	June 30, 2015			
		Investment Maturities (In Years)		
Investment Type	Fair Value	Less Than 1	1-5	More Than 5
U.S. agencies	$ 50,937,353	$ -	$ 50,937,353	$ -
Asset-backed securities	111,541,227	21,833,637	89,707,590	-
Corporate bonds	339,824,175	82,113,170	257,711,005	-
Government	30,932,107	1,399,958	29,532,149	-
Money market funds	216,154,016	216,154,016	-	-
Mortgage-backed securities	63,675,293	256,985	63,418,308	-
Municipal bonds	63,109,279	27,467,154	35,642,125	-
Tax exempt	28,068,172	23,061,987	5,006,185	-
U.S. treasury notes	305,693,010	50,052,498	255,640,512	-
Cash	2,165,479	2,165,479	-	-
		$ 424,504,884	$ 787,595,227	$ -
Accrued interest receivable	2,543,960			
	$ 1,214,644,071			

Investment with fair values highly sensitive to interest rate fluctuations – When interest rates fall, debt is refinanced and paid off early. The reduced stream of future interest payments diminishes the fair value of the investment. The mortgage-backed and asset-backed securities in the CalOptima portfolio are of high credit quality, with relatively short average lives that represent limited prepayment and interest rate exposure risk. CalOptima's investments include the following investments that are highly sensitive to interest rate and prepayment fluctuations to a greater degree than already indicated in the information provided above:

	June 30,	
	2016	2015
Asset-backed securities	$ 115,567,448	$ 111,541,227
Mortgage-backed securities	39,116,803	63,675,293
	$ 154,684,251	$ 175,216,520

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Note 3 – Cash and Investments (continued)

Credit risk – CalOptima's investment policy conforms to the California Government Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments. The investment policy sets minimum acceptable credit ratings for investments from the three nationally recognized rating services: Standard and Poor's Corporation ("S&P"), Moody's Investor Service ("Moody's") and Fitch Ratings ("Fitch"). For an issuer of short-term debt, the rating must be no less than A-1 ("S&P"), P-1 ("Moody's") or F-1 ("Fitch"), while an issuer of long-term debt shall be rated no less than an "A."

As of June 30, 2016, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt From Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A/A-1	A-
U.S. Treasury notes	$ 616,851,820	N/A	$ 616,851,820	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	309,299,967	N/A	309,299,967	-	-	-	-	-	-
Corporate bonds	291,879,044	A-	-	6,770,725	20,108,792	33,512,510	81,895,966	100,120,087	49,470,964
FRN securities	109,240,846	A-	-	29,305,294	10,348,080	7,764,295	22,470,192	23,481,111	15,871,874
Asset-backed securities	124,658,150	AAA	-	87,932,577	15,578,743	15,523,429	1,836,149	3,787,252	-
Mortgage-backed securities	73,327,090	A	-	73,327,090	-	-	-	-	-
Municpal bonds	36,798,228	AAA	-	4,763,191	17,750,954	12,009,958	2,274,125	-	-
Supranational	27,322,075	AAA	-	27,322,075	-	-	-	-	-
Commercial Paper	19,930,039	A1/P1	-	19,930,039	-	-	-	-	-
Money market mutual funds	84,619,702	AAA	-	84,619,702	-	-	-	-	-
Total	$ 1,693,926,961		$ 926,151,787	$ 333,970,693	$ 63,786,569	$ 68,810,192	$ 108,476,432	$ 127,388,450	$ 65,342,838

As of June 30, 2015, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt From Disclosure	Rating as of Year-End					
				AAA	Aa & Aa+	Aa-	A+	A/A-1	A-
U.S. Treasury notes	$ 383,009,469	N/A	$ 383,009,469	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	135,084,602	N/A	-	135,084,602	-	-	-	-	-
Corporate bonds	341,140,654	A-	-	2,433,630	40,442,001	64,229,653	83,075,867	114,650,510	36,308,993
Asset-backed securities	111,574,036	AAA	-	111,574,036	-	-	-	-	-
Mortgage-backed securities	91,633,861	A	-	18,484,165	33,259,721	25,544,397	8,370,941	5,974,637	-
Municpal bonds	63,728,926	AAA	-	63,728,926	-	-	-	-	-
Certificates of Deposit	76,527,940	A1/P1	-	76,527,940	-	-	-	-	-
Commercial Paper	9,779,103	A1/P1	-	9,779,103	-	-	-	-	-
Money market mutual funds	19,194,096	AAA	-	19,194,096	-	-	-	-	-
Total	$ 1,231,672,687		$ 383,009,469	$ 436,806,498	$ 73,701,722	$ 89,774,050	$ 91,446,808	$ 120,625,147	$ 36,308,993

Note 3 – Cash and Investments (continued)

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of CalOptima's investment in a single issuer. CalOptima's investment policy limits to no more than 5 percent of the total fair value of investments in the securities of any one issuer, except for obligations of the U.S. government, U.S. government agencies or government-sponsored enterprises; and no more than 10 percent may be invested in one money market mutual fund unless approved by the governing board. The investment policy also places a limit of 35 percent of the amount of investment holdings with any one government-sponsored issuer and 5 percent of all other issuers. At June 30, 2016 and 2015, all holdings complied with the foregoing limitations. The following holdings exceeded 5 percent of the portfolio at June 30, 2016 and 2015:

		Percentage of Portfolio June 30,	
Investment Type	Issuer	2016	2015
U.S agency notes	Federal Home Loan Bank	5.28	-
U.S. Treasury notes	United States Treasury	35.14	25.22

Note 4 – Capital Assets

Capital assets activity during the year ended June 30, 2016 consisted of the following:

	June 30, 2015	Additions	Retirements	Transfers	June 30, 2016
Capital assets not being depreciated:					
Land	$ 5,876,002	$ -	$ -	$ -	$ 5,876,002
Construction in progress	3,011,170	3,263,116	-	(18,050)	6,256,236
	8,887,172	3,263,116	-	(18,050)	12,132,238
Capital assets being depreciated:					
Furniture and equipment	6,633,398	3,842,809	(216,612)	-	10,259,595
Computers and software	18,470,898	-	-	-	18,470,898
Land improvement	45,665	-	-	-	45,665
Leasehold improvements	5,043,363	-	-	-	5,043,363
Building	40,747,980	81,285	-	18,050	40,847,315
	70,941,304	3,924,094	(216,612)	18,050	74,666,836
Less accumulated depreciation for:					
Furniture and equipment	2,185,730	970,613	-	-	3,156,343
Computers and software	17,611,500	2,273,204	(216,612)	-	19,668,092
Land improvement	1,126,651	1,114,011	-	-	2,240,662
Leasehold improvements	1,560,341	578,631	-	-	2,138,972
Building	3,994,863	604,576	-	-	4,599,439
	26,479,085	5,541,035	(216,612)	-	31,803,508
Total depreciable assets, net	44,462,219	(1,616,941)	-	18,050	42,863,328
Capital assets, net	$ 53,349,391	$ 1,646,175	$ -	$ -	$ 54,995,566

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Note 4 – Capital Assets (continued)

Capital asset activity during the year ended June 30, 2015 consisted of the following:

	June 30, 2014	Additions	Retirements	Transfers	June 30, 2015
Capital assets not being depreciated:					
Land	$ 5,876,002	$ -	$ -	$ -	$ 5,876,002
Construction in progress	1,831,233	1,179,937	-	-	3,011,170
	7,707,235	1,179,937	-	-	8,887,172
Capital assets being depreciated:					
Furniture and equipment	4,140,487	3,333,808	(840,897)	-	6,633,398
Computers and software	18,470,898	-	-	-	18,470,898
Land improvement	45,665	-	-	-	45,665
Leasehold improvements	5,028,202	15,161	-	-	5,043,363
Building	37,566,076	3,181,904	-	-	40,747,980
	65,251,328	6,530,873	(840,897)	-	70,941,304
Less accumulated depreciation for:					
Furniture and equipment	1,733,057	865,577	(412,904)	-	2,185,730
Computers and software	15,326,699	2,284,801	-	-	17,611,500
Land improvement	5,137	1,121,514	-	-	1,126,651
Leasehold improvements	980,025	580,316	-	-	1,560,341
Building	3,390,287	604,576	-	-	3,994,863
	21,435,205	5,456,784	(412,904)	-	26,479,085
Total depreciable assets, net	43,816,123	1,074,089	(427,993)	-	44,462,219
Capital assets, net	$ 51,523,358	$ 2,254,026	$ (427,993)	$ -	$ 53,349,391

Note 5 – Medical Claims Liability

Medical claims liability consists of the following:

	June 30, 2016	June 30, 2015
Claims payable or pending approval	$ 18,004,864	$ 26,252,320
Provisions for IBNR claims	575,805,193	614,668,799
	$ 593,810,057	$ 640,921,119

The cost of health-care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been incurred but not yet reported. CalOptima estimates accrued claims payable based on historical claims payments and other relevant information. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in medical claims liability. Estimates are continually monitored and analyzed, and as settlements are made or estimates adjusted, differences are reflected in current operations. Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided.

Note 5 – Medical Claims Liability (continued)

The following is a reconciliation of the accrued claims liability:

	For the years ended June 30,	
	2016	2015
Beginning balance	$ 640,921,119	$ 314,763,658
Incurred:		
Current	1,654,655,048	1,685,700,529
Prior	(16,801,929)	(2,618,015)
	1,637,853,119	1,683,082,514
Paid		
Current	1,453,165,737	1,221,651,387
Prior	231,798,444	135,273,666
	1,684,964,181	1,356,925,053
Ending balance	$ 593,810,057	$ 640,921,119

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities at any year-end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established prior reporting period liability. Negative amounts reported for incurred, related to prior years, result from claims being adjudicated and paid for amounts less than originally estimated. The year ended June 30, 2016 results included a decrease of prior year incurred of approximately $16,802,000. The year ended June 30, 2015 results included a decrease of prior year incurred of approximately $2,618,015. Original estimates are increased or decreased as additional information becomes known regarding individual claims. Included within the Medical Claims Liability is a payable to the State of California pertaining to the accrual to meet the 85% medical loss ratio requirement described in Note 2.

Note 6 – Defined Benefit Pension Plan

Plan description – CalOptima's defined benefit pension plan, Miscellaneous Plan of the Orange County Health Authority (the "CalPERS Plan"), provides retirement and disability benefits, annual cost-of-living adjustments, and death benefits to plan members and beneficiaries. The CalPERS Plan is part of the public agency portion of the California Public Employees Retirement Systems ("CalPERS"), an agent multiple-employer plan administered by CalPERS, which acts as a common investment and administrative agent for participating public employers within the state of California. A menu of benefit provisions as well as other requirements is established by state statues within the Public Employees' Retirement Law. CalOptima selects optional benefit provisions from the benefit menu by contract with CalPERS and adopts those benefits through the Board of Directors' approval. CalPERS issues a publicly available financial report that includes financial statements and required supplementary information for CalPERS. Copies of the report can be obtained from CalPERS Executive Office, 400 P Street, Sacramento, CA 95814.

Benefits provided – CalPERS provides service retirement and disability benefits, annual cost of living adjustments and death benefits to plan members, who must be public employees and beneficiaries. Benefits are based on years of credited service, equal to one full year of full time employment. Members with five years of total service are eligible to retire at age 50 with statutorily reduced benefits. All members are eligible for non-duty disability benefits after 10 years of service. The death benefit is one of the following: the Basic Death Benefit, the 1957 Survivor Benefit, or the Optional Settlement 2W Death Benefit. The cost of living adjustments for the plan are applied as specified by the Public Employees' Retirement Law.

The CalPERS Plan's provisions and benefits in effect at June 30, 2016 are summarized as follows:

Hire Date	Prior to January 1, 2013	On or after January 1, 2013
Benefit formula	2% at 60	2% at 62
Benefit vesting schedule	5 years of service	5 years of service
Benefit payments	monthly for life	monthly for life
Retirement age	50-55	52-67
Monthly benefits as a % of eligible compensation	2.0% to 2.7%	1.0% to 2.5%
Required employee contribution rates	7.0%	7.0%
Required employer contribution rates	8.4%	8.4%

Note 6 – Defined Benefit Pension Plan (continued)

The following is a summary of plan participants:

	June 30, 2016	June 30, 2015
Active employees	1100	986
Retirees and beneficiaries:		
Receiving benefits	102	91
Deferred Retirement benefits:		
Terminated employees	1	2
Surviving spouses	5	4
Beneficiaries	0	2

Contributions – Section 20814(c) of the California Public Employees' Retirement Law ("PERL") requires that the employer contribution rates for all public employers are determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. The total plan contributions are determined through CalPERS' annual actuarial valuation process. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The employer is required to contribute the difference between the actuarially determined rate and the contribution rate of employees. The average active employee contribution rate is 6.82 percent and 6.95 percent of annual pay for the years ended June 30, 2016 and 2015, respectively. The employer's contribution rate is 8.65 percent and 8.41 percent of annual payroll for the years ended June 30, 2016 and 2015, respectively.

Net pension liability – Effective July 1, 2014 CalOptima adopted GASB 68 Accounting and Financial Reporting for Pensions. The impact of the adoption was retrospectively reflected in the first period presented. Accordingly, the pension benefit expense was increased by approximately $4,382,000 for the year ended June 30, 2015 to reflect the adoption of GASB 68.

Note 6 – Defined Benefit Pension Plan (continued)

CalOptima's net pension liability for the CalPERS Plan is measured as the total pension liability, less the pension plan's fiduciary net position. For the measurement period ended June 30, 2015 (the measurement date), the total pension liability was determined by rolling forward the June 30, 2014 total pension liability. Total pension liabilities were based on the following actuarial methods and assumptions as of June 30, 2015 and June 30, 2014, respectively:

Valuation Date	June 30, 2014
Measurement Date	June 30, 2015
Actuarial Cost Method	Entry Age Normal
Actuarial Assumptions:	
Discount Rate	7.65%
Inflation	2.75%
Salary Increases	Varies by Entry Age and Service
Investment Rate of Return	7.50%
Mortality Rate Table	Derived using CalPERS' Membership data for all funds
Post Retirement Benefit Increase	Contract COLA up to 2.75% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.75% thereafter

Note 6 – Defined Benefit Pension Plan (continued)

The underlying mortality table was developed based on CalPERS' specific data. The table includes 20 years of mortality improvements using Society of Actuaries Scale BB. All other actuarial assumptions used in the June 30, 2014 valuation were based on the results of an actuarial experience study for the period 1997 to 2011, including updates to salary increase mortality and retirement rates. The Experience Study report can be obtained at CalPERS' website.

Changes in the Net Pension Liability are as follows:

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2015	$ 83,711,464	$ 82,651,970	$ 1,059,494
Changes during the year:			
Service Cost	8,363,183	-	8,363,183
Interest on the total pension liability	6,620,025	-	6,620,025
Changes of benefit terms	-	-	-
Differences between expected and actual experience	1,444,808	-	1,444,808
Changes of assumptions	(1,963,270)	-	(1,963,270)
Contributions from the employer	-	3,033,171	(3,033,171)
Contributions from employees	-	4,142,126	(4,142,126)
Net investment income	-	1,913,380	(1,913,380)
Benefit payments, including refunds of employee contributions	(1,676,666)	(1,676,666)	-
Administrative expenses	-	(101,246)	101,246
Net changes during the year	12,788,080	7,310,765	5,477,315
Balance at June 30, 2016	$ 96,499,544	$ 89,962,735	$ 6,536,809

Note 6 – Defined Benefit Pension Plan (continued)

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2014	$ 72,912,613	$ 65,410,580	$ 7,502,033
Changes during the year:			
Service Cost	6,464,105	-	6,464,105
Interest on the total pension liability	5,661,111	-	5,661,111
Changes of benefit terms	-	-	-
Differences between expected and actual experience	-	-	-
Changes of assumptions	-	-	-
Contributions from the employer	-	3,119,804	(3,119,804)
Contributions from employees	-	3,385,296	(3,385,296)
Net investment income	-	12,062,654	(12,062,654)
Benefit payments, including refunds of employee contributions	(1,326,364)	(1,326,364)	-
Net changes during the year	10,798,852	17,241,390	(6,442,538)
Balance at June 30, 2015	$ 83,711,465	$ 82,651,970	$ 1,059,495

Discount rate and long term rate of return – The discount rate used to measure the total pension liability was 7.65 percent for the CalPERS Plan. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, CalPERS stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. Based on the testing, none of the tested plans run out of assets. Therefore, the current 7.65 percent discount rate is adequate and the use of the municipal bond rate calculation is not necessary. The long term expected discount rate of 7.50 percent will be applied to all plans in the Public Employees Retirement Fund (PERF). The stress test results are presented in a detailed report called "GASB Crossover Testing Report" that can be obtained from the CalPERS website.

GASB 68 requires that the long-term discount rate should be determined without reduction for pension plan administrative expense. The 7.50 percent investment return assumption used is net of administrative expenses. Administrative expenses are assumed to be 15 basis points. An investment return excluding administrative expenses would have been 7.65 percent, which is the rate used for the year ended June 30, 2016.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

Note 6 – Defined Benefit Pension Plan (continued)

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Such cash flows were developed assuming that both members and employers will make the required contributions as scheduled in all future years. Using historical returns of all the funds' asset classes, expected compound returns were calculated over the short-term (first 10 years) and the long-term (11-60 years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equivalent to the single equivalent rate calculated above and rounded down to the nearest one quarter of one percent.

The table below reflects long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These geometric rates of return are net of administrative expenses.

New Strategic Asset Class	Real Return Allocation	Real Return Years 1-10 (a)	Years 11+ (b)
Global Equity	47.0%	5.25%	5.71%
Global Fixed Income	19.0%	0.99%	2.43%
Inflation Sensitive	6.0%	0.45%	3.36%
Private Equity	12.0%	6.83%	6.95%
Infrastructure and Forestland	3.0%	4.50%	5.09%
Liquidity	2.0%	-0.55%	-1.05%

(a) An expected inflation of 2.5% was used for this period
(b) An expected inflation of 3.0% was used for this period

Note 6 – Defined Benefit Pension Plan (continued)

The following presents the net pension liability of the CalPERS Plan calculated using the discount rate, as well as what the net pension liability would be if it were calculated using a discount rate that is 1-percentage point lower or 1-percentage point higher than the current rate:

	June 30, 2016		
	Discount Rate -1% 6.65%	Current Discount Rate 7.65%	Discount Rate +1% 8.65%
Net Pension Liability	$ 23,232,749	$ 6,536,809	$ (6,906,026)

	June 30, 2015		
	Discount Rate -1% 6.50%	Current Discount Rate 7.50%	Discount Rate +1% 8.50%
Net PensionLiability	$ 15,037,009	$ 1,059,495	$ (10,244,910)

Note 6 – Defined Benefit Pension Plan (continued)

Pension expense and deferred outflows/inflows of resources related to pensions – CalOptima recognized pension expense of approximately $9,219,000 and $2,256,000 for the years ended June 30, 2016 and 2015, respectively. At June 30, 2016, CalOptima recognized deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
June 30, 2015		
subsequent to the measurement date	$ 4,950,911	$ -
Net differences between projected and actual earnings on plan investments	$ -	$ 5,580,552
June 30, 2016		
Contributions from employers subsequent to the measurement date	3,787,544	
Net differences between projected and actual earnings on plan investments		$ 502,900
Changes in assumptions		1,651,640
Differences between expected and actual experiences	1,215,473	
	$ 5,003,017	$ 2,154,540

Note 6 – Defined Benefit Pension Plan (continued)

The deferred outflows of resources related to employer contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability during the year ended June 30, 2016. The net differences reported as deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Years ending June 30,	Deferred Inflows / (Outflows) of Resources
2017	$ 556,805
2018	556,805
2019	556,805
2020	(838,335)
2021	82,295
Thereafter	24,692
	$ 939,067

Note 7 – Employee Benefit Plans

Deferred compensation plan – CalOptima sponsors a deferred compensation plan created in accordance with Internal Revenue Code Section 457 (the "457 Plan") under which employees are permitted to defer a portion of their annual salary until future years. CalOptima may make discretionary contributions to the 457 Plan as determined by the Board of Directors. For the years ended June 30, 2016 and 2015, no discretionary employer contributions were made.

Defined contribution plan – Effective January 1, 1999, CalOptima established a supplemental retirement plan for its employees called the CalOptima Public Agency Retirement System Defined Contribution Supplemental Retirement Plan ("PARS Plan"). All regular and limited-term employees are eligible to participate in the PARS Plan. The current PARS Plan design does not require employee contributions. CalOptima makes discretionary employer contributions to the PARS Plan as authorized by the CalOptima Board of Directors. Vesting occurs over 16 quarters of service. For the years ended June 30, 2016 and 2015, CalOptima contributed approximately $2,467,000 and $2,187,000, respectively.

Note 8 – Postemployment Health-Care Plan

Plan description – CalOptima sponsors and administers a single-employer, defined benefit postemployment health-care plan (the "Plan") to provide medical and dental insurance benefits to eligible retired employees and their beneficiaries. Benefit provisions are established and may be amended by the CalOptima Board of Directors.

Effective January 1, 2004 CalOptima terminated postemployment health-care benefits for employees hired on or after January 1, 2004. For employees hired prior to January 1, 2004, the employee's eligibility for retiree health benefits remains similar to the eligibility requirements for the defined benefit pension plan.

During the year ended June 30, 2006, CalOptima modified the benefit offered to eligible participants, requiring participants to enroll in Medicare and specifying that CalOptima would be responsible only for the cost of Medicare supplemental coverage, subject to a cost sharing between the participant and CalOptima.

Funding policy – The contribution requirements of Plan members and CalOptima are established and may be amended by the CalOptima Board of Directors. Plan members receiving benefits contribute at the same rate as current active employees. CalOptima's contribution is based on projected pay-as-you-go financing requirements, with no additional amount to prefund benefits. CalOptima contributed $537,000, including $510,000 in premium payments for retirees and $27,000 for implied subsidies for the year ended June 30, 2016. CalOptima contributed $526,000, including $497,000 in premium payments for retirees and $29,000 for implied subsidies for the year ended June 30, 2015. The most recent actuarial report for the Plan was June 30, 2016. As of that point the actuarial accrued liability and unfunded actuarial accrued liability for benefits were approximately $26,057,000 and a funded ratio of 0.0 percent with a covered payroll of $7,397,000.

Note 8 – Postemployment Health-Care Plan (continued)

Annual other postemployment benefit cost and net obligation – CalOptima's annual other postemployment benefit (OPEB) cost (expense) is calculated based on the annual required contribution (ARC) of the employer, an amount actuarially determined in accordance with the parameter of GASB Codification Section P50. The ARC represents a level of funding that, if paid on an ongoing basis, is projected to cover normal costs each year and amortize any unfunded actuarial liabilities (or funding excess) over a 20-year closed amortization period. The following table shows the components of CalOptima's annual OPEB costs for the years, the amount actually contributed to the Plan, and changes in CalOptima's net OPEB obligation (dollars in thousands):

	Years Ended June 30,	
	2016	2015
ARC:		
Normal cost	$ 872	$ 899
Actuarial accrued liability (AAL) amortization	2,694	2,472
Total, end of year	$ 3,566	$ 3,371
Annual OPEB costs (ACC):		
ARC	$ 3,566	$ 3,371
Interst on net OPEB obligation (NOO)	1,032	982
Amortization of NOO	(2,791)	(1,824)
Total	$ 1,807	$ 2,529
Beginning NOO	$ 26,057	$ 24,799
AOC	1,807	2,529
Contributions	(537)	(526)
Ending NOO	$ 27,327	$ 26,802

CalOptima reported approximately $27,327,000 and $26,802,000 at June 30, 2016 and 2015, respectively, in postemployment health-care plan liabilities on the consolidated statements of net position.

Note 8 – Postemployment Health-Care Plan (continued)

CalOptima's annual OPEB cost, the percentage of annual OPEB cost contributed to the Plan, and the net postemployment health-care plan obligation at June 30, 2016 were as follows:

Years Ended June 30	Annual OPEB Cost	Percentage of Annual OPEB Cost Contributed	Net OPEB Obligation
2014	$ 2,446,000	22.1	$ 24,799,000
2015	2,529,000	29.5	26,802,000
2016	1,807,000	29.7	27,327,000

Projections of benefits for consolidated financial reporting purposes are based on the substantive plan (the plan as understood by the employer and plan members) and include the types of benefits provided at the time of each valuation and the historical pattern of sharing of benefit costs between employer and plan members to that point. The actuarial methods and assumptions used include techniques that are designed to reduce the effects of short-term volatility in actuarial accrued liabilities and the actuarial value of assets, consistent with the long-term perspective calculations.

Actuarial valuations involve estimates of the value of reported amounts and assumptions about the probability of events in the future and are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future. In the January 1, 2015 actuarial valuation, the entry age normal actuarial cost method was used. The actuarial assumptions included a 4.0 percent investment rate of return (net of administrative expenses) and annual health-care cost trend rates for medical from 8.0 percent to 8.3 percent (respective of the plan type and the population selected) initially, decreasing to 5.0 percent over six years; dental of 3.0 percent for all years; and vision of 3.0 percent for all years. Salary scale and demographic assumptions for withdrawal, mortality, disability and retirement rates were based on the CalPERS 1997-2002 experience study (2.0 percent at 60).

The required schedule of funding progress immediately following the notes to the consolidated financial statements presents multiyear trend information about the actuarial accrued liability for benefits.

Note 9 – Restricted Net Position

On June 28, 2000, CalOptima became a fully licensed health-care service plan under the Act, as required by statues governing the Healthy Families program. Under the Act, CalOptima is required to maintain and meet a minimum level of tangible net equity as of June 30, 2016 and 2015 of $89,283,747and $86,144,291, respectively. As of June 30, 2016, the Organization is in compliance with its TNE requirement.

The Act further required the CalOptima maintain a restricted deposit in the amount of $300,000. Both CalOptima and the Foundation meet the requirement as of June 30, 2016 and 2015.

Note 10 – Lease Commitments

CalOptima leases office space and equipment under noncancelable, long-term operating leases, with minimum annual payments as follows:

Years ending June 30,	Minimum Lease Payments
2017	$ 486,316
2018	500,906
2019	515,933
2020	531,411
2021	547,353
Thereafter	277,721
	$ 2,859,640

Rental expense under operating leases was approximately $471,000 and $471,000 for the years ended June 30, 2016 and 2015, respectively.

Note 11 – Contingencies

Litigation – CalOptima is party to various legal actions and is subject to various claims arising in the ordinary course of business. Management believes that the disposition of these matters will not have a material adverse effect on CalOptima's financial position or results of operations.

Note 11 – Contingencies (continued)

Regulatory matters – The health-care industry is subject to numerous laws and regulations of federal, state and local governments. Violations of these laws and regulations could result in expulsion from government health-care programs together with the imposition of significant fines and penalties. Management believes that CalOptima is in compliance with fraud and abuse, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time (see Note 12).

