NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, AUGUST 3, 2017
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Michelle Steel, 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. Senate Better Reconciliation Act
    b. Development Rights
    c. Program of All-Inclusive Care for the Elderly
    d. Member Health Needs Assessment
    e. Non-Medical Transportation
    f. CalOptima in the Community
    g. Strategic Plan
    h. 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 June 1, 2017 Regular Meeting of the CalOptima Board of Directors
    b. Receive and File Minutes of the May 11, 2017 Meeting of the CalOptima Board of Directors' Provider Advisory Committee; and the May 25, 2017 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee

REPORTS

3. Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

5. Consider Ratifying Amendment to Agreement with the California Department of Health Care Services

6. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute a Revised Amendment A03 or a new Amendment A04 to the Agreement with the California Department of Health Care Services for the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

7. Consider Authorizing Amendment of the Memorandum of Understanding Between Orange County Health Care Agency and CalOptima to Include Drug Medi-Cal Organized Delivery System

8. Consider Adoption of Resolution Approving Updated Human Resources Policies

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

10. Consider Authorizing Non-Binding Agreement Between CalOptima, Inland Empire Health Plan, L.A. Care Health Plan, and the Regents of the University of California to Outline General Goals for Collaboration

11. Consider Adoption of Resolution Approving CalOptima's Updated Policy No. AA.1217: Legal Claims and Judicial Review

12. Consider Actions Related to the Provision of Behavioral Health Services for CalOptima Medi-Cal Members

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

ADVISORY COMMITTEE UPDATES

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

15. Member Advisory Committee Update

16. Provider Advisory Committee Update

INFORMATION ITEMS

17. June 2017 and May 2017 Financial Summaries

18. Compliance Report

19. Federal and State Legislative Advocates Report

20. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

CS 1 CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION. Initiation of litigation pursuant to paragraph (4) of subdivision (d) of Section 54956.9: (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: (Paul Yost, M.D. and Lee Penrose)
Unrepresented Employee: (Chief Executive Officer)

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

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

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, September 7, 2017 at 2:00 p.m.

MEMORANDUM

DATE:	August 3, 2017
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

Senate Better Care Reconciliation Act (BCRA)
As of this writing, the Senate approved a "Motion to Proceed" on BCRA. Shortly thereafter, the Senate rejected BCRA and related amendments by Sens. Cruz and Portman by a 43–57 vote, and then rejected the "Repeal Now, Replace Later" amendment by Sen. Paul 45–55. Both of these bills would have significantly impacted Medicaid expansion and federal funding for Medicaid. As indicated by this activity, the path to repeal and replace the Affordable Care Act has been long and taken many unexpected turns. Because there is daily movement on this effort, I intend to provide the latest information at your Board's August meeting. In the meantime, CalOptima's Government Affairs team has compiled a valuable chronology of the U.S. House of Representatives and Senate activity and our advocacy efforts since March. The document is available in the Board materials under the Federal and State Legislative Advocates Reports.

Development Rights
Given the unknown status of Medicaid and the actions of the U.S. Congress, staff has been in communication with the City of Orange regarding our development agreement. CalOptima's current six-year development agreement expires in 2020 and allows for the construction of a ten-story office tower and a five-story parking structure in our parking lot off Lewis Street. However, the process for such a development is, at a minimum, a multiyear project. Given that 2020 is only a couple of years away and considering the uncertain health care landscape, staff has inquired and received a "conceptual" agreement with City of Orange staff for a development agreement extension from 2020 to 2026. CalOptima staff intends to bring an updated development agreement action plan to your Finance and Audit Committee and eventually to the Board. This may include a request for authority to officially pursue an extension.

Program of All-Inclusive Care for the Elderly (PACE)
CalOptima remains actively engaged in planning the future of our PACE program. As follow-up to the PACE study session and in response to your Board's request, CalOptima staff will soon distribute a PACE information binder that contains substantial background material. Also important to our next steps will be new guidance from the Department of Health Care Services (DHCS). As we shared at the study session, DHCS released a letter on April 20 with significant direction about delegation in PACE programs. The state received considerable feedback on the letter and subsequently announced that it would issue updated guidance, offering a two-week public comment period. That guidance is expected sometime in August. In the meantime, we are

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reviewing responses to our June Request for Information (RFI) related to extending PACE services using the Alternative Care Setting (ACS) model. CalOptima received 10 responses from eligible organizations interested in working with us on ACS, and eight of them are Community-Based Adult Services centers in our current or potential service area. Our procurement department is currently following up with the respondents to clarify certain responses. The DHCS guidance will inform our analysis of the RFI results and our plan of action, so once all are complete, we will bring a PACE item back to your Board.

Member Health Needs Assessment
CalOptima is about halfway through the process of conducting our Member Health Needs Assessment. During the first quarter of 2017, staff solicited vendors, ultimately contracting with Harder+Company Community Research. In the second quarter, we formed an advisory committee, which developed and approved the data collection tools, including member and provider surveys, and protocols for focus groups and key informant interviews. Data gathering has now begun. The provider survey was released in July, and the member survey will be mailed to approximately 42,000 members this month. In addition, 10 focus group meetings are scheduled and 15 more are planned. After analyzing the data, CalOptima will provide an executive summary and key findings to your Board in December.

Non-Medical Transportation (NMT)
Following final guidance released June 29 from DHCS, CalOptima implemented the mandated NMT Medi-Cal benefit on July 1. At this time, these NMT services include roundtrip transportation to locations offering Medi-Cal services covered by CalOptima. Later on October 1, NMT services will be expanded to services carved out of Medi-Cal managed care, such as dental care and California Children's Services. Because of the compressed timeline, CalOptima leveraged existing processes to launch the new benefit, which includes NMT services via taxi, bus and private passenger car with gas mileage reimbursement. At our August meeting, your Board will consider a request to ratify a contract amendment to expand NMT for all Medi-Cal members with American Logistics, which is already our vendor for taxi services for OneCare, OneCare Connect and some Medi-Cal services. We also created a new process to reimburse private drivers transporting members who attest that they have exhausted all other reasonable transportation options. Importantly, the state has not finalized how it will fund health plans for NMT, so CalOptima is continuing to work with DHCS to ensure appropriate reimbursement to cover the cost of the benefit. I will keep your Board informed as we move forward.

CalOptima in the Community
CalOptima's mission to provide access to quality health care for members is well known, but less recognized is our commitment to serving Orange County broadly. That's why we compiled a new publication, CalOptima in the Community, to share the impact we have in honoring and improving our community. It summarizes our dedication to partnership, collaboration and education, and it quantifies our financial investment of $37 million in the health care safety net and enhanced member care. The publication was mailed to local health care leaders and stakeholders and will be distributed at CalOptima's many public meetings and events.

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Strategic Plan
The first six months of CalOptima's 2017–19 Strategic Plan are complete, and staff is in the process of compiling a progress report.

Key Meetings

- **DHCS All Plan CEO Meeting:** On June 14, I attended the regulator's meeting to obtain the latest information on key topics affecting Medi-Cal, including the state budget, Mega Reg, new transportation benefit, palliative care, mental health and health homes among other issues.
- **Illumination Foundation:** On June 29, I met with leaders from the Illumination Foundation and toured the organization's new Recuperative Care Center in Midway City. The facility provides housing and intensive support for homeless people recently discharged from the hospital, followed by temporary housing offering more independence on the way to a transition to permanent housing.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

June 1, 2017

A Regular Meeting of the CalOptima Board of Directors was held on June 1, 2017, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:00 p.m. Director Schoeffel led the Pledge of Allegiance.

ROLL CALL

Members Present: Paul Yost, M.D., Chair; Lee Penrose, Vice Chair; Supervisor Lisa Bartlett (at 2:03 p.m.), Ria Berger, Ron DiLuigi (at 2:03 p.m.), Supervisor Andrew Do, Dr. Nikan Khatibi, Alexander Nguyen, M.D., Richard Sanchez (non-voting), Scott Schoeffel

Members Absent: All members present

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

Chair Yost announced the following changes to the agenda: the Board will consider Agenda Item 39, Consider Chief Executive Officer and Chief Counsel Performance Reviews, and Agenda Item 40, Election of Officers of the Board of Directors for Fiscal Year 2017-18, after Closed Session.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader reported that for the second year in a row, CalOptima's Employee Activities Committee (EAC) sponsored a scholarship essay contest, which awarded three scholarships ($1,000, $750, and $500) to CalOptima members working toward careers in health care. It was noted that EAC scholarship dollars are generated through fundraising events and voluntary donations; no public money was used.

Mr. Schrader commented on the proposed FY 2017-18 Operating and Capital Budgets for Board consideration, noting that for the past two years, the state has gradually lowered Medi-Cal Expansion (MCE) rates to more closely match Medi-Cal Classic rates. While the state is lowering CalOptima's rates for Classic and MCE members, the proposed FY 2017-18 Operating Budget does not recommend passing these reductions along to physicians, specialists, health networks for professional (physician) services, or the hospitals that CalOptima pays. The proposed operating budget recommends reducing capitation rates CalOptima pays to health networks for hospital services, which would also impact the size of health network shared risk pools. In doing its part, CalOptima proposed eliminating $17

million in capital projects, cutting 93 staff positions totaling $9.5 million, and eliminating $1.5 million in vendor services for a total of $28 million. Since receiving the state's rate reduction last month, staff has met with the Provider and Member Advisory Committees, the Hospital Association of Southern California, the Board of Directors' Finance and Audit Committee, and with the health networks regarding the proposed reductions.

PUBLIC COMMENTS

Bill Barcellona, CAPG; Daniela Ojeda, AltaMed; and Kenneth McFarland, Fountain Valley Regional Hospital – Oral re: Agenda Item 14, Consider Approval of the CalOptima Fiscal Year 2017-18 Operating Budget.

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the May 4, 2017 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the February 15, 2017 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee, the February 16, 2017 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the April 13, 2017 Meeting of the CalOptima Board of Directors' Provider Advisory Committee, and the March 9, 2017 Meeting of the CalOptima Board of Directors' Member Advisory Committee

3. Consider Approval of the CalOptima 2017 Utilization Management Program and 2017 Utilization Management Work Plan

4. Consider Approval of Revised 2017 Delegation Grid, Appendix B to 2017 Quality Improvement Program Description and Work Plan

5. Consider Appointment to the CalOptima Board of Directors' Investment Advisory Committee

6. Consider Adoption of the Proposed CalOptima Board of Directors Meeting Schedule for Fiscal Year 2017-18

7. Consider Adoption of Resolution Changing the Membership of the CalOptima Board of Directors' Member Advisory Committee

8. Consider Appointments to the Member Advisory Committee (MAC); Consider Appointment of MAC Chair and Vice Chair

9. Consider Appointments to the Provider Advisory Committee (PAC); Consider Appointment of PAC Chair and Vice Chair

10. Consider Appointments to the OCC Member Advisory Committee (OCC MAC); Consider Appointment of OCC MAC Chair and Vice Chair

11. Consider Adopting Resolution Authorizing and Directing the Chairman of the Board of Directors to Execute Contract MS-1718-41 with the California Department of Aging for the Multipurpose Senior Service Program for Fiscal Year 2017-18

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12. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreement with the California Department of Health Care Services (DHCS)

13. Consider Approval of the Revised Reinsurance Program for Catastrophic Claims and Update CalOptima Policy Accordingly

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

REPORTS

14. Consider Approval of the CalOptima Fiscal Year (FY) 2017-18 Operating Budget

Nancy Huang, Interim Chief Financial Officer, presented the following recommended actions: 1) Approve the CalOptima FY 2017-18 Operating Budget; 2) Authorize the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy; 3) Approve continued Medi-Cal medical expenditures at payment rates in effect on June 30, 2017, except for provider capitation payments for Hospital services for Medi-Cal Expansion members, which are being reduced by 29%, until the Board approves a final FY 2017-18 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; and 4) Ratify renewal of insurance policies in an amount not to exceed $2.1 million for net annual premiums.

As Chair of the Board of Directors' Finance and Audit Committee, Vice Chair Penrose reported that the Committee thoroughly reviewed the proposed operating budget at the May 18, 2017 meeting, and recommended approval of the FY 2017-18 Operating Budget. The Committee requested that staff take the following additional steps before presenting the final recommendation to the Board: meet with providers to discuss strategies to mitigate the impact of the rate reductions; review the administrative budget as it relates to vacancies; consider delaying the compensation study for which an RFP was authorized by the Board in August 2016; and longer term, look at steps that can be taken to ensure that Risk Adjustment Factor (RAF) scores reflect member acuity.

After considerable discussion, it was suggested that staff hold a workshop with the health networks to address any questions they have and help them to better understand the computations related to the rate reduction, and to consider developing a framework model to advocate together with a common goal regarding provider rates. An update on the activities to increase RAF scores was requested for presentation at a future Board meeting.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors 1) Approved the CalOptima FY 2017-18 Operating Budget; 2) Authorized the expenditure and appropriate the funds for items listed in Attachment B: Administrative Budget Details, which shall be procured in accordance with CalOptima Policy GA.5002: Purchasing Policy; 3) Approved continued Medi-Cal medical expenditures at payment rates in effect on June 30, 2017, except for provider capitation payments for Hospital services for Medi-Cal Expansion members, which are being reduced by 29%, until the Board approves a final FY 2017-18 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; and 4)***

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Ratify renewal of insurance policies in an amount not to exceed $2.1 million for net annual premiums. (Motion carried 9-0-0)

15. Consider Approval of the CalOptima FY 2017-18 Capital Budget

Ms. Huang presented the recommended actions to approve the CalOptima FY 2017-18 Capital Budget, and authorize the expenditure and appropriate the funds for the items listed in Attachment A: Fiscal Year 2017-18 Capital Budget by Project, which shall be procured in accordance with CalOptima policy. The proposed $8.4 million 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 Nguyen, seconded and carried, the Board of Directors approved the CalOptima FY 2017-18 Capital Budget, and authorized the expenditure and appropriated funds for the items listed in Attachment A: FY 2017-18 Capital Budget by Project. (Motion carried 9-0-0)***

16. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Clinic Contracts, Except Those Associated With the University of California-Irvine and St. Joseph Healthcare and its Affiliates

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisors Bartlett and Do did not participate in the discussion and vote on this item due to potential conflicts of interest based on campaign contributions under the Levine Act.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the Chief Executive Officer (CEO), with the assistance of legal counsel, to: 1) Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) clinic contracts through June 30, 2018, except those associated with the University of California-Irvine or St. Joseph Healthcare and its affiliates; 2) Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and 3) Amend these contracts' terms to reflect applicable regulatory requirements. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

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

Directors Nguyen and Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisor Bartlett did not participate in the discussion and vote due to potential conflicts of interest based on campaign contributions under the Levine Act.

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to: 1) Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) clinic contracts through June 30, 2018 associated with the University of California-Irvine; 2) Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and 3) Amend these contracts' terms to reflect applicable regulatory requirements. (Motion***

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carried 6-0-0; Supervisor Bartlett recused; Directors Nguyen and Schoeffel absent)

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

Director Schoeffel did not participate on this item due to potential conflicts of interest and left the room during the discussion and vote. Due to their provider affiliations, Director DiLuigi and Vice Chair Penrose did not participate in this item, and Vice Chair Penrose left the room during the discussion and vote. Supervisor Bartlett did not participate due to potential conflicts of interest based on campaign contributions under the Levine Act.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to: 1) Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) clinic contracts through June 30, 2018 associated with St. Joseph Healthcare and its affiliates; 2) Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and 3) Amend these contracts' terms to reflect applicable regulatory requirements. (Motion carried 5-0-0; Supervisor Bartlett and Director DiLuigi recused; Vice Chair Penrose and Director Schoeffel absent)***

19. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service (FFS) Primary Care Physician (PCP) Contracts Associated with St. Joseph Healthcare and its Affiliates

Due to potential conflicts of interest, Vice Chair Penrose and Director Schoeffel did not participate in this item and left the room during the discussion and vote. Supervisors Bartlett and Do did not participate due to potential conflicts of interest based on campaign contributions under the Levine Act.

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to: 1) Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care contracts through June 30, 2018 associated with St. Joseph Healthcare and its affiliates; 2) Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and 3) Amend these contracts' terms to reflect applicable regulatory requirements. (Motion carried 5-0-0; Supervisors Bartlett and Do recused; Vice Chair Penrose and Director Schoeffel absent)***

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

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisors Bartlett and Do did not participate due to potential conflicts of interest based on campaign contributions under the Levine Act.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to: 1) Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care contracts through June 30, 2018, except those associated with the University of***

California-Irvine or St. Joseph Healthcare and its affiliates; 2) Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and 3) Amend these contracts' terms to reflect applicable regulatory requirements. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)

21. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For-Service (FFS) Primary Care Physician (PCP) Contracts Associated with the University of California – Irvine

Due to potential conflicts of interest, Directors Nguyen and Schoeffel did not participate in this item and left the room during the discussion and vote. Supervisors Bartlett and Do did not participate due to potential conflicts of interest based on campaign contributions under the Levine Act.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to: 1) Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) Primary Care contracts through June 30, 2018 associated with the University of California-Irvine; 2) Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and 3) Amend these contracts' terms to reflect applicable regulatory requirements. (Motion carried 5-0-0; Supervisors Bartlett and Do recused; Directors Nguyen and Schoeffel absent)***

22. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Ancillary Contracts that Expire During Fiscal Year 2017-18

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisors Bartlett and Do did not participate due to potential conflicts of interest based on campaign contributions under the Levine Act.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to: 1) Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) ancillary service provider contracts through June 30, 2018; and 2) Amend these contracts' terms to reflect applicable regulatory requirements. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Directors Nguyen and Schoeffel absent)***

23. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Hospital Contracts

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisors Bartlett and Do did not participate due to potential conflicts of interest based on campaign contributions under the Levine Act. Due to his provider affiliations, Vice Chair Penrose did not participate in the discussion and vote on this item.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to: 1) Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) hospital contracts through June 30, 2018; 2) Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and 3) Amend these contracts' terms to reflect applicable regulatory***

requirements. (Motion carried 5-0-0; Vice Chair Penrose, and Supervisors Bartlett and Do recused; Directors Schoeffel absent)

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

Supervisors Bartlett and Do did not participate due to potential conflicts of interest based on campaign contributions under the Levine Act. Due to potential conflicts of interest, Director Schoeffel did not participate in this item and left the room during the discussion and vote.

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to: 1) Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts through June 30, 2018, except those associated with the University of California-Irvine, Children's Hospital of Orange County (CHOC) or St. Joseph Healthcare and its affiliates; 2) Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and 3) Amend these contracts' terms to reflect applicable regulatory requirements. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

25. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Specialist Physician Contracts Associated with the University of California-Irvine

Due to potential conflicts of interest, Directors Nguyen and Schoeffel did not participate in this item and left the room during the discussion and vote. Supervisors Bartlett and Do did not participate due to potential conflicts of interest based on campaign contributions under the Levine Act.

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to: 1) Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts associated with the University of California-Irvine through June 30, 2018; 2) Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and 3) Amend these contracts' terms to reflect applicable regulatory requirements. (Motion carried 5-0-0; Supervisors Bartlett and Do recused; Directors Nguyen and Schoeffel absent)***

26. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Specialist Physician Contracts Associated with St. Joseph Healthcare and its Affiliates

Chair Yost did not participate in this item due to his relationship as a physician with St. Joseph Healthcare, and he passed the gavel to Director Berger. Vice Chair Penrose did not participate in this item due to his affiliation with St. Joseph Healthcare, and Director Schoeffel did not participate due to potential conflicts of interest, and both left the room during the discussion and vote. Supervisor Do did not participate in the discussion and vote due to potential conflicts of interest based on campaign contributions under the Levine Act.

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Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to: 1) Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts associated with the St. Joseph Healthcare and its affiliates through June 30, 2018; 2) Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and 3) Amend these contracts' terms to reflect applicable regulatory requirements. (Motion carried 5-0-0; Chair Yost and Supervisor Do recused; Vice Chair Penrose and Director Schoeffel absent)***

27. Consider Authorizing Extensions and Amendments of the CalOptima Medi-Cal, OneCare, OneCare Connect and PACE Fee-For Service (FFS) Specialist Physician Contracts Associated with Children's Hospital of Orange County (CHOC)

Due to potential conflicts of interest based on his relationship as a physician with CHOC, Chair Yost did not participate in the discussion and vote on this item, and he passed the gavel to Vice Chair Penrose. Supervisors Bartlett and Do did not participate due to potential conflicts of interest based on campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to: 1) Extend the Medi-Cal, OneCare, OneCare Connect and PACE fee-for-service (FFS) specialist physician contracts associated with Children's Hospital of Orange County through June 30, 2018; 2) Amend these contracts and revise member rates to the extent authorized by the Board of Directors in a separate Board action; and 3) Amend these contracts' terms to reflect applicable regulatory requirements. (Motion carried 5-0-0; Chair Yost and Supervisors Bartlett and Do recused; Director Schoeffel absent)***

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

Supervisor Bartlett did not participate in this item due to potential conflicts of interest based on campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors, subject to approval of the Department of Health Care Services, authorized the CEO, with the assistance of legal counsel, to extend the current Medi-Cal full-risk health network contract with Kaiser Permanente that currently expires on June 30, 2017 for up to 12 months, and to amend the contract terms to reflect updated regulatory requirements, as applicable. (Motion carried 7-0-0; Supervisor Bartlett recused; Director Schoeffel absent)***

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

Supervisors Bartlett and Do did not participate in this item due to potential conflicts of interest based on campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the CEO, to enter into Medi-Cal full-risk health network contract amendments, with the assistance of legal counsel, with Heritage Provider Network, Inc., Monarch Family Healthcare, and Prospect Medical Group that: 1) Extend the contracts expiring on June 30, 2017 through June 30, 2018; 2) Revise the rates for assigned Medi-Cal members effective July 1, 2017, to the extent authorized by the Board in a separate Board action; and 3) amend the contracts' terms to reflect applicable new regulatory requirements. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

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

Supervisors Bartlett and Do did not participate in this item due to potential conflicts of interest based on campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized the CEO, to enter into Medi-Cal SRG health network physician contract amendments, with the assistance of legal counsel, for AltaMed Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Network that: 1) Extend the contracts through June 30, 2018; 2) Revise the capitation rates for assigned Medi-Cal members effective July 1, 2017, to the extent authorized by the Board in a separate Board action; and 3) amend the contracts' terms to reflect applicable new regulatory requirements. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

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31. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Physician Contracts for AMVI Care Health Network, Family Choice Network, Orange County Advantage Medical Group, and Fountain Valley Regional Medical Center
Supervisors Bartlett and Do did not participate in this item due to potential conflicts of interest based on campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized the CEO to enter into contract amendments, with the assistance of legal counsel, for AMVI Care Health Network, Family Choice Network, Orange County Advantage Medical Group, and Fountain Valley Regional Medical Center Medi-Cal Physician Hospital Consortium (PHC) health network contracts to 1) Extend contracts through June 30, 2018; 2) Revise the capitation rates for assigned members effective July 1, 2017, to the extent authorized by the Board in a separate Board action; and 3) amend the contracts' terms to reflect applicable regulatory requirements. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

32. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium Health Network Physician Contracts for, CHOC Physicians Network and Children's Hospital of Orange County
Due to potential conflicts of interest based on his affiliation with CHOC, Chair Yost did not participate in the discussion and vote on this item, and he passed the gavel to Vice Chair Penrose. Supervisor Bartlett did not participate due to potential conflicts of interest based on campaign contributions under the Levine Act. Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized the CEO, to enter into contract amendments, with the assistance of legal counsel, for CHOC Physicians Network and Children's Hospital of Orange County Physician Hospital Consortium health network contracts to: 1) Extend the contracts through June 30, 2018; 2) Revise the capitation rates for assigned Medi-Cal Expansion members effective July 1, 2017, to the extent authorized by the Board in a separate action; and 3) amend the contracts' terms to reflect applicable regulatory requirements. (Motion carried 6-0-0; Chair Yost and Supervisor Bartlett recused; Director Schoeffel absent)***

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized expenditures of $9,700 for full Board membership in the National Association of Corporate Directors (NACD) for Fiscal Year 2017-18, and authorized up to $20,300 for additional seminars and related travel expenses. (Motion carried 9-0-0)***

34. Consider Authorizing Extension of License Agreement with the County of Orange for Use of Space at the County Community Service Center

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Action: ***On motion of Director Berger, seconded and carried, the Board of Directors: 1) Authorized the CEO, with the assistance of legal counsel, to negotiate an Amendment to the License Agreement compliant with CalOptima's obligations under applicable state and federal laws regarding the privacy of CalOptima members and their protected health information, and extend the License Agreement with the County of Orange for up to an additional four years through June 30, 2021, which allows use of approximately 362 square feet of space at the County Community Service Center, located at 15496 Magnolia Street, Suite 111, Westminster, CA 92683; 2) Approved the allocation of $18,831.76, which has been included in CalOptima's proposed FY 2017-18 Operating Budget to fund the extension of the License Agreement; and 3) Authorized staff expenditures of $66,230 in FY 2017-18, plus equipment for a full-time Customer Service Representative at the licensed site. (Motion carried 9-0-0)***

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

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors adopted Resolution No. 17-0601-03, Approve Updated Human Resources Policy GA.8058: Salary Schedule, and approved proposed market adjustments for various positions. (Motion carried 9-0-0)***

36. Consider Authorizing the Chief Executive Officer to Approve New and Revised Credentialing Policies, and to Retire Those No Longer Needed

Richard Bock, M.D., Deputy Chief Medical Officer, presented a brief overview of the proposed new and revised credentialing policies. The proposed changes differentiate requirements for practitioners and Health Delivery Organizations, and clarifies processes for adverse activity monitoring, the fair hearing process, and board certification requirements.

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors authorized the CEO to: 1) Approve new policies GG.1650: Credentialing & Re-Credentialing of Practitioners, and GG.1651: Credentialing and Re-Credentialing of Health Delivery Organizations (formerly GG.1609: Credentialing and Re-Credentialing and GG.1606: Credentialing & Re-Credentialing of Mid-Levels, with proposed changes); 2) Approve proposed revisions to policies GG.1616: Fair Hearing, GG.1607: Monitoring of Adverse Activity, and GG.1633: Board Certification; and 3) Retire policies GG.1609: Credentialing & Re-Credentialing, and GG.1606: Credentialing & Re-Credentialing of Mid-Levels. (Motion carried 9-0-0)***

37. Consider Adopting a Support Position for the Reauthorization of the Federal Children's Health Insurance Program (CHIP)

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, provided a brief overview of the CHIP program, a state-federal partnership that provides health insurance to low-income children, which is currently funded through September 30, 2017 as part of the Medicare Access and CHIP Reauthorization Act of 2015. In order to ensure continuity of care for the over 109,000 children who receive their health care services from CalOptima, a support position was recommended for future legislation that reauthorizes CHIP.

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Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors adopted a support position for the reauthorization of the federal Children's Health Insurance Program. (Motion carried 9-0-0)***

38. Consider Authorizing Contracts with the Orange County Health Care Agency and Other Participating Organizations for the Whole Person Care Pilot

Candice Gomez, Executive Director, Program Implementation, reported that in order to participate in the Whole Person Care (WPC) pilot, CalOptima is required to enter into an agreement with the Orange County Health Care Agency (OCHCA). As proposed, CalOptima anticipates entering into agreements with various entities participating in the WPC pilot to support information sharing in compliance with all applicable State and Federal privacy laws.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized the CEO, with the assistance of legal counsel, to contract with the Orange County Health Care Agency for the Whole Person Care pilot, and authorized the CEO, with the assistance of legal counsel, to enter into information sharing agreements with other organizations participating in the Whole Person Care pilot, subject to compliance with all applicable State and Federal privacy laws. (Motion carried 9-0-0)***

Agenda Items 39 and 40 were considered after Closed Session.

ADVISORY COMMITTEE UPDATES

41. Provider Advisory Committee (PAC) Update

Teri Miranti, PAC Chair, provided an update on activities at the May 11, 2017 PAC meeting, including updates from CalOptima staff on the proposed FY 2017-18 budget process, and Medi-Cal rate reductions received from the State for Classic and Expansion members totaling $117 million. The PAC also received a report on the proposed reinsurance policy changes, and the OneCare Connect comparison of financial and utilization performance of the CalOptima Community Network and contracted health networks.

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

OCC MAC Chair Patty Mouton reported that at the May 25, 2017 meeting, the Committee approved the FY 2016-17 Accomplishments, and the FY 2017-18 OCC MAC Goals and Objectives. Ms. Mouton noted that two non-voting OCC MAC agency representative seats are vacant: Social Services Agency and In-Home Supportive Services – Public Authority. Once the respective agencies have identified replacements for these positions, the candidates will be submitted to the Board for consideration.

43. Member Advisory Committee (MAC) Update

Mallory Vega, MAC Chair, presented an overview of the activities at the May 11, 2017 MAC meeting, including the approval of the FY 2016-17 Accomplishments, and the FY 2017-18 Goals and Objectives. The MAC also received updates on the Group Needs Assessment, and the results of the 2016 Community-Based Adult Services and skilled nursing facilities surveys.

INFORMATION ITEMS

The following Information Items were accepted as presented:

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44. April 2017 Financial Summary
45. Compliance Report
46. Federal and State Legislative Advocates Report
47. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Board members extended thanks to staff for their work in preparing CalOptima's FY 2017-18 Operating and Capital Budgets.

Chair Yost commented on the formation of an ad hoc to make recommendations to the full Board on the expenditure of Intergovernmental Transfer (IGT) 6 and 7 funds, and appointed Directors Khatibi, Nguyen and Schoeffel to serve on this ad hoc.

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 4:09 p.m. pursuant to: 1) Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer); 2) Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS: Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose), Unrepresented Employee: (Chief Executive Officer); 3) Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Counsel); and 4) Government Code Section 54957.6, CONFERENCE WITH LABOR NEGOTIATORS: Agency Designated Representatives: (Paul Yost, M.D. and Lee Penrose), Unrepresented Employee: (Chief Counsel).

The Board reconvened to open session at 5:47 p.m. with no reportable actions taken.

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

Chair Yost reported that the Board met to consider Chief Executive Officer (CEO) Michael Schrader's performance evaluation, and stated that the Board gave him an overall rating of "Exceeds Expectations" for the period ending March 31, 2017. Compensation will be awarded consistent with the CEO's contract.

The Board also considered the performance of Chief Counsel Gary Crockett. Based on the input provided by the Board, and the overall rating of "Exceeds Expectations" for the period ending March 31, 2017, it was recommended that the Chief Counsel be awarded a merit increase consistent with CalOptima's merit matrix. The recommended merit is calculated as a function of both the evaluation score and the base salary and range, and is the same merit matrix that is used for all CalOptima employees.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors awarded Chief Counsel an overall rating of "Exceeds Expectations" based on the input provided by the Board for the period ending March 31, 2017, and a merit increase consistent with CalOptima's merit matrix. (Motion carried 9-0-0)***

40. Election of Officers of the Board of Directors for Fiscal Year 2017-18

On behalf of the Nominations Ad Hoc Committee, Director Alexander Nguyen, M.D. reported on the process to solicit nominations for Chair and Vice Chair positions, which included: 1) making information available on the duties, responsibilities, and number of extra hours the Chair and Vice Chair positions typically require above and beyond serving as a member of the CalOptima Board; and 2) to bring forward a list of Board members interested and willing to serve as Chair or Vice Chair for

terms beginning on July 1, 2017 through June 30, 2018. The ad hoc, composed of Supervisor Bartlett and Director Nguyen, met on May 30, 2017 to review the nominations received. Based on this input, the Nominations Ad Hoc submitted the following slate of candidates for consideration: Paul Yost, M.D., to serve as Board Chair, and Lee Penrose to serve as Board Vice Chair, for Fiscal Year 2017-18.

Director Nguyen opened the floor for additional nominations. Seeing none, nominations for Chair and Vice Chair were closed, and the Board took the following action.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors elected Paul Yost, M.D. to serve as Board Chair, and Lee Penrose to serve as Vice Chair for terms beginning on July 1, 2017 through June 30, 2018. (Motion carried 9-0-0)***

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 5:51 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: August 3, 2017

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MINUTES

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

May 11, 2017

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, May 11, 2017, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

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

ESTABLISH QUORUM

Members Present:	Teri Miranti, Chair; Suzanne Richards, MBA, FACHE, Vice Chair; Donald Bruhns; Theodore Caliendo, M.D.; Alan Edwards, M.D.; Steve Flood; Jena Jensen; Pamela Kahn, R.N.; John Nishimoto, O.D.; Mary Pham, Pharm.D., CHC; George Orras, Ph.D., FAAP; Barry Ross, R.N., MPH, MBA; Jacob Sweidan, M.D.
Members Absent:	Anjan Batra, M.D.; Pamela Pimentel, R.N.
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Nancy Huang, Interim Chief Financial Officer; Michelle Laughlin, Executive Director, Network Operations; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Laura Guess, Supervisor, Quality Improvement; Marsha Choo, Manager, Quality Initiatives; Becki Melli, Staff to the Member Advisory Committee

MINUTES

Approve the Minutes of the April 13, 2017 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Ross, seconded and carried, the Committee approved the minutes of the April 13, 2017 meeting. (Motion carried 13-0-0; Members Batra and Pimentel absent)***

PUBLIC COMMENTS

No requests for public comment were received.

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REPORTS

Consider Recommendation of PAC Slate of Candidates , PAC Chairperson and Vice Chairperson

Member Pham summarized the recommendations of the PAC Nominations Ad Hoc Subcommittee, which consisted of Members Batra, Bruhns and Pham. The ad hoc met on April 24, 2017 to review the applications for the four seats available and to recommend candidates for the PAC Chair and Vice Chair positions. The four seats expiring are Community Health Clinic Representative, Hospital Representative, Physician Representative, and Traditional/Safety Net Representative.

The ad hocreviewed eight (8) applications: four (4) for the Community Health Clinic Representative seat; one (1) for the Hospital Representative seat; one (1) for the Physician Representative seat and two (2) for the Traditional/Safety Net Representative seat.

The ad hoc subcommittee recommended the following candidates for the four expiring seats: Craig G. Myers (new appointment) for the Community Health Clinic seat; Suzanne Richards (reappointment) for the Hospital seat; Jacob Sweidan, M.D. (reappointment) for the Physician seat; and Jena Jensen (reappointment) for the Traditional/Safety Net seat.

Action: ***On motion of Member Caliendo, seconded and carried, the Committee approved the recommendations of the PAC Nominations Ad Hoc e for the four expiring seats for a three-year term as presented. (Motion carried 10-0-3; Members Richards, Sweidan and Jensen abstained; Members Batra and Pimentel absent).***

The ad hoc recommended the reappointment of Teri Miranti as PAC Chairperson for FY 2017-18.

Action: ***On motion of Member Ross, seconded and carried, the Committee approved the recommendation of the PAC Nominations Ad Hoc to reappoint Teri Miranti as PAC Chair for FY 2017-18. (Motion carried 12-0-1; Chair Miranti abstained; Members Batra and Pimentel absent).***

The ad hoc recommended the reappointment of Suzanne Richards as PAC Vice Chairperson for FY 2017-18.

Action: ***On motion of Member Sweidan, seconded and carried, the Committee approved the recommendation of the PAC Nominations Ad Hoc to reappoint Suzanne Richards as PAC Vice Chair for FY 2017-18. (Motion carried 12-0-1; Vice Chair Richards abstained; Members Batra and Pimentel absent).***

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CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer reported on the budget process for FY 2017-2018, and noted that CalOptima received the Medi-Cal rates from the State for both Classic and Expansion members. The rates included a reduction of $55M for classic members and $62M for expansion members, totaling $117M in rate reductions to CalOptima. There was extended discussion about the new rate among the members and CalOptima staff.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, reported on the complimentary direct deposit through U.S. Bank established for providers that went into effect on April 10, 2017. She noted that the providers could now access their funds directly and review their claim details electronically.

Chief Medical Officer Update

Richard Bock, M.D., Deputy Chief Medical Officer introduced Marsha Choo, Manager of Quality Initiatives, who presented a verbal update on initiatives that are being worked on in the Quality Initiatives department. Ms. Choo also discussed the member/provider incentive and provided information on breast cancer screening, cervical cancer screening and postpartum check-ups. Ms. Choo noted that 60,000 women who had not had these screenings and checkups to date were sent fliers in their threshold language.

Chief Financial Officer Update

Nancy Huang, Interim Chief Financial Officer, presented CalOptima's Financial Summary as of March 2017, including a report of the Health Network Enrollment for the month of March 2017. Ms. Huang summarized CalOptima's financial performance and current reserve levels.

Provider Network Operations Update

Michelle Laughlin, Executive Director, Provider Network Operations, provided an update on the incentive program that was approved by the Board in December 2016 for screening of adolescents for clinical depression that will be rolled out the week of May 15, 2017. Approximately 600 primary care physicians may be participating in this incentive program for screening these adolescents.

Federal and State Budget Update

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, provided a State and Federal legislative update. On the Federal front, Mr. Tsunoda noted that the Congressional Budget Office (CBO) would release the CBO scoring of the American Health Care Act (AHCA) the week of May 22, 2017. On the State side, it was anticipated that the Governor would release the May Revise on May 11, 2017, which adjusts his proposed budget released in January 2017. It is anticipated that the May Revise will restate the Governor's commitment to continue the Cal MediConnect program (OneCare Connect) through December 31, 2019. He also noted that the recently passed Tobacco Tax Increase Initiative (Proposition 56) will generate annual additional revenue for fiscal year 2017/18 of approximately $1.2B. The Senate Committee on Budget and Fiscal Review has reported that the Governor would like to use that revenue to fund Medi-Cal program expenditure growth above last year's levels. This is specifically tied to the Medi-Cal

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Expansion Program (MCE) where the State is anticipating an increased cost in upcoming years. Mr. Tsunoda noted that the California Medical Association (CMA) and the California Dental Association (CDA) are requesting that $900M in Proposition 56 revenue be used to provide incentive based supplemental payments to physicians and dentists based on the number of Medi-Cal patients served.