Patient protection and affordable care act – In March 2010, the President signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Healthcare Reform Legislation), which considerably transforms the U.S. health-care system and increases regulations within the U.S. health insurance industry. This legislation is intended to expand the availability of health insurance coverage to millions of Americans. The Healthcare Reform Legislation contains provisions that take effect from 2010 through 2018, with most measures effective in 2015. Under the Healthcare Reform Legislation, Medi-Cal coverage expanded as of January 2015 for low-income families, children, pregnant women, seniors, and persons with disabilities. For the years ending June 30, 2016 and 2015, CalOptima served an average of 199,000 and 156,800 Medi-Cal Expansion members per month, with increased revenues by approximately $100,431,000 and $111,123,000, respectively.

Note 12 – CMS and DHCS Audits

CMS audit (November 2013) – CMS conducted an audit from November 4, 2013 through November 15, 2013 on the OneCare program. The audit focused on CalOptima's performance in Part D formulary and benefit administration; Part D coverage determinations, appeals, and grievances; Part C organizational determinations, appeals, grievances, and dismissals; outbound enrollment verification; compliance program effectiveness, and special needs plan model of care. CMS had identified Corrective Actions Required in different operational areas.

CMS notified CalOptima on Jan 24, 2014 of its determination to impose intermediate sanctions on Medicare Advantage-Prescription Drug Plan (MA-PD) Contract H5433 – OneCare. These intermediate sanctions (effective January 24, 2014) consist of suspension of enrollment of Medicare beneficiaries into CalOptima plans, and the suspension of all marketing activities to Medicare beneficiaries.

In January 2015, CMS conducted a validation audit to evaluate whether deficiencies that were the basis for sanctions were corrected and not likely to recur. CMS determined that CalOptima's deficiencies have been sufficiently corrected. On February 5, 2015, CalOptima received a notice of release of intermediate sanctions from CMS.

Note 12 – CMS and DHCS Audits (continued)

DHCS medical review (February 2014) – DHCS conducted a Focused Medical Review of CalOptima's Medi-Cal program in February 2014. The corrective actions from the DHCS report were received in March 2014 and were consistent with the corrective actions that were identified by CMS.

DHCS listed its findings and recommendations in seven areas: Utilizations Management, Prior Authorization Procedures, Referral Tracking System, Delegation of Utilization Management, Pharmaceutical Services, Grievances and Appeals, and Antifraud and Abuse Program.

During the year ended June 30, 2015, CalOptima had passed the audit from CMS and the medical review from DHCS. CMS sanction had been lifted during the year ended June 30, 2015.

Note 13 – Consolidating Information

The consolidating assets, deferred outflows of resources, liabilities, deferred inflows of resources and net position at June 30, 2016 are as follows:

ASSETS	CalOptima	CalOptima Foundation	Eliminations	Consolidated
Current Assets				
Cash and cash equivalents	$ 255,951,392	$ 2,894,845	$ -	$ 258,846,237
Investments	1,019,264,632	-	-	1,019,264,632
Capitation receivable from the State of California, net	470,263,571	-	-	470,263,571
Prepaid expenses and other	23,261,087	35,359	-	23,296,446
Due From Affiliates	61	-	(61)	-
Total current assets	1,768,740,743	2,930,204	(61)	1,771,670,886
Board-Designated Assets and Restricted Cash				
Cash and cash equivalents	10,132,014	-	-	10,132,014
Investments	465,713,886	-	-	465,713,886
Restricted deposit	300,000	-	-	300,000
	476,145,900	-	-	476,145,900
Capital Assets, net	54,995,566			54,995,566
Total assets	2,299,882,209	2,930,204	(61)	2,302,812,352
Deferred Outflows of Resources	5,003,017	-	-	5,003,017
Total assets and deferred outflows of resources	$ 2,304,885,226	$ 2,930,204	$ (61)	$ 2,307,815,369
LIABILITIES AND NET POSITION				
Current Liabilities				
Medical claims liability and capitation payable				
Medical claims liability	$ 593,810,057	$ -	$ -	$ 593,810,057
Capitation and withholds	401,826,300	-	-	401,826,300
Accrued insurance costs	4,884,800	-	-	4,884,800
Payable to State of California and the Centers for Medicare & Medicaid Services (CMS)	179,113	-	-	179,113
Unearned revenue	586,185,868	-	-	586,185,868
	1,586,886,138	-	-	1,586,886,138
Accounts payable and other	10,571,340	35,298	-	10,606,638
Accrued payroll and employee benefits and other	11,837,190	-	-	11,837,190
Due to affiliates	-	61	(61)	-
Total current liabilities	1,609,294,668	35,359	(61)	1,609,329,966
Postemployment health-care plan	27,327,000	-	-	27,327,000
Net pension liability	6,536,809			6,536,809
Total Liabilities	1,643,158,477	35,359	(61)	1,643,193,775
Deferred Inflows of Resources	2,154,540	-	-	2,154,540
Net position				
Net investment in capital assets, net of related debt	54,995,566	-	-	54,995,566
Restricted - required tangible net equity and restricted deposit	89,283,747	-	-	89,283,747
Unrestricted	515,292,896	2,894,845	-	518,187,741
Total net position	659,572,209	2,894,845	-	662,467,054
Total liabilities, deferred inflows of resources and net position	$ 2,304,885,226	$ 2,930,204	$ (61)	$ 2,307,815,369

Note 13 – Consolidating Information (continued)

The consolidating assets, deferred outflows of resources, liabilities, deferred inflows of resources and net position at June 30, 2015 are as follows:

ASSETS	CalOptima	CalOptima Foundation	Eliminations	Consolidated
Current Assets				
Cash and cash equivalents	$ 22,518,055	$ 2,912,920	$ -	$ 25,430,975
Investments	745,792,608	-	-	745,792,608
Capitation receivable from the State of California, net	559,110,130	-	-	559,110,130
Prepaid expenses and other	20,360,500	50,063	-	20,410,563
Due From Affiliates	5,035	-	(5,035)	-
Total current assets	1,347,786,328	2,962,983	(5,035)	1,350,744,276
Board-Designated Assets and Restricted Cash				
Cash and cash equivalents	866,365	-	-	866,365
Investments	459,282,739	-	-	459,282,739
Restricted deposit	300,000	-	-	300,000
	460,449,104	-	-	460,449,104
Capital Assets, net	53,349,391			53,349,391
Total assets	1,861,584,823	2,962,983	(5,035)	1,864,542,771
Deferred outflows of resources - pension contributions	4,950,911	-	-	4,950,911
Total assets and deferred outflows of resources	$ 1,866,535,734	$ 2,962,983	$ (5,035)	$ 1,869,493,682
LIABILITIES AND NET POSITION				
Current Liabilities				
Medical claims liability and capitation payable				
Medical claims liability	$ 640,921,119	$ -	$ -	$ 640,921,119
Capitation and withholds	290,632,911	-	-	290,632,911
Accrued insurance costs	29,412,181	-	-	29,412,181
Payable to State of California and the Centers for Medicare & Medicaid Services (CMS)	17,705,126	-	-	17,705,126
Unearned revenue	207,946,164	-	-	207,946,164
	1,186,617,501	-	-	1,186,617,501
Accounts payable and other	10,195,763	51,344	-	10,247,107
Accrued payroll and employee benefits and other	9,232,081	-	-	9,232,081
Due to affiliates	-	5,035	(5,035)	-
Total current liabilities	1,206,045,345	56,379	(5,035)	1,206,096,689
Postemployment Health-Care Plan	26,802,492	-	-	26,802,492
Net Pension Liability	1,059,495			1,059,495
Total Liabilities	1,233,907,332	56,379	(5,035)	1,233,958,676
Deferred inflows of resources - excess earnings	5,580,552	-	-	5,580,552
Net position				
Net investment in capital assets, net of related debt	53,349,391	-	-	53,349,391
Restricted - required tangible net equity and restricted deposit	86,144,291	-	-	86,144,291
Unrestricted	487,554,168	2,906,604	-	490,460,772
Total net position	627,047,850	2,906,604	-	629,954,454
Total liabilities, deferred inflows of resources and net p	$ 1,866,535,734	$ 2,962,983	$ (5,035)	$ 1,869,493,682

Note 13 – Consolidating Information (continued)

The consolidating statements of revenues, expenses, and changes in net position for the year ended June 30, 2016 are as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
Operating revenues				
Capitation revenues	$ 3,163,753,022	$ -	$ -	$ 3,163,753,022
Other income	-	653,323	(348,732)	304,591
Total operating revenues	3,163,753,022	653,323	(348,732)	3,164,057,613
Operating expenses				
Medical expenses				
Provider capitation	935,360,536	-	-	935,360,536
Claim payments to providers and facilities	1,349,950,877	-	-	1,349,950,877
Prescription drugs	391,480,137	-	-	391,480,137
OneCare	86,724,744	-	-	86,724,744
OneCare Connect	205,122,734	-	-	205,122,734
Other medical	69,272,018	-	-	69,272,018
Total medical expenses	3,037,911,046	-	-	3,037,911,046
Administrative expenses				
Salaries, wages and employee benefits	64,645,790	363,086	(341,928)	64,666,948
Professional fees	4,368,357	-	-	4,368,357
Purchased services	10,032,627	-	-	10,032,627
Supplies, occupancy, insurance and other	24,677,045	301,996	(6,804)	24,972,237
Depreciation	3,142,262	-	-	3,142,262
Total administrative expenses	106,866,081	665,082	(348,732)	107,182,431
Total operating expenses	3,144,777,127	665,082	(348,732)	3,145,093,477
Operating income	18,975,895	(11,759)	-	18,964,136
Non-operating revenues and expenses				
Investment income and other	13,880,954	-	-	13,880,954
Rental income, net of related expenses	(332,490)	-	-	(332,490)
Total non-operating revenues and expenses	13,548,464	-	-	13,548,464
Increase in net position	32,524,359	(11,759)	-	32,512,600
Net position, beginning of year	627,047,850	2,906,604	-	629,954,454
Net position, end of year	$ 659,572,209	$ 2,894,845	$ -	$ 662,467,054

Note 13 – Consolidating Information (continued)

The consolidating statements of revenues, expenses, and changes in net position for the year ended June 30, 2015 are as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
Operating revenues				
Capitation revenues	$ 3,111,945,148	$ -	$ -	$ 3,111,945,148
Other income	4,983,502	484,761	(235,477)	5,232,786
Total operating revenues	3,116,928,650	484,761	(235,477)	3,117,177,934
Operating expenses				
Medical expenses				
Provider capitation	856,409,999	-	-	856,409,999
Claim payments to providers and facilities	1,219,710,161	-	-	1,219,710,161
Prescription drugs	300,408,516	-	-	300,408,516
OneCare	167,697,672	-	-	167,697,672
Other medical	256,931,809	-	-	256,931,809
Total medical expenses	2,801,158,157	-	-	2,801,158,157
Administrative expenses				
Salaries, wages and employee benefits	54,288,798	303,396	(224,582)	54,367,612
Professional fees	4,688,952	-	-	4,688,952
Purchased services	6,943,850	-	-	6,943,850
Supplies, occupancy, insurance and other	19,002,983	274,786	(10,895)	19,266,874
Depreciation	3,114,714	-	-	3,114,714
Total administrative expenses	88,039,297	578,182	(235,477)	88,382,002
Total operating expenses	2,889,197,454	578,182	(235,477)	2,889,540,159
Operating income	227,731,196	(93,421)	-	227,637,775
Non-operating revenues and expenses				
Investment income	3,255,038	-	-	3,255,038
Rental income, net of related expenses	134,078	-	-	134,078
Total non-operating revenues and expenses	3,389,116	-	-	3,389,116
Increase in net position	231,120,312	(93,421)	-	231,026,891
Net position, beginning of year	395,927,538	3,000,025	-	398,927,563
Net position, end of year	$ 627,047,850	$ 2,906,604	$ -	$ 629,954,454

Note 13 – Consolidating Information (continued)

The consolidating statement of cash flows for the year ended June 30, 2016 is as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
CASH FLOWS FROM OPERATING ACTIVITIES				
Capitation payments received and other	$ 3,630,477,289	$ 666,587	$ -	$ 3,631,143,876
Payment to providers and facilities	(3,015,522,582)		-	(3,015,522,582)
Payments to vendors	(41,937,528)	(321,576)	-	(42,259,104)
Payments of premium tax	-		-	-
Payments to employees	(59,175,049)	(363,086)	-	(59,538,135)
Net cash provided by operating activities	513,842,130	(18,075)	-	513,824,055
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES				
Purchases of capital assets	(4,788,437)	-	-	(4,788,437)
Net cash used in capital and related financing activities	(4,788,437)	-	-	(4,788,437)
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment income received	10,003,777	-	-	10,003,777
Purchases of securities	(435,633,131)	-	-	(435,633,131)
Sales of securities	150,008,998	-	-	150,008,998
Net cash provided by (used in) investing activities	(275,620,356)	-	-	(275,620,356)
Net increase (decrease) in cash and cash equivalents	233,433,337	(18,075)	-	233,415,262
CASH AND CASH EQUIVALENTS, beginning of year	22,518,055	2,912,920	-	25,430,975
CASH AND CASH EQUIVALENTS, end of year	$ 255,951,392	$ 2,894,845	$ -	$ 258,846,237

The consolidating statement of cash flows for the year ended June 30, 2015 is as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
CASH FLOWS FROM OPERATING ACTIVITIES				
Capitation payments received and other	$ 3,223,788,685	$ 528,259	$ -	$ 3,224,316,944
Payment to providers and facilities	(2,388,753,456)		-	(2,388,753,456)
Payments to vendors	(35,155,123)	(336,978)	-	(35,492,101)
Payments of premium tax	-		-	-
Payments to employees	(53,624,908)	(303,396)	-	(53,928,304)
Net cash provided by operating activities	746,255,198	(112,115)	-	746,143,083
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES				
Purchases of capital assets	(4,940,747)	-	-	(4,940,747)
Net cash used in capital and related financing activities	(4,940,747)	-	-	(4,940,747)
CASH FLOWS FROM INVESTING ACTIVITIES				
Investment income received	25,380,546	-	-	25,380,546
Purchases of securities	(7,998,645,037)	-	-	(7,998,645,037)
Sales of securities	7,203,413,969	-	-	7,203,413,969
Net cash provided by (used in) investing activities	(769,850,522)	-	-	(769,850,522)
Net increase (decrease) in cash and cash equivalents	(28,536,071)	(112,115)	-	(28,648,186)
CASH AND CASH EQUIVALENTS, beginning of year	51,054,126	3,025,035	-	54,079,161
CASH AND CASH EQUIVALENTS, end of year	$ 22,518,055	$ 2,912,920	$ -	$ 25,430,975

SUPPLEMENTARY INFORMATION

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ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA

SCHEDULE OF CHANGES IN NET PENSION LIABILITY AND RELATED RATIOS

	JUNE 30, 2016	JUNE 30, 2015
Total Pension Liability		
Service Cost	$ 8,363,183	$ 6,464,105
Interest	6,620,025	5,661,111
Changes in Benefit Terms	-	-
Differences Between Expected and Actual Experience	1,444,808	-
Changes in Assumptions	(1,963,270)	-
Benefit Payments, Including Refunds of Employee Contributions	(1,676,666)	(1,326,364)
Net Change in Total Pension Liability	12,788,080	10,798,852
Total Pension Liability - Beginning	83,711,464	72,912,613
Total Pension Liability - Ending	$ 96,499,544	$ 83,711,465
Plan Fiduciary Net Position		
Contributions - Employer	$ 3,033,171	$ 3,119,804
Contributions - Employee	4,142,126	3,385,296
Net Investment Income	1,913,380	12,062,654
Benefit Payments, Including Refunds of Employee Contrbutions	(1,676,666)	(1,326,364)
Other Changes in Fiduciary Net Position	(101,246)	-
Net Change in Fiduciary Net Position	7,310,765	17,241,390
Plan Fiduciary Net Position - Beginning	82,651,970	65,410,580
Plan Fiduciary Net Position - Ending	$ 89,962,735	$ 82,651,970
Plan Net Pension Liability - Ending	$ 6,536,809	$ 1,059,495
Plan Fiduciary Net Position as Percentage of the Total Liability	93.23%	98.73%
Covered-Employee Payroll	$ 55,676,606	$ 40,940,556
Plan Net Pension Liability as a Percentage of Covered Employee Payroll	11.74%	2.59%

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA
SCHEDULE OF PLAN CONTRIBUTIONS

	YEARS ENDED JUNE 30,	
	2016	2015
Actuarially Determined Contributions	$ 3,033,171	$ 3,119,804
Contributions in Relation To the Actuarially Determined Contribution	(3,033,171)	(3,119,804)
Contribution Deficiency (Excess)	$ -	$ -
Covered-Employee Payroll	$ 55,676,606	$ 40,940,556
Contributions as a Percentage of Covered-Employee Payroll	5.45%	7.62%

See accompanying report of independent auditors.
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ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA

SCHEDULE OF FUNDING PROGRESS – POSTEMPLOYMENT HEALTH CARE PLAN

JUNE 30, 2016

(IN THOUSANDS)

(UNAUDITED)

Actuarial Valuation Date	Actuarial Value of Assets	Actuarial Accrued Liability (AAL)-- Entry Age	Unfunded AAL (UAAL)	Funded Ratio	Covered Payroll	UAAL as a Percentage of Covered Payroll
6/30/2009	$ -	$ 17,618	$ 17,618	$ 0.0%	$ 9,476	$ 185.9%
6/30/2012	-	19,184	19,184	0.0%	8,547	224.5%
6/30/2013	-	24,799	24,799	0.0%	7,606	326.0%
6/30/2014	-	26,057	26,057	0.0%	7,379	353.1%

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FOR THE YEAR ENDED JUNE 30, 2016

Federal Grantor/Pass-Through Grantor/ Program or Cluster Title	Federal CFDA Number	Pass-Through/ Program Number	Federal Expenditures
U.S. Department of Health and Human Services:			
Pass-through program from the California Department of Aging			
Medical Assistance Program	93.778	MS-1516-41	$ 2,121,936
Total Expenditures of Federal Awards			$ 2,121,936

See accompanying notes to the schedule of expenditures of federal awards.
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Note 1 – Basis of Presentation

The accompanying schedule of expenditures of federal awards (the "Schedule") includes the federal award activity of Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") under programs of the federal government for the year ended June 30, 2016. The CalOptima financial reporting entity, as defined in Note 1 to the consolidated financial statements, consists of CalOptima and the CalOptima Foundation (the "Foundation"). The information in this Schedule is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* ("Uniform Guidance"). Because the Schedule presents only a selected portion of the operations of CalOptima, it is not intended to, and does not, present the financial position, changes in net position or cash flows of CalOptima.

Note 2 – Summary of Significant Accounting Policies

Expenditures reported on the Schedule are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement. Pass-through entity identifying numbers are presented where available. For the purposes of the Schedule, awards include all federal assistance entered into directly between CalOptima and the federal government and subawards from nonfederal organizations made under federally sponsored agreements. The Schedule does not include payments received under Medicare and Medicaid reimbursement programs. CalOptima did not elect to use the 10-percent de minimis indirect cost rate allowed under the Uniform Guidance.

Note 3 – Relationship to Federal Financial Reports

Federal awards revenue for the Medical Assistance Program's Multipurpose Senior Services Program (MSSP) is reported as capitation revenue in the consolidated financial statements of CalOptima. MSSP program expenditures are reported as medical expenses. Amounts reported in the Schedule agree, in all material respects, with the amounts reported in the related federal financial reports.

MOSS-ADAMS LLP
Certified Public Accountants | Business Consultants

REPORT OF INDEPENDENT AUDITORS ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH GOVERNMENT AUDITING STANDARDS

The Board of Directors
Orange County Health Authority, a Public Agency/
dba Orange Prevention and Treatment Integrated Medical Assistance/
dba CalOptima

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the consolidated financial statements of Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima (a discrete component unit of the County of Orange, California) (CalOptima), as of and for the year ended June 30, 2016, and the related notes to the consolidated financial statements, which collectively comprise CalOptima's basic consolidated financial statements, as listed in the table of contents, and have issued our report thereon dated September 16, 2016.

Internal Control Over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered CalOptima's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of CalOptima's internal control. Accordingly, we do not express an opinion on the effectiveness of CalOptima's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's consolidated financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether CalOptima's consolidated financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of consolidated financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Moss Adams LLP

Irvine, California
September 16, 2016

MOSS-ADAMS LLP
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REPORT OF INDEPENDENT AUDITORS ON COMPLIANCE FOR THE MAJOR FEDERAL PROGRAM AND REPORT ON INTERNAL CONTROL OVER COMPLIANCE AS REQUIRED BY THE UNIFORM GUIDANCE

The Board of Directors
Orange County Health Authority, a Public Agency/
dba Orange Prevention and Treatment Integrated Medical Assistance/
dba CalOptima

Report on Compliance for the Major Federal Program

We have audited Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima (CalOptima) compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on the major federal program for the year ended June 30, 2016. CalOptima's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations, and the terms and conditions of its federal award applicable to its federal program.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for CalOptima's major federal program based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about CalOptima's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for the major federal program. However, our audit does not provide a legal determination of CalOptima's compliance.

Opinion on the Major Federal Program

In our opinion, CalOptima complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on its major federal program for the year ended June 30, 2016.

Report on Internal Control Over Compliance

Management of CalOptima is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered CalOptima's internal control over compliance with the types of requirements that could have a direct and material effect on the major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for the major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of CalOptima's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

Moss Adams LLP

Irvine, California
September 16, 2016

Section I – Summary of Auditor's Results

Financial Statements

Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP: *Unmodified*

Internal control over financial reporting:

- Material weakness(es) identified? ☐ Yes ☒ No
- Significant deficiency(ies) identified? ☐ Yes ☒ None reported

Noncompliance material to financial statements noted? ☐ Yes ☒ No

Federal Awards

Internal control over major federal programs:

- Material weakness(es) identified? ☐ Yes ☒ No
- Significant deficiency(ies) identified? ☐ Yes ☒ None reported

Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)? ☐ Yes ☒ No

Identification of major federal programs and type of auditor's report issued on compliance for major federal programs:

CFDA Numbers	*Name of Major Federal Program or Cluster*	*Type of Auditor's Report Issued on Compliance for Major Federal Programs*
93.778	Medical Assistance Program	*Unmodified*

Dollar threshold used to distinguish between type A and type B programs: $750,000

Auditee qualified as low-risk auditee? ☒ Yes ☐ No

Section II – Financial Statement Findings

None noted.

Section III – Federal Award Findings and Questioned Costs

None noted.

Report of Independent Auditors and
Schedule of Expenditures of Federal Awards

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/ dba CalOptima

June 30, 2016

MOSS-ADAMS LLP

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ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA
SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FOR THE YEAR ENDED JUNE 30, 2016

Federal Grantor/Pass-Through Grantor/ Program or Cluster Title	Federal CFDA Number	Pass-Through/ Program Number	Federal Expenditures
U.S. Department of Health and Human Services:			
Pass-through program from the California Department of Aging			
Medical Assistance Program	93.778	MS-1516-41	$ 2,121,936
Total Expenditures of Federal Awards			$ 2,121,936

See notes to schedule of expenditures of federal awards.

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ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA
NOTES TO SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS
FOR THE YEAR ENDED JUNE 30, 2016

Note 1 – Basis of Presentation

The accompanying schedule of expenditures of federal awards (the "Schedule") includes the federal award activity of Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") under programs of the federal government for the year ended June 30, 2016. The CalOptima financial reporting entity, as defined in Note 1 to the consolidated financial statements, consists of CalOptima and the CalOptima Foundation (the "Foundation"). The information in this Schedule is presented in accordance with the requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* ("Uniform Guidance"). Because the Schedule presents only a selected portion of the operations of CalOptima, it is not intended to, and does not, present the financial position, changes in net position or cash flows of CalOptima.

Note 2 – Summary of Significant Accounting Policies

Expenditures reported on the Schedule are reported on the accrual basis of accounting. Such expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement. Pass-through entity identifying numbers are presented where available. For the purposes of the Schedule, awards include all federal assistance entered into directly between CalOptima and the federal government and subawards from nonfederal organizations made under federally sponsored agreements. The Schedule does not include payments received under Medicare and Medicaid reimbursement programs. CalOptima did not elect to use the 10-percent de minimis indirect cost rate allowed under the Uniform Guidance.

Note 3 – Relationship to Federal Financial Reports

Federal awards revenue for the Medical Assistance Program's Multipurpose Senior Services Program (MSSP) is reported as capitation revenue in the consolidated financial statements of CalOptima. MSSP program expenditures are reported as medical expenses. Amounts reported in the Schedule agree, in all material respects, with the amounts reported in the related federal financial reports.

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REPORT OF INDEPENDENT AUDITORS ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH GOVERNMENT AUDITING STANDARDS

The Board of Directors
Orange County Health Authority, a Public Agency/
dba Orange Prevention and Treatment Integrated Medical Assistance/
dba CalOptima

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards* issued by the Comptroller General of the United States, the consolidated financial statements of Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima (a discrete component unit of the County of Orange, California) (CalOptima), as of and for the year ended June 30, 2016, and the related notes to the consolidated financial statements, which collectively comprise CalOptima's basic consolidated financial statements, as listed in the table of contents, and have issued our report thereon dated September 16, 2016

Internal Control Over Financial Reporting

In planning and performing our audit of the consolidated financial statements, we considered CalOptima's internal control over financial reporting (internal control) to determine the audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the consolidated financial statements, but not for the purpose of expressing an opinion on the effectiveness of CalOptima's internal control. Accordingly, we do not express an opinion on the effectiveness of CalOptima's internal control.

A *deficiency in internal control* exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A *material weakness* is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's consolidated financial statements will not be prevented, or detected and corrected on a timely basis. A *significant deficiency* is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given these limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

MOSS-ADAMS LLP

Compliance and Other Matters

As part of obtaining reasonable assurance about whether CalOptima's consolidated financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the determination of consolidated financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards*.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the entity's internal control or on compliance. This report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the entity's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

Moss Adams LLP

Irvine, California
September 16, 2016

MOSS-ADAMS LLP
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REPORT OF INDEPENDENT AUDITORS ON COMPLIANCE FOR THE MAJOR FEDERAL PROGRAM; REPORT ON INTERNAL CONTROL OVER COMPLIANCE; AND REPORT ON THE SCHEDULE OF EXPENDITURES OF FEDERAL AWARDS AS REQUIRED BY THE UNIFORM GUIDANCE

The Board of Directors
Orange County Health Authority, a Public Agency/
dba Orange Prevention and Treatment Integrated Medical Assistance/
dba CalOptima

Report on Compliance for the Major Federal Program

We have audited Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima (CalOptima) compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on the major federal program for the year ended June 30, 2016. CalOptima's major federal program is identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility

Management is responsible for compliance with federal statutes, regulations, and the terms and conditions of its federal award applicable to its federal program.