INFORMATION ITEMS

Community Based Adult Services (CBAS) and Skilled Nursing Facility (SNF) 2016 Satisfaction Survey

Laura Guest, Supervisor, Quality Improvement, presented the CBAS and SNF Satisfaction survey results. For the CBAS Centers, surveys were distributed to 30 CBAS centers with nearly 1,000 surveys returned. The greatest concerns noted by the participants included dissatisfaction with meals, transportation issues, concerns not being addressed and physical and/occupational therapy not meeting their needs. These concerns are being addressed with the facilities and steps are being taken internally to correct these concerns. For the SNFs, 10 SNFs received surveys for 20 members each, for a total of 200 surveys with 124 (64%) surveys returned with an overall satisfaction score of 77%. The greatest concerns were dissatisfaction with the meals, services provided by the dietician, activities are not meaningful and concerns not being addressed.

Reinsurance Policy Changes

Ms. Huang, presented on the proposed changes to the Reinsurance Policy. Currently, CalOptima pays 90% of the hospital claims for patients exceeding $100,000 within a one-year period. The proposed change would reduce this to 80% of claims for patients exceeding $150,000. For physicians, CalOptima currently pays 90% of physician claims for patients who exceed $13,000 in medical costs. As proposed CalOptima would pay 80% of claims for patients who exceed $17,000 in medical costs within a one year period.

Comparison Report of the CalOptima Community Network (CCN) to Contract Health Networks – Financials and Utilization Performance

Ms. Huang also presented a comparison report of the CCN to the contracted health networks. The members and staff discussed the comparison study and PAC members expressed their desire to provide additional metrics that would be included in the CalOptima comparison prior to presentation at a CalOptima Board meeting.

PAC Member Updates

Member Ross noted that this would be his last PAC meeting. PAC members and CalOptima executives thanked Member Ross for serving as the Community Clinic's Representative for the last six years. Member Ross thanked the PAC for their support throughout his tenure.

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ADJOURNMENT

There being no further business before the Committee, Chair Miranti adjourned the meeting at 10:11 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: June 8, 2017

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MINUTES

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

May 25, 2017

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on May 25, 2017, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Chair Patty Mouton called the meeting to order at 3:08 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Patty Mouton, Chair; Gio Corzo, Vice Chair; Ted Chigaros, Christine Chow, Josefina Diaz, Sandy Finestone, Sara Lee
Members Absent:	John Dupies, Donta Harrison, George Crits, M.D. (non-voting); Erin Ulibarri (non-voting)
Others Present:	Ladan Khamseh, Chief Operating Officer; Dr. Donald Sharps, Medical Director; Candice Gomez, Executive Director Program Implementation; Sesha Mudunuri, Executive Director, Operations; Belinda Abeyta, Director, Customer Service; Albert Cardenas, Associate Director, Customer Service; Becki Melli, Customer Service; Pamela Reichardt, Executive Assistant

MINUTES

Approve the Minutes of the March 23, 2017 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

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

PUBLIC COMMENT
There were no requests for public comment.

REPORTS

Consider Approval of Fiscal Year (FY) 2016-2017 OCC MAC Accomplishments
Chair Mouton presented the OCC MAC's FY 2016-2017 Accomplishments for approval. The Accomplishments will be presented to the Board of Directors at the June 1, 2017 meeting.

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

Consider Approval of FY 2017-2018 OCC MAC Meeting Schedule

Chair Mouton presented the FY 2017-2018 meeting schedule for approval. Member Ted Chigaros suggested revising the December 2017 meeting from December 28 to December 14, 2017. Upon discussion, OCC MAC members concurred with the suggested revision.

Action: ***On motion of Member Christine Chow, seconded and carried, the OCC MAC approved the FY 2017- 2018 OCC MAC Meeting Schedule as revised.***

Consider Approval of FY 2017-2018 OCC MAC Goals and Objectives

Member Christine Chow reported that the Goals and Objectives Ad Hoc, composed of Members Sara Lee, Erin Ulibarri and Christine Chow, met on March 16, 2017 to develop the OCC MAC goals and objectives for FY 2017-18.

Action: ***On motion of Member Ted Chigaros, seconded and carried, the OCC MAC approved the FY 2017- 2018 MAC Goals and Objectives.***

Consider Recommendation of OCC MAC Slate of Candidates and FY 2017-2018 Chair/Vice Chair

Member Chigaros reported on the Nomination Ad Hoc Subcommittee's recommended slate of candidates, Chair and Vice Chair. The ad hoc, composed of OCC MAC members Lena Berlove, Ted Chigaros and Patty Mouton, met on April 19, 2017 to evaluate each of the applications for the vacant seats, and for the Chair and Vice Chair for FY 2017-18. After reviewing the applications and selecting a candidate for each open seat, the Nominations Ad Hoc recommended the following slate of candidates: Sandy Finestone as the representative for Persons with Disabilities; Sara Lee as the representative for Persons from an Ethnic or Cultural Community; Richard Santana as the representative for the IHSS/Union Provider; and Josefina Diaz as the representative for a OCC Member/Family Member. There were no eligible applicants for the second vacant OCC MAC member/family member seat. OCC MAC is reopening recruitment for this seat.

Action: ***On motion of Member Sandy Finestone, seconded and carried, OCC MAC approved the Slate of Candidates as presented.***

The Nomination Ad Hoc recommended the appointment of Gio Corzo as the FY 2017-2018 OCC MAC Chair.

Action: ***On motion of Member Ted Chigaros, seconded and carried, OCC MAC approved the FY 2017-2018 Chair as recommended.***

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The Nomination Ad Hoc recommended the appointment of Patty Mouton as the FY 2017-2018 OCC MAC Vice Chair.

Action: ***On motion of Member Ted Chigaros, seconded and carried, OCC MAC approved the FY 2017-2018 Vice Chair as recommended.***

The recommended nominations will be presented to the Board of Directors for consideration at the June 1, 2017 meeting.

PRESENTATIONS

Cal MediConnect Evaluation Survey Results

Megan Juring, Program Officer, The Scan Foundation, presented an update on waves one (1) through four (4) of the Cal MediConnect (CMC) Evaluation Survey Results. Ms. Juring explained that the objective of this survey was to track beneficiary transition into Cal MediConnect over time. Based on polling results, CMC enrollee satisfaction increased over the four polling cycles.

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer Update

Ladan Khamseh, Chief Operating Officer, reported that CalOptima's proposed budget will be considered by the Board of Directors at the June 1, 2017 Board Meeting. Ms. Khamseh provided an update on the deeming period for OCC Members. She explained that CalOptima's deeming period is currently one month; however, CalOptima is reviewing whether to change to a two-month deeming period.

Chief Medical Officer (CMO) Update

Dr. Donald Sharps, Medical Director, Behavioral Health, reported that CalOptima is working with Magellan to improve behavioral health services. CalOptima has had site visits to Magellan's call center and provided feedback on improving call center metrics. In addition, Dr. Sharps provided a brief update on CalOptima's continuing efforts to mitigate the opioid problem, reporting that CalOptima introduced pharmacy-related programs, such as placing restrictions on the amount/length of opioid prescriptions and limiting members to a single prescriber or pharmacy for their opioid prescriptions.

INFORMATION ITEMS:

OCC MAC Member Updates

Chair Mouton asked for volunteers to present the OCC MAC member presentation at an upcoming meeting. Member Christine Chow volunteered to present an update on the strategic plan on aging at the June meeting.

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In response to Chair Mouton's request for future agenda items, the following items were suggested: OCC aid code eligibility; coordination of veteran's health care/OCC benefits; and availability of geri-psych beds.

Chair Mouton announced that OCC MAC members are invited to the Community-Based Adult Services (CBAS) Center Open House on May 31, 2017 at 4:30pm in Garden Grove.

Quarterly Ombudsman Update

Member Sara Lee, Health Consumer Action Center of the Legal Aid Society of Orange County (LASOC), presented the Quarterly Ombudsman Update. Member Lee reported that LASOC continues to receive direct referrals from CalOptima regarding OneCare Connect members' eligibility issues. She explained that many of the cases involve Medi-Cal termination due to failure to complete the redetermination on time. Ms. Lee also discussed other OCC issues such as coordination of benefits between the veteran's health care and OCC, confusion about dental benefits and confusion about OCC aid codes.

Community-Based Adult Services (CBAS) Eligibility Processes

Cindy Osborn, Program Manager, Long-Term Support Services, provided an update on the CBAS eligibility process. Ms. Osborn explained that referrals are initiated from a variety of sources, such as a CBAS center, case manager or primary care provider. Potential CBAS members must complete a preliminary evaluation to determine eligibility. To be eligible, the member must be enrolled in CalOptima, must be 18 years of age or older and meet one of five categories of CBAS medical necessity.

Chair Mouton announced that the next OCC MAC Meeting is Thursday, June 22, 2017.

ADJOURNMENT

Hearing no further business, Chair Mouton adjourned the meeting at 4:30 p.m.

/s/ Pamela Reichardt
Pamela Reichardt

Executive Assistant

Approved: May 25, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

3. Consider Ratification of Amendment to Contract with American Logistics; Consider Actions Related to Implementing Medi-Cal Non-Medical Transportation Benefit

Contact

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

Recommended Actions

1. Ratify amendment to contract with American Logistics expanding the scope of work to include the Medi-Cal covered taxi services benefit, excluding services provided for members assigned to Kaiser Permanente, for nine months beginning July 1, 2017;
2. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend other existing contracts through no later than March 31, 2018 as necessary to ensure that qualifying Medi-Cal members have access to covered non-medical transportation services; and
3. Authorize the CEO to conduct a Request for Proposal (RFP) process to solicit bids from vendors providing non-medical transportation for CalOptima Medi-Cal, effective April 1, 2018.

Background

Medi-Cal managed care plan (MCP) benefits include emergency transportation, non-emergency medical transportation (NEMT) and, prior to July 1, 2017, non-medical transportation (NMT) only for children accessing Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. However, AB 2394 (Garcia, 2016) amends the covered outpatient services delineated in Welfare & Institutions Code section 14312 to expressly include NMT for all Medi-Cal members, including adults, effective July 1, 2017, "subject to utilization controls and permissible time and distance standards, for a beneficiary to obtain covered Medi-Cal services."

On June 29, 2017, the California Department of Health Care Services (DHCS) released All Plan Letter (APL) 17-010 providing MCPs with guidance for NEMT and NMT. Per the APL, beginning July 1, 2017, MCPs were expected to update their NEMT policy and procedures and begin providing NMT for all Medi-Cal members. NMT services include round trip transportation for medically necessary covered and carved-out Medi-Cal services. MCPs are required to provide NMT by passenger car, taxicab, or any other form of public or private conveyance (including private vehicle), as well as gas mileage reimbursement under certain conditions.

Transportation must be physically and geographically accessible and consistent with disability rights laws. One attendant, such as a parent, spouse or guardian may accompany the member. Additionally, a minor can travel without a parent for services which do not require parental consent and otherwise with parental consent.

Prior authorization may, at the discreation of the MCP, be required and reauthorized every 12 months when necessary. When applicable, the MCP is responsible for ensuring that parental consent is obtained in advance of arranging transportation. For NMT requests by private conveyance (e.g.,

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family members, friends, neighbors, etc.), members must attest, in person, by phone, or electronically, that no other methods of transporation are reasonably available and alternatives have been reasonably exhausted. The attestation may include confirmation that the member:

- Has no valid driver's license;
- No working vehicle available in the household;
- Is unable to travel or wait for medical or dental services alone; or
- Has a physical, cognitvie, mental, or developmental limitation.

Reimbursement for private conveyance includes only mileage at the Internal Revenue Service (IRS) standard mileage rates for medical purposes (the 2017 reimbursement rate is $0.17 per mile) and can be made only for drivers compliant with California driving requirements, which includes a valid driver's license, vehicle registration and vehicle insurance. Neither the legislation nor the APL establish any additional specific requirements or criteria for driver eligibility.

Prior to July 1, 2017, CalOptima contracted with American Logistics to provide taxi servcies for OneCare and OneCare Connect members, as well as Medi-Cal members receiving EPSDT services. The agreement with American Logistics covering transporation to and from EPSDT services was authorized by the CalOptima Board on September 3, 2015, with the contract covering Medicare services authorized by the Board on April 7, 2016 and executed on July 1, 2016. Considering the short lead time between the DHCS's issuance of APL 17-010 on June 29, 2017 and the required implementation date (the following day), CalOptima staff amended the American Logistics contract on a short term basis to broaden the scope of work to include the Medi-Cal NMT benefit to ensure that the benefit was available to members while a longer term solution was being developed.

Discussion

CalOptima staff leveraged an existing transportation contract to ensure that the effective date for the new NMT requirement was met. On July 1, 2017, CalOptima began providing the expanded NMT services including the amended contract with American Logistics, as well as via taxi, bus, and private conveyance arranged by members. This benefit is separate from other existing transportation benefits, and members can continue to access emergency and NEMT services in accordance with existing processes. To access NMT services, members can contact CalOptima's Customer Service Department to discuss and coordinate transportation.

Should all other reasonable transportation options be exhausted and private conveyance be required, CalOptima's Customer Service Department will issue a reference number, and members can arrange for their own transportation, with their private drivers submitting gas mileage receipts for reimbursement to CalOptima. In order to receive reimbursement, private drivers will also be required to submit proof that they meet California driving requirements which include valid driver's license, vehicle registration, and evidence of vehicle insurance.

In order to ensure that qualifying Medi-Cal members have access to public conveyance options, bus and taxi services are being offered. CalOptima will continue to procure passes from the Orange County Transit Authority (OCTA) for both bus and OC ACCESS, for members who are unable to use regular bus service due to functional limitations caused by a disability. For taxi services, the

scope of work of the current contract with American Logistics (CalOptima's contracted provider for OneCare and OneCare Connect) has been amended through March 31, 2018 as a short term measure to ensure that this transportation benefit is available to Medi-Cal members.

During this nine month period, CalOptima staff will consider longer term options for providing the NMT benefit and conduct an RFP to identify potential vendors and return to the Board with the RFP results and recommendations. In addition, staff is in the process of developing a comprehensive transportation program, and will be returning to the Board with recommendations and policy updates.

Fiscal Impact
The recommended action to ratify the amendment to the American Logistics contract, amend contracts with existing providers, and conduct an RFP process is expected to result in an increase in both claims and administration expense for CalOptima. However, because non-medical transportation is a newly-mandated benefit and since no projected utilization data has been provided by DHCS, the fiscal impact of this benefit is not currently known. CalOptima staff will continue to work with DHCS to ensure that funding for non-medical transportation will be appropriate and sufficient to fully cover the costs of the benefit. On a prospective basis, staff will update the Board as appropriate on the expenses associated with providing this benefit. Long term, staff anticipates that the program will be budget neutral to CalOptima.

Rationale for Recommendation
CalOptima staff recommends the above actions in order to be compliant with the NMT requirements.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Board Action dated September 3, 2015, Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)
2. Board Action dated April 7, 2016, Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016
3. July 17, 2017 DHCS All Plan Letter 17-010 (Revised) Non-Emergency Medical and Non-Medical Transportation Services

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **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

Report Item

VIII. F. Authorize Extension of OneCare/OneCare Connect Taxi Services Contracts, Implementation of Taxi Services Benefit for Qualifying Medi-Cal Children to Meet Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Guidelines, Conduct a Request for Proposal Process for Taxi Services, and Contract with Selected Vendor(s)

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:

1. Extend current OneCare/OneCare Connect taxi services contract for an additional six months from January 1, 2016 through June 30, 2016;
2. Amend budget based on Department of Health Care Services (DHCS) requirements for taxi services for qualifying Medi-Cal children and their caregiver and/or guardian per 2015 EPSDT guidelines for the 2015-2016 fiscal year;
3. Amend contracts with existing taxi services providers to include the Medi-Cal program EPSDT benefit; and
4. Issue a Request for Proposal (RFP) for taxi services for the OneCare, OneCare Connect and Medi-Cal lines of business, and authorize the CEO to contract with vendor(s) selected through this process, with contracts to be effective July 1, 2016 for a two-year term, with three additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background and Discussion

Taxi transportation is a supplemental benefit for OneCare (OC) and a required benefit for OneCare Connect (OCC) members. CalOptima has contracted with American Logistics since January 1, 2008 for services to OneCare members, as a result of an RFP process was conducted in 2007. At its November 6, 2008 meeting, the Board authorized CalOptima's OC Taxi Transportation supplemental benefit, including extension of CalOptima's contract with American Logistics. At its January 2013 meeting, the Board authorized staff to leverage the OC provider network as the basis for the Duals Delivery system, and OCC was added to the current OC contract. The current contract expires December 31, 2015, based on the previous contract extensions.

Currently, the OC and OCC benefits allow for thirty (30) one-way trips per calendar year for each Member. To access this benefit, Members call American Logistics directly and schedule their taxi pick-up in order to receive one-way transportation to their appointment. This is an important benefit for dual eligible beneficiaries, for many of whom availability of transportation may determine whether they are able to obtain appropriate medical services.

The Department of Health Care Services (DHCS), through the EPSDT guidance, requires that non-medical transportation via taxi be made available to qualifying children in the Medi-Cal program. Based on projected membership and expected cost per member per month (PMPM) for Fiscal Year (FY) 2015-16, a budget of $200,000 is requested to meet this requirement, and CalOptima's current

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contract with the taxi provider for OneCare and OneCare Connect are to be amended to include Medi-Cal for the qualifying EPSDT children.
As mentioned above, American Logistics has been the sole taxi provider contracted January 1, 2008 as a result of an RFQ released in 2007. In accordance with vendor management best practices, it is appropriate to complete a new RFP process, with the targeted effective date of new contract(s) of July 1, 2016.

CalOptima's Medical Management and Customer Service staff have reviewed the utilization performance of this provider, evaluated the access needs of CalOptima members, and determined that American Logistics adequately meets CalOptima's requirements for the extended contract period. The extension is requested to allow for an appropriate time frame to complete an RFP process and review all candidates. Therefore, staff recommends extending the current contract for an additional six months, through June 30, 2015.

Fiscal Impact
Based on forecasted OneCare and OneCare Connect enrollment for FY 2015-2016, the fiscal impact of the recommended action to extend the existing OneCare/OneCare Connect taxi services contract for an additional six months from January 1, 2016, through June 30, 2016, is approximately $2,709,863. The recommended action is a budgeted item under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015.

Based on projected membership and expected cost PMPM for qualifying Medi-Cal children enrollment for FY 2015-16, the fiscal impact of the recommended action is expected to be approximately $200,000. This is an unbudgeted item. Funding for this recommended action is expected to be available from anticipated increase in net assets in the current fiscal year.

Rationale for Recommendation
CalOptima staff recommends authorizing an extension to the contract with American Logistics for six months to ensure that OneCare and OneCare Connect members continue to have access to covered services, authorize budget and contract amendment as soon as possible for EPSDT requirement per DHCS, and issuing an RFP for a taxi services effective July 1, 2016 to ensure that members have access to taxi services prospectively.

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 April 7, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
10. Consider Selection of Taxi Vendor and Authorize Contract for Taxi Services Effective July 1, 2016

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with American Logistics to serve as CalOptima's Taxi Vendor for OneCare Connect, OneCare, and Medi-Cal EPSDT members effective July 1, 2016, for a two (2) year term with three (3) additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The current taxi services contract for CalOptima's Medicare programs has been in place since January 1, 2008. It was awarded to American Logistics through a competitive procurement process. The agreement expires on June 30, 2016.

On September 3, 2015, the CalOptima Board of Directors authorized CalOptima staff to issue a Request for Proposal (RFP) for Taxi services for the contract period commencing July 1, 2016.

Following CalOptima's standard RFP process, an RFP was issued and a total of three responses were received.

Discussion
The responses to the RFP were reviewed by CalOptima's evaluation team consisting of the Senior Program Manager for Medicare, Customer Service Director, Customer Service Manager, Executive Director Medical Operations, Contracts Manager, and representatives from the following departments: Finance, Compliance, and Information Services. All vendors were provided a Scope of Work document and the CalOptima base contract at the time of the RFP.

The evaluation team's final weighted scoring for the RFP is as follows:

Vendor	Score
American Logistics	3.96
Access2Care	3.66
Veyo	3.19

Based upon the weighted scores each vendor received, American Logistics finished with the highest score at 3.96 out of a possible 5.0 of the evaluation. Access2Care finished second with a score of 3.66.

American Logistics was the only bidder who proved to have an established transportation network in the Orange County service area.

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Fiscal Impact
Under the terms of the proposed contract, consolidated taxi expenses are projected to decrease 4.9% in the next fiscal year. Management will include expenses associated with the proposed contract in the CalOptima FY 2016-17 operating budgets.

Rationale for Recommendation
CalOptima staff believes that contracting with the highest scoring taxi vendor, American Logistics, will meet the goal of continuing to ensure that CalOptima members receive safe, reliable transportation services in a cost-effective manner. CalOptima staff reviewed qualified taxi vendor responses and identified the candidate believed to best meet CalOptima's needs for safe, reliable, regulatory compliance, technological advances, administrative simplification, as well as overall cost savings. Accordingly, staff recommends that the Board authorize the CEO to contract with the existing taxi vendor as a result of completion of the RFP process authorized by the Board in September, 2015.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *04/01/2016*
Authorized Signature — **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: July 17, 2017

ALL PLAN LETTER 17-010 (*REVISED)*

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: NON-EMERGENCY MEDICAL AND NON-MEDICAL TRANSPORTATION SERVICES

PURPOSE:
This All Plan Letter (APL) provides Medi-Cal managed care health plans (MCPs) with guidance regarding Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services. With the passage of Assembly Bill (AB) 2394 (Chapter 615, Statutes of 2016), which amended Section 14132 of the Welfare and Institutions Code (WIC), the Department of Health Care Services (DHCS) is clarifying MCPs' obligations to provide and coordinate NEMT and NMT services. In addition, this APL provides guidance on the application of NEMT and NMT services due to the Medicaid Mental Health Parity Final Rule (CMS-2333-F)[1]. *Revised text is found in italics.*

BACKGROUND:
DHCS administers the Medi-Cal Program, which provides comprehensive health care services to millions of low-income families and individuals through contracts with MCPs. Pursuant to Social Security Act (SSA) Section 1905(a)(29) and Title 42 of the Code of Federal Regulations (CFR) Sections 440.170, 441.62, and 431.53, MCPs are required to establish procedures for the provision of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for qualifying members to receive medically necessary transportation services. NEMT services are authorized under SSA Section 1902 (a)(70), 42 CFR Section 440.170, and Title 22 of the California Code of Regulations (CCR) Sections 51323, 51231.1, and 51231.2.

AB 2394 amended WIC Section 14132(ad)(1) to provide that, effective July 1, 2017, NMT is covered, subject to utilization controls and permissible time and distance standards, for MCP members to obtain covered Medi-Cal medical, dental, mental health, and substance use disorder services. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services and must make their best effort to refer for and coordinate NMT for all Medi-Cal services

[1] CMS-2333-F

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not covered under the MCP contract. Effective October 1, 2017, in part to comply with CMS-2333-F and to have a uniform delivery system, MCPs must also provide NMT for Medi-Cal services that are not covered under the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other services delivered through the Medi-Cal fee-for-service (FFS) delivery system.

REQUIREMENTS:

Non-Emergency Medical Transportation
NEMT services are a covered Medi-Cal benefit when a member needs to obtain medically necessary covered services and when prescribed in writing by a physician, dentist, podiatrist, or mental health or substance use disorder provider. NEMT services are subject to a prior authorization, except when a member is transferred from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility or an intermediate care facility licensed pursuant to Health and Safety Code (HSC) Section 1250[2].

MCPs must ensure that the medical professional's decisions regarding NEMT are unhindered by fiscal and administrative management, in accordance with their contract with DHCS[3]. MCPs are also required to authorize, at a minimum, the lowest cost type of NEMT transportation (see modalities below) that is adequate for the member's medical needs. For Medi-Cal services that are not covered by the MCP's contract, the MCP must make its best effort to refer for and coordinate NEMT. MCPs must ensure that there are no limits to receiving NEMT as long as the member's medical services are medically necessary and the NEMT has prior authorization.

MCPs are required to provide medically appropriate NEMT services when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for obtaining medically necessary services[4]. MCPs are required to provide NEMT for members who cannot reasonably ambulate or are unable to stand or walk without assistance, including those using a walker or crutches[5]. MCPs shall also ensure door-to-door assistance for all members receiving NEMT services.

Unless otherwise provided by law, MCPs must provide transportation for a parent or a guardian when the member is a minor. With the written consent of a parent or guardian, MCPs may arrange NEMT for a minor who is unaccompanied by a parent or a guardian.

[2] 22 CCR Section 51323 (b)(2)(C)
[3] Exhibit A, Attachment 1 (Organization and Administration of the Plan)
[4] 22 CCR Section 51323 (a)
[5] Manual of Criteria for Medi-Cal Authorization, Chapter 12.1 Criteria for Medical Transportation and Related Services

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MCPs must provide transportation services for unaccompanied minors when applicable State or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.

MCPs must provide the following four available modalities of NEMT transportation in accordance with the Medi-Cal Provider Manual[6] and the CCR[7] when the member's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated and transportation is required for the purpose of obtaining needed medical care:

1. MCPs must provide **NEMT ambulance services** for[8]:
    - Transfers between facilities for members who require continuous intravenous medication, medical monitoring or observation.
    - Transfers from an acute care facility to another acute care facility.
    - Transport for members who have recently been placed on oxygen (does not apply to members with chronic emphysema who carry their own oxygen for continuous use).
    - Transport for members with chronic conditions who require oxygen if monitoring is required.

2. MCPs must provide **litter van services** when the member's medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following:
    - Requires that the member be transported in a prone or supine position, because the member is incapable of sitting for the period of time needed to transport[9].
    - Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[10].

3. MCPs must provide **wheelchair van services** when the member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
    - Renders the member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport[11].

[6] Medi-Cal Provider Manual: Medical Transportation – Ground
[7] 22 CCR Section 51323(a) and (c)
[8] Medi-Cal Provider Manual: Medical Transportation – Ground, page 9, Ambulance: Qualified Recipients
[9] 22 CCR Section 51323 (2)(A)(1)
[10] 22 CCR Section 51323 (2)(B)
[11] 22 CCR Section 51323 (3)(A)

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- Requires that the member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation[12].
- Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance[13].

Members with the following conditions may qualify for wheelchair van transport when their providers submit a signed Physician Certification Statement (PCS) form (as described below)[14]:

- Members who suffer from severe mental confusion.
- Members with paraplegia.
- Dialysis recipients.
- Members with chronic conditions who require oxygen but do not require monitoring.

4. MCPs must provide **NEMT by air** only under the following conditions[15]:
   - When transportation by air is necessary because of the member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or mental health or substance use disorder provider.

NEMT Physician Certification Statement Forms

MCPs and transportation brokers must use a DHCS approved PCS form to determine the appropriate level of service for Medi-Cal members. Once the member's treating physician prescribes the form of transportation, the MCP cannot modify the authorization. In order to ensure consistency amongst all MCPs, all NEMT PCS forms must include, at a minimum, the components listed below:

- Function Limitations Justification: For NEMT, the physician is required to document the member's limitations and provide specific physical and medical limitations that preclude the member's ability to reasonably ambulate *without* assistance or be transported by public or private vehicles.
- Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
- Mode of Transportation Needed: List the mode of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).

[12] 22 CCR Section 51323 (3)(B)
[13] 22 CCR Section 51323 (3)(C)
[14] Medi-Cal Provider Manual: Medical Transportation – Ground, page 11, Wheelchair Van
[15] 22 CCR Section 51323 (c)(2)

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- Certification Statement: Prescribing physician's statement certifying that medical necessity was used to determine the type of transportation being requested.

Each MCP must have a mechanism to capture and submit data from the PCS form to DHCS. Members can request a PCS form from their physician by telephone, electronically, in person, or by another method established by the MCP.

Non-Medical Transportation
NMT has been a covered benefit when provided as an EPSDT service[16]. Beginning on July 1, 2017, MCPs must provide NMT for MCP members to obtain medically necessary MCP-covered services. For all Medi-Cal services not covered under the MCP contract, MCPs must make their best effort to refer for and coordinate NMT.

Effective October 1, 2017, MCPs must provide NMT for all Medi-Cal services, including those not covered by the MCP contract. Services that are not covered under the MCP contract include, but are not limited to, specialty mental health, substance use disorder, dental, and any other benefits delivered through the Medi-Cal FFS delivery system.

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Physicians may authorize NMT for members if they are currently using a wheelchair but the limitation is such that the member is able to ambulate without assistance from the driver. The NMT requested must be the least costly method of transportation that meets the member's needs.

MCPs are contractually required to provide members with a Member Services Guide that includes information on the procedures for obtaining NMT transportation services[17]. The Member Services Guide must include a description of NMT services and the conditions under which NMT is available.

At a minimum, MCPs must provide the following NMT services[18]:

- Round trip transportation for a member by passenger car, taxicab, or any other form of public or private conveyance (private vehicle)[19], as well as mileage reimbursement for medical purposes[20] when conveyance is in a private vehicle arranged by the member and not through a transportation broker, bus passes, taxi vouchers or train tickets.

[16] WIC 14132 (ad)(7)
[17] Exhibit A, Attachment 13 (Member Services), Written Member Information
[18] WIC Section 14132(ad)
[19] Vehicle Code (VEH) Section 465
[20] IRS Standard Mileage Rate for Business and Medical Purposes

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- Round trip NMT is available for the following:
    - Medically necessary covered services.
    - Members picking up drug prescriptions that cannot be mailed directly to the member.
    - Members picking up medical supplies, prosthetics, orthotics and other equipment.
- MCPs must provide NMT in a form and manner that is accessible, in terms of physical and geographic accessibility, for the member and consistent with applicable state and federal disability rights laws.

Conditions for Non-Medical Transportation Services:

- MCP may use prior authorization processes for approving NMT services and re-authorize services every 12 months when necessary.
- NMT coverage includes transportation costs for the member and one attendant, such as a parent, guardian, or spouse, to accompany the member in a vehicle or on public transportation, subject to prior authorization at time of initial NMT authorization request.
- With the written consent of a parent or guardian, MCPs may arrange for NMT for a minor who is unaccompanied by a parent or a guardian. MCPs must provide transportation services for unaccompanied minors when state or federal law does not require parental consent for the minor's service. The MCP is responsible to ensure all necessary written consent forms are received prior to arranging transportation for an unaccompanied minor.
- NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
- For private conveyance, the member must attest to the MCP in person, electronically, or over the phone that other transportation resources have been reasonably exhausted. The attestation may include confirmation that the member:
    - Has no valid driver's license.
    - Has no working vehicle available in the household.
    - Is unable to travel or wait for medical or dental services alone.
    - Has a physical, cognitive, mental, or developmental limitation.

Non-Medical Transportation Private Vehicle Authorization Requirements

The MCPs must authorize the use of private conveyance (private vehicle)[21] when no other methods of transportation are reasonably available to the member or provided by the MCP. Prior to receiving approval for use of a private vehicle, the member must exhaust all other reasonable options and provide an attestation to the MCP stating other methods of transportation are not available. The attestation can be made over the

[21] VEH Section 465

phone, electronically, or in person. In order to receive gas mileage reimbursement for use of a private vehicle, the driver must be compliant with all California driving requirements, which include[22]:

- Valid driver's license.
- Valid vehicle registration.
- Valid vehicle insurance.

MCPs are only required to reimburse the driver for gas mileage consistent with the Internal Revenue Service standard mileage rate for medical transportation[23].

Non-Medical Transportation Authorization

MCPs may authorize NMT for each member prior to the member using NMT services. If the MCP requires prior authorization for NMT services, the MCP is responsible for developing a process to ensure that members can request authorization and be approved for NMT in a timely matter. The MCP's prior authorization process must be consistently applied to medical/surgical, mental health and substance use disorder services as required by CMS-2333-F.

Non-Medical Transportation and Non-Emergency Medical Transportation Access Standards

MCPs are contractually required to meet timely access standards[24]. MCPs that have a Knox-Keene license are also required to meet the timely access standards contained in Title 28 CCR Section 1300.67.2.2. The member's need for NMT and NEMT services do not relieve the MCPs from complying with their timely access standard obligations.

MCPs are responsible for ensuring that their delegated entities and subcontractors comply with all applicable state and federal laws and regulations, contractual requirements, and other requirements set forth in DHCS guidance, including APLs and Dual Plan Letters. MCPs must timely communicate these requirements to all delegated entities and subcontractors in order to ensure compliance.

[22] VEH Section 12500, 4000, and 16020
[23] IRS Standard Mileage Rate for Business and Medical Purposes
[24] 28 CCR Section1300.51(d)(H); Exhibit A, Attachment 9 (Access and Availability)

If you have any questions regarding this APL, contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original Signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Approval of Recommended Expenditure Categories for Intergovernmental Transfer (IGT) 6 and IGT 7, Reallocation of Prior IGT Funds, and Extension of Deadline for the University of California, Irvine (UCI) Observation Stay Pilot

Contact

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

Recommended Actions

1. Approve recommended expenditure categories for IGT 6 and 7;
2. Authorize proposed reallocation of IGT funds as detailed herein to Strategies to Reduce Readmission~~; and~~
3. ~~Extend deadline for the parties to reach agreement on terms UCI Observation Stay Pilot Program to October 31, 2017.~~ *Continued to a future Board meeting.*

Rev. 8/3/17

Background/Discussion

Intergovernmental Transfers (IGT) are transfers of public funds between eligible government entities which are used to draw down matching federal funds for the Medi-Cal program. The IGT funds are to be used to provide enhanced/additional benefits to existing Medi-Cal beneficiaries. There is no guarantee of future availability of the IGT Rate Range program. Consequently, these funds are best suited for one-time investments or as seed capital for new services or initiatives for the benefit of Medi-Cal beneficiaries.

Funds received by CalOptima for IGTs 1-5, which have totaled $47.3 million, have been previously allocated to projects which support CalOptima Board-approved funding categories to guide community health investments for the benefit of CalOptima members. CalOptima's share of the combined net proceeds of IGTs 6 and 7 are projected to be approximately $22.1million.

IGT 6 and 7 Proposed Expenditure Categories

The Board of Directors' IGT Ad Hoc committee appointed by the Board Chair met on July 6, 2017, to receive an update on current IGT projects and review potential IGT 6 and IGT 7 expenditure categories. The ad hoc committee consists of Directors Khatibi, Nguyen, and Schoeffel. The Ad Hoc committee recommends utilizing CalOptima's share of IGT 6 and IGT 7 funds to support programs addressing the following areas:

- Opioid and Other Substance Overuse
- Children's Mental Health
- Homeless Health
- Community Grants to support program areas beyond those funded by IGT 5

Staff will return to the Board with recommendations once a more detailed expenditure plan is developed.

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Prior IGT Funding Reallocations and Changes

Several projects under previous IGTs were recently completed, and in order to balance out the accounts, staff is recommending several reallocations between projects. The table below outlines the proposed reallocation of IGT funds as well as changes to previously approved projects:

From (Project/ IGT)	Proposed Action	To (Project/IGT)	Reason
FHQC Support Phase 2/ IGT 2	Reallocate $22,909	Strategies to Reduce Readmission/ IGT 1	Strategies to Reduce Readmission has a negative balance of $77,836 due to delayed reimbursements to the health network. FQHC Support Phase 2 is complete with a remaining balance of $22,909
Autism Screening/IGT 2	Reallocate $54,927	Strategies to Reduce Readmission/ IGT 1	Autism screening reimbursements has had lower interest level from providers than anticipated
UCI Observation Stay Payment Pilot/ IGT 4	Extend 90 day time limit for negotiation of project terms to October 31, 2017	N/A	At its December 1, 2016 meeting, the Board authorized up to $750,000 in IGT 4 dollars to fund an observation pilot at UCI, subject to the parties agreeing to terms within 90 days. As terms continue to be negotiated, staff recommends extending the deadline to reach term to October 31, 2017.

Fiscal Impact

The recommended action has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefits of CalOptima members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the Medi-Cal plan for Orange County is committed to continuing to work with our provider and community partners to address gaps and work to improve the availability, access and quality of health care services available to Medi-Cal beneficiaries.