Auditor's Responsibility

Our responsibility is to express an opinion on compliance for CalOptima's major federal program based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about CalOptima's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for the major federal program. However, our audit does not provide a legal determination of CalOptima's compliance.

MOSS-ADAMS LLP

Opinion on the Major Federal Program

In our opinion, CalOptima complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on its major federal program for the year ended June 30, 2016.

Report on Internal Control Over Compliance

Management of CalOptima is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered CalOptima's internal control over compliance with the types of requirements that could have a direct and material effect on the major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for the major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of CalOptima's internal control over compliance.

A *deficiency in internal control over compliance* exists when the design or operation of a control over compliance does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, noncompliance with a type of compliance requirement of a federal program on a timely basis. A *material weakness in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance such that there is a reasonable possibility that material noncompliance with a type of compliance requirement of a federal program will not be prevented, or detected and corrected, on a timely basis. A *significant deficiency in internal control over compliance* is a deficiency, or a combination of deficiencies, in internal control over compliance with a type of compliance requirement of a federal program that is less severe than a material weakness in internal control over compliance, yet important enough to merit attention by those charged with governance.

Our consideration of internal control over compliance was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control over compliance that might be material weaknesses or significant deficiencies. We did not identify any deficiencies in internal control over compliance that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

MOSS-ADAMS LLP

Report on the Schedule of Expenditures of Federal Awards Required by the Uniform Guidance

We have audited the basic consolidated financial statements of CalOptima as of and for the year ended June 30, 2016, and have issued our report thereon dated September 16, 2016 which contained an unmodified opinion on those basic consolidated financial statements. Our audit was conducted for the purpose of forming an opinion on the basic consolidated financial statements as a whole. The accompanying schedule of expenditures of federal awards is presented for purposes of additional analysis as required by the Uniform Guidance and is not a required part of the basic consolidated financial statements. Such information is the responsibility of management and was derived from and relates directly to the underlying accounting and other records used to prepare the basic consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic consolidated financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic consolidated financial statements or to the basic consolidated financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated, in all material respects, in relation to the basic consolidated financial statements as a whole.

Moss Adams LLP

Irvine, California
September 16, 2016

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA
SUMMARY SCHEDULE OF PRIOR AUDIT FINDINGS
JUNE 30, 2016

Section I – Summary of Auditor's Results

Financial Statements

Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP: *Unmodified*

Internal control over financial reporting:

- Material weakness(es) identified? ☐ Yes ☒ No
- Significant deficiency(ies) identified? ☐ Yes ☒ None reported

Noncompliance material to financial statements noted? ☐ Yes ☒ No

Federal Awards

Internal control over major federal programs:

- Material weakness(es) identified? ☐ Yes ☒ No
- Significant deficiency(ies) identified? ☐ Yes ☒ None reported

Any audit findings disclosed that are required to be reported in accordance with 2 CFR 200.516(a)? ☐ Yes ☒ No

Identification of major federal programs and type of auditor's report issued on compliance for major federal programs:

CFDA Numbers	*Name of Major Federal Program or Cluster*	*Type of Auditor's Report Issued on Compliance for Major Federal Programs*
93.778	Medical Assistance Program	*Unmodified*

Dollar threshold used to distinguish between type A and type B programs: $750,000

Auditee qualified as low-risk auditee? ☒ Yes ☐ No

Section II – Financial Statement Findings

None noted.

Section III – Federal Award Findings and Questioned Costs

None noted.

2016 Audit Results

COMMUNICATION WITH THOSE IN CHARGE OF GOVERNANCE

CalOptima

OCTOBER 6, 2016

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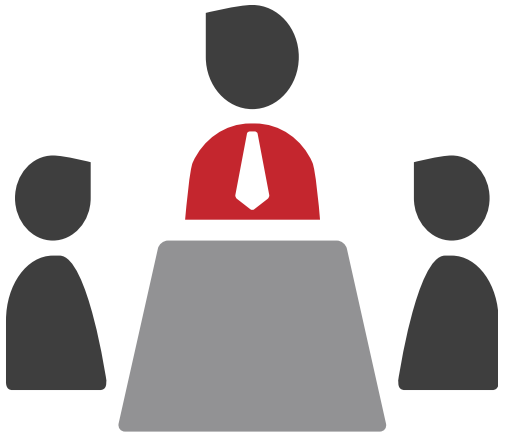
- Scope of Services
- Report of Independent Auditors
- Areas of Audit Emphasis
- Communication with *Those Charged with Governance*



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Scope of Services

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Scope of Services

We have performed the following services for CalOptima:

- Annual consolidated financial statement audit for the fiscal year ending June 30, 2016
- Non-Attest Services
  - Assist management with drafting the consolidated financial statements for the year ending June 30, 2016

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Report of Independent Auditors

MOSS-ADAMS LLP

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Independent Auditors Report on the Consolidated Financial Statements

Unmodified Opinion

- The consolidated financial statements as of and for the years ended June 30, 2016 and 2015, are presented fairly, in all material respects, in accordance with U.S. GAAP

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Areas of Audit Emphasis

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Areas of Audit Emphasis

- Capitation Revenue and Receivables
- Cash and Investments
- Medical Claims Liability
- Payable to State of California

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Capitation Revenue and Receivables

Accounting Issue	Audit Risk	Moss Adams Audit Response	Moss Adams Audit Results
• Program revenue recognition	• Revenue recognition could be inappropriate	• Developed independent expectation of revenue using membership data and rates	• Revenue recognition is considered appropriate
• Valuation of premium receivables	• Receivables can be overstated	• Verifying subsequent receipt of cash	• Receivables are valued properly

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Cash and Investments

Accounting Issue	Audit Risk	Moss Adams Audit Response	Moss Adams Audit Results
• Existence of cash investments	• Cash and investments have been misappropriated • Cash and investments recorded in financial statements do not exist, or FV of investments has been impaired	• Confirmation of cash and investments with financial institutions or other custodian • Tested the FV of investments • Tested the bank reconciliation	• Cash and investments recorded in the financial statements exist • There were no fair value impairments of the investments
• Restrictions on cash and investments have not been properly disclosed	• Restrictions on cash and investments are not disclosed	• Performed testing to determine whether all restrictions have been disclosed	• All restrictions have been properly disclosed in the financial statements

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Medical Claims Liability

Accounting Issue	Audit Risk	Moss Adams Audit Response	Moss Adams Audit Results
• Claims are accurately recorded in the period the service was provided	• Claims expense is understated • Medical Claims Liability for claims incurred prior to the balance sheet date but not received is understated	• We tested the internal controls for the claims system • We tested the data used by the actuary to estimate the accrual • We reviewed the experience and qualifications of the actuary • We performed a retrospective review of the prior year estimate	• Claims expense is properly stated • The current year accrual is materially correct • Normal estimation differences between actual payments and the amount accrued in the prior year is considered immaterial

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Payable to State of California

Accounting Issue	Audit Risk	Moss Adams Audit Response	Moss Adams Audit Results
• Completeness of liabilities recorded for 85% minimum medical loss ratio requirements	• Allowable expenses, defined by DHCS, to meet the MLR requirement are overstated • Estimated payable to State of California is understated	• We obtained an understanding of the methodology to calculate the additional reserves and reviewed for significant assumptions for reasonableness • We tested allowable expenses • We obtained management's estimation methodology and agreed significant inputs to supporting documentation	• Expense recorded for amounts due back to State of California is properly stated • The liability is properly stated

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Communication with
Those Charged with Governance

MOSS-ADAMS LLP
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Our Responsibility Under U.S. and Government Auditing Standards

1. To express our opinion on whether the consolidated financial statements with your oversight are fairly presented, in all material respects, and conform to U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.

2. To perform an audit in accordance with generally accepted auditing standards issued by the AICPA and the Comptroller General of the United States, and design the audit to obtain reasonable, rather than absolute, assurance about whether the consolidated financial statements are free of material misstatement.

3. To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.

4. To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, **we** are not required to design procedures for the purpose of identifying other matters to communicate to you.

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Matters to Be Communicated

Significant Accounting Policies & Unusual Transactions

Difficulties Encountered in Performing the Audit

Disagreements with Management

Significant Audit Adjustments & Unadjusted Differences Considered by Management To Be Immaterial

Our Comments

- There were no changes to significant accounting policies for the year ended June 30, 2016.
- No significant difficulties were encountered during our audit of the Organization's financial statements.
- We are pleased to report that there were no disagreements with management.
- There were no material misstatements identified as a result of our audit.

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Required Communications Contained in Other Auditing Standards

AU-C 240, *Consideration of Fraud in a Financial Statement Audit*

AU-C 250, *Consideration of Laws and Regulations in an Audit of Financial Statements*

AU-C 550, *Related Parties*

Our Comments

- There were no instances of fraud or illegal acts that came to our attention.
- There were no instances of non-compliance with laws and regulations that came to our attention
- No additional risks were identified pertaining to related parties.

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Deficiencies in Internal Control

Any material weaknesses and significant deficiencies in the design or operation of internal control that came to the auditor's attention during the audit must be reported to the audit committee.

Our Comments

- Material weakness
  - None noted
- Significant deficiencies
  - Nothing to communicate

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CALOPTIMA FOUNDATION BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 6, 2016
Meeting of the CalOptima Foundation Board of Directors

Report Item
22. Receive and File the Fiscal Year 2016 CalOptima Foundation Audited Financial Statements

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

Recommended Action
Receive and file the Fiscal Year (FY) 2016 CalOptima Foundation audited financial statements as submitted by Moss-Adams, LLP.

Background
At the May 19, 2016, Finance and Audit Committee (FAC) meeting, the CalOptima Foundation's contracted financial auditor, Moss-Adams, LLP presented on the 2016 Audit Plan. The plan included performing the mandatory annual consolidated financial statement audit, and the drafting of the consolidated financial statements for the year ending June 30, 2016.

Discussion
Moss-Adams, LLP performed the interim audit from May 23, 2016, through May 27, 2016, and the on-site audit from July 25, 2016, through August 12, 2016.

CalOptima Foundation Financial Statement Summary
The following table shows key operating indicators and the CalOptima Foundation's financial position, for the fiscal years ended June 30, 2016 and 2015.

Key Financial Indicators	FY 2015-16	FY 2014-15
Operating revenues	$653,323	$484,761
Operating expenses	665,082	578,182
Change in net position	(11,759)	(93,421)
Financial Position		
Total assets	$2,930,204	$2,962,983
Total liabilities	$35,359	$56,379
Net position	$2,894,845	$2,906,604

FY 2016 Audit Results
Results from the CalOptima Foundation's FY 2016 Audit were very positive. The auditor made no changes in the Foundation's approach to applying the critical accounting policies. They did not encounter any significant difficulties during the audit. And, there were no material misstatements identified by the auditor. As such, Management recommends the Foundation Board to accept the CalOptima Foundation Fiscal 2016 audited financial statements.

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Fiscal Impact
There is no fiscal impact related to this recommended action.

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

Attachments
1. FY 2016 CalOptima Foundation Audited Financial Statements
2. Presentation by Moss Adams, LLP

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

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Report of Independent Auditors and
Financial Statements for

CalOptima Foundation

June 30, 2016 and 2015

MOSS-ADAMS LLP

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Introduction

CalOptima Foundation (the "Foundation") is a not-for-profit benefit and foundation established by Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") in June 2010. It was formed for the benefit of CalOptima members and others in the Orange County community. One of the primary objectives for the Foundation is to take advantage of health related programs and funding opportunities that are not available to governmental entities. Besides the existing CalOptima Regional Extension Center ("COREC") programs, other planned activities are focused on addressing unmet community needs and increasing provider capacity.

The following discussion and analysis of the Foundation's financial statements presents an overview of the financial position and activities as of June 30, 2016 and 2015. This discussion has been prepared by management and should be read in conjunction with the accompanying financial statements and related notes.

Using the Financial Statements

The Foundation's annual report contains three financial statements: the statement of net position, the statement of revenues, expenses and changes in net position, and the statement of cash flows. The report was prepared using the accrual basis of accounting. These statements provide information on the Foundation as a whole and present the Foundation's financial position and results of operations. In the opinion of management, the financial statements represent accurately the financial situation of the Foundation as of June 30, 2016 and 2015. The various components of the financial statements document financial position and growth of the Foundation and its ability to meet its financial obligations as they come due.

Financial Highlights

The Foundation was formed in June 2010. The total assets and liabilities as of June 30, 2016 and 2015 were $2,930,204 and $2,962,983, respectively. The balances were the result of the Health Information Technology for Economic and Clinical Health ("HITECH") grant activities performed during the year.

COREC, which is part of the CalOptima Foundation, achieved 100 percent of the HITECH grant goal to assist local doctors with the use of electronic health record systems.

Statements of Net Position

The statements of net position are point-in-time financial statements. The purpose of these statements is to present a fiscal snapshot of the Foundation to the readers of the financial statements at June 30, 2016 and 2015. The statements of net position include year-end information concerning current and noncurrent assets, current and noncurrent liabilities, and net position (assets less liabilities). Current assets and liabilities include other assets and obligations that can reasonably expect to be sold, collected, consumed or paid within 12 months of the date of the statement. The statements also present the available assets that can be used to satisfy those liabilities.

The following table summarizes the Foundation's assets, liabilities and net position as of June 30:

	2016	2015
Current assets	$ 2,930,204	$ 2,962,983
Total assets	$ 2,930,204	$ 2,962,983
Current liabilities	$ 35,359	$ 56,379
Net position	2,894,845	2,906,604
Total liabilities and net position	$ 2,930,204	$ 2,962,983

Statements of Revenues, Expenses and Changes in Net Position

Changes in net position as presented on the statements of net position are based on the activity presented in the statements of revenues, expenses and changes in net position. The purpose of the statements is to present the revenue received by the Foundation, both operating and nonoperating, and the expenses paid by the Foundation, both operating and nonoperating, and any other revenues, expenses, gains and losses received or incurred by the Foundation.

The following table summarizes the Foundation's revenues, expenses and changes in net position for the years ended June 30:

	2016	2015	2014
Revenues			
Operating revenues			
Grant revenue	$ 304,593	$ 249,283	$ 1,197,673
Contributions	348,730	235,478	3,331,040
Total revenues	653,323	484,761	4,528,713
Operating expenses	665,082	578,182	1,528,713
Change in net position	(11,759)	(93,421)	3,000,000
Net position			
Beginning	2,906,604	3,000,025	25
Ending	$ 2,894,845	$ 2,906,604	$ 3,000,025

Operating revenues – For the years ended June 30, 2016, 2015 and 2014, operating revenues totaled $653,323, $484,761, and $4,528,713, respectively. The revenues are from HITECH grant activities and in-kind contributions from CalOptima. CalOptima provided $348,730, $235,478, and $3,331,040, respectively, of in-kind donations as of June 30, 2016, 2015, and 2014.

Operating expenses – For the years ended June 30, 2016, 2015 and 2014, operating expenses totaled $665,082, $578,182, and $1,528,713, respectively. The expenses from the HITECH grant activities include staff services, miscellaneous supplies, and travel.

Economic Factors That May Affect the Future

In 2010 the Foundation was awarded the HITECH grant with projected total revenues in excess of $6.6 million over four years. As of June 30, 2016, the Foundation has received $6.6 million of the HITECH grant. The remaining balance of this grant is $35,359 as of June 30, 2016.

Requests for Information

This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of CalOptima Foundation's operations. If the reader has questions or would like additional information about CalOptima Foundation, please direct the request to CalOptima Foundation, 505 City Parkway West, Orange, CA 92868 or call 714.347.3237.

REPORT OF INDEPENDENT AUDITORS

The Board of Directors
CalOptima Foundation

Report on Financial Statements
We have audited the accompanying financial statements of CalOptima Foundation (the "Foundation"), a component unit of the Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima, as of and for the years ended June 30, 2016 and 2015, and the related notes to the financial statements, which collectively comprise the Foundation's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements
Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility
Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence obtained is sufficient and appropriate to provide a basis for our audit opinion.

MOSS-ADAMS LLP

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Foundation as of June 30, 2016 and 2015, and the respective changes in financial position and, where applicable, cash flows thereof for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1-3 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquires, the basic financial statements and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Moss Adams LLP

Irvine, California
September 16, 2016

CALOPTIMA FOUNDATION
STATEMENTS OF NET POSITION

	JUNE 30, 2016	JUNE 30, 2015
ASSETS		
CURRENT ASSETS		
Cash	$ 2,894,845	$ 2,912,920
Grants receivables	35,359	48,623
Prepaid expenses	-	1,440
Total assets	$ 2,930,204	$ 2,962,983
LIABILITIES AND NET POSITION		
CURRENT LIABILITIES		
Accounts payable	$ 35,298	$ 49,904
Deferred liabilities	-	1,440
Payable to CalOptima	61	5,035
Total liabilities	35,359	56,379
UNRESTRICTED NET POSITION	2,894,845	2,906,604
Total liabilities and net position	$ 2,930,204	$ 2,962,983

See accompanying notes.

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CALOPTIMA FOUNDATION
STATEMENTS OF REVENUES, EXPENSES AND CHANGES IN NET POSITION

	YEARS ENDED JUNE 30,	
	2016	2015
Operating Revenues		
Grant revenue	$ 304,593	$ 249,283
Total operating revenues	304,593	249,283
Operating Expenses		
Salaries, wages and employee benefits	363,086	303,396
Supplies and other	301,996	274,786
Total operating expenses	665,082	578,182
Operating loss	(360,489)	(328,899)
Nonoperating Revenues		
Contributions	348,730	235,478
Total nonoperating revenues	348,730	235,478
Change in net position	(11,759)	(93,421)
Net Position		
Beginning	2,906,604	3,000,025
Ending	$ 2,894,845	$ 2,906,604

See accompanying notes.

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CALOPTIMA FOUNDATION
STATEMENTS OF CASH FLOWS

	YEARS ENDED JUNE 30, 2016	YEARS ENDED JUNE 30, 2015
CASH FLOWS FROM OPERATING ACTIVITIES		
Grant payments and contributions received	$ 317,857	$ 292,781
Payments to vendors	(321,576)	(336,978)
Payments to employees	(14,356)	(67,918)
Net cash used in operating activities	(18,075)	(112,115)
Net change in cash	(18,075)	(112,115)
Cash		
Beginning	2,912,920	3,025,035
Ending	$ 2,894,845	$ 2,912,920
Reconciliation of operating loss to net cash used in operating activities		
Operating loss	$ (360,489)	$ (328,899)
Adjustments to reconcile operating loss to net cash used in operating activities:		
Changes in assets and liabilities		
Grant receivables	13,264	43,498
Accounts payable and deferred liabilities	(14,606)	(42,227)
Payable to CalOptima	(4,974)	(19,965)
Net cash used in operating activities	$ (366,805)	$ (347,593)
SUPPLEMENTAL SCHEDULE OF NON-CASH OPERATING ACTIVITIES		
Cash received from contributions	$ 348,730	$ 235,478

See accompanying notes.

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Note 1 – Nature of Operations, Reporting Entity and Significant Accounting Policies

Nature of operations – CalOptima Foundation (the Foundation) is a nonprofit organization formed in June 2010 in the state of California. The operations of the Foundation include, but are not limited to, applying for and administering grants dedicated to the betterment of public health-care services. The Foundation is organized and operated exclusively to benefit Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") program needs.

Reporting entity – The Foundation has no component units, but is a component unit of CalOptima because the Foundation's governing body is the same as the governing body of CalOptima. The financial statements present only the Foundation, and do not purport to, and do not present, the financial position of CalOptima as of June 30, 2016 and 2015, or the changes in its financial position, or its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

Basis of accounting – The financial statements of the Foundation have been prepared using the economic resource management focus and the accrual basis of accounting. Revenues are recognized when earned, and expenses and liabilities are recognized when incurred.

The Foundation considers grant revenues earned as operating revenue. Expenses associated with managing the grant and the Foundation are considered operating expenses. All revenues and expenses not meeting this definition are reported as nonoperating revenues and expenses.

Accounting estimates – The preparation of financial statements in conformity with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and that reported amounts of revenues, expenses, gains, losses and other changes in net position during the reporting period. Actual results could differ from those estimates.

Net position – Net position represents the difference between assets and liabilities. Net position is reported as restricted if there are limitations imposed on their use. When an expense is incurred for purposes for which both restricted and unrestricted net positions are available, the Foundation first applies restricted resources. The Foundation had no restricted net position at June 30, 2016 or 2015.

Revenue recognition – Grant revenue and in-kind contributions are recorded as earned over the period covered in accordance with the grant provisions.

Income tax status – The Internal Revenue Service has recognized the Foundation as exempt from federal and state income tax on related income under Section 501(c)(3) of the Internal Revenue Code. The Foundation is not classified as a private foundation. The Foundation has reviewed its tax positions for all open tax years and has concluded that no liabilities exist as of June 30, 2016 and 2015. The Foundation files tax returns with the U.S. federal and the State of California jurisdictions.

Note 2 – Cash and Custodial Credit Risk

As of June 30, 2016 and 2015, all cash deposits held with financial institutions were insured by the Federal Deposit Insurance Corporation and through securities pledged by the financial institutions held in an individual collateral pool by a depository regulated under California state law.

Note 3 – Related-Party Transactions

CalOptima provides certain services for the benefit of the Foundation at no charge. The cost of the services provided by CalOptima is reported as in-kind income and expenses by the Foundation. These services include, but are not limited to: staff compensation, travel, equipment and supplies. Total contributions from CalOptima were $348,730 and $235,478, for the years ended June 30, 2016 and 2015, respectively. As of June 30, 2016 and 2015, the Foundation has recorded a payable to CalOptima of $61 and $5,035, respectively.

Note 4 – Grant Revenue

The Foundation was awarded a four-year HITECH grant on September 26, 2010, plus a one year post-award amendment effective until September 26, 2015. During the year ended June 30, 2016, the Foundation received an additional one year post-award amendment, which extended the award to September 26, 2016. This grant is for the Foundation to assist Orange County health-care providers with adopting and implementing electronic health records. The Foundation is responsible for enrolling 1,000 providers as well as project management of multiple phases of demonstrating meaningful use. Grant income is recognized when qualifying expenditures have been incurred and upon achievement of other criteria. Recipients of the HITECH grant are required to meet a 10 percent match in proportion to the expenditures of the federal share of the total project costs. CalOptima provides this match through in-kind contributions.

2016 Audit Results

COMMUNICATION WITH THOSE IN CHARGE OF GOVERNANCE

CalOptima Foundation

OCTOBER 6, 2016

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

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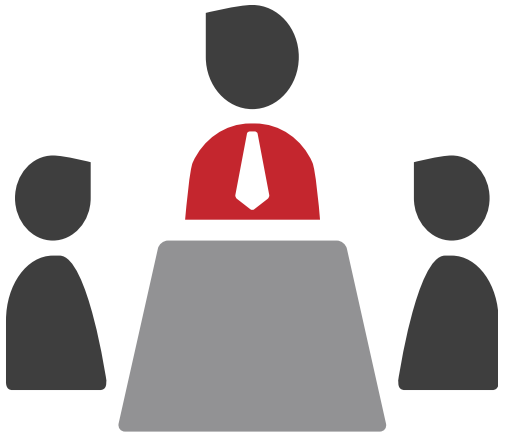
Agenda

- Scope of Services
- Report of Independent Auditors
- Areas of Audit Emphasis
- Communication with *Those Charged with Governance*



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Scope of Services

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Scope of Services

We have performed the following services for CalOptima Foundation:

- Annual financial statement audit as of and for the fiscal year ending June 30, 2016
- Non-Attest Services
  - Assist management with drafting the financial statements for the year ending June 30, 2016
  - Prepared the Form 990 for the year ending June 30, 2016

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Report of Independent Auditors

MOSS-ADAMS LLP

Certified Public Accountants | Business Consultants

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Independent Auditors Report on the Financial Statements

Unmodified Opinion

- The financial statements as of and for the years ended June 30, 2016 and 2015, are presented fairly, in all material respects, in accordance with U.S. GAAP

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Areas of Audit Emphasis

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Areas of Audit Emphasis

- Grant Revenue
- Cash

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Grant Revenue

Accounting Issue	Audit Risk	Moss Adams Audit Response	Moss Adams Audit Results
• Grant revenue recognition	• Revenue recognition could be inappropriate	• Developed independent expectation of revenue based on qualifying expenses incurred and paid during FY 2016	• Revenue recognition is considered appropriate

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Cash

Accounting Issue	Audit Risk	Moss Adams Audit Response	Moss Adams Audit Results
• Existence of cash	• Cash has been misappropriated • Cash recorded in the financial statements does not exist	• Confirmation of cash with financial institutions • Tested the bank reconciliation	• Cash recorded in the financial statements exists
• Restrictions on cash have not been properly disclosed	• Restrictions on cash are not disclosed	• Performed testing to determine whether all restrictions have been disclosed	• All restrictions have been properly disclosed in the financial statements

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Communication with
Those Charged with Governance

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Our Responsibility Under U.S. and Government Auditing Standards

1. To express our opinion on whether the consolidated financial statements with your oversight are fairly presented, in all material respects, and conform to U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.

2. To perform an audit in accordance with generally accepted auditing standards issued by the AICPA and the Comptroller General of the United States, and design the audit to obtain reasonable, rather than absolute, assurance about whether the consolidated financial statements are free of material misstatement.

3. To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.

4. To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, **we** are not required to design procedures for the purpose of identifying other matters to communicate to you.

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Matters to Be Communicated

Significant Accounting Policies & Unusual Transactions

Difficulties Encountered in Performing the Audit

Disagreements with Management

Material Misstatements & Significant Audit Adjustments

Our Comments

- There were no changes to significant accounting policies for the year ended June 30, 2016.
- No significant difficulties were encountered during our audit of the Foundation's financial statements.
- We are pleased to report that there were no disagreements with management.
- There were no material misstatements identified as a result of our audit.

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Required Communications Contained in Other Auditing Standards

AU-C 240, *Consideration of Fraud in a Financial Statement Audit*

AU-C 250, *Consideration of Laws and Regulations in an Audit of Financial Statements*

AU-C 550, *Related Parties*

Our Comments

- There were no instances of fraud or illegal acts that came to our attention.
- There were no instances of non-compliance with laws and regulations that came to our attention
- No additional risks were identified pertaining to related parties.

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Deficiencies in Internal Control

Any material weaknesses and significant deficiencies in the design or operation of internal control that came to the auditor's attention during the audit must be reported to the audit committee.

Our Comments

- Material weakness
  - None noted
- Significant deficiencies
  - Nothing to communicate

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Pulled from the agenda on 10/6/2016

AGENDA ITEM 23

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

Staff will provide additional details at or before the October 6, 2016 Board meeting.

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AGENDA ITEM 24 TO FOLLOW CLOSED SESSION

Consider Chief Executive Officer and Chief Counsel Performance Evaluation and Compensation

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Board of Directors Meeting
October 6, 2016

Provider Advisory Committee (PAC) Update

September 8, 2016 PAC Meeting

Fourteen (14) PAC members were in attendance for the September PAC meeting.