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Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: IGT Update and Proposed Funding Categories for IGT 6 and 7

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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IGT Update & Proposed Funding Categories for IGT 6 & 7

Board of Directors Meeting

August 3, 2017

Cheryl Meronk

Director, Strategic Development

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Intergovernmental Transfers (IGT) Background

- Medi-Cal program is funded by state and federal funds
- IGT process enables CalOptima to secure additional federal revenue to increase California's low Medi-Cal managed care capitation rates
- Funds must be used to deliver enhanced services for the Medi-Cal population

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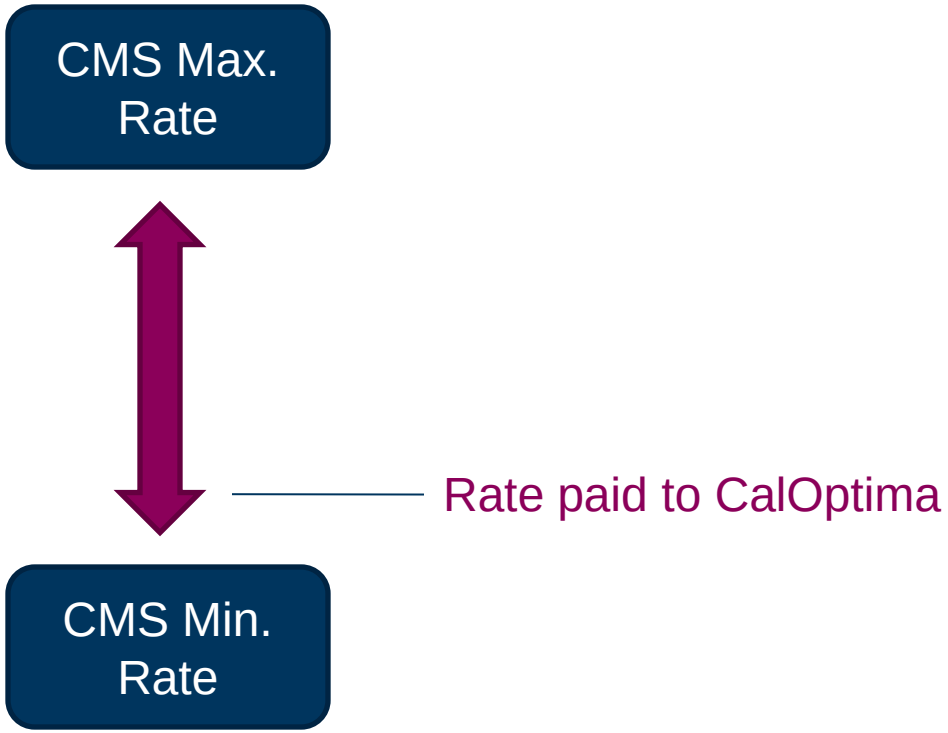
Low Medi-Cal Managed Care Rates

- CMS approves a rate range for Medi-Cal managed care
- California pays near the bottom of the range



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IGT Funds Availability and Process

- Available pool of dollars based on difference paid to CalOptima and the maximum rate
- Access to IGT dollars is contingent upon eligible government entities contributing dollars to be used as match for federal dollars
- Funds secured through cooperative transactions among eligible governmental funding entities, CalOptima, DHCS and CMS

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CalOptima Share Totals To-Date

IGTs	CalOptima Share
IGT 1	$12.52 M
IGT 2	$8.60 M
IGT 3	$4.88 M
IGT 4	$6.97 M
IGT 5	$14.42 M
Total	**$47.39 M**

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IGT 1 Status

Project	Budget	Balance	Notes
Personal Care Coordinators	$3,850,000	$0	Completed
Case Management System	$2,099,000	$0	Completed
Strategies to Reduce Readmissions	$533,585	($77,836)	Completed
Program for High-Risk Children	$500,000	$481,440	*Complete by 12/31/2018*
Case Management System Consulting	$866,415	$16,320	*Complete by 12/31/2017*
OCC PCC Program	$3,550,000	$0	Completed
Reallocated	*$1.1 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Total	**$11.4 M**	**$0.5 M**	

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IGT 2 Status

Project	Budget	Balance	Notes
Facets System Upgrade & Reconfiguration	$1,756,620	$0	Completed
Security Audit Remediation	$98,000	$0	Completed
Continuation of COREC	$970,000	$186,745	*Complete by 10/31/2018*
OCC PCC Program	$2,400,000	$2,400,000	*Complete by 3/31/2018*
Children's Health/ Safety Net Services	$1,300,000	$25,875	*Complete by 9/30/2017*
Wraparound Services	$1,400,000	$448,400	*Complete by 6/30/2018*
Recuperative Care	$500,000	$146,300	*Complete by 12/31/2018*
Program Administration	$100,000	$0	Completed
PACE EHR System	$80,000	$0	Completed
Total	**$8.6 M**	**$3.2 M**	

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IGT 3 Status

Project	Budget	Balance	Notes
Recuperative Care (Phase 2)	$500,000	$500,000	*Complete by 12/31/2018*
Program Administration	$165,000	$70,885	*Complete by 12/31/2017*
Reallocated	*$4.2 M*	*$0*	*Dollars reallocated to projects under IGT 4*
Remaining Total	**$0.7 M**	**$0.6 M**	

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IGT 4 Status

Project	Budget	Balance	Notes
Data Warehouse Expansion	$750,000	$553,588	*Complete by 3/31/2018*
Depression Screenings	$1,000,000	$1,000,000	*Complete by 3/31/2019*
Member Health Homes	$250,000	$250,000	*Complete by 12/31/2017*
Member Health Needs Assessment	$500,000	$479,805	*Complete by 12/31/2017*
Personal Care Coordinators	$7,000,000	$6,982,240	*Complete by 6/30/2018*
Provider Portal Communications & Interconnectivity	$1,500,000	$1,472,480	*Complete by 12/31/2018*
UCI Observation Stay Payment Pilot	$750,000	$750,000	TBD
Program Administration	$529,608	$510,428	*Complete by 12/31/2018*
Reallocated	*$0*	*$5.3 M*	*Dollars reallocated from IGTs 1 & 3 (included in IGT 4 total)*
Total	**$12.3 M**	**$12.0 M**	

As of 5/31/2017

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CalOptima A Public Agency Better. Together.

IGT 5

- $14.4M allocated for competitive community grants
- Community grant initiatives to be developed, pending results from CalOptima's Member Health Needs Assessment

- Funding Categories:
  - Adult Mental Health
  - Children's Mental Health
  - Strengthening the Safety Net
  - Childhood Obesity
  - Improving Children's Health

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Member Health Needs Assessment (IGT 5)

- Builds upon previous surveys and assessments, e.g.
  - CalOptima Group Needs Assessment
  - OC Health Care Agency – OC Health Profile
  - Hospital Community Needs Assessments
- Deeper focus on needs of diverse, underserved Medi-Cal membership, including:
  - 7 threshold languages + others never previously represented
  - Homeless
  - Mentally ill
  - Older adults
  - Persons with disabilities

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Member Health Needs Assessment (IGT 5)

- Comprehensive assessment to identify gaps in and barriers to service
  - Access to PCPs, specialists & hospitals
  - Pharmacy and lab
  - Oral health services
  - Mental health services
- Insights into social determinants of health
  - Economic stability/employment status
  - Housing status
  - Education/literacy level
  - Social isolation
  - Transportation issues
  - Cultural differences
  - Communication barriers

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Estimated IGT 6 and 7 Totals

IGT	CalOptima Share
IGT 6	≈ $9.95 M (Anticipated December 2017)
IGT 7	≈ $12.16 M (Anticipated May 2018)
Total	**≈ $22.11 M**

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Proposed IGT Funding Categories - IGT 6 and 7

- Funds to be used to deliver enhanced services for the Medi-Cal population

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Opioid/Other Substances Overuse

- Nationwide, 78 opioid overdose deaths per day
  - 45% of Rx drug overdose deaths are Medicaid beneficiaries
- In OC, 286 opioid-related drug overdose deaths in 2016
  - Opioid dependence second leading cause of substance-related hospitalizations in OC after alcohol dependence syndrome

- Potential solutions to be funded:
  - Expand access to pain management, addiction treatment and recovery services
  - Outreach and education
  - Technical assistance to community groups working to reduce opioid and other substance overuse

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Children's Mental Health

- Estimated 52,500 OC youth living with a mental health condition
- Hospitalization rate for major depression among children and youth continues to rise
- Only 32 psychiatric acute care beds in OC for adolescents, and zero for children under 12
  - New CHOC facility will add 18 beds, for ages 3-18

- Potential solutions to be funded:
  - Expand inpatient and outpatient psychiatric services capacity for children 3-18

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Homeless Health

- Homelessness in OC on the rise
  - 2017 Point-in-Time count identified 4,792 homeless individuals
  - 2015 Point-in-Time count was 4,452
  - As of 2015, estimated 15,291 homeless individuals in OC
    - Approximately 11,000+ of these are CalOptima members
- Economic impact of homelessness ≈ $300M over 12-month period between 2014-15
  - Includes $121M for health care costs
- Potential solutions to be funded:
  - Expand recuperative care services
  - Increase/expand mobile health clinics

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Competitive Community Grants

- Funding to fill gaps and address barriers to service beyond IGT 5 funding categories:
  - Examples of possible additional priority areas:
    - Older Adult Health
    - Dental Health
    - Persons with Disabilities
    - Maternal/perinatal Health

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CalOptima Projects and Program Admin

- Approx. 10% of total IGT 6 & 7 set aside for internal priorities and program administration, e.g.:
  - Expansion of provider electronic records capabilities
  - IGT program administration
  - Grant development and administration

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Next Steps

- Gather stakeholder input
  - PAC
  - MAC
  - OCC MAC
  - Community organizations
- Develop expenditure plans for Board approval

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CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
5. Consider Ratifying Amendment to Agreement with the California Department of Health Care Services (DHCS)

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

Recommended Action
Ratify Amendment 01 to Agreement 16-93274 between CalOptima and DHCS.

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

In 2016, DHCS extracted the MIPPA-compliant language from the Primary agreement and placed it in a standalone agreement, Agreement 16-93274. The Chairman of CalOptima's Board of Directors executed that agreement, an action that was ratified during the August 2016 meeting of the Board. Agreement 16-93274 is set to terminate on December 31, 2017. The agreement contains no rates of payment.

Discussion

Amendment to Agreement 16-93274
On June 12, 2017, DHCS notified CalOptima of a forthcoming amendment to extend Agreement 16-93274 for an additional year, through December 31, 2018. On June 13, 2017, DHCS sent the amendment to CalOptima for immediate signature and return.

The amendment contains no language changes other than the extension of the expiration date. The amendment contains no rates of payment. The Board previously ratified Agreement 16-93274 during its August 2016 meeting.

DHCS's urgency in requesting CalOptima's immediate response was tied to a requirement of the Centers for Medicare & Medicaid Services (CMS) that plans renewing their D-SNP programs must submit evidence of a MIPPA-compliant Medicaid contract for the 2018 contract year no later than July 3, 2017. Executing Amendment 01 to Agreement 16-93274 was required in order

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for CalOptima to meet CMS's filing requirements, and continue to operate the CalOptima's D-SNP "OneCare and its Cal MediConnect program "OneCare Connect" in contract year 2018.

Fiscal Impact
The recommended action to ratify Amendment 01 to Agreement 16-93274 between CalOptima and DHCS is projected to be budget neutral to CalOptima.

Rationale for Recommendation
CalOptima's execution of Amendment 01 to the Agreement 16-93274 with the DHCS is necessary to ensure that CalOptima meets CMS requirements in order for CalOptima to operate the OneCare and OneCare Connect programs during 2018.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Appendix summary of amendments to Primary and Secondary Agreements with DHCS

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

7/27/2017 — **Date**

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APPENDIX TO AGENDA ITEM 5.

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

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

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A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2015 and included language that incorporates provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015

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A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015
A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 incorporates the Hospital Quality Assurance Fee (QAF) into CalOptima's Optional Expansion rates for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into the primary agreement	October 2, 2014
A-29 added optional expansion rates for January- June 2015; also added updates to MLR language	April 2, 2015
A-30 incorporates language regarding Provider Preventable Conditions (PPC), determination of rates, and adjustments to 2014-2015 capitation rates with respect to Intergovernmental Transfer (IGT) Rate Range and Hospital Quality Assurance Fee (QAF).	December 1, 2016
A-31 extends the Primary Agreement with DHCS to December 31, 2020.	December 1, 2016

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Amendments to Secondary Agreement	Board Approval
A-01 implemented rate amendments to conform to rate amendments contained in the Primary Agreement with DHCS (08-85214).	July 8, 2010
A-02 implemented rate adjustments to reflect a decrease in the statewide average cost for Sensitive Services for the rate period July 1, 2010 through June 30, 2011.	August 4, 2011
A-03 extended the term of the Secondary Agreement to December 31, 2014.	June 6, 2013
A-04 incorporates rates for the periods July 1, 2011 through June 30, 2012, and July 1, 2012 through June 30, 2013 as well as extends the current term of the Secondary Agreement to December 31, 2015	January 5, 2012 (FY 11-12 and FY 12-13 rates) May 1, 2014 (term extension)
A-05 incorporates rates for the periods July 1, 2013 through June 30, 2014, and July 1, 2014 through June 30, 2015. For the period July 1, 2014 through June 30, 2015, Amendment A-05 also adds funding for the Medi-Cal expansion population for services provided through the Secondary Agreement.	December 4, 2014
A-06 incorporates rates for the period July 1, 2015 onward. A-06 also extends the term of the Secondary Agreement to December 31, 2016.	May 7, 2015 (term extension) April 7, 2016 (Ratification)
A-07 extends the Secondary Agreement with the DHCS to December 31, 2020.	December 1, 2016

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing and Directing the Chairman of the Board of Directors to Execute a Revised Amendment A03 or a new Amendment A04 to the Agreement with the California Department of Health Care Services (DHCS) for the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

Richard Helmer, Chief Medical Officer, (714) 246-8400
Nancy Huang, Interim Chief Financial Officer, (714) 246-8400

Recommended Actions

1. Authorize and direct the Chairman of the Board of Directors (Board) to execute a revised Amendment A03 or a new Amendment A04 to the PACE Agreement between DHCS and CalOptima ("DHCS Agreement"); and
2. Until such Amendment is provided, authorize and direct the Chairman of the Board to provide assurances to the DHCS, with the assistance of legal counsel, of CalOptima's intent to comply with all applicable requirements.

Background

Since October 2009, the CalOptima Board of Directors has taken numerous actions related to the CalOptima PACE program. On June 6, 2013, the Board authorized the execution of the DHCS Agreement as well as the agreement with the Centers for Medicare & Medicaid Services (CMS) for the operation of the CalOptima PACE site. On September 3, 2015, the Board authorized execution of amendments A01 and A02 to the DHCS Agreement for the Calendar Year (CY) 2014 and CY 2015 rates, respectively. On December 1, 2016, the Board authorized CalOptima PACE to pursue a waiver to allow nurse practitioners to provide primary care at PACE, which was approved on March 30, 2017 and incorporated as an amendment to CalOptima's CMS PACE agreement.

On March 29, 2017, DHCS provided CalOptima with Amendment A03 for the DHCS Agreement that includes revised Upper Payment Limit (UPL) and capitation rates for calendar year 2016, and incorporates a revised HIPAA Business Associate Addendum, Exhibit H, which requires compliance with DHCS's revised data security standards. On May 4, 2017, the Board authorized execution of Amendment A03 to the CalOptima-DHCS Agreement for the CY 2016 rates and an updated Health Insurance Portability and Accountability Act (HIPAA) Business Associate Addendum.

The CalOptima DHCS PACE Agreement specifies, among other terms and conditions, the capitation payment rates CalOptima receives from DHCS to provide health care services. The current Agreement expires on December 31, 2017, while the capitation rates are meant to be renewed on a calendar year basis.

Discussion

On June 6, 2017, DHCS's Contracts Management Unit (CMU) informed CalOptima of a requirement for all DHCS contracts to contain revised language reflecting the Americans with Disabilities Act

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(ADA). Inclusion of the updated ADA provision requires a revised Amendment A03 or new Amendment A04. The new language reads as follows:

Provision 6, "Americans with Disabilities Act" of *Exhibit A: Scope of Work* is added to read:

> 6. Americans with Disabilities Act
>
> Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement shall comply with the accessibility requirements of Section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973 as amended (29 U.S.C. § 794 (d), and regulations implementing that act as set forth in Part 1194 of Title 36 of the Federal Code of Regulations. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code section 11135 codifies section 508 of the Act requiring accessibility of electronic and information technology.

CalOptima staff does not foresee any challenges in ensuring compliance with the accessibility provision included in the ADA language as there are already existing processes in place for materials and electronic information, such as for the website, to be compliant with section 508 of the Rehabilitation Act of 1973, as amended (29 USC section 794(d).

All other terms and conditions in the CalOptima DHCS PACE Agreement remain unchanged.

Fiscal Impact
There is no anticipated fiscal impact for the recommended action to ratify Amendment A03 to include the updated ADA provision.

Rationale for Recommendation
CalOptima's execution of a revised Amendment A03 or new Amendment A04 to its Primary Agreement with DHCS is necessary to ensure compliance with the requirements and for the continued operation of CalOptima's PACE. CalOptima's FY 2017-18 Operating Budget incorporated the draft CY 2017 rates for PACE based on the CY 2016 capitation. Execution of a revised Amendment A03 or new Amendment A04 will ensure that revenues and cash payments are consistent with the approved budget.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to PACE Primary Agreements

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM 6.

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

Amendments to Primary Agreement with DHCS	Board Approval
A01 provided revised Upper Payment Limit (UPL) and capitation rates for Calendar Year (CY) 2013 for the period of October 1, 2013 through December 31, 2013; and UPL methodology and CY 2014 rates for the period of January 1, 2014 through December 31, 2014. Revised capitation rates for the Medi-Cal *Dual* population and *Medi-Cal only* population to have built-in adjustments for Medi-Cal program changes. Also incorporated adult expansion group into aid code table: a. Added adult expansion aid codes M1, L1, 7U under adult expansion group. b. Added aid codes 3D and M3 under Family group.	September 3, 2015
A02 provided revised UPL and capitation rates for CY 2015 for the period of January 1, 2015 through December 31, 2015. Revised capitation rates for the *Full-Dual* population and *Non-Dual eligible* population to have built-in adjustments for Medi-Cal program changes.	September 3, 2015
A03 provided revised UPL and capitation rates for CY 2016 for the period of January 1, 2016 through December 31, 2016, and applied the Managed Care Organization (MCO) Tax for the period July 1, 2016 through December 31, 2016. Beginning on January 1, 2017 and onward, the rates revert back to the non-MCO tax period rates in effect from January 1, 2016 through June 30, 2016, until the 2017 rates are developed and implemented with a future amendment to the CalOptima DHCS PACE Agreement. Incorporates a revised HIPAA Business Associate Addendum, Exhibit H, to replace the former Exhibit G, as of the Amendment effective date, which will require compliance with DHCS' revised data security standards.	May 4, 2017
Amend contract to include revised language reflecting the Americans with Disabilities Act (ADA) for 508 compliance.	Pending
Amendments to Primary Agreement with CMS	**Board Approval**
A01 CalOptima PACE initiated a waiver to allow Nurse Practitioners to provide primary care at PACE, which was approved by CMS on March 30, 2017 and added *Appendix T: Regulatory Waivers* to the CMS PACE Agreement.	December 1, 2016

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Authorizing Amendment of the Memorandum of Understanding Between Orange County Health Care Agency and CalOptima to Include Drug Medi-Cal Organized Delivery System

Contact

Richard Helmer, M.D., Chief Medical Officer, (714) 246-8400
Donald Sharps, M.D., Medical Director, Behavioral Health, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend the current Memorandum of Understanding (MOU) between the Orange County Health Care Agency (OCHCA) and CalOptima for the provision of Drug Medi-Cal services as defined by the Department of Health Care Services (DHCS), effective no sooner than October 1, 2017.

Background

The Drug Medi-Cal (DMC) substance use treatment services was first established in California in 1980 to provide medically necessary substance use disorder (SUD) treatment services to eligible Medi-Cal beneficiaries for specific approved services. The Department of Health Care Services (DHCS) is the single state agency responsible for administrative and fiscal oversight of DMC substance use treatment services. CalOptima members in need of SUD treatment services are referred to the County of Orange department responsible for substance use treatment, DMC program, or other community resources. Separately, CalOptima covers acute inpatient alcohol and SUD treatment services if the services are part of an inpatient course of treatment for a medical condition.

DHCS expanded SUD treatment services in January 2014 when it began requiring managed care plans (MCPs) including CalOptima to begin covering Screening, Brief Interventions, and Referral to Treatment (SBIRT), an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol. The SBIRT benefit is aligned with the U.S. Preventive Services Task Force recommendation on screening and behavioral counseling for alcohol misuse and is available to Medi-Cal beneficiaries 18 years and older in primary care settings. Brief interventions are offered to those who screen positively for risky or hazardous alcohol use or a potential alcohol use disorder. Members identified with possible alcohol use disorders are referred to the County of Orange alcohol and drug program for evaluation and treatment.