While the ad hoc committee for the PAC chair and vice chair did not meet since there was only one committee member each who expressed interest in the positions, the PAC approved a recommended action to appoint Teri Miranti, Health Network Representative as the PAC chair and Suzanne Richards, Hospital Representative as the PAC vice chair for the remainder of the FY2016-17 fiscal year. A CalOptima staff report is being developed and will be forwarded to the Board for consideration.

Michael Schrader, Chief Executive Officer, updated the PAC on Board actions from the September 1, 2016 Board Meeting. He also gave the PAC the great news about the NCQA awarding CalOptima a "Commendable" rating and also discussed the possibility that there might be lower HEDIS scores that could affect CalOptima's number one ranking in California. After discussion during the meeting, PAC members have indicated their willingness to form a HEDIS Ad Hoc Committee and work with CalOptima staff to help address the lower scores.

Dr. Richard Bock, Deputy Chief Medical Officer, provided an update on the Pay for Value program which elicited a robust discussion among members. Dr. Bock also provided an informational presentation on the hazards of nicotine and the use of e-cigarettes among minors and young adults.

PAC received an update on the Whole Person Care pilot program by Cheryl Meronk, Director, Strategic Development.

Member Ross updated his fellow PAC members on the progress of the CAHPS Ad Hoc subcommittee. He noted that the committee had met three times since June and that one of the goals of the committee is to improve the member experience for adults and children while attempting to achieve an NCQA rating of three (3) on consumer satisfaction by 2018. The ad hoc's focus will be on system issues, sharing best practices of high performers, developing individual provider dashboards, surveying networks on program they offer providers and education/mentoring for low performers. The ad hoc committee will reconvene when further data is available.

PAC received the following updates from CalOptima executive staff at the September 8, 2016 PAC meeting: CFO Financial Update covering July financials, COO Update and a review of the Legislative Matrix provided by Government Affairs.

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

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Board of Directors Meeting
October 6, 2016

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

At the August 25, 2016, OneCare Connect Member Advisory Committee (OCC MAC) meeting, OCC MAC members welcomed newly appointed OneCare Connect Member representative John Dupies.

OCC MAC members received an update on OCC Member Enrollment. As of August 15, 2016, OCC enrollment was 18,273 members with a July opt-out rate of 57.09%. The July opt-out rate for Long-Term Care (LTC) facilities was 56.10%.

OCC MAC members received a presentation from The SCAN Foundation on the findings from waves 1-3 on the Coordinated Care Initiative (CCI) evaluation survey. The survey evaluated and tracked beneficiary transitions into Cal MediConnect over time. OCC MAC members also received CalOptima updates on a Healthcare Effectiveness Data and Information Set (HEDIS) and an overview of the dental plan for OneCare Connect members. OCC MAC member, Sara Lee, presented on the Quarterly Ombudsman Update.

OCC MAC opened nominations for the Chair and Vice Chair positions and will make candidate recommendations to the CalOptima Board at an upcoming meeting in conjunction with the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC).

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

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Board of Directors Meeting
October 6, 2016

Member Advisory Committee Update

A quorum was not reached at the September 8, 2016 Member Advisory Committee (MAC) meeting.

The MAC recruitment for the vacant Recipients of CalWORKs' representative, Chair and Vice Chair started July 11, 2016 and ended on August 1, 2016. The MAC Nominations Ad Hoc, composed of members Lisa Workman, Christine Tolbert and Suzanne Butler met on August 31, 2016, to review nominations individually and to select the slate of candidates for MAC's consideration and approval at the September 8, 2016 meeting. MAC will be forwarding those recommended candidates to the CalOptima Board for consideration at a future meeting.

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

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Financial Summary

August 2016

Board of Directors Meeting

October 6, 2016

Chet Uma

Chief Financial Officer

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FY 2016-17: Consolidated Enrollment

- August 2016 MTD:
  - Overall enrollment was 798,243 member months
    - Actual lower than budget by 1,535 or 0.2%
      - Medi-Cal: favorable variance of 2,474 members
        - Medi-Cal Expansion (MCE) growth higher than budget
        - SPD enrollment higher than budget due to less than anticipated dual eligible members transferring to OneCare Connect
        - Offset by lower than budget TANF enrollment
      - OneCare Connect: unfavorable variance of 3,942 members
    - 0.1% decrease from prior month
      - OneCare Connect: decrease of 657 from July
      - Medi-Cal: decrease of 178 from July
    - 4.5% or 34,046 increase in enrollment from prior year

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FY 2016-17: Consolidated Enrollment

- August 2016 YTD:
  - Overall enrollment was 1,597,326 member months
    - Actual lower than budget by 946 or 0.1%
      - Medi-Cal: favorable variance of 6,516 members
        - Medi-Cal Expansion (MCE) growth higher than budget
        - SPD enrollment higher than budget due to less than anticipated dual eligible members transferring to OneCare Connect
        - Offset by lower than budget TANF enrollment
      - OneCare Connect: unfavorable variance of 7,326 members
      - OneCare: unfavorable variance of 157 members

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FY 2016-17: Consolidated Revenues

- August 2016 MTD:
  - ➢ Actual lower than budget by $2.2 million or 0.8%
    - Medi-Cal: favorable to budget by $8.5 million
      - ABA prior year revenue adjustment of $5.1 million
      - IHSS estimated revenue $2.5 million higher than budget
      - Favorable volume variance of $0.7 million
    - OneCare Connect: unfavorable variance of $10.2 million
      - Unfavorable price variance of $2.0 million due to cohort mix
      - Unfavorable volume variance of $8.1
    - OneCare: unfavorable to budget by $0.5 million

- August 2016 YTD:
  - ➢ Actual lower than budget by $3.6 million or 0.6%
    - Medi-Cal: favorable to budget by $16.2 million
    - OneCare Connect: unfavorable variance of $19.9 million
    - OneCare: favorable to budget $9.0 thousand

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FY 2016-17: Consolidated Medical Expenses

- August 2016 MTD:
  - Actual higher than budget by $0.6 million or 0.2%
    - Medi-Cal: unfavorable variance of $10.0 million
      - MLTSS variance $7.2 million
        - IHSS $4.2 million due to higher utilization
        - LTC $3.0 million due to less than anticipated LTC members enrolled in OneCare Connect
      - Prescription Drugs higher than budget by $3.0 million
    - OneCare Connect: favorable variance of $8.7 million
      - Volume variance of $7.6 million
      - Price variance of $1.1 million, mainly attributable to
        - $3.5 million in LTC
        - Offset by $2.9 million in Prescription Drugs

FY 2016-17: Consolidated Medical Expenses (Cont.)

- August 2016 YTD:
  - Actual higher than budget by $0.4 million
    - Medi-Cal: unfavorable variance of $19.8 million
      - Price variance of ($17.9) million due to IHSS estimated expenses $4.5 million higher than budget
      - Volume variance of ($1.9) million
    - OneCare Connect: favorable variance of $18.9 million

- Medical Loss Ratio (MLR):
  - August 2016 MTD: Actual: 96.8% Budget: 95.9%
  - August 2016 YTD: Actual: 96.6% Budget: 95.9%

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FY 2016-17: Consolidated Administrative Expenses

- August 2016 MTD:
  - Actual lower than budget by $2.0 million or 18.1%
    - Salaries and Benefits: favorable variance of $1.6 million driven by lower than budgeted FTE of 99
    - Other categories: favorable variance of $0.4 million
- August 2016 YTD:
  - Actual lower than budget by $5.5 million or 23.1%
    - Salaries and Benefits: favorable variance of $3.4 million driven by lower than budgeted FTE of 197
    - Other categories: favorable variance of $2.1 million
- Administrative Loss Ratio (ALR):
  - August 2016 MTD: Actual: 3.3% Budget: 4.0%
  - August 2016 YTD: Actual: 3.3% Budget: 4.2%

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FY 2016-17: Change in Net Assets

- August 2016 MTD:
  - $0.1 million deficit
  - $0.7 million unfavorable to budget
    - Attributable to:
      - Lower than budgeted revenue of $2.2 million
      - Higher medical expenses of $0.6 million
      - Lower administrative expenses of $2.0 million
      - Lower investment income of $0.1 million

- August 2016 YTD:
  - $1.6 million surplus
  - $1.8 million favorable to budget
    - Attributable to:
      - Lower than budgeted revenue of $3.6 million
      - Higher medical expenses of $0.4 million
      - Lower administrative expenses of $5.5 million
      - Higher investment income of $0.2 million

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Enrollment Summary: August 2016

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
57,464	54,919	2,545	4.6%	Aged	114,398	109,677	4,721	4.3%
635	675	(40)	(5.9%)	BCCTP	1,269	1,351	(82)	(6.1%)
48,331	47,508	823	1.7%	Disabled	96,784	95,048	1,736	1.8%
334,146	338,666	(4,520)	(1.3%)	TANF Child	669,176	676,562	(7,386)	(1.1%)
103,046	109,759	(6,713)	(6.1%)	TANF Adult	207,055	219,488	(12,433)	(5.7%)
3,280	2,677	603	22.5%	LTC	6,516	5,348	1,168	21.8%
231,753	221,978	9,775	4.4%	MCE	462,290	443,503	18,787	4.2%
778,655	**776,181**	**2,474**	**0.3%**	**Medi-Cal**	**1,557,488**	**1,550,972**	**6,516**	**0.4%**
18,245	**22,187**	**(3,942)**	**(17.8%)**	**OneCare Connect**	**37,147**	**44,473**	**(7,326)**	**(16.5%)**
179	**170**	**9**	**5.3%**	**PACE**	**356**	**335**	**21**	**6.3%**
1,164	**1,240**	**(76)**	**(6.1%)**	**OneCare**	**2,335**	**2,492**	**(157)**	**(6.3%)**
798,243	**799,778**	**(1,535)**	**(0.2%)**	**CalOptima Total**	**1,597,326**	**1,598,272**	**(946)**	**(0.1%)**

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Financial Highlights: August 2016

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
798,243	799,778	(1,535)	(0.2%)	Member Months	1,597,326	1,598,272	(946)	(0.1%)
279,225,706	281,383,321	(2,157,615)	(0.8%)	Revenues	558,787,416	562,430,774	(3,643,358)	(0.6%)
270,332,425	269,706,404	(626,021)	(0.2%)	Medical Expenses	539,615,901	539,242,597	(373,304)	(0.1%)
9,181,740	11,207,153	2,025,413	18.1%	Administrative Expenses	18,249,897	23,725,147	5,475,251	23.1%
(288,459)	**469,764**	**(758,223)**	**(161.4%)**	**Operating Margin**	**921,618**	**(536,970)**	**1,458,589**	**(271.6%)**
141,869	143,250	(1,381)	(1.0%)	Non Operating Income (Loss)	655,782	286,500	369,282	128.9%
(146,590)	**613,014**	**(759,604)**	**(123.9%)**	**Change in Net Assets**	**1,577,401**	**(250,470)**	**1,827,871**	**(729.8%)**
96.8%	95.9%	(1.0%)		Medical Loss Ratio	96.6%	95.9%	(0.7%)	
3.3%	4.0%	0.7%		Administrative Loss Ratio	3.3%	4.2%	1.0%	
(0.1%)	0.2%	(0.3%)		Operating Margin Ratio	0.2%	(0.1%)	0.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: August 2016 (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
0.0	0.0	0.0	Medi-Cal	0.2	(0.7)	0.8
(0.1)	0.0	(0.1)	OneCare	0.1	0.1	0.1
(0.4)	0.6	(1.0)	OCC	0.6	0.6	0.0
0.1	(0.2)	0.4	PACE	0.0	(0.5)	0.6
(0.3)	**0.5**	**(0.8)**	**Operating**	**0.9**	**(0.5)**	**1.5**
0.1	0.1	0.0	Inv./Rental Inc, MCO tax	0.7	0.3	0.4
0.1	**0.1**	**0.0**	**Non-Operating**	**0.7**	**0.3**	**0.4**
(0.1)	**0.6**	**(0.8)**	**TOTAL**	**1.6**	**(0.3)**	**1.8**

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Consolidated Revenue & Expense: August 2016 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	546,902	231,753	$ 778,655	1,164	18,245	179	798,243
REVENUES							
Capitation Revenue	136,153,905	105,444,331	$ 241,598,236	$ 970,939	$ 35,570,921	$ 1,085,610	$ 279,225,706
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	136,153,905	105,444,331	241,598,236	970,939	35,570,921	1,085,610	279,225,706
MEDICAL EXPENSES							
Provider Capitation	32,281,263	42,129,491	74,410,754	406,913	6,758,132	-	81,575,798
Facilitities	25,880,196	31,354,932	57,235,128	91,403	10,278,678	172,199	67,777,407
Ancillary				44,832	893,265	-	938,097
Skilled Nursing				22,191	5,163,325	-	5,185,515
Professional Claims	9,183,960	8,141,524	17,325,484	-	-	137,788	17,463,272
Prescription Drugs	18,859,686	18,624,085	37,483,771	410,052	9,635,600	98,371	47,627,794
Quality Incentives					365,120		365,120
Long-term Care Facility Payments	38,128,706	6,315,960	44,444,667	-	-	(20,409)	44,424,258
Contingencies	-	-	-	-	-	-	-
Medical Management	2,846,458	-	2,846,458	16,680	932,465	353,615	4,149,217
Reinsurance & Other	(348,968)	948,643	599,675	5,042	127,813	93,417	825,947
Total Medical Expenses	126,831,301	107,514,636	234,345,937	997,111	34,154,397	834,981	270,332,425
Medical Loss Ratio	**93.2%**	**102.0%**	**97.0%**	**102.7%**	**96.0%**	**76.9%**	**96.8%**
GROSS MARGIN	9,322,604	(2,070,305)	**7,252,299**	**(26,173)**	**1,416,524**	**250,630**	**8,893,280**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			5,480,537	(5,046)	415,566	90,960	5,982,016
Professional Fees			196,487	12,881	78,105	1,938	289,411
Purchased Services			680,313	24,054	167,420	5,240	877,028
Printing and Postage			256,375	799	107,365	220	364,759
Depreciation and Amortization			262,097			2,014	264,111
Other Expenses			1,012,645	595	65,097	7,166	1,085,503
Indirect Cost Allocation, Occupancy Expense			(650,544)	29,494	937,491	2,471	318,912
Total Administrative Expenses			7,237,910	62,777	1,771,044	110,009	9,181,740
Admin Loss Ratio			**3.0%**	**6.5%**	**5.0%**	**10.1%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			14,389	(88,949)	(354,520)	140,621	(288,459)
INVESTMENT INCOME			-	-	-	-	136,062
NET RENTAL INCOME			-	-	-	-	5,711
OTHER INCOME			96	-	-	-	96
CHANGE IN NET ASSETS			**$ 14,485**	**$ (88,949)**	**$ (354,520)**	**$ 140,621**	**$ (146,590)**
BUDGETED CHANGE IN ASSETS			27,268	38,696	643,815	(240,015)	613,014
VARIANCE TO BUDGET - FAV (UNFAV)			(12,782)	(127,646)	(998,335)	380,636	(759,604)

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Consolidated Revenue & Expense: August 2016 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	1,095,198	462,290	$ 1,557,488	2,335	37,147	356	1,597,326
REVENUES							
Capitation Revenue	272,009,588	209,956,483	$ 481,966,071	$ 2,880,270	$ 71,786,950	$ 2,154,125	$ 558,787,416
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	272,009,588	209,956,483	481,966,071	2,880,270	71,786,950	2,154,125	558,787,416
MEDICAL EXPENSES							
Provider Capitation	64,776,776	84,177,000	148,953,776	778,668	14,926,327	-	164,658,771
Facilitities	52,616,499	66,183,805	118,800,303	696,427	19,663,801	497,686	139,658,216
Ancillary				81,959	1,422,288	-	1,504,247
Skilled Nursing				65,005	10,217,602	-	10,282,607
Professional Claims	18,778,116	15,609,385	34,387,501	-	-	352,124	34,739,625
Prescription Drugs	35,629,421	34,617,688	70,247,109	897,756	18,036,995	194,781	89,376,641
Quality Incentives					743,900		743,900
Long-term Care Facility Payments	76,139,357	12,348,805	88,488,162	-	-	(14,808)	88,473,354
Contingencies	-	-	-	-	-	-	-
Medical Management	5,908,162	-	5,908,162	44,769	1,904,589	707,313	8,564,833
Reinsurance & Other	(727,625)	1,921,099	1,193,474	10,250	234,817	175,165	1,613,706
Total Medical Expenses	253,120,707	214,857,782	467,978,488	2,574,833	67,150,319	1,912,261	539,615,901
Medical Loss Ratio	**93.1%**	**102.3%**	**97.1%**	**89.4%**	**93.5%**	**88.8%**	**96.6%**
GROSS MARGIN	18,888,881	(4,901,299)	13,987,582	305,437	4,636,632	241,864	19,171,515
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			10,788,365	12,797	1,509,068	180,881	12,491,111
Professional Fees			381,698	34,881	182,055	6,876	605,510
Purchased Services			1,272,134	44,334	284,355	5,240	1,606,062
Printing and Postage			378,439	3,184	121,783	442	503,848
Depreciation and Amortization			526,688			4,028	530,716
Other Expenses			1,738,866	1,309	66,590	16,202	1,822,966
Indirect Cost Allocation, Occupancy Expense			(1,249,203)	58,988	1,874,982	4,917	689,682
Total Administrative Expenses			13,836,986	155,492	4,038,832	218,587	18,249,897
Admin Loss Ratio			**2.9%**	**5.4%**	**5.6%**	**10.1%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			150,597	149,945	597,800	23,277	921,618
INVESTMENT INCOME			-	-	-	-	646,924
NET RENTAL INCOME			-	-	-	-	8,511
OTHER INCOME			348	-	-	-	348
CHANGE IN NET ASSETS			**$ 150,944**	**$ 149,945**	**$ 597,800**	**$ 23,277**	**$ 1,577,401**
BUDGETED CHANGE IN ASSETS			(686,420)	68,091	614,287	(532,928)	(250,470)
VARIANCE TO BUDGET - FAV (UNFAV)			837,364	81,854	(16,488)	556,206	1,827,871

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Balance Sheet: As of August 2016

ASSETS		
Current Assets		
	Operating Cash	$170,094,030
	Catastrophic Reserves	11,664,256
	Investments	1,510,623,228
	Capitation receivable	250,869,196
	Receivables - Other	17,496,341
	Prepaid Expenses	11,604,066
	Total Current Assets	**1,972,351,118**
Capital Assets	Furniture and equipment	28,851,790
	Leasehold improvements	12,185,423
	505 City Parkway West	46,707,144
		87,744,356
	Less: accumulated depreciation	(32,719,360)
	Capital assets, net	**55,024,997**
Other Assets	Restricted deposit & Other	281,658
	Board-designated assets	
	Cash and cash equivalents	2,896,809
	Long term investments	472,496,705
	Total Board-designated Assets	475,393,514
	Total Other Assets	**475,675,172**
	Deferred outflows of Resources - Pension Contributions	3,787,544
	Deferred outflows of Resources - Difference in Experience	1,215,473
TOTAL ASSETS & OUTFLOWS		**2,508,054,303**

LIABILITIES & FUND BALANCES		
Current Liabilities		
	Accounts payable	$3,211,822
	Medical claims liability	612,076,921
	Accrued payroll liabilities	9,894,997
	Deferred revenue	751,980,562
	Deferred lease obligations	260,711
	Capitation and withholds	431,171,268
	Total Current Liabilities	**1,808,596,280**
Other employment benefits liability		27,860,642
Net Pension Liabilities		8,148,262
Long Term Liabilities		150,000
TOTAL LIABILITIES		**1,844,755,184**
Deferred inflows of Resources - Excess Earnings		502,900
Deferred inflows of Resources - changes in Assumptions		1,651,640
Tangible net equity (TNE)		90,017,313
Funds in excess of TNE		571,127,266
Net Assets		**661,144,579**
TOTAL LIABILITIES, INFLOWS & FUND BALANCES		**2,508,054,303**

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Board Designated Reserve and TNE Analysis
As of August 2016

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	135,228,414				
	Tier 1 - Logan Circle	125,291,977				
	Tier 1 - Wells Capital	125,265,429				
Board-designated Reserve		385,785,819	287,128,548	448,762,488	98,657,271	(62,976,669)
TNE Requirement	Tier 2 - Logan Circle	89,607,695	90,017,313	90,017,313	(409,618)	(409,618)
	Consolidated:	**475,393,514**	**377,145,861**	**538,779,801**	**98,247,653**	**(63,386,287)**
	Current reserve level	*1.76*	*1.40*	*2.00*		

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CalOptima A Public Agency Better. Together.

UNAUDITED FINANCIAL STATEMENTS

August 2016

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CalOptima - Consolidated
Financial Highlights
For the Two Months Ended August 31, 2016

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
798,243	799,778	(1,535)	(0.2%)	Member Months	1,597,326	1,598,272	(946)	(0.1%)
279,225,706	281,383,321	(2,157,615)	(0.8%)	Revenues	558,787,416	562,430,774	(3,643,358)	(0.6%)
270,332,425	269,706,404	(626,021)	(0.2%)	Medical Expenses	539,615,901	539,242,597	(373,304)	(0.1%)
9,181,740	11,207,153	2,025,413	18.1%	Administrative Expenses	18,249,897	23,725,147	5,475,251	23.1%
(288,459)	**469,764**	**(758,223)**	**(161.4%)**	**Operating Margin**	**921,618**	**(536,970)**	**1,458,589**	**(271.6%)**
141,869	143,250	(1,381)	(1.0%)	Non Operating Income (Loss)	655,782	286,500	369,282	128.9%
(146,590)	**613,014**	**(759,604)**	**(123.9%)**	**Change in Net Assets**	**1,577,401**	**(250,470)**	**1,827,871**	**(729.8%)**
96.8%	95.9%	(1.0%)		Medical Loss Ratio	96.6%	95.9%	(0.7%)	
3.3%	4.0%	0.7%		Administrative Loss Ratio	3.3%	4.2%	1.0%	
(0.1%)	0.2%	(0.3%)		Operating Margin Ratio	0.2%	(0.1%)	0.3%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima
Financial Dashboard
For the Two Months Ended August 31, 2016

MONTH

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	778,655	776,181	2,474	0.3%
OneCare	1,164	1,240	(76)	(6.1%)
OneCare Connect	18,245	22,187	(3,942)	(17.8%)
PACE	179	170	9	5.3%
Total	798,243	799,778	(1,535)	(0.2%)

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 14	$ 27	$ (13)	(46.9%)
OneCare	(89)	39	(128)	(329.9%)
OneCare Connect	(355)	644	(998)	(155.1%)
PACE	141	(240)	381	158.6%
505 Bldg.	6	(65)	71	108.8%
Investment Income & Other	136	208	(72)	(34.6%)
Total	$ (146)	$ 613	$ (760)	(123.9%)

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.0%	96.2%	(0.8)
OneCare	102.7%	90.7%	(12.0)
OneCare Connect	96.0%	93.8%	(2.3)

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 7,238	$ 8,794	$ 1,556	17.7%
OneCare	63	95	32	33.8%
OneCare Connect	1,771	2,208	437	19.8%
PACE	110	110	(0)	(0.2%)
Total	$ 9,182	$ 11,207	$ 2,025	18.1%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	830	886	56
OneCare	2	3	1
OneCare Connect	216	239	22
PACE	36	57	20
Total	1,084	1,184	100

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	938	876	62
OneCare	750	413	337
OneCare Connect	84	93	(9)
PACE	5	3	2
Total	1,777	1,385	392

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	1,557,488	1,550,972	6,516	0.4%
OneCare	2,335	2,492	(157)	(6.3%)
OneCare Connect	37,147	44,473	(7,326)	(16.5%)
PACE	356	335	21	6.3%
Total	1,597,326	1,598,272	(946)	(0.1%)

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 151	$ (686)	$ 837	122.0%
OneCare	150	68	82	120.2%
OneCare Connect	598	614	(16)	(2.7%)
PACE	23	(533)	556	104.4%
505 Bldg.	9	(130)	139	106.5%
Investment Income &	647	417	231	55.3%
Total	$ 1,578	$ (250)	$ 1,828	729.9%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.1%	96.2%	(0.9)
OneCare	89.4%	91.0%	1.6
OneCare Connect	93.5%	93.8%	0.3

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 13,837	$ 18,269	$ 4,432	24.3%
OneCare	155	191	35	18.5%
OneCare Connect	4,039	5,037	998	19.8%
PACE	219	228	10	4.3%
Total	$ 18,250	$ 23,725	$ 5,475	23.1%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,624	1,772	148
OneCare	9	6	(3)
OneCare Connect	464	477	13
PACE	74	113	39
Total	2,171	2,368	197

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	959	875	84
OneCare	268	415	(147)
OneCare Connect	80	93	(13)
PACE	5	3	2
Total	1,312	1,387	(75)

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CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended August 31, 2016

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	798,243		799,778		(1,535)	
Revenues						
Medi-Cal	$ 241,598,236	$ 310.28	$ 233,142,991	$ 300.37	$ 8,455,245	$ 9.90
OneCare	970,939	834.14	1,427,982	1,151.60	(457,043)	(317.46)
OneCare Connect	35,570,921	1,949.63	45,737,267	2,061.44	(10,166,346)	(111.82)
PACE	1,085,610	6,064.86	1,075,081	6,324.01	10,529	(259.14)
Total Operating Revenue	279,225,706	349.80	281,383,321	351.83	(2,157,615)	(2.03)
Medical Expenses						
Medi-Cal	234,345,937	300.96	224,321,440	289.01	(10,024,497)	(11.96)
OneCare	997,111	856.62	1,294,516	1,043.96	297,404	187.34
OneCare Connect	34,154,397	1,871.99	42,885,096	1,932.89	8,730,700	60.91
PACE	834,981	4,664.70	1,205,352	7,090.31	370,372	2,425.61
Total Medical Expenses	270,332,425	338.66	269,706,404	337.23	(626,021)	(1.43)
Gross Margin	8,893,281	11.14	11,676,917	14.60	(2,783,636)	(3.46)
Administrative Expenses						
Salaries and benefits	5,982,016	7.49	7,588,454	9.49	1,606,438	1.99
Professional fees	289,411	0.36	372,966	0.47	83,555	0.10
Purchased services	877,028	1.10	875,942	1.10	(1,086)	(0.00)
Printing and Postage	364,759	0.46	456,753	0.57	91,994	0.11
Depreciation and amortization	264,111	0.33	385,117	0.48	121,006	0.15
Other	1,085,503	1.36	1,099,752	1.38	14,249	0.02
Indirect Cost Allocation, Occupancy Expense	318,912	0.40	428,170	0.54	109,258	0.14
Total Administrative Expenses	9,181,740	11.50	11,207,153	14.01	2,025,413	2.51
Income (Loss) From Operations	(288,459)	(0.36)	469,764	0.59	(758,223)	(0.95)
Investment income						
Interest income	1,191,786	1.49	208,333	0.26	983,453	1.23
Realized gain/(loss) on investments	45,180	0.06	-	-	45,180	0.06
Unrealized gain/(loss) on investments	(1,100,904)	(1.38)	-	-	(1,100,904)	(1.38)
Total Investment Income	136,062	0.17	208,333	0.26	(72,271)	(0.09)
Net Rental Income	5,711	0.01	(65,083)	(0.08)	70,794	0.09
Other Income	96	0.00	-	-	96	0.00
Change In Net Assets	**(146,590)**	**(0.18)**	**613,014**	**0.77**	**(759,604)**	**(0.95)**
Medical Loss Ratio	**96.8%**		**95.9%**		**(1.0%)**	
Administrative Loss Ratio	**3.3%**		**4.0%**		**0.7%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

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CalOptima - Consolidated - Year to Date
Statement of Revenue and Expenses
For the Two Months Ended August 31, 2016

	Year to Date					
	Actual		Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	1,597,326		1,598,272		(946)	
Revenues						
Medi-Cal	$ 481,966,071	$ 309.45	$ 465,761,261	$ 300.30	$ 16,204,809	$ 9.15
OneCare	2,880,270	1,233.52	2,871,233	1,152.18	9,037	81.34
OneCare Connect	71,786,950	1,932.51	91,678,973	2,061.45	(19,892,023)	(128.94)
PACE	2,154,125	6,050.91	2,119,307	6,326.29	34,818	(275.38)
Total Operating Revenue	558,787,416	349.83	562,430,774	351.90	(3,643,358)	(2.07)
Medical Expenses						
Medi-Cal	467,978,488	300.47	448,179,025	288.97	(19,799,463)	(11.50)
OneCare	2,574,833	1,102.71	2,612,381	1,048.31	37,548	(54.41)
OneCare Connect	67,150,319	1,807.69	86,027,398	1,934.37	18,877,080	126.68
PACE	1,912,261	5,371.52	2,423,793	7,235.20	511,532	1,863.68
Total Medical Expenses	539,615,901	337.82	539,242,597	337.39	(373,304)	(0.43)
Gross Margin	19,171,515	12.00	23,188,177	14.51	(4,016,662)	(2.51)
Administrative Expenses						
Salaries and benefits	12,491,111	7.82	15,855,541	9.92	3,364,430	2.10
Professional fees	605,510	0.38	710,863	0.44	105,353	0.07
Purchased services	1,606,062	1.01	1,832,659	1.15	226,596	0.14
Printing and Postage	503,848	0.32	915,525	0.57	411,677	0.26
Depreciation and amortization	530,716	0.33	770,234	0.48	239,518	0.15
Other	1,822,966	1.14	2,783,985	1.74	961,019	0.60
Indirect cost allocation, Occupancy Expense	689,682	0.43	856,340	0.54	166,657	0.10
Total Administrative Expenses	18,249,897	11.43	23,725,147	14.84	5,475,251	3.42
Income (Loss) From Operations	921,618	0.58	(536,970)	(0.34)	1,458,589	0.91
Investment income						
Interest income	1,927,489	1.21	416,667	0.26	1,510,822	0.95
Realized gain/(loss) on investments	95,982	0.06	-	-	95,982	0.06
Unrealized gain/(loss) on investments	(1,376,547)	(0.86)	-	-	(1,376,547)	(0.86)
Total Investment Income	646,924	0.41	416,667	0.26	230,257	0.14
Net Rental Income	8,511	0.01	(130,167)	(0.08)	138,678	0.09
Other Income	348	0.00	-	-	348	0.00
Change In Net Assets	**1,577,401**	**0.99**	**(250,470)**	**(0.16)**	**1,827,871**	**1.14**
Medical Loss Ratio	**96.6%**		**95.9%**		**(0.7%)**	
Administrative Loss Ratio	**3.3%**		**4.2%**		**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 August 31, 2016

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	546,902	231,753	$ 778,655	1,164	18,245	179	798,243
REVENUES							
Capitation Revenue	136,153,905	105,444,331	$ 241,598,236	$ 970,939	$ 35,570,921	$ 1,085,610	$ 279,225,706
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	136,153,905	105,444,331	241,598,236	970,939	35,570,921	1,085,610	279,225,706
MEDICAL EXPENSES							
Provider Capitation	32,281,263	42,129,491	74,410,754	406,913	6,758,132	-	81,575,798
Facilitities	25,880,196	31,354,932	57,235,128	91,403	10,278,678	172,199	67,777,407
Ancillary				44,832	893,265	-	938,097
Skilled Nursing				22,191	5,163,325	-	5,185,515
Professional Claims	9,183,960	8,141,524	17,325,484	-	-	137,788	17,463,272
Prescription Drugs	18,859,686	18,624,085	37,483,771	410,052	9,635,600	98,371	47,627,794
Quality Incentives					365,120		365,120
Long-term Care Facility Payments	38,128,706	6,315,960	44,444,667	-	-	(20,409)	44,424,258
Contingencies	-	-	-	-	-	-	-
Medical Management	2,846,458	-	2,846,458	16,680	932,465	353,615	4,149,217
Reinsurance & Other	(348,968)	948,643	599,675	5,042	127,813	93,417	825,947
Total Medical Expenses	126,831,301	107,514,636	234,345,937	997,111	34,154,397	834,981	270,332,425
Medical Loss Ratio	**93.2%**	**102.0%**	**97.0%**	**102.7%**	**96.0%**	**76.9%**	**96.8%**
GROSS MARGIN	9,322,604	(2,070,305)	**7,252,299**	**(26,173)**	**1,416,524**	**250,630**	**8,893,280**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			5,480,537	(5,046)	415,566	90,960	5,982,016
Professional Fees			196,487	12,881	78,105	1,938	289,411
Purchased Services			680,313	24,054	167,420	5,240	877,028
Printing and Postage			256,375	799	107,365	220	364,759
Depreciation and Amortization			262,097			2,014	264,111
Other Expenses			1,012,645	595	65,097	7,166	1,085,503
Indirect Cost Allocation, Occupancy Expense			(650,544)	29,494	937,491	2,471	318,912
Total Administrative Expenses			7,237,910	62,777	1,771,044	110,009	9,181,740
Admin Loss Ratio			**3.0%**	**6.5%**	**5.0%**	**10.1%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			14,389	(88,949)	(354,520)	140,621	(288,459)
INVESTMENT INCOME			-	-	-	-	136,062
NET RENTAL INCOME			-	-	-	-	5,711
OTHER INCOME			96	-	-	-	96
CHANGE IN NET ASSETS			**$ 14,485**	**$ (88,949)**	**$ (354,520)**	**$ 140,621**	**$ (146,590)**
BUDGETED CHANGE IN ASSETS			27,268	38,696	643,815	(240,015)	613,014
VARIANCE TO BUDGET - FAV (UNFAV)			(12,782)	(127,646)	(998,335)	380,636	(759,604)

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the Two Months Ended August 31, 2016

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	1,095,198	462,290	$ 1,557,488	2,335	37,147	356	1,597,326
REVENUES							
Capitation Revenue	272,009,588	209,956,483	$ 481,966,071	$ 2,880,270	$ 71,786,950	$ 2,154,125	$ 558,787,416
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	272,009,588	209,956,483	481,966,071	2,880,270	71,786,950	2,154,125	558,787,416
MEDICAL EXPENSES							
Provider Capitation	64,776,776	84,177,000	148,953,776	778,668	14,926,327	-	164,658,771
Facilitities	52,616,499	66,183,805	118,800,303	696,427	19,663,801	497,686	139,658,216
Ancillary				81,959	1,422,288	-	1,504,247
Skilled Nursing				65,005	10,217,602	-	10,282,607
Professional Claims	18,778,116	15,609,385	34,387,501	-	-	352,124	34,739,625
Prescription Drugs	35,629,421	34,617,688	70,247,109	897,756	18,036,995	194,781	89,376,641
Quality Incentives					743,900		743,900
Long-term Care Facility Payments	76,139,357	12,348,805	88,488,162	-	-	(14,808)	88,473,354
Contingencies	-	-	-	-	-	-	-
Medical Management	5,908,162	-	5,908,162	44,769	1,904,589	707,313	8,564,833
Reinsurance & Other	(727,625)	1,921,099	1,193,474	10,250	234,817	175,165	1,613,706
Total Medical Expenses	253,120,707	214,857,782	467,978,488	2,574,833	67,150,319	1,912,261	539,615,901
Medical Loss Ratio	**93.1%**	**102.3%**	**97.1%**	**89.4%**	**93.5%**	**88.8%**	**96.6%**
GROSS MARGIN	18,888,881	(4,901,299)	13,987,582	305,437	4,636,632	241,864	19,171,515
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			10,788,365	12,797	1,509,068	180,881	12,491,111
Professional Fees			381,698	34,881	182,055	6,876	605,510
Purchased Services			1,272,134	44,334	284,355	5,240	1,606,062
Printing and Postage			378,439	3,184	121,783	442	503,848
Depreciation and Amortization			526,688			4,028	530,716
Other Expenses			1,738,866	1,309	66,590	16,202	1,822,966
Indirect Cost Allocation, Occupancy Expense			(1,249,203)	58,988	1,874,982	4,917	689,682
Total Administrative Expenses			13,836,986	155,492	4,038,832	218,587	18,249,897
Admin Loss Ratio			**2.9%**	**5.4%**	**5.6%**	**10.1%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			150,597	149,945	597,800	23,277	921,618
INVESTMENT INCOME			-	-	-	-	646,924
NET RENTAL INCOME			-	-	-	-	8,511
OTHER INCOME			348	-	-	-	348
CHANGE IN NET ASSETS			**$ 150,944**	**$ 149,945**	**$ 597,800**	**$ 23,277**	**$ 1,577,401**
BUDGETED CHANGE IN ASSETS			(686,420)	68,091	614,287	(532,928)	(250,470)
VARIANCE TO BUDGET - FAV (UNFAV)			837,364	81,854	(16,488)	556,206	1,827,871

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SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is ($0.1) million, ($0.8) million unfavorable to budget
- Operating deficit is ($0.2) million with a surplus in non-operating of $0.1 million

YEARLY RESULTS:

- Change in Net Assets is $1.6 million, $1.8 million favorable to budget
- Operating surplus is $0.9 million with a surplus in non-operating of $0.7 million

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
0.0	0.0	0.0	Medi-Cal	0.2	(0.7)	0.8
(0.1)	0.0	(0.1)	OneCare	0.1	0.1	0.1
(0.4)	0.6	(1.0)	OCC	0.6	0.6	0.0
0.1	(0.2)	0.4	PACE	0.0	(0.5)	0.6
(0.2)	**0.4**	**(0.8)**	**Operating**	**0.9**	**(0.5)**	**1.5**
0.1	0.1	0.0	Inv./Rental Inc, MCO tax	0.7	0.3	0.4
0.1	**0.1**	**0.0**	**Non-Operating**	**0.7**	**0.3**	**0.4**
(0.1)	**0.6**	**(0.8)**	**TOTAL**	**1.6**	**(0.3)**	**1.8**

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Enrollment Summary

For the Two Months Ended August 31, 2016

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
57,464	54,919	2,545	4.6%	Aged	114,398	109,677	4,721	4.3%
635	675	(40)	(5.9%)	BCCTP	1,269	1,351	(82)	(6.1%)
48,331	47,508	823	1.7%	Disabled	96,784	95,048	1,736	1.8%
334,146	338,666	(4,520)	(1.3%)	TANF Child	669,176	676,562	(7,386)	(1.1%)
103,046	109,759	(6,713)	(6.1%)	TANF Adult	207,055	219,488	(12,433)	(5.7%)
3,280	2,677	603	22.5%	LTC	6,516	5,348	1,168	21.8%
231,753	221,978	9,775	4.4%	MCE	462,290	443,503	18,787	4.2%
778,655	**776,181**	**2,474**	**0.3%**	**Medi-Cal**	**1,557,488**	**1,550,972**	**6,516**	**0.4%**
18,245	**22,187**	**(3,942)**	**(17.8%)**	**OneCare Connect**	**37,147**	**44,473**	**(7,326)**	**(16.5%)**
179	**170**	**9**	**5.3%**	**PACE**	**356**	**335**	**21**	**6.3%**
1,164	**1,240**	**(76)**	**(6.1%)**	**OneCare**	**2,335**	**2,492**	**(157)**	**(6.3%)**
798,243	**799,778**	**(1,535)**	**(0.2%)**	**CalOptima Total**	**1,597,326**	**1,598,272**	**(946)**	**(0.1%)**
				Enrollment (By Network)				
47,699	47,016	683	1.5%	HMO	94,979	93,646	1,333	1.4%
231,010	233,902	(2,892)	(1.2%)	PHC	463,028	467,441	(4,413)	(0.9%)
343,708	341,361	2,347	0.7%	Shared Risk Group	689,031	683,286	5,745	0.8%
156,238	153,903	2,335	1.5%	Fee for Service	310,450	306,604	3,846	1.3%
778,655	**776,181**	**2,474**	**0.3%**	**Medi-Cal**	**1,557,488**	**1,550,972**	**6,516**	**0.4%**
18,245	**22,187**	**(3,942)**	**(17.8%)**	**OneCare Connect**	**37,147**	**44,473**	**(7,326)**	**(16.5%)**
179	**170**	**9**	**5.3%**	**PACE**	**356**	**335**	**21**	**6.3%**
1,164	**1,240**	**(76)**	**(6.1%)**	**OneCare**	**2,335**	**2,492**	**(157)**	**(6.3%)**
798,243	**799,778**	**(1,535)**	**(0.2%)**	**CalOptima Total**	**1,597,326**	**1,598,272**	**(946)**	**(0.1%)**

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CalOptima
Enrollment Trend by Network Type
Fiscal Year 2017

Network Type	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	MMs
HMO													
Aged	351	350	-	-	-	-	-	-	-	-	-	-	701
BCCTP	1	1	-	-	-	-	-	-	-	-	-	-	2
Disabled	1,799	1,797	-	-	-	-	-	-	-	-	-	-	3,596
TANF Child	24,211	24,455	-	-	-	-	-	-	-	-	-	-	48,666
TANF Adult	7,929	7,872	-	-	-	-	-	-	-	-	-	-	15,801
LTC	-	-	-	-	-	-	-	-	-	-	-	-	-
MCE	12,989	13,224	-	-	-	-	-	-	-	-	-	-	26,213
	47,280	47,699	-	-	-	-	-	-	-	-	-	-	94,979
PHC													
Aged	1,495	1,464	-	-	-	-	-	-	-	-	-	-	2,959
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	7,903	7,872	-	-	-	-	-	-	-	-	-	-	15,775
TANF Child	169,358	168,529	-	-	-	-	-	-	-	-	-	-	337,887
TANF Adult	15,260	14,945	-	-	-	-	-	-	-	-	-	-	30,205
LTC	-	-	-	-	-	-	-	-	-	-	-	-	-
MCE	38,002	38,200	-	-	-	-	-	-	-	-	-	-	76,202
	232,018	231,010	-	-	-	-	-	-	-	-	-	-	463,028
Shared Risk Group													
Aged	7,658	7,627	-	-	-	-	-	-	-	-	-	-	15,285
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	14,428	14,307	-	-	-	-	-	-	-	-	-	-	28,735
TANF Child	118,748	118,149	-	-	-	-	-	-	-	-	-	-	236,897
TANF Adult	63,849	62,814	-	-	-	-	-	-	-	-	-	-	126,663
LTC	-	-	-	-	-	-	-	-	-	-	-	-	-
MCE	140,640	140,811	-	-	-	-	-	-	-	-	-	-	281,451
	345,323	343,708	-	-	-	-	-	-	-	-	-	-	689,031
Fee for Service (Dual)													
Aged	43,684	45,173	-	-	-	-	-	-	-	-	-	-	88,857
BCCTP	27	26	-	-	-	-	-	-	-	-	-	-	53
Disabled	19,790	20,086	-	-	-	-	-	-	-	-	-	-	39,876
TANF Child	3	2	-	-	-	-	-	-	-	-	-	-	5
TANF Adult	1,179	1,162	-	-	-	-	-	-	-	-	-	-	2,341
LTC	2,868	2,910	-	-	-	-	-	-	-	-	-	-	5,778
MCE	2,960	2,975	-	-	-	-	-	-	-	-	-	-	5,935
	70,511	72,334	-	-	-	-	-	-	-	-	-	-	142,845
Fee for Service (Non-Dual)													
Aged	3,746	2,850	-	-	-	-	-	-	-	-	-	-	6,596
BCCTP	606	608	-	-	-	-	-	-	-	-	-	-	1,214
Disabled	4,533	4,269	-	-	-	-	-	-	-	-	-	-	8,802
TANF Child	22,710	23,011	-	-	-	-	-	-	-	-	-	-	45,721
TANF Adult	15,792	16,253	-	-	-	-	-	-	-	-	-	-	32,045
LTC	368	370	-	-	-	-	-	-	-	-	-	-	738
MCE	35,946	36,543	-	-	-	-	-	-	-	-	-	-	72,489
	83,701	83,904	-	-	-	-	-	-	-	-	-	-	167,605
MEDI-CAL TOTAL													
Aged	56,934	57,464	-	-	-	-	-	-	-	-	-	-	114,398
BCCTP	634	635	-	-	-	-	-	-	-	-	-	-	1,269
Disabled	48,453	48,331	-	-	-	-	-	-	-	-	-	-	96,784
TANF Child	335,030	334,146	-	-	-	-	-	-	-	-	-	-	669,176
TANF Adult	104,009	103,046	-	-	-	-	-	-	-	-	-	-	207,055
LTC	3,236	3,280	-	-	-	-	-	-	-	-	-	-	6,516
MCE	230,537	231,753	-	-	-	-	-	-	-	-	-	-	462,290
	778,833	778,655	-	-	-	-	-	-	-	-	-	-	1,557,488
PACE	177	179	-	-	-	-	-	-	-	-	-	-	356
OneCare	1,171	1,164	-	-	-	-	-	-	-	-	-	-	2,335
OneCare Connect	18,902	18,245	-	-	-	-	-	-	-	-	-	-	37,147
TOTAL	799,083	798,243	-	-	-	-	-	-	-	-	-	-	1,597,326

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ENROLLMENT:

Overall MTD enrollment was 798,243

- Unfavorable to budget by 1,535
- Decreased 840 or 0.1% from prior month
- Increased 34,046 or 4.5% from prior year (August 2015)

Medi-Cal enrollment was 778,655

- Favorable to budget by 2,474 primarily driven by:
    - Medi-Cal Expansion favorable by 9,775 and SPD by 3,931
    - Offset by TANF unfavorable by 11,233
- Decreased 178 from prior month

OneCare enrollment was 1,164

- Unfavorable to budget by 76
- Decreased 7 from prior month

OneCare Connect enrollment was 18,245

- Unfavorable to budget by 3,942
- Decreased 657 from prior month

PACE enrollment at 179

- Favorable to budget by 9
- Increased 2 from prior month

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CalOptima - MediCal Total
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
778,655	776,181	2,474	0.3%	Member Months	1,557,488	1,550,972	6,516	0.4%
				Revenues				
241,598,236	233,142,991	8,455,245	3.6%	Capitation revenue	481,966,071	465,761,261	16,204,809	3.5%
241,598,236	233,142,991	8,455,245	3.6%	Total Operating Revenues	481,966,071	465,761,261	16,204,809	3.5%
				Medical Expenses				
74,410,754	74,885,459	474,705	0.6%	Provider capitation	148,953,776	149,731,756	777,980	0.5%
57,235,128	56,526,765	(708,362)	(1.3%)	Facilities	118,800,303	112,838,535	(5,961,768)	(5.3%)
17,325,484	16,761,742	(563,742)	(3.4%)	Professional Claims	34,387,501	33,233,263	(1,154,238)	(3.5%)
37,483,771	34,501,873	(2,981,898)	(8.6%)	Prescription drugs	70,247,109	68,863,007	(1,384,102)	(2.0%)
44,444,667	37,278,479	(7,166,188)	(19.2%)	MLTSS	88,488,162	74,497,390	(13,990,773)	(18.8%)
2,846,458	4,320,455	1,473,997	34.1%	Medical Management	5,908,162	8,921,741	3,013,579	33.8%
599,675	46,667	(553,009)	(1185.0%)	Reinsurance & other	1,193,474	93,333	(1,100,141)	(1178.7%)
234,345,937	224,321,440	(10,024,497)	(4.5%)	Total Medical Expenses	467,978,488	448,179,025	(19,799,463)	(4.4%)
7,252,299	8,821,551	(1,569,252)	(17.8%)	Gross Margin	13,987,582	17,582,236	(3,594,654)	(20.4%)
				Administrative Expenses				
5,480,537	6,565,815	1,085,279	16.5%	Salaries, wages & employee benefits	10,788,365	13,715,420	2,927,055	21.3%
196,487	287,222	90,735	31.6%	Professional fees	381,698	566,650	184,952	32.6%
680,313	706,154	25,841	3.7%	Purchased services	1,272,134	1,413,157	141,023	10.0%
256,375	310,062	53,687	17.3%	Printing and postage	378,439	624,645	246,205	39.4%
262,097	383,061	120,964	31.6%	Depreciation & amortization	526,688	766,122	239,434	31.3%
1,012,645	1,081,805	69,161	6.4%	Other operating expenses	1,738,866	2,262,338	523,473	23.1%
(650,544)	(539,837)	110,707	20.5%	Indirect cost allocation	(1,249,203)	(1,079,674)	169,529	15.7%
7,237,910	8,794,283	1,556,373	17.7%	Total Administrative Expenses	13,836,986	18,268,657	4,431,671	24.3%
				Operating Tax				
10,475,660	8,804,221	(1,671,439)	(19.0%)	Tax Revenue	20,795,048	17,594,071	(3,200,978)	(18.2%)
10,281,461	0	(10,281,461)	0.0%	Premium tax expense	20,562,923	0	(20,562,923)	0.0%
194,198	8,804,221	8,610,022	97.8%	Sales tax expense	232,126	17,594,071	17,361,945	98.7%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
157,500	287,500	(130,000)	(45.2%)	Grant Revenue	157,500	575,000	(417,500)	(72.6%)
133,875	250,000	116,125	46.5%	Grant expense - Service Partner	133,875	500,000	366,125	73.2%
23,625	37,500	13,875	37.0%	Grant expense - Adminsitrative	23,625	75,000	51,375	68.5%
0	0	0	0.0%	Total Net Grant Income	0	0	0	0.0%
96	0	96	0.0%	Other income	348	0	348	0.0%
14,485	27,268	(12,782)	(46.9%)	Change in Net Assets	150,944	(686,420)	837,364	122.0%
97.0%	96.2%	(0.8%)	(0.8%)	Medical Loss Ratio	97.1%	96.2%	(0.9%)	(0.9%)
3.0%	3.8%	0.8%	20.6%	Admin Loss Ratio	2.9%	3.9%	1.1%	26.8%

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MEDI-CAL INCOME STATEMENT – AUGUST MONTH:

REVENUES of $241.6 million are favorable to budget by $8.5 million, driven by:

- Price related favorable variance of $7.7 million due to IHSS of $2.5M and an ABA retro rate adjustment of $5.1M
- Volume related favorable variance of $0.7 million

MEDICAL EXPENSES: Overall $234.3 million, unfavorable to budget by $10.0 million due to:

- **Long term care claim payments (MLTSS)** are unfavorable to budget $7.2 million due to:
    - Unfavorable variance of: $7.0 million related to County IHSS expense reporting ($4.2M) and LTC experience ($3.0M) due to less than anticipated LTC members in OneCare Connect
- **Prescription Drugs** are unfavorable to budget $3.0 million due to:
    - Price related unfavorable variance of: $2.9 million related to claims actuarial experience
    - Volume related unfavorable variance of: $0.1 million

ADMINISTRATION EXPENSES are $7.2 million, favorable to budget $1.6 million, driven by:

- Salary & Benefits: $1.1 million favorable to budget due to open positions
- Non-Salary: $0.5 million favorable to budget across all categories

CHANGE IN NET ASSETS is $14.5 thousand for the month, unfavorable to budget by $12.8 thousand

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
18,245	22,187	(3,942)	(17.8%)	Member Months	37,147	44,473	(7,326)	(16.5%)
				Revenues				
35,570,921	45,737,267	(10,166,346)	(22.2%)	Capitation revenue	71,786,950	91,678,973	(19,892,023)	(21.7%)
35,570,921	45,737,267	(10,166,346)	(22.2%)	Total Operating Revenue	71,786,950	91,678,973	(19,892,023)	(21.7%)
				Medical Expenses				
6,758,132	9,613,301	2,855,169	29.7%	Provider capitation	14,926,327	19,269,572	4,343,245	22.5%
10,278,678	11,607,014	1,328,336	11.4%	Facilities	19,663,801	23,255,629	3,591,828	15.4%
893,265	694,214	(199,051)	(28.7%)	Ancillary	1,422,288	1,391,533	(30,756)	(2.2%)
5,163,325	10,479,898	5,316,573	50.7%	Long Term Care	10,217,602	21,006,639	10,789,037	51.4%
9,635,600	8,232,950	(1,402,651)	(17.0%)	Prescription drugs	18,036,995	16,450,706	(1,586,289)	(9.6%)
365,120	457,868	92,748	20.3%	Quality incentives	743,900	917,783	173,883	18.9%
932,465	1,160,902	228,438	19.7%	Medical management	1,904,589	2,454,781	550,192	22.4%
127,813	638,950	511,137	80.0%	Other medical expenses	234,817	1,280,756	1,045,939	81.7%
34,154,397	42,885,096	8,730,700	20.4%	Total Medical Expenses	67,150,319	86,027,398	18,877,080	21.9%
1,416,524	2,852,171	(1,435,646)	(50.3%)	Gross Margin	4,636,632	5,651,575	(1,014,943)	(18.0%)
				Administrative Expenses				
415,566	913,089	497,524	54.5%	Salaries, wages & employee benefits	1,509,068	1,909,763	400,695	21.0%
78,105	69,077	(9,028)	(13.1%)	Professional fees	182,055	110,880	(71,174)	(64.2%)
167,420	149,312	(18,109)	(12.1%)	Purchased services	284,355	378,645	94,290	24.9%
107,365	132,955	25,590	19.2%	Printing and postage	121,783	264,399	142,616	53.9%
65,097	6,432	(58,665)	(912.1%)	Other operating expenses	66,590	498,619	432,029	86.6%
937,491	937,491	(0)	(0.0%)	Indirect cost allocation, Occupancy Expense	1,874,982	1,874,981	(0)	(0.0%)
1,771,044	2,208,356	437,312	19.8%	Total Administrative Expenses	4,038,832	5,037,287	998,456	19.8%
				Operating Tax				
(757,611)	0	(757,611)	0.0%	Tax Revenue	(1,539)	0	(1,539)	0.0%
(757,560)	0	757,560	0.0%	Premium tax expense	0	0	0	0.0%
(51)	0	51	0.0%	Sales tax expense	(1,539)	0	1,539	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
(354,520)	643,815	(998,335)	(155.1%)	Change in Net Assets	597,800	614,287	(16,488)	(2.7%)
96.0%	93.8%	(2.3%)	(2.4%)	Medical Loss Ratio	93.5%	93.8%	0.3%	0.3%
5.0%	4.8%	(0.2%)	(3.1%)	Admin Loss Ratio	5.6%	5.5%	(0.1%)	(2.4%)