On August 13, 2015, DHCS announced that the Center for Medicare & Medicaid Services (CMS) had approved California's Drug Medi-Cal Organized Delivery system (DMC-ODS) Waiver amendment which provides a continuum of care for SUD treatment services. The DMC-ODS enables more local control and accountability, provides greater administrative oversight, creates controls to improve case

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and efficient use of resources, and implements advanced evidence based practices in substance abuse treatment while providing coordination with other systems of care.
The Orange County Health Care Agency, Behavioral Health Services (OCHCA BHS) notified CalOptima in January 2016 of its interest in applying for the five year Drug Medi-Cal Services demonstration project. HCA BHS collaborated with CalOptima, other partner agencies, providers, Medi-Cal beneficiaries, family and community members to develop the DMC-ODS implementation plan. The implementation plan was submitted to DHCS in October 2016 and received DHCS approval on December 23, 2016. As part of the implementation plan, DHCS requires a MOU between OCHCA BHS and CalOptima that outlines the mechanism for sharing information and coordination of services.

Discussion
CalOptima has a longstanding MOU with OCHCA to ensure that coordinated comprehensive care is provided for Medi-Cal beneficiaries with physical and behavioral health needs. It is the primary vehicle for ensuring beneficiary access to necessary and appropriate mental health services. It addresses policies and procedures for management of the beneficiary's care, including but not limited to, screening, assessment, referral, medical necessity determination, care coordination, and exchange of information. The MOU was last updated in February 2015 to include the expansion of mental health services covered by CalOptima for Medi-Cal beneficiaries with a mild to moderate level of impairment.

As proposed, the MOU between OCHCA and CalOptima will be amended to include an addendum for the DMC-ODS as part of the DHCS requirements. All required elements as set forth in the Special Terms and Conditions (STC) in the DHCS approved implementation plan have been reviewed and discussed by CalOptima and HCA staffs and are to be included in the addendum.

Fiscal Impact
The recommended action to amend the MOU between Orange County Health Care Agency (HCA) and CalOptima for the provision of Drug Medi-Cal services as defined by the Department of Health Care Services (DHCS) is budget neutral to CalOptima.

Rationale for Recommendation
Amending the existing MOU between CalOptima and HCA will ensure all Medi-Cal beneficiaries will have access to comprehensive SUD treatment services and coordination of care under DMC-ODS. As such, staff requests that the Board authorize the CEO to amend the current MOU between CalOptima and HCA.

Concurrence
Gary Crockett, Chief Counsel

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Attachments

1. Memorandum of Understanding between the Orange County Health Care Agency and Orange County Health Authority DBA CalOptima for the Coordination of Mental Health Services
2. Amendment I to the Memorandum of Understanding for the Coordination of Mental Health Services

/s/ Michael Schrader — *7/27/2017*

Authorized Signature — **Date**

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MEMORANDUM OF UNDERSTANDING
BETWEEN
THE ORANGE COUNTY HEALTH CARE AGENCY
AND
ORANGE COUNTY HEALTH AUTHORITY DBA CALOPTIMA
FOR THE COORDINATION OF MENTAL HEALTH SERVICES

This Memorandum of Understanding (MOU) between the Orange County Health Care Agency ("HCA" or "COUNTY") and the Orange County Health Authority, doing business as CalOptima, ("CALOPTIMA"), a public agency, is entered into this 1st day of February, 2015, and contains program content and purpose, along with specific guidelines for the activities to support the coordination of Medi-Cal mental health services.

HCA and CALOPTIMA may be referred to individually as "Party," and collectively as "the Parties." The relationship between HCA and CALOPTIMA, with regard to this MOU, is based upon the following:

1. HCA provides a full spectrum of specialty mental health services for the evaluation, diagnosis, treatment, and follow-up of seriously and persistently mentally ill adults and seriously emotionally disturbed children and youth who meet medical necessity criteria as defined by the Title IX. The Section 1915(b) Freedom of Choice waiver entitled Medi-Cal Specialty Mental Health Services, requires Orange County, California Medi-Cal beneficiaries needing specialty mental health services to access these services through HCA.
2. CALOPTIMA is a local public agency which, by statute, has the responsibility of operating a County Organized Health System (COHS) for Orange County, California. CALOPTIMA coordinates the provision of health care services, including non-specialty mental health services, to Orange County Medi-Cal beneficiaries using managed care principals.
3. COUNTY and CALOPTIMA are partners in facilitating access to prompt evaluation, diagnosis, treatment and follow up of mental illness for Medi-Cal beneficiaries who are CALOPTIMA members.
4. Pursuant to Section 28 of Senate Bill X1-1 of the First Extraordinary Session (Hernandez & Steinberg, Chapter 4, Statutes of 2013) which added Welfare and Institutions Code Sections 14132.03 and 14189 and the Patient Protection and Affordable Care Act, beginning January 1, 2014 CALOPTIMA is responsible for mental health assessments and medically necessary outpatient mental health services in addition to obligations under its contract with the DHCS that existed as of that date.
5. Department of Health Care Services (DHCS) requires that, as a Medi-Cal managed care benefit, CALOPTIMA must administer the program in a specified manner, including updating, amending, or replacing any existing Medi-Cal Behavioral Health Services MOU with HCA to account for the new outpatient mental health covered services that will be provided by CALOPTIMA. Therefore, this MOU shall replace the Medi-Cal MOU between Orange-Prevention-and Treatment-Integrated Medical

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Assistance Plan, CALOPTIMA, and Orange County Health Care Agency/Behavioral Health Services/Mental Health Plan (HCA/MPH) dated May 2001.

I. TERM

The term of this MOU shall commence on February 1, 2015, following execution by both Parties, and continue year to year, unless otherwise terminated earlier pursuant to the terms of this MOU. This MOU may be altered in writing through mutual consent of both Parties and will be reviewed annually.

II. TERMINATION

Either party may terminate this MOU without any further obligations and without cause upon sixty (60) days prior written notice to the other Party.

III. PURPOSE

The purpose of this MOU is to describe the responsibilities of HCA and CALOPTIMA for the coordination of Medi-Cal mental health services in order to ensure that CalOptima Members are able to access necessary and appropriate mental health services. Neither Party may seek to enforce the terms and conditions of this MOU against each other in law or equity.

IV. DEFINITIONS

A. "California Department of Health Care Services (DHCS)" means the single State department responsible for administration of the federal Medicaid program (referred to as Medi-Cal in California), California Children Services, Genetically Handicapped Persons Program, Child Health and Disabilities Prevention, and other health related providers. DHCS provides State oversight of Managed Care Plans and County Mental Health Programs.

B. "Medically Necessary" or "Medical Necessity" means reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.

When determining the medical necessity of covered services for a Medi-Cal beneficiary under the age of 21, "medical necessity" is expanded to include the standards set forth in Title 22 CCR Sections 51340 and 51340.1.

Medical necessity for specialty mental health services is defined at Title 9, CCR, Sections 1820.205 (inpatient), 1830.205 (outpatient), and 1830.210 (outpatient for beneficiaries under the age of 21).

C. "Member" means an eligible Medi-Cal beneficiary who has enrolled in CALOPTIMA.

D. "Outpatient Mental Health Services" means the services listed below, when medically necessary and provided by PCPs or licensed mental health professionals in the CalOptima provider network within the scope of their practice:

1. Individual and group mental health evaluation and treatment (psychotherapy);

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2. Psychological testing, when clinically indicated to evaluate a mental health condition;
3. Outpatient services for the purposes of monitoring drug therapy;
4. Outpatient laboratory, drugs, supplies, and supplements (excluding medications listed in Attachment 2); and,
5. Psychiatric consultation.

E. "Quality Improvement" means the result of an effective quality improvement system.

F. "Quality of Care" means the degree to which CALOPTIMA/HCA in creases the likelihood of desired health outcomes of CALOPTIMA enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge in at least one of the six domains of quality, as specified by the Institute of Medicine. The six domains are as follows: efficiency, effectiveness, equity, patient-centeredness, patient safety, and timeliness.

G. "Specialty Mental Health Services" means an array of mental health services as described in regulation (Title IX). The authority for HCA to determine which services within that array shall be available and adequate to meet the needs of the community is also specified in regulation (Title IX) and within the federally approved State's Medi-Cal 1915(b) waiver.

V. POPULATION TO BE SERVED

Individuals to be served pursuant to this MOU are Members who meet the mental health services eligibility requirements described in Attachment 1-A.

VI. COVERED SERVICES

Covered mental health services related to this MOU are those services described in Attachment 1-B.

VII. DELIVERY OF COVERED SERVICES

Beginning January 1, 2014, CALOPTIMA shall provide Medi-Cal Outpatient Mental Health Services covered in the state plan as a Managed Care Benefit to Members with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder as defined by the current DSM, that are outside the PCP's scope of practice. CALOPTIMA will ensure the delivery of mental health services are within the mental health care providers' scope of practice. CALOPTIMA is responsible for the monitoring and oversight of duties delegated to its subcontractor.

CALOPTIMA shall ensure that its Primary Care Physicians (PCPs) continue to perform, within their scope of practice, mental health screenings of all Members. In addition, CALOPTIMA shall cover and ensure the provision of psychotherapeutic drugs prescribed by its PCPs or other health professionals, except those drugs specifically excluded as stipulated in Attachment 2.

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CALOPTIMA shall continue to provide the following medically necessary covered services for Members receiving specialty mental health services:

- Pharmaceutical services and prescription drugs
- Laboratory, radiological, and radioisotope services
- Emergency room facility charges and professional services
- Emergency and non-emergency medical transportation
- Home health services
- Medically necessary Covered Services to Members who are patients in psychiatric inpatient hospitals

HCA shall continue to provide Medi-Cal specialty mental health services to Members.

VIII. SCREENING, ASSESSMENT, AND REFERRAL

HCA and CALOPTIMA have developed and agreed to the written CALOPTIMA Policies for screening, assessment, and referral processes, including screening and assessment tools used in determining if HCA or CALOPTIMA will provide mental health services.

CALOPTIMA is obligated to provide mental health screenings of all Members by network PCPs. Members with positive screening results may be treated by a network PCP within the PCP's scope of practice. When the condition is beyond the PCP's scope of practice, the PCP will refer the Member to the Access Line for a mental health screening. The mental health screening will include the use of the mutually agreed upon Mental Health Level of Care Screening Tool to assess the Member's disorder, level of impairment, and appropriate care needed. If the level of care initially determined to be appropriate is Specialty Mental Health Services, the call will be treated as a request for services to the County Mental Health Plan.

CALOPTIMA shall establish and maintain mechanisms to identify Members who require non-covered psychiatric services and ensure that appropriate referrals are made. CALOPTIMA shall consult with HCA as necessary to locate other appropriate community resources and to assist Member to locate available non-covered mental health services.

Referring Members to COUNTY specialty mental health services:

CALOPTIMA shall ensure that its network providers refer Members with significant impairment resulting from a covered mental health diagnosis to HCA via the Access Line. Also, when the Member has a significant impairment, but the diagnosis is uncertain, or the diagnosis is a tentative psychiatric diagnosis which meets eligibility criteria for referral to HCA as defined in MMCD Mental Health Policy Letter 00-01 Revised, CALOPTIMA shall ensure that the Member is referred to HCA via the Access Line for further assessment.

- HCA shall accept referrals from CALOPTIMA staff, providers, and Members' self-referrals through the Access Line for determination of medical necessity for specialty mental health services. When medical necessity criteria are met as assessed by HCA, HCA will arrange for specialty mental health services. In the case of self-referrals or referrals from providers other than the Member's PCP, in

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which the planned specialty mental health services involves a psychiatrist, HCA will inform the Member's PCP of services to be rendered.

Referring Members to CALOPTIMA outpatient mental health services:

- HCA shall refer a Member to CALOPTIMA when the service needed is one provided by CALOPTIMA and not HCA, and when it has been determined by HCA that the Member does not meet the specialty mental health medical necessity criteria.

- CALOPTIMA shall accept referrals from HCA staff, providers and Members' self-referral for assessment, make a determination of medical necessity for Outpatient Mental Health Services, and provide referrals within CALOPTIMA mental health provider network.

IX. AFTER-HOURS POLICIES AND PROCEDURES

CALOPTIMA and HCA maintain a central 24 hour/7days a week direct telephone Access Line for mental health emergencies during non-business hours for Members to access services and for Providers to coordinate care with HCA Evaluation and Treatment Services (ETS), Centralized Assessment Team (CAT), or emergency room personnel during a crisis. For emergency/crisis situations, Access Line staff shall conduct a warm transfer via telephone to CAT and/or 911.
Emergency Services and Care – Emergency Room Facility Charges and Professional Services:

- CALOPTIMA will cover and pay for the facility charges resulting from the emergency services and care of a Member, whose condition meets medical necessity criteria, when such services and care do not result in the admission of the member for psychiatric inpatient hospital services, or when such services result in an admission of the Member for psychiatric inpatient hospital services at a different facility.

- CALOPTIMA will cover and pay for all professional services except the professional services of a mental health specialist when required for the emergency services and care of a Member whose conditions meets medical necessity criteria.

- CALOPTIMA will cover and pay for the facility charges and the medical professional services required for the emergency services and care of a Member with an excluded diagnosis or a Member whose condition does not meet medical necessity criteria and such services and care do not result in the admission of the member for psychiatric inpatient hospital services. Payment for professional services of a mental health specialist required for the emergency services and care of a Member with an excluded diagnosis is the responsibility of the Medi-Cal fee-for-service system.

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- HCA will be responsible for the facility charges resulting from the emergency services and care of a Member whose condition meets the medical necessity criteria when such services and care do result in the admission of the member for psychiatric inpatient hospital services at the same facility. The facility charge is not paid separately but is included in the per diem rate for the inpatient stay.

- HCA will be responsible for facility charges directly related to the professional services of a mental health specialist provided in the emergency room when these services do not result in the admission of the Member for psychiatric inpatient hospital services at that facility or any other facility.

X. CARE COORDINATION

When CALOPTIMA has been determined to be the mental health care provider, CALOPTIMA will be responsible for initiating, providing, and maintaining ongoing care coordination as mutually agreed upon in CALOPTIMA and HCA protocols.

When HCA has been determined to be the mental health care provider, HCA will be responsible for initiating, providing, and maintaining ongoing care coordination as mutually agreed upon by CALOPTIMA and HCA.

Both parties shall agree to policies and procedures for coordinating inpatient and outpatient medical and mental health care for beneficiaries enrolled in CALOPTIMA and receiving specialty mental health services through HCA. CALOPTIMA shall continue to provide medical case management and cover and pay for all medically necessary Medi-Cal covered physical health care services for Members receiving specialty mental health services; and will coordinate these services with HCA.

CALOPTIMA and HCA shall provide transition of care for members transitioning to or from CALOPTIMA or HCA mental health services. HCA clinical consultation, including consultation on medications, shall be provided to CALOPTIMA's PCPs who are treating Members with mental illness.

Coordination of Care for Inpatient Mental Health Treatment:

- Inpatient hospital provider shall notify a Member's PCP within 24 hours of admission and discharge from an inpatient mental health treatment to arrange for appropriate follow-up services.

- If applicable, inpatient hospital provider shall notify a member's behavioral health provider after a member has been admitted and discharged from an inpatient mental health treatment.
- Member's PCP and outpatient behavioral health provider shall review and update the care plan of the Member as clinically indicated.

Coordination of Care for Pharmacy Services:

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- HCA shall provide the names and qualifications of the HCA's prescribers to CALOPTIMA.

- CALOPTIMA shall provide CALOPTIMA's procedures for obtaining authorization of prescribed drugs and laboratory services and a list of available pharmacies and laboratories to HCA.

Coordination of Care for Emergency Services:

- CALOPTIMA shall provide emergency room facility and related services other than specialty mental health services, home health agency services as described in Title 22, section 51337, non-emergency medical transportation, and services to treat the physical health needs of Members who are receiving psychiatric inpatient hospital services, including the history and physical required upon admission.

- CALOPTIMA shall provide direct transfers between psychiatric inpatient hospital services and inpatient hospital services required to address a Member's medical problems based on changes in the Member's mental health or medical condition.

- HCA shall provide emergency assessment of mental health condition.

XI. OVERSIGHT

CALOPTIMA covered behavioral health provider network shall be provided through its subcontracted network. CALOPTIMA shall conduct a full comprehensive compliance audit at its subcontracted provider network offices and/or facilities annually, or as deemed necessary, by CALOPTIMA.

The CalOptima/HCA Collaboration Committee shall function as the HCA and CALOPTIMA's joint mental health Medi-Cal oversight and multidisciplinary clinical teams. The committee includes representatives of HCA and CALOPTIMA and is responsible for the following:

- Program oversight
- Quality improvement
- Problem and dispute resolution
- Ongoing management of the MOU
- Oversight for clinical operations (screenings, assessment, referrals, care management, care coordination, and exchange of medical information)

XII. DISPUTE RESOLUTION

CALOPTIMA and HCA shall facilitate timely resolution of clinical and administrative disputes, including differences of opinion about whether CALOPTIMA or HCA should provide mental health services. The review process shall not result in delays in member access to services or prescription drugs while the decision from the formal dispute resolution process is pending. CALOPTIMA and HCA agree to follow the resolution of dispute process in accordance Title 9 CCR, Section 1850.505.

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When the dispute involves CALOPTIMA continuing to provide services to a Member CALOPTIMA believe requires specialty mental health services from HCA, HCA shall identify and provide CALOPTIMA with the name and telephone number of a psychiatrist or other qualified licensed mental health professional available to provide clinical consultation, including consultation on medications to the CALOPTIMA provider responsible for the Member's care.

When HCA has a dispute with CALOPTIMA regarding a referral to specialty mental health services, HCA staff shall attempt to resolve the dispute with the Access Line staff who conducted the initial mental health assessment. If the dispute is unresolved, HCA Mental Health Service Chief and the Director of Clinical Operation at the Access Line shall participate in the dispute resolution process. If the dispute remains unresolved, HCA Medical Director and CALOPTIMA Behavioral Health Medical Director shall take the lead in resolving the dispute.

When a dispute between CALOPTIMA and HCA cannot be resolved, CALOPTIMA and/or HCA may submit a request for resolution to the DHCS. A request for resolution by either party will be submitted to the respective party within 30 calendar days of the completion of the dispute resolution process between both parties. The request for resolution will contain the following information:

- A summary of the issue and a statement of the desired remedy, including any disputed services that have or are expected to be delivered to the Member and the expected rate of payment for each type of services.
- History of attempts to resolve the issue.
- Justification for the desired remedy.
- Documentation regarding the issue.

Upon receipt of a request for resolution, the DHCS will notify the other party within 7 calendar days. The notice to the other party will include a copy of the request and will ask for a statement of the party's position on the issue included by the other party in its request. The other party will submit the requested documentation within 21 calendar days, or the DHCS will decide the dispute based solely on the documentation filed by the initiating party.