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ONECARE CONNECT INCOME STATEMENT – AUGUST MONTH:

REVENUES of $35.6 million are unfavorable to budget by $10.2 million driven by:

- Price related unfavorable variance of: $2.0 million due to cohort experience
- Volume related unfavorable variance of: $8.1 million due to the higher enrollment

MEDICAL EXPENSES are favorable to budget $8.7 million due to:

- Volume variance of $7.6 million
- Price variance of $1.1 million
  - $3.5 million in LTC
  - ($2.9) million in Prescription Drugs

ADMINISTRATIVE EXPENSES are favorable to budget by $0.4 million

CHANGE IN NET ASSETS is ($0.4) million, unfavorable to budget by $1.0 million

CalOptima - OneCare
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,164	1,240	(76)	(6.1%)	Member Months	2,335	2,492	(157)	(6.3%)
				Revenues				
970,939	1,427,982	(457,043)	(32.0%)	Capitation revenue	2,880,270	2,871,233	9,037	0.3%
970,939	1,427,982	(457,043)	(32.0%)	Total Operating Revenue	2,880,270	2,871,233	9,037	0.3%
				Medical Expenses				
406,913	388,366	(18,547)	(4.8%)	Provider capitation	778,668	780,980	2,312	0.3%
91,403	319,290	227,887	71.4%	Inpatient	696,427	641,999	(54,428)	(8.5%)
44,832	49,538	4,706	9.5%	Ancillary	81,959	99,577	17,618	17.7%
22,191	23,579	1,388	5.9%	Skilled nursing facilities	65,005	47,396	(17,609)	(37.2%)
410,052	473,686	63,634	13.4%	Prescription drugs	897,756	952,157	54,401	5.7%
16,680	12,500	(4,180)	(33.4%)	Medical management	44,769	31,000	(13,769)	(44.4%)
5,042	27,557	22,515	81.7%	Other medical expenses	10,250	59,272	49,022	82.7%
997,111	1,294,516	297,404	23.0%	Total Medical Expenses	2,574,833	2,612,381	37,548	1.4%
(26,173)	133,466	(159,639)	(119.6%)	Gross Margin	305,437	258,852	46,585	18.0%
				Administrative Expenses				
(5,046)	20,536	25,582	124.6%	Salaries, wages & employee benefits	12,797	43,204	30,407	70.4%
12,881	13,333	452	3.4%	Professional fees	34,881	26,667	(8,214)	(30.8%)
24,054	19,422	(4,632)	(23.8%)	Purchased services	44,334	38,804	(5,530)	(14.3%)
799	11,897	11,097	93.3%	Printing and postage	3,184	22,922	19,738	86.1%
595	89	(506)	(571.6%)	Other operating expenses	1,309	177	(1,131)	(638.6%)
29,494	29,494	(0)	(0.0%)	Indirect cost allocation, Occupancy Expense	58,988	58,987	(0)	(0.0%)
62,777	94,770	31,993	33.8%	Total Administrative Expenses	155,492	190,761	35,269	18.5%
(88,949)	38,696	(127,646)	(329.9%)	Change in Net Assets	149,945	68,091	81,854	120.2%
102.7%	90.7%	(12.0%)	(13.3%)	Medical Loss Ratio	89.4%	91.0%	1.6%	1.7%
6.5%	6.6%	0.2%	2.6%	Admin Loss Ratio	5.4%	6.6%	1.2%	18.7%

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CalOptima - PACE
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
179	170	9	5.3%	Member Months	356	335	21	6.3%
				Revenues				
803,200	760,387	42,813	5.6%	Medi-Cal capitation revenue	1,582,609	1,498,243	84,366	5.6%
282,410	314,694	(32,284)	(10.3%)	MediCare capitation revenue	571,516	621,064	(49,548)	(8.0%)
1,085,610	1,075,081	10,529	1.0%	Total Operating Revenues	2,154,125	2,119,307	34,818	1.6%
				Medical Expenses				
257,097	383,493	126,397	33.0%	Clinical salaries & benefits	502,308	800,520	298,212	37.3%
0	0	0	0.0%	Pace Center Support salaries & benefits	0	0	0	0.0%
				Provider capitation				
172,199	221,316	49,117	22.2%	Claims payments to hospitals	497,686	436,124	(61,562)	(14.1%)
137,788	233,061	95,273	40.9%	Professional Claims	352,124	458,650	106,526	23.2%
98,371	126,468	28,097	22.2%	Prescription drugs	194,781	249,216	54,435	21.8%
(20,409)	22,667	43,076	190.0%	Long-term care facility payments	(14,808)	44,667	59,475	133.2%
59,617	70,361	10,744	15.3%	Patient Transportation	115,052	138,652	23,600	17.0%
48,342	49,349	1,007	2.0%	Depreciation & amortization	96,684	98,698	2,014	2.0%
37,655	37,214	(441)	(1.2%)	Occupancy expenses	75,310	74,428	(882)	(1.2%)
10,326	13,833	3,507	25.4%	Utilities & Facilities Expense	32,667	27,666	(5,001)	(18.1%)
195	258	63	24.4%	Purchased Services	345	508	163	32.1%
21,678	24,547	2,869	11.7%	Indirect Allocation	42,718	49,094	6,376	13.0%
12,122	22,785	10,663	46.8%	Other Expenses	17,395	45,570	28,175	61.8%
834,981	1,205,352	370,372	30.7%	Total Medical Expenses	1,912,261	2,423,793	511,532	21.1%
250,630	(130,271)	380,901	292.4%	Gross Margin	241,864	(304,486)	546,350	179.4%
				Administrative Expenses				
90,960	89,013	(1,946)	(2.2%)	Salaries, wages & employee benefits	180,881	187,154	6,273	3.4%
1,938	3,333	1,395	41.9%	Professional fees	6,876	6,667	(210)	(3.1%)
5,240	1,054	(4,186)	(397.2%)	Purchased services	5,240	2,054	(3,186)	(155.1%)
220	1,839	1,619	88.1%	Printing and postage	442	3,559	3,118	87.6%
2,014	2,056	42	2.0%	Depreciation & amortization	4,028	4,112	84	2.0%
7,166	11,426	4,260	37.3%	Other operating expenses	16,202	22,851	6,649	29.1%
2,471	1,023	(1,448)	(141.6%)	Indirect cost allocation, Occupancy Expense	4,917	2,045	(2,871)	(140.4%)
110,009	109,744	(265)	(0.2%)	Total Administrative Expenses	218,587	228,442	9,856	4.3%
140,621	(240,015)	380,636	158.6%	Change in Net Assets	23,277	(532,928)	556,206	104.4%
76.9%	112.1%	35.2%	31.4%	Medical Loss Ratio	88.8%	114.4%	25.6%	22.4%
10.1%	10.2%	0.1%	0.7%	Admin Loss Ratio	10.1%	10.8%	0.6%	5.9%

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CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
24,056	21,285	2,772	13.0%	Rental income	48,113	42,570	5,543	13.0%
24,056	21,285	2,772	13.0%	Total Operating Revenue	48,113	42,570	5,543	13.0%
				Administrative Expenses				
1,235	2,085	850	40.8%	Professional fees	2,469	4,170	1,701	40.8%
32,393	22,405	(9,989)	(44.6%)	Purchase services	69,059	44,810	(24,249)	(54.1%)
144,226	210,141	65,914	31.4%	Depreciation & amortization	288,453	420,282	131,829	31.4%
16,000	14,300	(1,700)	(11.9%)	Insurance expense	32,001	28,601	(3,400)	(11.9%)
56,634	189,537	132,903	70.1%	Repair and maintenance	180,489	379,075	198,586	52.4%
83,596	0	(83,596)	0.0%	Other Operating Expense	148,701	0	(148,701)	0.0%
(315,739)	(352,100)	(36,361)	(10.3%)	Indirect allocation, Occupancy Expense	(681,569)	(704,200)	(22,631)	(3.2%)
18,346	86,368	68,023	78.8%	Total Administrative Expenses	39,602	172,737	133,135	77.1%
5,711	(65,083)	70,794	108.8%	Change in Net Assets	8,511	(130,167)	138,678	106.5%

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OTHER STATEMENTS – AUGUST MONTH:

ONECARE INCOME STATEMENT

REVENUES of $1.0 million are unfavorable to budget by $0.5 million due to prior year direct subsidy restatement

CHANGE IN NET ASSETS is ($88.9) thousand, $127.6 thousand unfavorable to budget

PACE INCOME STATEMENT

- **Change in Net Assets** for the month is $140.6 thousand, which is operating favorable to budget by $380.6 thousand

505 CITY PARKWAY BUILDING INCOME STATEMENT

- **Change in Net Assets** for the month is $5.7 thousand which is favorable to budget $70.8 thousand

CalOptima
BALANCE SHEET
August 31, 2016

ASSETS				**LIABILITIES & FUND BALANCES**	
Current Assets				Current Liabilities	
	Operating Cash	$170,094,030		Accounts payable	$3,211,822
	Catastrophic Reserves	11,664,256		Medical claims liability	612,076,921
	Investments	1,510,623,228		Accrued payroll liabilities	9,894,997
	Capitation receivable	250,869,196		Deferred revenue	751,980,562
	Receivables - Other	17,496,341		Deferred lease obligations	260,711
	Prepaid Expenses	11,604,066		Capitation and withholds	431,171,268
				Total Current Liabilities	**1,808,596,280**
	Total Current Assets	**1,972,351,118**			
Capital Assets	Furniture and equipment	28,851,790			
	Leasehold improvements	12,185,423			
	505 City Parkway West	46,707,144		Other employment benefits liability	27,860,642
		87,744,356			
	Less: accumulated depreciation	(32,719,360)		Net Pension Liabilities	8,148,262
	Capital assets, net	**55,024,997**		Long Term Liabilities	150,000
				TOTAL LIABILITIES	**1,844,755,184**
Other Assets	Restricted deposit & Other	281,658			
				Deferred inflows of Resources - Excess Earnings	502,900
	Board-designated assets			Deferred inflows of Resources - changes in Assumptions	1,651,640
	Cash and cash equivalents	2,896,809			
	Long term investments	472,496,705		Tangible net equity (TNE)	90,017,313
	Total Board-designated Assets	475,393,514		Funds in excess of TNE	571,127,266
	Total Other Assets	**475,675,172**			
				Net Assets	**661,144,579**
	Deferred outflows of Resources - Pension Contributions	3,787,544			
	Deferred outflows of Resources - Difference in Experience	1,215,473			
TOTAL ASSETS & OUTFLOWS		**2,508,054,303**		**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,508,054,303**

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CalOptima
Board Designated Reserve and TNE Analysis
as of August 31, 2016

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	135,228,414				
	Tier 1 - Logan Circle	125,291,977				
	Tier 1 - Wells Capital	125,265,429				
Board-designated Reserve		385,785,819	287,128,548	448,762,488	98,657,271	(62,976,669)
TNE Requirement	Tier 2 - Logan Circle	89,607,695	90,017,313	90,017,313	(409,618)	(409,618)
	Consolidated:	**475,393,514**	**377,145,861**	**538,779,801**	**98,247,653**	**(63,386,287)**
	Current reserve level	*1.76*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
August 31, 2016

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	(146,590)	1,577,401
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	264,111	530,716
Changes in assets and liabilities:		
Prepaid expenses and other	331,175	(4,819,819)
Catastrophic reserves		
Capitation receivable	(13,557,476)	218,385,470
Medical claims liability	(1,604,310)	13,382,063
Deferred revenue	78,736,771	161,277,921
Payable to providers	16,856,368	29,344,966
Accounts payable	(10,648,953)	(4,140,251)
Other accrued liabilities	249,107	1,726,979
Net cash provided by/(used in) operating activities	70,480,203	417,265,445
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	(376,396,009)	(491,358,596)
Purchase of property and equipment	(230,298)	(560,149)
Change in Board designated reserves	545,436	460,194
Net cash provided by/(used in) investing activities	(376,080,870)	(491,458,550)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(305,600,668)	(74,193,106)
CASH AND CASH EQUIVALENTS, beginning of period	$487,358,954	255,951,393
CASH AND CASH EQUIVALENTS, end of period	**$ 181,758,287**	**$ 181,758,287**

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BALANCE SHEET:

ASSETS Increased $83.4 million from July

- **Cash and Cash Equivalents** decreased by $305.6 million from July based upon timing of state checks received, month-end cut-off and cash funding requirements

- **Net Capitation Receivables** increased $16.4 million based upon membership changes and receipt timing. The retro ABA rate increase contributes $6.4 million in August.

- **Investments** increased $376.4 million due to month-end cut-off and cash funding requirements

LIABILITIES increased $83.6 million from July

- **Deferred Revenue** increased by $78.7 million from July due to:
    - DHS overpayments

- **Accrued Payables and Accrued Expenses** decreased by $11.7 million from July based upon tax accruals and payment timing

- **Total Capitation Payable** increased $16.9 million based upon timing of pool estimates, recalculations and payouts

NET ASSETS are $661.1 million

CalOptima Foundation
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2016
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
893	2,264	(1,372)	(60.6%)	Income - Grant	20,277	4,529	15,748	347.7%
10,036	0	10,036	100.0%	In Kind Revenue - HITEC Grant	42,085	0	42,085	100.0%
10,928	2,264	8,664	382.6%	Total Operating Revenue	62,362	4,529	57,833	1277.0%
				Operating Expenditures				
(4,295)	6,184	10,479	169.4%	Personnel	16,871	12,368	(4,503)	(36.4%)
10,069	2,985	(7,084)	(237.3%)	Taxes and Benefits	20,863	5,970	(14,893)	(249.5%)
0	0	0	0.0%	Travel	(3)	0	3	100.0%
(13)	0	13	100.0%	Supplies	77	10,000	9,923	99.2%
1,001	0	(1,001)	(100.0%)	Contractual	20,388	17,174	(3,214)	(18.7%)
4,166	232,065	227,899	98.2%	Other	4,166	464,130	459,964	99.1%
10,928	241,234	230,306	95.5%	Total Operating Expenditures	62,362	509,642	447,280	87.8%
0	0	0	0.0%	**Investment Income**	0	0	0	0.0%
0	(238,970)	(238,970)	(100.0%)	**Program Income**	0	(505,114)	(505,114)	(100.0%)

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CalOptima Foundation
Balance Sheet
August 31, 2016

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,894,845	Accounts payable-Current	0
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,894,845**	Grants-Foundation	0
		Total Current Liabilities	**0**
		Total Liabilities	**0**
		Net Assets	**2,894,845**
TOTAL ASSETS	**2,894,845**	**TOTAL LIABILITIES & NET ASSETS**	**2,894,845**

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CALOPTIMA FOUNDATION

INCOME STATEMENT:

Revenues

- Revenues from Health Information Technology for Economics and Clinical Health (HITEC) and in-kind contributions from CalOptima
- The Foundation recognized $10.9 thousand for August, 2016
    - HITEC Grant revenue totaled $20.3 thousand YTD, which leaves $6.9 thousand remaining in HITEC Grant funding as of August, 2016
    - CalOptima in-kind contribution totaled $42.1 thousand
- Revenue budget variances attributed to:
    - Grant funding originally allocated July-September 2016 for original extension, later ONC extended it through September 2016
    - CalOptima in-kind revenue was not included in FY17 budget

Expenses

- $62.3 thousand for grant related activities incurred as of August, 2016 YTD
- Expense categories include staff services, travel and miscellaneous supplies
    - $447.0 thousand favorable variance YTD
    - FY17 budget was based on remaining fund balance in Foundation total assets
    - Actual expenses were much lower than anticipated for CalOptima support activities

BALANCE SHEET:

Assets

- Cash of $2.9 million remains from the FY14 $3.0 million transfer from CalOptima for grants and programs in support of providers and community
- $0.0 current month grant receivable for ONC draw down of HITEC grant

Liabilities

- $0.0 current month provider payable for HITEC grant services

Budget Allocation Changes
Reporting changes for August 2016

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	OneCare Connect	Office of Compliance - Professional Fees (Consultant for Annual CPE Audit & CMS Mock Audit)	Office of Compliance - Professional Fees - Consultant for DMHC Mock Audit	$69,000	Re-purpose $53,631 from Professional Fees (Consultant for Annual CPE Audit) and $15,369 from Professional Fees (Consultant for CMS Mock Audit) to pay for consultant for DMHC Mock Audit	2017
July	COREC	REC - Other	REC - Comp Supply/Minor Equip	$10,000	Re-allocate funds to cover costs for computer equipment upgrade which is approved ONC grant managers	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$63,810	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for FY17 Ceridian Software Maintenance	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$15,010	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for FY17 Talentova Learning Management System	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$23,900	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for Silk Road	2017
July	Medi-Cal	Claims Administration - Purchased Services - Integration of Claim Editing Software	Claims Administration - Purchased Services - LTC Rate Adjustments	$98,000	Re-purpose funds from within Purchased Services (Integration of Claim Editing Software) to pay for LTC Adjustments (TriZetto Robot Process)	2017
July	Medi-Cal	Human Resources - Advertising, Travel, Comp Supply/Minor Equip, Subscriptions, Courier/Delivery	Human Resources - Professional Fees (Salary & Compensation Research), Public Activities, Office Supplies, Food Service Supplies, Professional Dues, Training & Seminars, Cert./Cont. Education	$84,491	Re-allocate HR FY17 Budget based on HR dept's past spending trends to better meet department's need	2017
July	Medi-Cal	IS-Infrastructure - Telephone - General Telecommunication and Network Connectivity	IS-Infrastructure - Purchased Services - Disaster Recovery Services	$35,575	Re-allocate funds from Telephone (General Telecommunication and Network Connectivity) to Purchased Services to pay for Disaster Recovery Services	2017
August	Medi-Cal	Other Pay	Quality Analytics - Purchased Services	$67,000	Re-allocate funds to Quality Analytics Purchased Services for additional funds that is needed for CG-CAHPS survey	2017
August	Medi-Cal	Other Pay	Community Relations - Professional Fees & Printing	$43,640	Re-allocate funds to Community Relations Professional Fees and Printing budgets for contracts with Tony Lam and Communications Lab and printing costs of Community Option Fair	2017
August	Medi-Cal	IS-Application Management - Purchased Services - Healthcare Productivity Automation	IS-Application Management - Purchased Services - Direct Hire Fees	$10,957	Re-purpose funds from Purchased Services (Healthcare Productivity Automation) to pay for Direct Hire fees	2017
August	Medi-Cal	Other Pay	IS-Application Development - Comp Supplies/Minor Equipments	$20,400	Re-allocate funds to cover costs of DocuSign, Box, and Primal Script 2016	2017
August	Medi-Cal	Claims Administration - Purchased Services	Claims Administration - Office Supplies, Training & Seminars, Printing	$15,000	Re-allocate funds from Purchased Services (Integration of Claim Editing Software & Inventory Management Forecasting) to Office Supplies, Training & Seminars, and Printing to better meet department's needs	2017

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
October 6, 2016

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and external audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

   One-Third Financial Audit: On September 1, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the final calendar year (CY) 2013 one-third financial audit report for CalOptima's OneCare program. CMS considers the audit closed, and there will be no further communication from CMS regarding this audit. However, CMS expects CalOptima to remediate and monitor any identified deficiencies and observations. The final report identified the following finding and observation:

   - Finding: Testing of a targeted sample of fifty (50) prescription drug event (PDE) records revealed that nine (9) PDEs contained incorrect gross drug cost above (GDCA) and gross drug cost below (GDCB) out-of-pocket threshold amounts.

   - Observation: Of the thirty one (31) sets of potential duplicate records tested by CMS, thirteen (13) PDEs were true duplicates resulting in an overstatement of GDCB.

2. OneCare Connect

   - OneCare Connect CMS Mock Audit: In preparation for a full-scope CMS program audit of its OneCare Connect program, CalOptima has engaged a consultant to conduct a mock audit on its OneCare Connect program using the 2016 CMS audit protocols. Mock audit activities began in June 2016 and will continue through November 2016. Remediation of mock audit findings, including improvements made to policies and procedures, is currently ongoing.

   - OneCare Connect DMHC Mock Audit: The Department of Managed Health Care (DMHC) will begin an audit of Medicaid-based services in OneCare Connect beginning on February 7, 2017. In preparation, CalOptima has engaged a consultant to conduct a mock audit on its OneCare Connect program using the DMHC Cal MediConnect Technical Assistance Guides (TAG) tools. Mock audit activities began the week of June 16, 2016. Associated efforts, including remediation of mock audit findings, continue through September 2016.

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3. PACE

- 2016 Annual PACE Audit: On June 30, 2016, CMS issued an engagement letter to CalOptima PACE for the annual audit scheduled to occur from August 29 - September 1, 2016. A total of fourteen (14) audit elements were reviewed by CMS and the Department of Health Care Services (DHCS) during the audit, and there were three (3) findings. The findings pertain to three (3) audit elements as follows: Infection Control (ENV 02), Internal Quality Assessment and Performance Improvement Program Activities (QAP 06), and Transportation Services (TRS 01). QAP 06 and TRS 01 were both related to transportation services and the CalOptima Regulatory Affairs & Compliance department is currently working with PACE staff and Secure Transportation (vendor) on the corrective action plan for CMS and DHCS review.

- 2016 PACE Level of Care (LOC) Audit: On August 2, 2016, DHCS issued an engagement notice to CalOptima PACE for the level of care (LOC) audit scheduled to occur on October 26, 2016. The purpose of the audit is to ensure the information submitted on the initial LOC documents is consistent with the assessments documented by the Interdisciplinary Care Team.

4. Medi-Cal

- 2015 Medi-Cal Audit: The DHCS conducted an onsite audit of CalOptima's Medi-Cal program from February 8 – 19, 2016. The review period was from February 1, 2015 - November 30, 2015. The DHCS Medi-Cal audit consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, organization and administration of CalOptima, facility site reviews, and medical records review. On July 13, 2016, DHCS issued the final audit report, which identified findings in the following three (3) areas --- case management and care coordination, member's rights, and administrative and organizational capacity. Specifically, the findings were as follows:

  - Case Management and Care Coordination:
    - Medical record documentation for the completion of an Initial Health Assessment requirement is inadequate.
    - The Plan's methodology to monitor compliance with the Initial Health Assessment requirement is inadequate.
  - Member's Rights: The Plan did not submit the completed report of investigation to all required DHCS personnel.
  - Administrative and Organizational Capacity: The Plan did not report a suspected fraud and abuse case to the DHCS within the required timeframe.

  CalOptima submitted its corrective action plans (CAPs) to the DHCS by the August 15, 2016 deadline. CalOptima is pending acceptance of the CAPs and closure of the audit by the DHCS.

5. Other

- 2016 DMHC Routine Examination: The DMHC began an onsite routine examination of CalOptima's financial and administrative affairs on August 15, 2016. The onsite portion of the audit concluded the week ending September 16, 2016. The audit primarily focused on CalOptima's Healthy Families Program in place during the review period, and on CalOptima's organization-wide finances and administration. The DMHC will provide CalOptima with a Draft/Preliminary Audit Report within sixty (60) days of the last day of the audit as a next step, and will give CalOptima a chance to review and comment on the report prior to its finalization.

- 2015 OneCare Medicare Program Audit: The CMS Part C and D Oversight and Enforcement Group recently released the 2015 Medicare Program Audit and Enforcement Report. The report summarizes activities for the 2015 audit year and includes the validation audit of CalOptima's OneCare, labeled "Orange County Health Authority". The report contains several "Sponsor Tips" that align with CalOptima's audit preparation such as Health Network (HN) / delegate monthly universe submissions and mock audits. CalOptima's overall audit score was 0.53, the 2nd best of the 22 audited plan sponsors. Most notably, CalOptima scored 0.25 in Organization Determinations Appeals and Grievances (ODAG) which previously scored 3.75 based on the CY 2013 Program Audit Report. *Note: The lower the score, the better.*

B. Regulatory Compliance Notices

There were no regulatory compliance notices received since the last Monthly Compliance Report to the Board of Directors.

C. Updates on Internal /External Audits

1. Internal Audits: Medi-Cal

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness for Routine	Timeliness for Denials	Clinical Decision Making (CDM for Denials	Letter Score for Denials	Timeliness for Extended
April 2016	67%	100%	85%	0%	94%	88%	88%	18%
May 2016	7%	NA	NA	23%	88%	89%	87%	38%
June 2016	10%	NA	NA	0%	60%	90%	77%	14%

➢ The lower scores for timeliness of urgent PA requests were due to the following reasons:

  - Failure to meet decision timeframe (72 hours)

- The lower scores for timeliness of routine PA requests were due to the following reasons:
  - Failure to meet decision timeframe (5 business days)
  - Failure to meet provider initial notification timeframe (24 hours)
  - Failure to meet provider written notification timeframe (2 business days)

- The lower scores for timeliness of denials were due to the following reasons:
  - Failure to meet decision timeframe (5 business days)
  - Failure to meet provider initial notification timeframe (24 hours)

- The lower scores for timeliness of extended PA requests were due to the following reasons:
  - Failure to meet extended decision timeframe (14 calendar days)
  - Failure to meet provider initial notification timeframe (24 hours) and written notification timeframe (2 business days)
  - Failure to meet member written notification timeframe (2 business days)

- The lower scores for clinical decision making (CDM) of denials were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision
  - Failure to obtain adequate clinical information for decision

- The lower letter scores for denials were due to the following reasons:
  - Failure to use lay language for services description
  - Failure to describe reason the request did not meet criteria in lay language
  - Failure to provide alternative direction

- Medi-Cal Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2016	93%	97%	100%	100%
May 2016	90%	100%	100%	97%
June 2016	70%	97%	87%	100%

- The lower review scores for paid claims timeliness in May 2016 and June 2016 were due to a failure to meet the claims processing timeframe (45 business days/60 calendar days).

- The compliance rate for paid claims accuracy has decreased from 100% to 97% from May 2016 to June 2016 due to an overpayment of claims.

- The compliance rate for denied claims timeliness has decreased from 100% to 87% due to failure to process clean claims within timeframe (45 business days).

- The compliance rate for denied claims accuracy increased from 97% to 100% from May 2016 to June 2016.

- Medi-Cal Claims: Provider Dispute Resolution (PDR)

Month	Letter Accuracy	Determination Timeliness	Acknowledgement Timeliness
April 2016	100%	94%	100%
May 2016	94%	94%	100%
June 2016	100%	83%	100%

- The monitoring results for letter accuracy has increased from 94% to 100% from May 2016 to June 2016.

- The monitoring results for determination timeliness decreased from 94% to 83% from May 2016 to June 2016 due to the following reasons:
  - PDR processed incorrectly as authorization was attached
  - PDR upheld Incorrectly
  - Interest incorrectly paid.

- The monitoring results for acknowledgement timeliness have remained 100% compliant from April 2016 to June 2016.

- Medi-Cal Customer Service: Central Call Center and Member Liaison Call Center

Month	Medi-Cal Call Center	Member Liaison Call Center
April 2016	100%	99%
May 2016	98%	100%
June 2016	98%	100%

- The monitoring results for Medi-Cal Call Center have remained at or above 98% from April 2016 to June 2016.

- The monitoring results for Member Liaison Call Center have remained at or above 99% from April 2016 to June 2016.

2. Internal Audits: OneCare

- OneCare Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
April 2016	100%
May 2016	100%
June 2016	100%

  - Monitoring scores for coverage determination timeliness remains consistent at 100% from April 2016 to June 2016.

- OneCare Pharmacy: Coverage determinations for protected classes of drugs are reviewed weekly to ensure that they are processed in accordance with the regulatory requirements and the appropriate timeframe.

Month	Protected Drug Cases Reviewed	Protected Drug Cases Failed	Overall Compliance
April 2016	1	0	100%
May 2016	3	0	100%
June 2016	1	0	100%

  - The compliance rate for protected classes of drugs remains consistent at 100% from April 2016 to June 2016.

- OneCare Pharmacy: Coverage determinations for unprotected classes of drugs are reviewed weekly to ensure that they are processed in accordance with the regulatory requirements and appropriate timeframe.

Month	Unprotected Drug Cases Reviewed	Unprotected Drug Cases Failed	Overall Compliance
April 2016	20	2	90%
May 2016	29	2	93%
June 2016	19	0	100%

  - The monitoring score for unprotected classes of drugs has increased from 93% to 100% from May 2016 to June 2016.

- OneCare Pharmacy: Direct member reimbursement (DMR) requests are reviewed on a monthly basis to ensure that they are processed in accordance with the regulatory requirements and appropriate timeframe.

Month	% of DMR Cases Compliant
April 2016	No DMR Requests
May 2016	100%
June 2016	50%

  - The DMR monitoring score has decreased from 100% to 50% from May 2016 to June 2016 due to an untimely DMR payment to the member.
  - There were no DMR requests for April 2016.

- OneCare Utilization Management

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
April 2016	Nothing to Report	Nothing to Report	Nothing to Report	100%	78%	Nothing to Report	Nothing to Report	Nothing to Report
May 2016	Nothing to Report	Nothing to Report	Nothing to Report	100%	67%	Nothing to Report	Nothing to Report	Nothing to Report
June 2016	Nothing to Report	Nothing to Report	Nothing to Report	100%	50%	Nothing to Report	Nothing to Report	Nothing to Report

  - The lower letter scores for SOD were due to the following reasons:
    - Failure to use approved CMS letter template(s)
    - Failure to use lay language

- OneCare Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2016	90%	100%	100%	83%
May 2016	100%	100%	100%	100%
June 2016	100%	100%	100%	100%

  - The monitoring scores for denied claims timeliness have remained consistent at 100% from April 2016 to June 2016.
  - The monitoring scores for paid claims accuracy have remained consistent at 100% from April 2016 to June 2016.

- The monitoring scores for paid claims timeliness and denied claims accuracy have remained consistent at 100% from May 2016 to June 2016.

- OneCare Claims: Provider Dispute Resolution

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check Lag
April 2016	94%	100%	94%	100%
May 2016	90%	100%	75%	100%
June 2016	60%	100%	90%	NA

- The monitoring results for determination accuracy have decreased from 90% to 60% from May 2016 to June 2016 due to the following reasons:
  - Claim Upheld Incorrectly
  - Incorrect Pricing

- The monitoring results for letter accuracy have remained 100% compliant from April 2016 to June 2016.

- The low score for acknowledgement timeliness was due to failure to process paid claim within timeframe (30 days from the PDR received date)

- The monitoring results for check lag have been 100% compliant for April 2016 to May 2016.

- OneCare Customer Service: Call Center

Month	OneCare Call Center
April 2016	100%
May 2016	99%
June 2016	99%

- The monitoring results for OneCare call center have been at or above 99% compliant from April 2016 to June 2016.

3. Internal Audits: OneCare Connect

- OneCare Connect Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
April 2016	100%
May 2016	100%
June 2016	100%

  - Timeliness for coverage determinations remained consistent at 100% from April 2016 to June 2016.

- OneCare Connect Pharmacy: Coverage determinations for protected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements and in the appropriate timeframe.

Month	Protected Drug Cases Reviewed	Protected Drug Cases Failed	Overall Compliance
April 2016	10	0	100%
May 2016	29	0	100%
June 2016	22	0	100%

  - The monitoring scores for coverage determinations for protected drug cases remain consistent at 100% from April 2016 to June 2016.

- OneCare Connect Pharmacy: Coverage determinations for unprotected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements and in the appropriate timeframe.

Month	Unprotected Drug Cases Reviewed	Unprotected Drug Cases Failed	Overall Compliance
April 2016	110	7	94%
May 2016	121	7	94%
June 2016	98	1	99%

  - The monitoring scores for coverage determinations for unprotected classes of drugs range from 94% to 99% from April 2016 to June 2016.

- OneCare Connect Pharmacy: Direct member reimbursement requests are reviewed on a monthly basis to ensure that they are processed in accordance with regulatory requirements and in the appropriate timeframe.

Month	DMR Cases Reviewed	DMR Cases Failed	Overall Compliance
April 2016	13	0	100%
May 2016	8	0	100%
June 2016	5	0	100%

  - The monitoring scores for direct member reimbursements are consistent at 100% from April 2016 to June 2016.

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Review for Urgents	Timeliness For Routine	Letter Review for Routine	Timeliness for Denials	Clinical Decision Making (CDM) for Denials	Letter Review for Denials	Timeliness for Deferrals	Clinical Decision Making (CDM) for Deferrals	Letter Review for Deferrals
April 2016	0%	100%	94%	25%	50%	67%	100%	89%	Nothing to Report	Nothing to Report	Nothing to Report
May 2016	57%	NA	71%	91%	78%	75%	92%	100%	Nothing to Report	Nothing to Report	Nothing to Report
June 2016	0%	NA	70%	40%	70%	50%	92%	100%	Nothing to Report	Nothing to Report	Nothing to Report

  - The lower monitoring scores for timelines of urgent PA requests were due to failure to meet the decision timeframe (72 hours).
  - The lower monitoring scores for letter review of urgent PA requests were due to failure to use lay language.
  - The lower monitoring scores for timeliness of routine PA requests were due to failure to meet the decision timeframe (5 business days).
  - The lower monitoring scores for letter scores of routine PA requests were due to failure to use lay language.
  - The lower scores for timelines for denied PA requests was due to failure to meet decision timeframe (5 business days).
  - The lower score for clinical decision making for denied PA requests was due to failure to cite specific criteria utilized to make the decision.

- OneCare Connect Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2016	88%	88%	100%	100%
May 2016	77%	87%	100%	100%
June 2016	67%	93%	100%	100%

  - The monitoring scores for paid claims timeliness decreased from May 2016 to June 2016 due to incorrect development of claim.
  - The monitoring scores for paid claims accuracy has increased from 87% to 93% from May 2016 to June 2016.
  - The monitoring scores for denied claims timeliness and accuracy have remained at 100% from April 2016 to June 2016.

- OneCare Connect Claims: Provider Dispute Resolution Claims

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check Lag
April 2016	100%	100%	100%	100%
May 2016	94%	100%	100%	100%
June 2016	94%	100%	100%	50%

  - The monitoring scores for determination accuracy have remained consistent at 94% from May 2016 to June 2016. The decrease in score from April 2016 of 100% was due to the following reasons:
    - Incorrect interest payment
    - Incorrectly processed as a denied claim.
  - The monitoring score for both letter accuracy and acknowledgement timeliness have remained 100% compliant from April 2016 to June 2016.
  - The monitoring score for check lag have decreased from 100% to 50% from May 2016 to June 2016 due to failure to clear check within timeframe (14 days).

- OneCare Connect Customer Service: Call Center

Month	OneCare Call Center
April 2016	98%
May 2016	99%
June 2016	100%

  - The compliance rate for OneCare Connect Call Center has increased from 99% to 100% from May 2016 to June 2016.

- PACE Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2016	100%	100%	100%	100%
May 2016	100%	100%	100%	100%
June 2016	100%	100%	100%	92%

  - The monitoring scores for paid and denied claims timeliness and paid claims accuracy have remained consistent at 100% from April 2016 to June 2016.

  - The monitoring scores for denied claims accuracy was lower in June 2016 due to a claim being denied improperly for authorization.

- PACE Claims: Provider Dispute Resolution

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check LAG
April 2016	86%	100%	100%	NA%
May 2016	100%	100%	100%	100%
June 2016	100%	100%	100%	NA%

  - The monitoring scores for letter accuracy and acknowledgement timeliness have remained consistent at 100% from April 2016 to June 2016.

  - The monitoring scores for determination accuracy increased to 100% from April 2016 to June 2016. The low score for April was due to an incorrect adjustment using the wrong authorization for a different date of service.

4. External Audits: Medi-Cal

- Medi-Cal Utilization Management: Prior Authorization Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM for Urgents	Letter Score for Urgents	imelines for Routine	imelines for Denials	CDM for Denials	Letter Score for Denials	imelines for Modifieds	CDM for lodified	Letter Score for lodified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
April 2016	95%	100%	100%	98%	89%	97%	95%	85%	95%	98%	39%	100%	85%
May 2016	80%	100%	100%	77%	76%	89%	95%	91%	93%	97%	50%	67%	77%
June 2016	86%	83%	100%	89%	80%	92%	94%	92%	95%	99%	50%	87%	78%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days);
  - Failure to meet timeframe for member notification (Routine – 2 business days);
  - Failure to meet timeframe for provider initial notification (24 hours);
  - Failure to provide proof of successful initial written notification to requesting provider (24 hours); and
  - Failure to meet time for extended decision (14 calendar days).

- The lower scores for CDM were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision;
  - No indication that the medical reviewer was involved in the denial determination; and
  - No indication of adequate clinical information obtained to make the decision to deny.

- The lower letter scores were due to the following reasons:
  - Provider notification did not include name and contact information for the medical director responsible for the decision to delay;
  - Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document;
  - Failure to provide letter with description of services in lay language;
  - Failure to provide letter in member's primary language;
  - Failure to provide lay language explaining why the request did not meet criteria;
  - Failure to include name and contact information for health care professional responsible for decision to deny;
  - Failure to notify member of delayed decision and anticipated decision date;
  - Failure to provide peer -to peer discussion of the decision with medical reviewer;

- Failure to notify provider of delayed decision and anticipated decision date; and
- Failure to provide referral back to PCP on denial letter.

- Medi-Cal Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
April 2016	98%	95%
May 2016	98%	99%
June 2016	100%	89%

➢ The compliance rate for misclassified paid claims has remained stable at or above 98% from April 2016 to June 2016.

➢ The compliance rate for misclassified denied claims decreased to 89% due to submission of PCP claims, invalid procedure codes billed and duplicate claims, which should be excluded from the universe.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2016	89%	88%	100%	100%
May 2016	93%	98%	98%	95%
June 2016	93%	81%	86%	91%

➢ The compliance rate for paid claims timeliness remained stable at 93% for May 2016 and June 2016.

➢ The compliance rate for paid claims accuracy, denied claims timeliness and accuracy has decreased in June 2016 from previous months due to denying ER claims and interest paid in error.

- Medi-Cal Claims: Misclassified Hospital Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
April 2016	100%	77%
May 2016	100%	74%
June 2016	100%	57%

  - The compliance rate for misclassified denied claims decreased to 57% in June 2016 as a result of paid claims that were reported as denied claims.

- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2016	100%	100%	100%	100%
May 2016	100%	100%	100%	100%
June 2016	100%	100%	93%	100%

  - The compliance rate for paid claims timeliness and accuracy as well as denied claims accuracy has remained at 100% from April 2016 to June 2016.

  - The compliance rate for denied claims timeliness decreased to 93% in June 2016 due to claims exceeding turnaround time (45 working days).

5. External Audits: OneCare

- OneCare Utilization Management: Prior Authorization 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
April 2016	100%	Nothing to Report	91%	100%	96%	100%	100%	100%
May 2016	100%	Nothing to Report	100%	100%	81%	100%	89%	100%
June 2016	100%	Nothing to Report	98%	100%	97%	100%	89%	95%

- The lower letter scores were due to the following reasons:
  - Failure to use approved CMS letter template; and
  - Failure to provide letter with description of services in lay language.

- The lower scores for CDM were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision.

- OneCare Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
April 2016	98%	97%
May 2016	100%	100%
June 2016	99%	97%

- The compliance rate for misclassified paid claims decreased to 99% in June 2016 due to a claim line item denial that should have been excluded from the universe.

- The compliance rate for misclassified denied claims decreased to 97% in June 2016 due to OneCare Connect member reported on OneCare Universe.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2016	98%	98%	100%	83%
May 2016	100%	100%	100%	100%
June 2016	91%	92%	100%	95%

- The compliance rate for paid claims timeliness, paid claims accuracy, and denied claims accuracy decreased in June 2016 due to the following reasons:
  - Misclassified claim line item denial;
  - Claim processed untimely and no interest paid;
  - OneCare Connect member on OneCare universe; and
  - Claim not processed in timeframe (60 calendar days).

- The compliance rate for denied claims timeliness has remained stable at 100% from April 2016 to June 2016.

6. External Audits: OneCare Connect

- OneCare Connect Utilization Management: Prior Authorization Requests

Month	imelines for Urgents	Clinical Decision Making for Urgents	Letter Score for Urgent	imelines For Routine	Letter Score for Routin	imelines for Denials	Clinical Decisior Making for Denials	Letter Score for Denials	imelines for Modifieds	Clinical Decision Making for Modifieds	Letter Score for lodified	imelines for Deferrals	Clinical Decision Making for Deferrals	Letter Score for Deferrals
April 2016	86%	89%	86%	94%	77%	66%	100%	98%	43%	83%	89%	100%	100%	100%
May 2016	92%	100%	78%	87%	83%	51%	92%	85%	33%	100%	90%	100%	100%	100%
June 2016	84%	99%	82%	76%	80%	66%	100%	87%	75%	100%	97%	Nothing to Report	Nothing to Report	Nothing to Report

  - The lower scores for timeliness were due to the following reasons:
    - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days);
    - Failure to meet timeframe for provider initial notification (24 hours); and
    - Failure to provide proof of successful initial written notification to requesting provider (24 hours).

  - The lower scores for clinical decision making were due to the following reasons:
    - Failure to cite the criteria utilized to make the decision.

  - The lower letter scores were due to the following reasons:
    - Failure to provide letter in member's primary language;
    - LAP insert was not provided to member and typographical errors were identified throughout the document;
    - Failure to outline reason for not meeting the criteria (lay language) in denial letter;
    - Failure to include name and contact information for health care professional responsible for decision to deny;
    - Failure to provide letter with description of services in lay language; and
    - Failure to provide peer-to-peer discussion of the decision with medical reviewer.

- OneCare Connect Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
April 2016	100%	100%
May 2016	98%	92%
June 2016	99%	100%

  - The compliance rate for misclassified paid claims increased to 99% in June 2016.

  - The compliance rate for misclassified denied claims increased to 100% in June 2016.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
April 2016	99%	93%	100%	85%
May 2016	98%	98%	100%	89%
June 2016	94%	96%	100%	94%

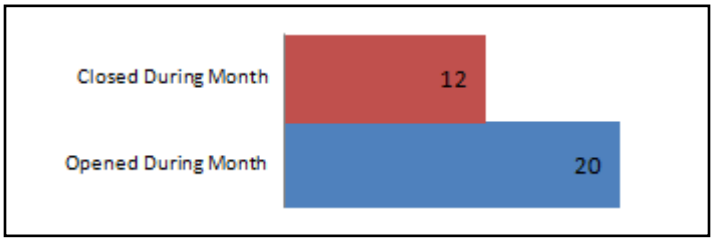
- The lower compliance rates for paid claims timeliness and paid claims accuracy were due to the following reasons:
  - Misclassified line item denial;
  - Claims processed beyond the turnaround time; and
  - Failure to pay correct amount on claim.

- The compliance rate for denied claims timeliness has remained stable at 100% from April 2016 to June 2016.

- The compliance rate for denied claims accuracy increased to 94% in June 2016.

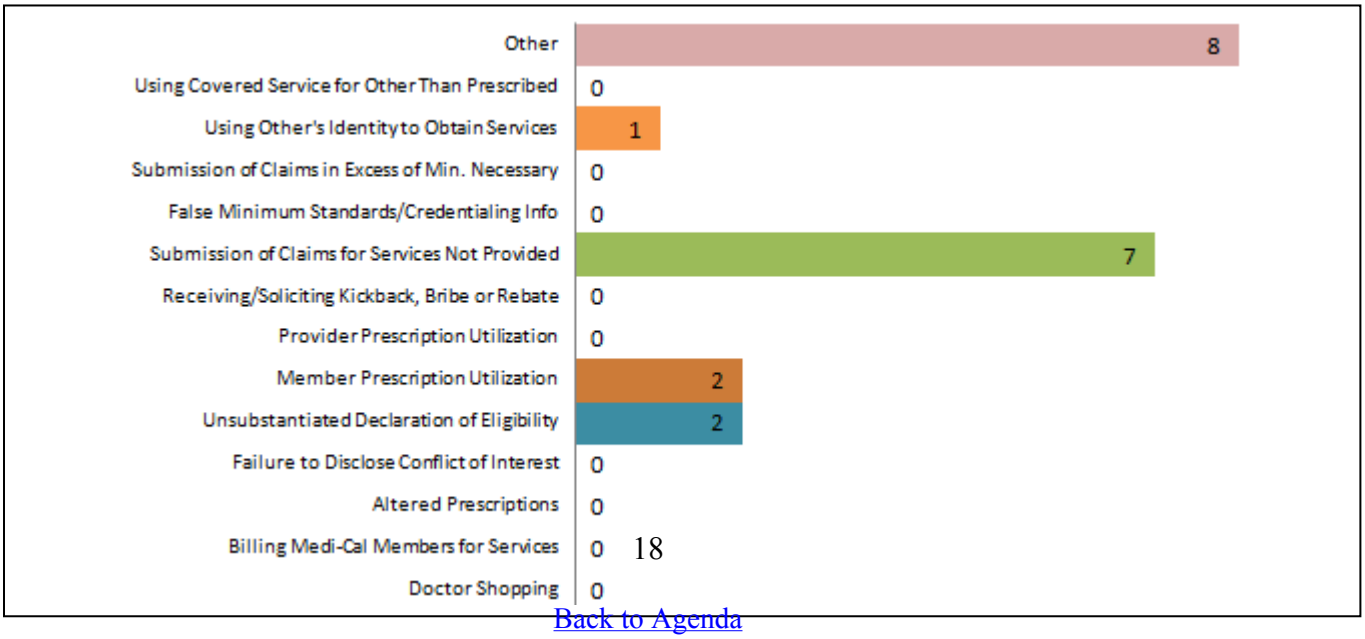
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations (August 2016)

Case Status
Case status at the end of August 2016

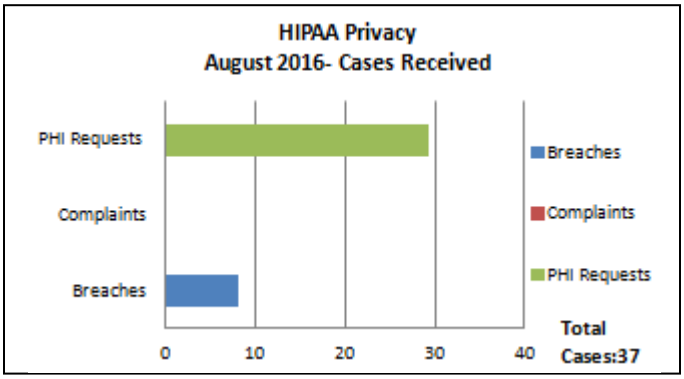


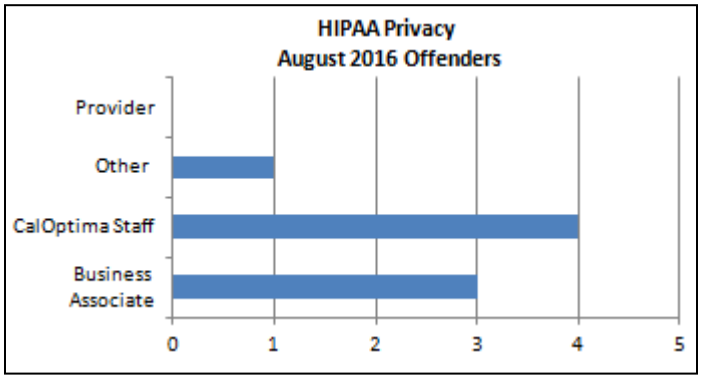
Note: Cases that are referred to DHCS or the MEDIC are not "closed" until CalOptima receives notification of case closure from the applicable government agency.

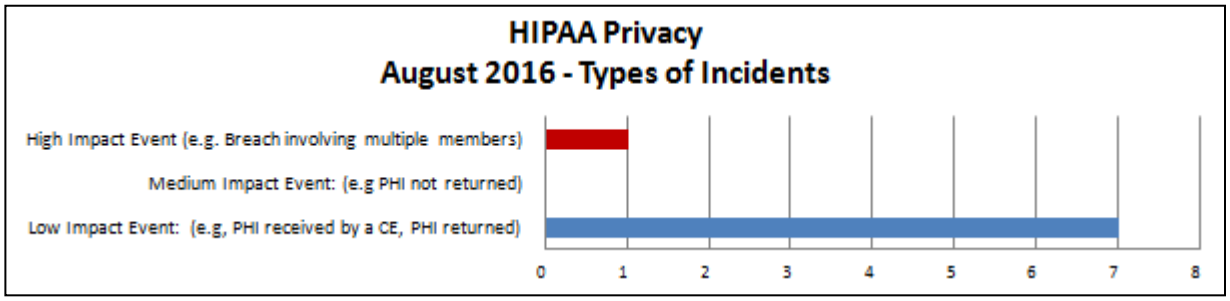
Types of FWA Cases:
(Received in August 2016)



E. Privacy Cases (August 2016)







PRIVACY STATISTICS

Total Number of Breaches Reported to DHCS (State)	7
Total Number of Breaches Reported to DHCS and Office of Civil Rights (OCR)	1
Total Number of Breaches	**8**

A Public Agency

CalOptima

Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting

October 6, 2016

James McConnell / Edelstein Gilbert Robson & Smith

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CalOptima
Washington Report
September 26, 2016

Congress returned to Washington on September 6 after its seven-week recess, leaving it three-plus weeks to prepare for the start of the new federal fiscal year on October 1, before recessing again for the election campaign. Given that the Appropriations Committees routinely are unable to complete work on their 12 annual spending bills, a Continuing Resolution (CR)—a temporary spending measure—is necessary to keep the government running until a massive, catch-all Omnibus Appropriations bill can be drafted containing all 12 individual bills in one huge spending package. The Omnibus legislation will fund departments and agencies at new FY 2017 spending levels, as well as include policy riders directing changes in federal policy.

In addition to continuing spending at the FY 2016 level, the CR does not, for the most part, contain legislation changing operating policies in federal departments and agencies. The Senate has gone first in development of the CR this month and has identified December 9 at the target date for passage of the FY 2017 Omnibus.

House leadership is in agreement with the Senate acting first, as well as with a December 9 end date for the CR. Some House conservatives are less enthusiastic about the December 9 date. The Freedom Caucus would like temporary funding to go into March in order to give the Trump Administration time to put its stamp on FY 2017 funding requests—while finessing the question of what they might propose if the election results in a Clinton Administration.

Notwithstanding the timing question, development of the CR has been slowed by questions of what additional spending and policy riders will be included in the legislation. By definition, a CR should only extend existing spending levels until full year funding can be enacted, at which time new spending levels and policy decisions will be included. However, there are some issues which Members want to see addressed this fall in the CR.

The primary driver of the debate over additional spending is $1.1 billion to combat the Zika virus in southern Florida, and potentially elsewhere, and whether the additional funding should be offset with cuts to existing programs. Tied to this is the question of mosquito spraying generally, which has been opposed by some environmental groups for fear a six month waiver of spraying regulations could lead to a permit exemption. By the third week of the month, however, the six month waiver was off the table.

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Another health issue has been whether federal dollars would be banned from going to health clinics in Puerto Rico which also receive funding from Planned Parenthood. And, the drinking water crisis in Flint, Michigan will apparently be addressed in the CR, though the level of funding has not been determined. That question may be tied to the level of funding available to help Louisiana cope with the results of recent flooding there.

Meanwhile, the Obama Administration testified on September 14 at the hearing of the House Oversight and Government Reform Committee on the subject of premium increases in Affordable Care Act (ACA) plans for 2017. Mandy Cohen, chief operating officer and chief of staff in the Department of Health and Human Services' Office of the Administrator said the large increases are the result of "one-time factors putting upward pressure on premiums" because some marketplace issuers initially priced below the cost of new enrollees and are now catching up.

Among Ms. Cohen's suggestions for making ACA plans more affordable were to implement President Obama's call to increase federal tax subsidies that would help consumers pay for plans. The hearing highlighted the problems that the ACA exchanges will face in 2017, which include reduced carrier participation due to plan losses.

She also noted that, in addition to catching up on the cost of covering sicker-than-expected ACA enrollees, two programs intended to protect insurers from pricing uncertainty in the first three years of the law's implementation will expire at the end of 2016, putting more pressure on marketplace insurers.

Open enrollment for 2017 is scheduled to take place November 1, 2016, through January 31, 2017. Tax credit subsidies are used by about 85 percent of the 11 million enrollees in the 2016 marketplaces, and a majority of consumers can get coverage for less than $75 a month.

Committee Chairman Jason Chaffetz (R-UT) and Ranking Member Elijah Cummings (D-MD) both pointed to high drug costs as a factor in premium increases. However, despite increases marketplace premiums are 12 to 20 percent lower than the Congressional Budget Office (CBO) predicted when the ACA was passed. Ms. Cohen also pointed to the 8.6 percent uninsured rate, "the lowest on record," as an accomplishment of the law.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Alan L. Edelstein OF COUNSEL

CALOPTIMA LEGISLATIVE REPORT

by Don Gilbert and Trent Smith
September 26, 2016

The Legislature adjourned shortly after midnight on August 31. With legislators returning to their districts for the fall, attention now turns to the Governor who must deal with hundreds of bills sitting on his desk. The Governor has until September 30 to either sign or veto bills. Like the Legislature, Governor's usually wait until the last minute to act on legislation before them. Governor Brown is following suit, doing most of his work in the last week before the signing or veto deadline.