Nothing in this section will preclude a Member from utilizing CALOPTIMA or HCA's problem resolution process for Members or any similar process, or to request a fair hearing.

XIII. INFORMATION EXCHANGE

Both Parties shall agree to policies that ensure timely sharing of information and describe agreed upon roles and responsibilities for sharing protected health information (PHI) for the purposes of medical and behavioral health care coordination pursuant to Title 9, CCR, Section 1810.370(a)(3), and in compliance with HIPAA and other State and federal privacy laws.

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XIV. REPORTING AND QUALITY IMPROVEMENT

Both Parties have agreed to the following policies, procedures, and reports to address quality improvement requirements for mental health services including, but not limited to:

a. Regular meetings, as agreed upon by both Parties, to review referral and care coordination process, to monitor member engagement and utilization, and to review information exchange protocols and processes.

b. No less than semi-annual calendar year review of referral and care coordination processes to improve quality of care; and at least semi-annual reports summarizing quality findings, as determined in collaboration with DHCS. Reports summarizing findings of the review address the systemic strengths and barriers for effective collaboration between both Parties.

c. Reports that track cross-system referrals, beneficiary engagement, and service utilization are to be determined in collaboration with DHCS, including but not limited to, the number of disputes between both Parties, the dispositions/outcomes of those disputes, the number of grievances related to referrals and network access, and the dispositions/outcomes of those grievances. Reports shall also address utilization of mental health services by members receiving such services from CALOPTIMA and HCA, as well as quality strategies to address duplication of services.

d. Performance measures and quality improvement initiatives to be determined in collaboration with DHCS.

XV. MEMBER AND PROVIDER EDUCATION

Both parties have determined requirements for coordination of member and provider information about access to CALOPTIMA and HCA covered mental health services.

CALOPTIMA shall develop and maintain a list of mental health providers or provider organizations for CALOPTIMA covered services. HCA shall develop and maintain a list of mental health providers or provider organizations for HCA specialty mental health services. The lists of CALOPTIMA and HCA prov iders shall be made available to Members.

Both parties have agreed to:

- Credential and contract with sufficient numbers of licensed mental health professionals to maintain a provider network sufficient to meet the needs of the Members.
- Continually monitor the provider network to ensure Member access to quality mental health care.

XVI. INDEMNIFICATION

CalOptima agrees to indemnify, defend with counsel approved in writing by COUNTY, and hold COUNTY, its elected and appointed officials, officers, employees, agents and those special districts and agencies for which COUNTY's Board of Supervisors acts as

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the governing Board ("COUNTY INDEMNITEES") harmless from any claims, demands, including defense costs, or liability of any kind or nature, including but not limited to personal injury or property damage, arising from or related to the services, products or other performance provided by CalOptima pursuant to this Agreement.

COUNTY agrees to indemnify, defend with counsel approved in writing by CalOptima, and hold CalOptima, its elected and appointed officials, officers, employees, agents, directors, members and/or affiliates ("CALOPTIMA INDEMNITIES") harmless from any claims, demands, including defense costs, or liability of any kind of nature, including, but not limited to personal injury or property damage, arising from or related to services, products or other performance provided by COUNTY pursuant to this Agreement.

If judgement is entered against one Party by a court of competent jurisdiction because of the concurrent active negligence of the other Party or that Party's Indemnities, the Parties agree that liability will be apportioned as determined by the court.

XVII. NOTICE AND CORRESPONDENCE

All notices and correspondence concerning this MOU will be in writing, and sent to:

HCA:

Attn.: Contract Services
405 W. 5th Street, Suite 600
Santa Ana, CA 92701

CALOPTIMA:

Attn: Contracting Department
505 City Parkway West
Orange, CA 92868

All notices shall be deemed effective when in writing and deposited in the United States mail, first class, postage prepaid, and addressed as above. Any notices, claims, correspondence, reports and/or statements authorized or required by this MOU addressed in any other fashion shall be deemed not given. In the event of a change of address by one Party, that Party shall notify the other, in writing, in accordance with the notice provisions herein of the new address to which notices are sent.

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WHEREFORE, the parties hereto have executed the Memorandum of Understanding in the County of Orange, California.

By: Mark A. Refowitz
Director
HCA

Dated: 3/31/15

By: William A. Jones
Chief Operating Officer
CALOPTIMA

Dated: 3/2/15

Approved As To Form
County Counsel
County of Orange, California

By: Deputy

Dated: 2/27/15

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Attachment 1-A
Mental Health Services Description Chart for Medi-Cal Managed Care Members
ELIGIBILITY

CALOPTIMA OUTPATIENT	HCA OUTPATIENT	HCA INPATIENT
Mild to Moderate Impairment in Functioning	**Significant Impairment in Functioning**	**Emergency and Inpatient**
A Member is covered by CALOPTIMA for services if he or she is diagnosed with a mental health disorder as defined by the current DSM[1] resulting in mild to moderate distress or impairment of mental, emotional, or behavioral functioning: • Primary care providers identify the need for a mental health screening and refer to a specialist within their network. Upon assessment, the mental health specialists can assess the mental health disorder and the level of impairment and refer Members that meet medical necessity criteria to HCA for a Specialty Mental Health Services (SMHS) assessment. • When a Member's condition improves under SMHS and the mental health providers of CALOPTIMA and HCA coordinate care, the Member may return to the mental health provider in the CALOPTIMA network. *Note. Conditions that the current DSM identifies as relational problems are not covered, i.e. couples counseling or family counseling*	A Member is eligible for services if he or she meets all of the following medical necessity criteria: 1. Has an included mental health diagnosis;[2] 2. Has a significant impairment in an important area of life function, or a reasonable probability of significant deterioration in an important area of life function, or a reasonable probability of not progressing developmentally as individually appropriate; 3. The focus of the proposed treatment is to address the impairment(s) described in #2; 4. The expectation that the proposed treatment will significantly diminish the impairment, prevent significant deterioration in an important area of life function, and 5. The condition would not be responsive to physical health care-based treatment. *Note For members under age 21 who meet criteria for EPSTD specialty mental health services, the criteria allow for a range of impairment levels[1] and include treatment that allows the child to progress developmentally as individually appropriate.*	A Member is eligible for services if he or she meets the following medical necessity criteria: 1. An included diagnosis; 2. Cannot be safely treated at a lower level of care; 3. Requires inpatient hospital services due to one of the following which is the result of an included mental disorder: a. Symptoms or behaviors which represent a current danger to self or others, or significant property destruction; b. Symptoms or behaviors which prevent the beneficiary from providing for, or utilizing, food, clothing, or shelter; c. Symptoms or behaviors which present a severe risk to the beneficiary's physical health; d. Symptoms or behaviors which represent a recent, significant deterioration in ability to function; e. Psychiatric evaluation or treatment which can only be performed in an acute psychiatric inpatient setting or through urgent or emergency intervention provided in the community or clinic; and f. Serious adverse reactions to medications, procedures or therapies requiring continued hospitalization.

[1] Current policy is based on DSM IV and will be updated to DSM 5 in the future
[2] As specified in regulations Title IX, Sections 1820.205 and 1830.205 for adults and 1830.210 for those under age 21.

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Attachment 1-B
Mental Health Services Description Chart for Medi-Cal Managed Care Members
SERVICES

CALOPTIMA-OUTPATIENT	HCA-OUTPATIENT	HCA- INPATIENT
Mental health services[1] when provided by licensed mental health care professionals (as defined in the Medi-Cal provider bulletin) acting within the scope of their license: • Individual and group mental health evaluation and treatment (psychotherapy) • Psychological testing when clinically indicated to evaluate a mental health condition • Outpatient services for the purposes of monitoring medication therapy • Outpatient laboratory, medications[2], supplies[3], and supplements[4] • Psychiatric consultation	Medi-Cal Specialty Mental Health Services: • Mental Health Services o Assessment o Plan development o Therapy o Rehabilitation o Collateral • Medication Support Services • Day Treatment Intensive • Day Rehabilitation • Crisis Residential • Adult Crisis Residential • Crisis Intervention • Crisis Stabilization • Targeted Case Management	• Acute psychiatric inpatient hospital services • Psychiatric Health Facility Services • Psychiatric Inpatient Hospital Professional Services if the beneficiary is in fee-for-service hospital

[1] The number of visits for outpatient mental health services is not limited as long as the CALOPTIMA member meets medical necessity criteria.
[2] Excludes medications listed in Attachment 2. Outpatient laboratory testing may include tests to determine a baseline assessment before prescribing psychiatric medications or to monitor side effects from psychiatric medications.
[3] Supplies may include laboratory supplies.
[4] Supplements may include vitamins that are specifically excluded in the Medi-Cal formulary and that are scientifically proven effective in the treatment of mental health disorders (although none are currently indicated for this purpose).

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Attachment 2
Drugs Excluded from CALOPTIMA Coverage

1. Amantadine HCl
2. Aripiprazole
3. Asenapine (Saphris)
4. Benztropine Mesylate
5. Biperiden HCl
6. Biperiden Lactate
7. Chlorpromazine HCl
8. Chlorprothixene
9. Clozapine
10. Fluphenazine Decanoate
11. Fluphenazine Enanthate
12. Fluphenazine HCl
13. Haloperidol
14. Haloperidol Decanoate
15. Haloperidol Lactate
16. Iloperidone (Fanapt)
17. Isocarboxazid
18. Lithium Carbonate
19. Lithium Citrate
20. Loxapine HCl
21. Loxapine Succinate
22. Lurasidone Hydrochloride
23. Mesoridazine Mesylate
24. Molindone HCl
25. Olanzapine
26. Olanzapine Fluoxetine HCl
27. Olanzapine Pamoate Monohydrate (Zyprexa Relprevv)
28. Paliperidone (Invega)
29. Paliperidone Palmitate (Invega Sustenna)
30. Perphenazine
31. Phenelzine Sulfate
32. Pimozide
33. Procyclidine HCl
34. Promazine HCl
35. Quetiapine
36. Risperidone
37. Risperidone Microspheres
38. Selegiline (transdermal only)
39. Thioridazine HCl
40. Thiothixene
41. Thiothixene HCl
42. Tranylcypromine Sulfate
43. Trifluoperazine HCl
44. Triflupromazine HCl
45. Trihexyphenidyl
46. Ziprasidone
47. Ziprasidone Mesylate

This list of excluded psychiatric drugs is subject to change by Medi-Cal. These excluded drugs are those currently listed in the Medi-Cal Provider Manual:
http://files.medi-cal.ca.gov/pubsdoco/publications/masters-mtp/part1/mcpgmc_z01.doc

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AMENDMENT I
TO THE
MEMORANDUM OF UNDERSTANDING
FOR THE COORDINATION OF MENTAL HEALTH SERVICES

THIS AMENDMENT I is entered into by and between the Orange County Health Authority, dba CalOptima ("CalOptima") and the Orange County Health Care Agency ("HCA" or "COUNTY") and shall become effective on the first day of the first month following execution of this Amendment I by both parties (the "Effective Date"), with respect to the following facts:

RECITALS

A. CalOptima and HCA entered into a Memorandum of Understanding for the Coordination of Mental Health Services on February 1, 2015 ("MOU") whereby CalOptima and HCA described the responsibilities of both parties for the coordination of mental health services to ensure access to necessary, appropriate and timely mental health services to CalOptima Members.

B. HCA provides a continuum of care for individuals with substance use disorders who meet medical necessity criteria as defined in 22 CCR Section 51303.

C. HCA has elected to partner with the State of California Department of Health Care Services (DHCS) to implement a Drug Medi-Cal Organized Delivery System ("DMC-ODS" or "Drug Medi-Cal") pilot program for the delivery of health care services for Medi-Cal eligible individuals with substance use disorder (SUD) that reside in Orange County, California. This pilot program requires HCA to provide or arrange for the provision of Drug Medi-Cal services.

D. The purpose of this Amendment I is to describe the responsibilities of HCA and CalOptima for the coordination of SUD services in order to ensure that CalOptima Members are able to access necessary, appropriate, and timely SUD services, and to describe certain elements that will be implemented at the point of care to ensure clinical integration between HCA and CalOptima for SUD services.

E. HCA's implementation date for the Drug Medi-Cal pilot program is targeted for July 1, 2017. HCA submitted its implementation plan to DHCS, on October 28, 2016. DHCS requires that HCA's implementation plan include a copy of this executed Amendment I to the MOU.

F. CalOptima and HCA now desire to amend the MOU on the terms and conditions set forth below.

NOW, THEREFORE, the parties agree as follows:

1. The title of this MOU shall be deleted and replaced in its entirety with "Memorandum of Understanding for the Coordination of Behavioral Health Services".

2. Addendum 1 “Drug Medi-Cal” shall be added to this MOU and incorporated herein via this Amendment I.

3. MOU REMAINS IN FULL FORCE AND EFFECT - Except where this Amendment I conflicts with and supersedes the MOU, all other conditions contained in the MOU shall continue in full force and effect.

IN WITNESS WHEREOF, the Parties have executed this Amendment I.

FOR HCA	FOR CALOPTIMA:
_____	_____
SIGNATURE	SIGNATURE
Mary Hale	Ladan Khamseh
PRINT NAME	PRINT NAME
Deputy Agency Director, BHS	Chief Operating Officer
TITLE	TITLE
_____	_____
DATE	DATE

ADDENDUM I
DRUG MEDI-CAL

I. DEFINITIONS

A. "American Society of Addiction Medicine (ASAM) Criteria" means a comprehensive set of guidelines for treatment placements, continued stay, and transfer/discharge of persons with SUD.

B. "Behavioral Health Services (BHS)" means mental health and substance use disorder prevention, intervention, treatment and recovery services, including crisis, inpatient, intensive outpatient, outpatient, residential and housing services for individuals who are living with a severe mental illness and/or substance use disorder.

C. "California Department of Health Care Services (DHCS)" means the single State department responsible for administration of the federal Medicaid program (referred to as Medi-Cal in California), California Children's Services, Genetically Handicapped Persons Program, Child Health and Disabilities Prevention, and other health related providers. DHCS provides State oversight of Managed Care Plans and County Behavioral Health Programs.

D. "Drug Medi-Cal" means Medicaid funding for services for eligible persons with SUD.

E. "Substance Use Disorder (SUD) services" means an array of substance use disorder services as defined in the federally approved State's Medi-Cal waiver 1115.

II. POPULATION TO BE SERVED

Individuals to be served pursuant to this Amendment I are Members who meet the SUD services Member eligibility requirements as described in Attachment 1-C.

III. COVERED SERVICES

Covered SUD services related to this Amendment I are those services described in Attachment 1-D.

IV. DELIVERY OF COVERED SERVICES

Beginning no sooner than July 1, 2017, HCA shall provide Drug Medi-Cal Organized Delivery System (DMC-ODS) substance use disorder (SUD) services in accordance with the intergovernmental contract between the State Department of Health Care Services and the County of Orange.

HCA has agreed to:

- Maintain a provider network of County and contracted programs sufficient to meet the needs of the Members, with acknowledgement that the following services are benefits outside of DMC-ODS:

    - medically monitored intensive inpatient services are the responsibility of HCA;

    - medically managed intensive inpatient services in an acute care hospital, for which CalOptima would provide referral coordination and care, are the responsibility of CalOptima; and

    - voluntary inpatient detoxification (VID) services in an acute care hospital are Medi-Cal fee for service benefits.

- Continually monitor and provide oversight to the DMC provider network to ensure Member access to quality SUD care.

HCA will ensure the delivery of SUD services are within the scope of the SUD providers' scope of practice.

V. SCREENING, ASSESSMENT AND REFERRAL

HCA and CalOptima shall maintain written policies for screening, assessment, and referral processes, including screening and assessment tools used in determining if a Member needs SUD services.

CalOptima is obligated to provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) screenings of all Members by network PCPs. Members with positive screening results indicating medical necessity for SUD treatment services shall be referred to HCA for further assessment and treatment pursuant to the agreed upon policies.

HCA and CalOptima shall establish and maintain mechanisms to identify Members who require non-covered SUD services and ensure that appropriate referrals are made. CalOptima shall consult with HCA as necessary to locate other appropriate community resources and to assist Members to locate available non-covered SUD services.

Referring Members to HCA for SUD services:

- CalOptima shall ensure that its network providers refer Members meeting medical necessity for SUD treatment to HCA via the ASO Access Line. Also, when the Member's SUD diagnosis is uncertain, or the diagnosis is a tentative diagnosis, CalOptima shall ensure that the Member is referred to HCA via the ASO Access Line for further assessment.

- HCA shall accept referrals from CalOptima staff, providers, and Members' self-referrals through the ASO Access Line for screening and referral. When medical

necessity criteria are met as assessed by HCA, HCA will arrange for SUD services. In the case of Member self-referrals or referrals from providers other than the Member's PCP, in which the planned SUD services involves a psychiatrist, HCA will inform the Member's PCP of services to be rendered, with signed consent.

VI. AFTER HOURS

Members receiving SUD treatment services may access crisis after hours services via the ASO 24/7 Access Line, the HCA BHS Centralized Assessment Team (CAT), and 911 for emergency inpatient care. For non-crisis services, Members may contact the National Alliance on Mental Illness (NAMI) WarmLine.

VII. CARE COORDINATION

Coordination of Care for SUD Services:

When it has been determined that a Member needs SUD services, the Member will be referred to a SUD provider in HCA's network. HCA will be responsible for initiating, providing, and maintaining ongoing care coordination as mutually agreed by HCA and CalOptima.

HCA and CalOptima will coordinate care within the limits of law regulating information exchange for that purpose. In order to facilitate an integrated care program that includes both HCA and CalOptima:

- Both parties shall agree to policies and procedures for coordinating SUD and physical health care for Members enrolled in CalOptima and receiving SUD services through HCA. CalOptima shall continue to provide medical case management for its Members.

- CalOptima and HCA will engage Members, caregivers and providers in the shared planning of their care, including development and ongoing modification of the care plan throughout the course of care.

- HCA plan coordinators will discuss the importance of coordinating care, including development and ongoing modification of the care plan throughout the course of care, with each Member at the time of engagement in care and will attempt to obtain authorization to exchange information with CalOptima for that purpose. Should the Member decline to permit an exchange of information, the care plan will include coordination of care as an ongoing goal.

- HCA will communicate with CalOptima for the purpose of coordination of care at the time of Member engagement in care, annually for the annual care plan update and at discharge to consult on recommended follow up and referrals. HCA will respond to requests to provide input on the development of CalOptima's care plans.

- HCA will facilitate navigation necessary for linking beneficiaries to needed services, both internal to and external to the BHS system, as part of the care coordination role of the care team members. In addition, HCA maintains a call line, OC Links, specifically to support callers, including beneficiaries, family members, and providers, in navigating the behavioral health system.

Coordination of Care for Emergency Services related to SUD:

- HCA's DMC-ODS physician(s) and pharmacist(s) shall be available to provide clinical consultations, including consultations on medications.

- Both Parties shall agree to policies that ensure timely sharing of information and describe agreed upon roles and responsibilities for sharing protected health information (PHI) for the purposes of medical and behavioral health care coordination pursuant to Title 9, CCR, Section 1810.370(a)(3), 42 CFR, 42 CFR part 2, and in compliance with HIPAA and other State and federal privacy laws.