One of the Governor's most consistent patterns is to veto bills that would cost the state money. One high profile example in 2016 was AB 1561 (Cristina Garcia) which would have created a sales and use tax exemption for menstrual products. AB 1561 drew national attention and passed unanimously out of both the Assembly and Senate. It would have resulted in a relatively modest state and local tax revenue cost of $20 million annually. Governor Brown vetoed the measure, however, along with a number of other bills that created new tax exemptions.

The Governor signed SB 586 into law on September 25. Authored by Senator Hernandez – the Chair of the Senate Health Committee – SB 586 is the California Children's Services (CCS) program reform bill. The bill will place CCS enrollees into managed care settings only in County Organized Health Systems (COHS).

AB 2394 by Assembly Member Eduardo Garcia, which proposed adding nonmedical transportation to the schedule of benefits covered under Medi-Cal, passed the Legislature and is awaiting action by the Governor. As referenced earlier, the Governor has vetoed dozens of bills that would cost the state money. Consequently, AB 2394 may be a prime target for a veto.

AB 2077 by Assembly Member Burke establishes procedures to ensure that eligible recipients of insurance affordability programs move between the Medi-Cal program and other insurance affordability programs without any breaks in coverage. The Governor is still mulling over whether to sign or veto AB 2077.

Another bill of interest to CalOptima is AB 1831 authored by Assembly Member Low. This bill requires all health plans to allow for early refill of covered topical ophthalmic products at 70 percent of the predicted days of use. AB 1831 awaits action by the Governor.

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SB 999 by Senator Pavley is also awaiting action the Governor. This measure would require health plans to authorize pharmacies to dispense a 12-month supply of FDA approved self-administered hormonal contraceptives.

SB 1335, which authorizes federally qualified health centers (FQHCs) and rural health clinics (RHCs) to provide Drug Medi-Cal (DMC) services, was unexpectedly derailed during the last week of the legislative session. This measure was easily moving through the Legislature with bipartisan support. However, at the last minute the Department of Health Care Services requested amendments that the author was unwilling to accept. Given the strong likelihood of a veto, Senator Mitchell chose to drop the bill. Negotiations are likely to continue on this issue next year.

AB 2207 (Wood) seeks to enact reforms in the Denti-Cal program. Denti-Cal has received negative attention in the media for years due to a poor record on access and preventative care. AB 2207 seeks to address some of these issues by expediting provider enrollment, imposing new access and utilization monitoring requirements on DHCS, and reforming the disenrollment process for providers. AB 2207 is currently on the Governor's desk.

Finally, AB 1696 (Holden) would make tobacco cessation services a covered benefit under Medi-Cal. In its final form, the provisions of the bill largely conformed with the state's existing cessation benefits policy under Medi-Cal. As a consequence, the bill's fiscal impact is minimal. It is currently on the Governor's desk.

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LEGISLATIVE TRACKING MATRIX

Bill No. Author	Bill Summary	Bill Status	CalOptima Position
SB 586 Hernandez	Authorizes the Department of Health Care Services (DHCS) to establish a Whole Child Model program that would transition the California Children's Services (CCS) program from the fee-for-service (FFS) delivery model to Medi-Cal managed care in specified health plans, including CalOptima. Requires CalOptima to provide CCS benefits for 11,810 CCS-enrolled children in Orange County.	**09/25/2016** – Approved by Governor	Watch
SB 833 Committee on Budget and Fiscal Review	Omnibus health trailer bill, which contains various fiscal changes to state-funded health programs. Most importantly for CalOptima, the bill will make changes to PACE programs by reforming the DHCS rate-setting methodology to address the unique features of PACE programs, such as drug costs, treatments, and day care activities. DHCS will be required to calculate a new upper payment limit for PACE, which will be 1) Based on utilization data, 2) Actuarially certified, and 3) Adjusted for geographic rate disparities, when appropriate. It is expected the new rate methodology will take effect by late 2017 or early 2018, subject to the current work of the actuarial workgroup, and, final approval from CMS.	**06/27/2016 –** Approved by Governor	Watch
SB 999 Pavley	Requires health plans, including CalOptima, to provide up to a 12-month supply of FDA approved self-administered hormonal contraceptives (SAHC) at the request of the member. Under current law, plans must pay for up to 13 cycles of oral contraceptives, up to 12 patches in a 90 day period, and up to four vaginal rings in a 90 day period, regardless of whether the provider is in or out of network. This bill expands this benefit by including all FDA approved SAHCs to the 12 month requirement, but does not require plans to cover out-of-network contraceptive prescriptions.	**09/23/2016** – Approved by Governor	Watch
SB 1010 Hernandez	Requires health plans or insurers, including CalOptima, to submit prescription drug rate information to the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI). This bill would have also required drug manufacturers to justify their drug prices in these situations.	**08/11/2016** – Removed from Assembly at the request of the author	Watch
SB 1034 Mitchell	Prohibits health plans from denying medically necessary Behavioral Health Treatment (BHT) services for members with Autism Spectrum Disorder (ASD) based on setting, location, time of treatment, or lack of parent/caregiver participation. CalOptima already complies with the provisions of this bill. The bill	**08/11/2016 –** Held under submission	Watch

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Bill No. Author	Bill Summary	Bill Status	CalOptima Position
	would have also eliminated the sunset date on the health insurance mandate for plans to cover BHT services.		
SB 1135 Monning	Requires health plans, including Medi-Cal managed care plans, to provide information to both enrollees and providers regarding standards for timely access to care; specifically, wait times for specialty and primary care services, telephone screenings, and available interpreter services. This bill requires CalOptima to provide the aforementioned information to contracted providers no less than annually, inform enrollees upon enrollment and no less than annually, and publish the information on our website.	**09/23/2016 –** Approved by Governor	Watch
SB 1273 Moorlach	Clarifies that Mental Health Services Act (MHSA) funds may be used by county mental health programs to provide outpatient crisis stabilization services (CSS) for eligible individuals. This bill did not directly impact CalOptima, but clarified that individuals (including CalOptima members) in need of CSS can receive outpatient care funded by MHSA.	**08/19/2016** – Removed at the request of the author	Support
SB 1308 Nguyen	Prohibits County Organized Health Systems (COHS), including CalOptima, from utilizing funds for staff retreats, promotional giveaways, or excessive executive compensation. This bill would have also prohibited COHS from purchasing media campaigns that feature elected public officials.	**04/06/2016** –Removed from Senate Committee on Health hearing agenda at the request of the author	Oppose
SB 1361 Nielsen	Restores Medi-Cal coverage to provide one pair of eyeglasses every two years to a beneficiary over 21 years old whose vision is equal to or poorer than 20/40. This bill would have made changes to vision benefits for CalOptima members.	**05/27/2016** – Held under submission	Watch
SB 1377 Nguyen	Appropriates $3.3 million from the General Fund to DHCS for allocation to contract with 11 non-profit Caregiver Resource Centers statewide, including one in Orange County. This bill may have potentially benefited caregivers that support cognitively impaired CalOptima members.	**05/27/2016** – Held under submission	Watch
SB 1436 Bates	Requires that final action on a local public agency's executive salary, salary schedule, or compensation paid in the form of fringe benefits be made a separate discussion item and not placed on the agency's consent calendar. Makes a procedural change to require an oral summary report of the merit increases for the specified executives before final action is taken.	**08/22/2016** – Approved by Governor	Watch

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Bill No. Author	Bill Summary	Bill Status	CalOptima Position
AB 1051 Maienschein	Appropriates $200 million from the General Fund to the DHCS for the Denti-Cal program, and requires DHCS to allocate these funds to increase funding for preventative care and case management services. Members who receive Denti-Cal benefits outside of CalOptima may have been affected by the funding increase for the Denti-Cal program.	**08/11/2016 –** Held under submission	Watch
AB 1605 Committee on Budget	Omnibus health trailer bill, which contained various fiscal changes to state-funded health programs. Most importantly for CalOptima, the bill would have made changes to PACE programs by reforming the DHCS rate-setting methodology to address the unique features of PACE programs, such as drug costs, treatments, and day care activities. DHCS would have been required to calculate a new upper payment limit for PACE, which would be 1) Based on utilization data, 2) Actuarially certified, and 3) Adjusted for geographic rate disparities, when appropriate. It is expected the new rate methodology would have taken effect by late 2017 or early 2018, subject to the current work of the actuarial workgroup, and, final approval from CMS.	**08/23/2016 –** Ordered to Senate inactive file	Watch
AB 1696 Holden	Expands tobacco cessation benefits for Medi-Cal managed care plans, including increasing the number of quit attempts, expanding the list of approved medication types, and eliminating the care authorization requirement.	**09/25/2016** – Approved by Governor	Watch
AB 1795 Atkins	Increases funding and expands benefits of the Breast and Cervical Cancer Treatment Program (BCCTP) by extending treatment services from 18 to 24 months to the total duration of service needed for the individual, so long as the individual continues to meet eligibility requirements. This bill may affect up to approximately 650 CalOptima members who currently receive BCCTP benefits.	**09/25/2016** – Approved by Governor	Watch
AB 2077 Burke Bonilla	Establishes procedures to ensure that beneficiaries who move between Medi-Cal and Covered California do not experience any breaks in coverage, and prohibits Medi-Cal benefits from being terminated until at least 20 days after a Notice of Action (NOA) is sent to the beneficiary from the county social services department. Under current law, NOAs are sent to Medi-Cal beneficiaries to notify them of any changes to their eligibility 10 days prior to the termination of Medi-Cal benefits.	**09/24/2016** – Vetoed by Governor	Watch
AB 2084 Wood	Requires comprehensive medication management (CMM) services to be a covered benefit under Medi-Cal, and requires plans that administer CMM services include the development and implementation of a written medication treatment plan.	**05/27/2016** – Held under submission	Watch

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Bill No. Author	Bill Summary	Bill Status	CalOptima Position
AB 2207 Wood	Adds performance measures for the Denti-Cal FFS program and seeks to improve access to care for Denti-Cal beneficiaries by increasing the number of providers. This bill may affect CalOptima members receiving Denti-Cal services.	**09/25/2016** – Approved by Governor	Watch
AB 2394 Garcia	Requires Medi-Cal health plans to provide non medical transportation (NMT) services for Medi-Cal beneficiaries. Expands NMT benefits for any form of public or private transportation, as well as mileage reimbursement. This bill makes changes to transportation benefits for CalOptima members.	**09/25/2016** — Approved by Governor	Watch
AB 2507 Gordon	Adds video and telephone communications to the definition of telehealth. Provided that the required consent from beneficiaries for telehealth services may be digital, oral, or written. As drafted, this bill would not have changed CalOptima's services or policies, as these benefits are already provided. However, it may have relaxed restrictions for beneficiaries to approve the use of telemedicine.	**05/27/2016** – Held under submission	Watch
AB 2670 Hernández	Requires DHCS to annually administer the Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan survey, which is developed for all Medi-Cal managed care plans. Increases the frequency of the survey, and requires it to be administered in all threshold languages. This bill would have required the survey to show detailed information on how factors such as location, ethnicity, and gender play into quality of health care.	**05/27/2016** – Held under submission	Watch
AB 2752 Nazarian	Requires health plans to notify members if a prescription drug is no longer covered by the plan, or if the plan changes its policy to no longer offer a specific drug. This bill would have required plans to annually update their provider directory with prescription drug information and to inform members through annual renewal materials if a prescription drug is no longer covered by their provider.	**05/27/2016** – Held under submission	Watch
AB 2821 Chiu	Requires the Department of Housing and Community Development (HCD) to coordinate with DHCS to establish a housing program for Medi-Cal beneficiaries and award grants to government agencies participating in a Whole Person Care (WPC) pilot program. This bill would have allowed HCA to be eligible to receive these grant funds which may have affected up to approximately 7,300 homeless CalOptima members.	**09/27/2016** – Vetoed by Governor	Watch

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The CalOptima Legislative Tracking Matrix includes information regarding legislation that directly impacts CalOptima and our members. These bills are closely followed and analyzed by CalOptima's Government Affairs Department throughout the legislative session. All official "Support" and "Oppose" positions are approved by the CalOptima Board of Directors. Bills with a "Watch" position are monitored by staff to determine the level of impact.

UPCOMING LEGISLATIVE DEADLINES

Final Recess Deadlines

Sept. 30: Last day for Governor to sign or veto bills passed by the Legislature before Sept. 1

Oct. 2: Bills enacted on or before this date take effect Jan. 1, 2017

Nov. 8: General Election

Nov. 30 Legislature officially adjourns at midnight

Dec. 5: 2017-18 Regular Session convenes for Organizational Session at 12:00 p.m.

2017

Jan. 1: Statutes take effect

* Holiday schedule subject to final approval by Rules Committee

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities in Orange County. Our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. As one of Orange County's largest health insurers, we provide coverage through four major programs: Medi-Cal, OneCare (HMO SNP) (a Medicare Advantage Special Needs Plan), OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) and PACE (Program of All-Inclusive Care for the Elderly).

If you have any questions regarding the above information, please contact:

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Sources: Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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Board of Directors Meeting
October 6, 2016

CalOptima Community Outreach Summary — September 2016

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in any of CalOptima's programs.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

Requests for sponsorship are considered based on several factors including: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates on a number of community meetings including coalitions/collaboratives, committees, and advisory groups focused on community health issues. CalOptima strives to address issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Events Update

On September 6, 2016 CalOptima officially started offering services at the newly expanded County Community Service Center (CCSC) "annex" in Westminster. Services offered at the CCSC Annex include:

- Behavioral Health: CalOptima staff will answer questions and provide information on accessing behavioral health services. Mondays, 8 a.m. to 12 p.m.

- OneCare Connect: CalOptima Community Partners will conduct outreach and education regarding OneCare Connect, a new health plan for people with Medicare and Medi-Cal, and assist people with enrollment. Wednesdays, 8 a.m. to 5 p.m.

- Customer Service: CalOptima Customer Service Leads will assist members with issues such as care coordination, referrals, changing their primary care provider or health network, and ID cards. Thursdays, 8 a.m. to 12 p.m.

- Community Relations: The CalOptima Community Relations department will host CCSC health education seminars on Fridays — the second Friday in English, third Friday in Spanish and the last Friday in Vietnamese. Community Relations Specialists will be available to serve members on the seminar days as well.

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For additional information or questions, please contact Tiffany Kaaiakamanu, Manager of Community Relations at 657-235-6872 or via email at tkaaiakamanu@caloptima.org.

Summary of Public Activities

CalOptima participated in 40 community events and coalition and committee meetings:

Date	Events/Meetings	Audience Reached
9/01	• Homeless Provider Forum	Health and Human Service Provider
	• Refugee Forum of Orange County	Health and Human Service Provider
9/02	• Covered Orange County - General Meeting	Health and Human Service Provider
9/05	• Orange County Health Care Agency - Mental Health Services Act Steering Committee	Health and Human Service Provider
9/06	• Collaborative to Assist Motel Families	Health and Human Service Provider
	• 8th Annual South County Veterans Resource Fair hosted by Orange County Supervisor Lisa Bartlett, Saddleback College and Orange County Veterans Service Office	Member/Potential Member
9/07	• Orange County Veterans and Families Collaborative General Meeting	Health and Human Service Provider
9/08	• Orange County Women's Health Project Advisory Board	Health and Human Service Provider
9/09	• Senior Citizens Advisory Council	Health and Human Service Provider
9/10	• 28th Annual Senior Saturday Community Festival hosted by Huntington Beach Council on Aging (*Sponsorship Fee: $1,500 included 1 table for outreach, banner display at event, half page ad in event program, name and logo on promotional flyers and event website*)	Member/Potential Member
9/12	• State Council on Developmental Disabilities Orange County - Regional Advisory Committee	Health and Human Service Provider
	• FOCUS Collaborative	Health and Human Service Provider
	• Safe Messaging and Reporting on Suicide hosted by Orange County Health Care Agency	Health and Human Service Provider
9/13	• Buena Clinton Neighborhood Coalition	Health and Human Service Provider
	• Susan G. Komen Orange County - Unidos Contra el Cancer del Seno Coalition	Health and Human Service Provider
9/14	• 20th Annual Senior Resource Fair hosted by the City of Lake Forest	Health and Human Service Provider
9/15	• Orange County Children's Partnership Committee	Health and Human Service Provider
	• Community Options Fair hosted by the State Council on Developmental Disabilities in conjunction with Fairview Developmental Center	Member/Potential Member
	• Faith Leaders Breakfast hosted by Mission Hospital	Health and Human Service Provider

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9/17	• 2nd Annual Anaheim Family Health and Resource Fair hosted by Office of Assemblyman Tom Daly	Member/Potential Member
	• Mid Autumn Moon Festival hosted by Orange County Supervisor Andrew Do and the Vietnamese Cultural Center (*Sponsorship Fee: $5,250.00 included 2 tables for outreach, 1,500 paper lantern to distribute to children at the event, stage time for CEO to provide remarks, banner on stage, name and logo on promotional flyers*)	Member/Potential Member
	• Route 66 Casino Night hosted by Acacia Adult Day Services (*Staff paid out of pocket*)	Health and Human Service Provider
9/18	• 9th Pacific Islander Festival Orange County hosted by Pacific Islander Health Partnership *(Registration Fee: $400 included 1 table for outreach and a full page ad in event program*)	Member/Potential Member
	• Foster Family Picnic hosted by Orange County Children and Family Services	Member/Potential Member
9/20	• Placentia Community Collaborative	Health and Human Service Provider
	• Coordinated Entry's Healthcare and Housing Integration Workgroup	Health and Human Service Provider
	• North Orange County Senior Collaborative	Health and Human Service Provider
9/21	• Covered Orange County Steering Committee	Health and Human Service Provider
	• Minnie Street Family Resource Center Professional Roundtable	Health and Human Service Provider
	• Orange County Promotoras	Health and Human Service Provider
9/22	• Vietnamese American Human Service Providers Networking Luncheon	Health and Human Service Provider
9/23	• Fall Harvest Festival hosted by Richman Elementary School	Member/Potential Member
9/24	• 14th Annual Walk-A-Thon, Resource Fair and Festival hosted by Madison Park Neighborhood Association (*Registration Fee: $500 included 1 table for outreach, name and logo on t-shirts, posters and flyers)*	Member/Potential Member Provider
9/26	• Stanton Collaborative	Health and Human Service Provider
9/27	• Orange County Senior Roundtable	Health and Human Service Provider
	• Santa Ana Building Healthy Communities	Health and Human Service Provider
9/28	• California Association of Area Agencies on Aging (C4A) Advisory Board	Health and Human Service Provider
	• Orange County Human Trafficking Task Force General	Health and Human Service Provider

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	Meeting	
9/30	• Latino Leadership Council Meeting • 27th Annual Southern California Alzheimer's Disease Research Conference hosted by UCI Mind and Alzheimer's Orange County (*Registration Fee: $335 included 1 table for outreach and conference registration for 2 staff*)	Health and Human Service Provider Health and Human Service Provider

CalOptima organized or convened the following 8 community stakeholder events, meetings and presentations:

Date	Event/Meeting	Audience Reached
9/01	• CalOptima Speakers Bureau Presentation for Cal State Fullerton — Topic: Aging Process and Available Services for the Elderly	Health and Human Service Provider
9/06	• Community Based Organization Presentation for Volunteers of America — Topic: CalOptima Overview	Health and Human Service Provider
9/14	• Community Alliances Forum — Topic: Orange County's Health - How Are We Doing? • Community Based Organization Presentation for Boys and Girls Club Brea, Placentia, and Yorba Linda — Topic: CalOptima Overview	Health and Human Service Provider Health and Human Service Provider
9/16	• County Community Service Center Education Seminar — Topic: The Importance of Vaccinations (*Spanish)*	Member/Potential Member Provider
9/22	• Vietnamese American Human Service Providers Networking Meeting — Topic: Introduction to OneCare Connect	Health and Human Service Provider
9/29	• CalOptima Community Resource Fair	Health and Human Service Provider
9/30	• County Community Service Center Education Seminar — Topic: Understanding Social Security Programs and Benefits (*Vietnamese*)	Member/Potential Member Provider

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CalOptima endorsed the following event during this reporting period (letters of support, program/public activity event with support, or use of name/logo):

1. Letter of Support for the Children and Families Commission of Orange County's application to the California Department of Health Care Services' (DHCS) Dental Transformation Initiative to serve as a Local Dental Pilot Project.

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CalOptima Board of Directors
Community Activities

For more information on the listed items, contact Tiffany Kaaiakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
September 2016			
Friday, 9/30 7:30-9am	++Latino Leadership Meeting	**Steering Committee Meeting: Open to Collaborative Members**	400 N. Tustin Ave. Santa Ana
Friday, 9/30 7:30am-5pm	+UC Irvine Mind and Alzheimer's Orange County 27th Annual So. California Alzheimer's Disease Research Project	**Health/Resource Fair Open to the Public**	1800 Von Karman Ave. Irvine
Friday, 9/30 to Saturday, 10/1 9am-5pm	+Cal State Fullerton Center for Successful Aging 3rd Annual Conference & Expo	**Health/Resource Fair Open to the Public**	800 N. State College Blvd. Fullerton
October 2016			
Saturday, 10/1 10am-1pm	+Santa Ana Senior Center 2016 Senior Health and Information Fair	**Health/Resource Fair Open to the Public**	424 W. 3rd St. Santa Ana
Monday, 10/3 1-4pm	++OCHCA Mental Health Services Act Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	505 E. Central Ave. Santa Ana

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Tuesday, 10/4 9:30-11am	++Collaborative to Assist Motel Families	**Steering Committee Meeting: Open to Collaborative Members**	250 East Center St. Anaheim
Wednesday, 10/5 9-10:30am	++OC Aging Services Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	2515 McCabe Way Irvine
Wednesday, 10/5 10am-12pm	++Anaheim Human Services Network	**Steering Committee Meeting: Open to Collaborative Members**	250 E. Center St. Anaheim
Thursday, 10/6 9-11am	++Homeless Provider Forum	**Steering Committee Meeting: Open to Collaborative Members**	1855 Orange Olive Blvd. Orange
Thursday, 10/6 2-5pm	+Children's Hospital Orange County and Courtney's Sandcastle Park Resource Fair	**Health/Resource Fair Open to the Public**	987 Avenida Vista Hermosa San Clemente
Friday, 10/7 8:30-10am	++Help Me Grow Advisory Meeting	**Steering Committee Meeting: Open to Collaborative Members**	2500 Redhill Ave. Santa Ana
Friday, 10/7 9-10:30am	++Covered Orange County General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	1575 e. 17th St. Santa Ana
Monday, 10/10 2:30-3:30pm	++Fullerton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	353 W. Commonwealth Ave. Fullerton
Tuesday, 10/11 10am-2pm	+Children's Hospital of Orange County Annual Resource Fair	**Steering Committee Meeting: Open to Collaborative Members**	12661 Sunswept Ave. Garden Grove
Tuesday, 10/11 11:30am-12:30pm	++Buena Clinton Neighborhood Coalition	**Health/Resource Fair Open to the Public**	1201 W. La Veta Ave. Orange

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Wednesday, 10/12 10-11:30am	++Buena Park Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	7150 La Palma Ave. Buena Park
Wednesday, 10/12 12-1:30pm	++Anaheim Homeless Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	500 W. Broadway Anaheim
Wednesday, 10/12 2:30-4pm	+Clinton Corner Family Campus Annual Community Resource Fair	**Health/Resource Fair Open to the Public**	13581 Clinton St. Garden Grove
Thursday, 10/13 11:30am-12:30pm	++FOCUS Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	11402 Magnolia Ave. Garden Grove
Thursday, 10/13 3-5pm	++OC Women's Health Project Advisory Board	**Steering Committee Meeting: Open to Collaborative Members**	1505 E. 17th St. Santa Ana
Saturday, 10/15 7am-5pm	+Diocese of Orange 2016 Diocesan Ministries Celebration	**Health/Resource Fair Open to the Public**	1202 W. Edinger Ave. Santa Ana
Tuesday, 10/18 10-11:30am	++Placentia Community Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	849 Bradford Ave. Placentia
Tuesday, 10/18 2-3:30pm	++Coordinated Entry's Healthcare and Housing Integration Workgroup	**Steering Committee Meeting: Open to Collaborative Members**	1505 E. 17th St. Santa Ana
Wednesday, 10/19 8:30-10:30am	++La Habra Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	1211 Fahringer Way La Habra
Wednesday, 10/19 9:15-10:45am	++Covered Orange County Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	18012 Mitchell S. Irvine

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Wednesday,10/19 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	1300 McFadden Ave. Santa Ana
Wednesday, 10/19 1-4pm	++Orange County Promotoras	**Steering Committee Meeting: Open to Collaborative Members**	Location Varies
Thursday, 10/20 8:30-10am	++Orange County Children's Partnership Committee	**Steering Committee Meeting: Open to Collaborative Members**	10 Civic Center Plaza Santa Ana
Thursday, 10/20 1-2:30pm	++Surf City Senior Providers Network	**Steering Committee Meeting: Open to Collaborative Members**	18041 Goldenwest St. Huntington Beach
Friday, 10/21 8:30am-3pm	+OC Women's Health Project 4th OC Women's Health Summit	**Presentation: Open to CBO's, Health Advocates, Service Providers and Public** **Health/Resource Fair: Public**	800 N. State College Blvd. Fullerton
Saturday, 10/22 9am-12pm	+2016 OASIS Senior Expo	**Health/Resource Fair Open to the Public**	801 Narcissus Ave. Corona Del Mar
Monday, 10/24 9-11am	++Community Health and Exchange	**Steering Committee Meeting: Open to Collaborative Members**	1128 W. Santa Ana Blvd. Santa Ana
Monday, 10/24 12:30-1:30pm	++Stanton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	7800 Katella Ave. Stanton
Tuesday, 10/25 7:30-9am	++OC Senior Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	170 S. Olive Orange
Tuesday, 10/25 1-3pm	++OC Transportation Authority Special Needs Advisory Committee	**Steering Committee Meeting: Open to Collaborative Members**	600 S. Main St. Orange

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Tuesday, 10/25 3:30-4:30pm	++Santa Ana Building Healthy Communities	**Steering Committee Meeting: Open to Collaborative Members**	1902 W. Chestnut Ave. Santa Ana
Wednesday, 10/26 9-11:30am	+Cypress Senior Center Medicare Info. Fair	**Health/Resource Fair Open to the Public**	9031 Grindlay St. Cypress
Wednesday, 10/26 10:30-11:30am	+OC Human Trafficking Task Force General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	1221 E. Dyer Rd. Santa Ana
Thursday, 10/27 8am-4pm	+Community Civic Assoc. of Laguna Woods Village Medicare Marketplace	**Health/Resource Fair Open to the Public**	Laguna Woods Village Clubhouse 5 Laguna Woods