VIII. OVERSIGHT

DMC-ODS covered SUD services shall be provided through HCA's County-operated clinics and contracted provider network. HCA is responsible for the monitoring and oversight of duties delegated to its subcontractor(s). HCA shall conduct a full and comprehensive compliance audit of its contracted providers annually, or as deemed necessary by HCA.

The CalOptima/HCA Collaboration Committee shall function as the HCA and CalOptima's joint DMC-ODS oversight and multidisciplinary clinical team. The committee includes representatives of HCA and CalOptima and is responsible for the following:

- Program oversight
- Quality improvement (including HCA's Quality Improvement Plan)
- Utilization Management Program
- Problem and dispute resolution
- Ongoing management of MOU
- Oversight for clinical operations (screenings, assessment, referrals, care management, care coordination, and exchange of medical information)

IX. DISPUTE RESOLUTION

CalOptima and HCA shall facilitate timely resolution of clinical and administrative disputes, including differences of opinion about whether a Member is eligible for SUD services or whether HCA should provide SUD services. The review process shall not result in delays in Member access to SUD services while the decision from the formal dispute resolution process is pending. CalOptima and HCA agree to follow the resolution of dispute process in accordance Title 9, CCR, Section 1850.505.

When the dispute involves HCA discontinuing services to a Member that CalOptima believes requires SUD services from HCA, HCA shall identify and provide CalOptima

contact information for a qualified licensed SUD professional available to provide clinical consultation, including consultation on medications to the CalOptima provider responsible for the Member's care.

When CalOptima has a dispute with HCA regarding a referral to SUD services, CalOptima staff shall attempt to initially resolve the dispute with the ASO Access Line staff who handled the referral. If the dispute is unresolved, CalOptima and HCA shall participate in the dispute resolution process.

When a dispute between CalOptima and HCA cannot be resolved, CalOptima and/or HCA may submit a request for resolution to the DHCS. A request for resolution by either party will be submitted to the respective party within 30 calendar days of the completion of the dispute resolution process between both parties. The request for resolution will contain the following information:

- A summary of the issue and a statement of the desired remedy, including any disputed services that have or are expected to be delivered to the Member and the expected rate of payment for each type of services.
- History of attempts to resolve the issue.
- Justification for the desired remedy.
- Documentation regarding the issue.

Upon receipt of a request for resolution, the DHCS will notify the other party within 7 calendar days. The notice to the other party will include a copy of the request and will ask for a statement of the party's position on the issue included by the other party in its request. The other party will submit the requested documentation within 21 calendar days, or the DHCS will decide the dispute based solely on the documentation filed by the initiating party.

Nothing in this section will preclude a Member from utilizing CalOptima or HCA's problem resolution process for Members or any similar process, or to request a fair hearing.

X. QUALITY IMPROVEMENT REQUIREMENTS AND REPORTING

Both Parties have agreed to the following policies, procedures, and reports to address quality improvement requirements for SUD services including, but not limited to:

a. Regular meetings, as agreed upon by both Parties, to review referral and care coordination process, to monitor Member engagement and utilization, and to review information exchange protocols and processes.

b. No less than semi-annual calendar year review of referral and care coordination processes to improve quality of care; and at least semi-annual reports summarizing quality findings, as determined in collaboration with DHCS. Reports summarizing findings of the review address the systemic strengths and barriers for effective collaboration between both Parties.

c. Review reports that track cross-system referrals, Member engagement, and service utilization are to be determined in collaboration with DHCS, including but not limited to, the number of disputes between both Parties, the dispositions/outcomes of those disputes, the number of grievances related to referrals and network access, and the dispositions/outcomes of those grievances. Reports shall also address utilization of mental health services by Members receiving such services from CalOptima and HCA, as well as quality strategies to address duplication of services.

d. Performance measures and quality improvement initiatives to be determined in collaboration with DHCS.

XI. MEMBER AND PROVIDER EDUCATION

Both parties have determined requirements for coordination of Member and provider information about access to HCA for covered SUD services.

HCA shall develop and maintain a list of DMC-ODS certified providers or provider organizations for DMC-ODS covered services. HCA shall develop and maintain a list of DMC-ODS certified providers or provider organizations for HCA SUD services. The list of HCA providers shall be made available to Members and CalOptima upon request.

Attachment 1-C
SUD Eligibility Criteria Chart for Medi-Cal Managed Care Members
ELIGIBILITY

DMC-ODS Medical Criteria

In order to receive SUD services through HCA, the Member must meet the following medical necessity criteria:

1. Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or be assessed to be at risk for developing substance use disorder (for youth under 21).

2. Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

3. If applicable, must meet the ASAM adolescent treatment criteria. As a point of clarification, Members under age 21 are eligible to received Medi-Cal services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, Members under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medi-Cal authority. Nothing in the DMC-ODS pilot overrides any EPSDT requirements.

DMC-ODS Determination of Medical Need

1. The initial medical necessity determination for the DMC-ODS benefit must be performed through face-to-face review or telehealth by a Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA). After establishing a diagnosis, the ASAM Criteria will be applied to determine placement into the level of assessed services.

2. Medical necessity qualification for ongoing receipt of DMC-ODS is determined at least every six months through the reauthorization process for individuals determined by the Medical Director, licensed physician or LPHA to be clinically appropriate, except for Narcotic Treatment Program (NTP) services which will require reauthorization annually.

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Attachment 1-D
SUD Services Description Chart for Medi-Cal Managed Care Members

SERVICES

ASAM Criteria Continuum of Care Services and the DMC-ODS System

ASAM Level of Care	Title	Description	Provider	Payer
0.5	Early Intervention	Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Managed care provider	CalOptima
1	Outpatient Services	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies	DHCS Certified Outpatient Facilities	County DMC
2.1	Intensive Outpatient Services	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability	DHCS Certified Intensive Outpatient Facilities	County DMC
2.5	Partial Hospitalization Services	20 or more hours of service/week for multidimensional instability not requiring 24-hour care	N/A (optional service)	N/A (optional service)
3.1	Clinically Managed Low-Intensity Residential Services	24-hour structure with available trained personnel; at least 5 hours of clinical service/week and prepare for outpatient treatment.	DHCS Licensed and DHCS/ASAM Designated Residential Providers	County DMC
3.3	Clinically Managed Population-Specific High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.	N/A (optional service)	N/A (optional service)
3.5	Clinically Managed High-Intensity Residential Services	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full milieu or therapeutic community	DHCS Licensed and DHCS/ASAM Designated Residential Providers	County DMC
3.7	Medically Monitored Intensive Inpatient Services	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hour/day counselor availability	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric hospitals	County DMC
4	Medically Managed Intensive Inpatient Services	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2, or 3. Counseling available to engage patient in treatment	Medical – Surgical acute care Hospitals (reflect both VID and MedSurg)	Medical Surgical = CalOptima VID = Medi-Cal FFS
OTP	Opioid Treatment Program	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder	DHCS Licensed OTP Maintenance Providers, licensed prescriber	County DMC

ASAM Criteria Withdrawal Services (Detoxification/Withdrawal Management) and the DMC-ODS System

Level of Withdrawal Management	Level	Description	Provider	Payer
Ambulatory withdrawal management without extended on-site monitoring	1-WM	Mild withdrawal with daily or less than daily outpatient supervision.	N/A (optional service)	N/A (optional service)
Ambulatory withdrawal management with extended on-site monitoring	2-WM	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation.	N/A (optional service)	N/A (optional service)
Clinically managed residential withdrawal management	3.2-WM	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	DHCS Licensed Residential Facility with Detox Certification; Physician, licensed prescriber; ability to promptly receive step-downs from acute level 4.	County DMC
Medically monitored inpatient withdrawal management	3.7-WM	Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring.	Chemical Dependency Recovery Hospitals; Hospital, Free Standing Psychiatric hospitals	County DMC
Medically managed intensive inpatient withdrawal management	4-WM	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Medical – Surgical acute care Hospitals (reflect both VID and MedSurg)	Medical Surgical = CalOptima VID = Medi-Cal FFS

Required and Optional DMC-ODS Services

Service	Required	Optional
Early Intervention (SBIRT)	• Provided and funded through FFS/managed care	
Outpatient Services	• Outpatient (includes oral naltrexone)	• Partial Hospitalization
Residential	• At least one ASAM level of service initially • All ASAM levels (3.1, 3.3, 3.5) within three years • Coordination with ASAM Levels 3.7 and 4.0 (provided and funded through FFS/managed care)	• Additional levels
NTP	• Required (includes buprenorphine, naloxone, disulfiram)	
Withdrawal Management	• At least one level of service	• Additional levels
Additional Medication Assisted Treatment		• Optional
Recovery Services	• Required	
Case Management	• Required	
Physician Consultation	• Required	

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

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

Contact
Ladan Khamseh, Chief Operations Officer, (714) 246-8400

Recommended Action
Adopt Resolution approving CalOptima's updated Human Resources Policies.

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.

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

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

	Policy No./Name	Summary of Changes	Reason for Change
1.	GA.8037 Leave of Absence	• Holiday Pay practice change for employees on Leave • Specify "calendar" days where applicable	-Provide clarification to definitions and make consistent with employee handbook
2.	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, including the addition of a position. A summary of the changes to the	- 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.

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	Policy No./Name	Summary of Changes	Reason for Change
		Salary Schedule is included for reference.	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)

In addition, also included as an attachment is a summary of changes to Executive compensation, which is provided as information to the Board consistent with the requirements under the Compensation Administration Guidelines adopted by the Board as part of CalOptima Policy GA. 8057: Compensation Program.

Fiscal Impact
There is no fiscal impact for the new position, Care Manager, since the position is currently vacant.

The fiscal impact for the Executive merit increases is $99,183.62. This is a budgeted item included in the CalOptima Fiscal Year 2017-18 Operating Budget approved on June 1, 2017.

Rationale for Recommendation
This new position is responsible for oversight and review of behavior analysis services offered to members with Autism Spectrum Disorders (ASD).

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 17-0803-01, Approve Updated Human Resources Policies
2. CalOptima Policies:
    a. GA. 8037 Leave of Absence (redlined and clean copies)
    b. GA. 8058 Salary Schedule – (redlined and clean copies) with revised Attachment
3. Summary of Changes to Salary Schedule and Executive Compensation

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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RESOLUTION NO. 17-0803-01

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

APPROVE UPDATED HUMAN RESOURCES POLICIES

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated Human Resources Policies: GA.8037 Leave of Absence; GA.8058 Salary Schedule.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 3rd day of August, 2017.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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Policy #:	GA.8037
Title:	**Leave of Absence**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	01/05/12
Last Review Date:	~~05/04~~08/0
Last Revised Date:	3/17
	~~05/04~~08/0
	3/17

~~*Board Approved Policy*~~

I. PURPOSE

This policy outlines the general rules and restrictions applicable to a Leave of Absence.

II. POLICY

A. Granting a Leave of Absence: CalOptima will grant a Leave of Absence (LOA) to eligible employees in accordance with CalOptima's respective policies and procedures. For leaves specified herein, an employee must submit ~~a~~an LOA request form to the Human Resources (HR) Department.

B. An employee's manager may approve up to five (5) scheduled ~~work days~~workdays of excused absences for an illness or pre-planned surgery; however, absences of more than five (5) scheduled ~~work days~~ workdays for illnesses or pre-planned surgery, must be submitted to and approved by HR. Use of PTO time for pre-planned vacations does not require HR approval.

C. If an employee requires additional time off work beyond the amount of time authorized herein, and his or her manager and HR grant Personal LOA pursuant to CalOptima Policy~~:~~ GA.8038: Personal Leave of Absence, the Personal LOA will start on the first day after the termination of the LOA granted pursuant to one (1) of the leaves authorized herein.

D. Types of LOA:

1. Pregnancy Disability Leave (PDL): Under California Pregnancy Regulations, employers must provide up to four (4) months (calculated based on number of days or hours the employee would normally work within four (4) calendar months) of unpaid disability leave per pregnancy to women requiring time off work because of a disability caused by an employee's pregnancy, childbirth, or a related medical condition as described in CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence.

2. Family and Medical Leave: Under the Family and Medical Leave Act (FMLA), employers must provide eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per twelve (12) month period. In most circumstances, FMLA leave will run at the same time as Pregnancy Disability Leave or California Family Rights Act (CFRA) leave (see below), where applicable, and is not in addition to those leaves, as outlined in CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and CFRA Leaves of Absence.

3. California Family Rights Leave: The California Family Rights Act (CFRA) provides eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per twelve (12) month period, as detailed in CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence.

4. Military Family Leave: Eligible employees may take an unpaid leave of absence under FMLA and CFRA to care for a spouse, child, or parent who is on covered active duty or has been notified of an impending call or order to active duty. FMLA also includes a special leave entitlement for eligible employees to take up to twenty-six (26) weeks of unpaid leave to care for a covered service-member with a qualifying serious injury or illness during a single twelve (12) month period, as outlined in CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence.

5. Military Service Leave: The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a Federal law that provides a cumulative of five (5) years of leave (with certain exceptions) and re-employment rights for veterans and members of the National Guard and Reserve following qualifying military service. USERRA requires that a person re-employed under its provisions be given credit for any months he or she would have been employed but for the military service in determining eligibility for FMLA leave. A person re-employed following military service should be given credit for the period of military service towards the months-of-employment eligibility requirement.

    a. Salary and Compensation for First Thirty (30) Calendar Days for Military Service LOA: Pursuant to Military and Veterans Code, Sections 395.01 and 395.05, an employee may be entitled to his or her full salary, or compensation, including all appropriate benefits, for the first thirty (30) calendar days of his or her absence while he or she is engaged in the performance of ordered duty, active military training, inactive duty training, encampment, naval cruises, special exercises, or like activity. Pay under this provision is limited to not more than thirty (30) calendar days in any given fiscal year.

    b. Supplemental Compensation and Continuation of Benefits for Military Service LOA resulting from the National Emergency declared as a Result of the War on Terror: Upon the exhaustion of pay and benefits for the first thirty (30) calendar days, an employee called to active duty or active training duty with the U.S. Armed Forces or National Guard as a result of the National Emergency, may receive supplemental pay in an amount equal to the difference between the amount of the employee's military pay, including any allotments or additional allowances paid to their families, as calculated at the beginning of the employee's leave, and the amount the employee earned as base salary at CalOptima in the month prior to the leave of absence, assuming the amount the employee earned at CalOptima is greater than his or her military pay. The employee is also authorized to receive a continuation of appropriate benefits, including CalOptima's payment of the employer cost for applicable health insurance premiums for employees and, if applicable, their dependents. In the event the employee's military pay is greater than their CalOptima base salary, CalOptima will continue the employee's eligible benefits, if elected, and pay for the employee's cost of such benefits without seeking reimbursement. In instances where training or service with the U.S. Armed Forces is not mandatory and is not covered by state, or federal law, the leave of absence will be unpaid.

6. Military Spouse Leave: Pursuant to Military & Veterans Code, Section 395.10, eligible employees may take up to ten (10) scheduled ~~work days~~workdays of unpaid leave when their

spouse is on leave from active duty in the U.S. Armed forces, Reserves or National Guard. Employee may use accrued paid time off (PTO) if sufficient PTO is accrued or may take this time as unpaid.

7. Workers' Compensation: In accordance with state law, CalOptima provides Workers' Compensation insurance coverage for employees in case of work-related injury. CalOptima may grant a leave of absence subject to any limitations permitted by law for work-related injuries, in accordance with CalOptima Policy GA.8041: Workers' Compensation Leave of Absence.

8. Jury or Witness Duty Leave: Employees may be granted a LOA with regular pay for those hours that coincide with the employee's regularly-scheduled working hours for jury duty, provided they remit the jury fee, excluding payments for mileage, to CalOptima. CalOptima may grant an employee a LOA with pay to appear as a witness in court, other than as a litigant, or to respond to an official order from another governmental jurisdiction for reasons not brought about through the connivance or misconduct of the employee. On days employees are not required to report to court, or on days when the court either dismisses the employee early or requests that the employee report at a later time, whenever practical, the employee must report to work to perform regular duties prior to or after completing jury duty or appearing as a witness, unless the employee's manager approves that the remaining work time is less than reasonable travel time to court and work location. Employees are expected to work with and coordinate with their manager to ensure that their time away from work does not adversely impact business needs, their coworkers, or CalOptima's members.

9. Parental School Attendance: Pursuant to Labor Code, Section 230.8, employees can take time off up to eight (8) hours in one (1) month or forty (40) hours each year to participate in Child-Related Activities, subject to limitations under applicable laws. Pursuant to Labor Code, Section 230.7, employees can take time off to appear in the school pursuant to a request made under Education Code, Section 48900.1 (suspension of pupil), subject to limitations under applicable laws. Accrued paid time off (PTO) shall automatically be used for time-off for Child-Related Activities and/or to appear in a pupil's school, subject to the limitations under applicable laws. Otherwise, the Employee may take this time as unpaid if there is not enough accrued PTO available in accordance with CalOptima Policy GA.8018: Paid Time Off (PTO) and the CalOptima Employee Handbook under Time Off to Appear in Pupil's School.

10. Bereavement Leave: With approval of an employee's manager, an employee may take up to three (3) scheduled workdays off with pay (maximum of twenty-four (24) hours) in the event of a death of an employee's: current spouse; registered domestic partner; biological, adopted, step or foster child; biological, adopted, step or foster parent; legal guardian; siblings, including step brother and step sister; grandparent; grandchild; parents-in-law; siblings-in-law; or child-in-law. Supporting documentation for bereavement leave must be submitted to Payroll within thirty (30) calendar days of leave. The employee's manager may approve additional time off of up to five (5) scheduled work days to be taken as either PTO, or unpaid time off. An employee must submit a LOA request form to HR and request a Personal LOA pursuant to CalOptima Policy GA.~~-~~8038: Personal Leave of Absence if the employee plans to take additional unpaid time off exceeding five (5) scheduled ~~work days~~workdays.

11. Victims of Domestic Violence, Sexual Assault or Stalking Leave: Subject to the requirements under Labor Code, Sections 230 and 230.1, an employee who is a victim of domestic violence, sexual assault, or stalking, may, with reasonable advance notice, unless the advance notice is not feasible, request a LOA. Employees may elect to use accrued PTO, if available, when a

LOA is granted; however, the PTO cannot be used to adjust the start date and will count as part of the LOA. After an employee exhausts his or her PTO accruals, if elected, the remaining time off will be unpaid. LOAs under this paragraph may be granted for any of the following:

a. To seek medical attention for injuries caused by domestic violence, sexual assault, or stalking;

b. To obtain services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence, sexual assault, or stalking;

c. To obtain psychological counseling related to an experience of domestic violence, sexual assault, or stalking;

d. To participate in safety planning and take other actions to increase safety from future domestic violence, sexual assault, or stalking, including temporary or permanent relocation; and/or

e. To obtain relief, including, but not limited to, a temporary restraining order, restraining order, or other injunctive relieve, to help ensure the health, safety, or welfare of the employee, or his or her child.

12. Victims of Crime Leave: An employee who is a victim of a crime or whose immediate family member(s) is/are a crime victim may take time off subject to the procedural conditions imposed pursuant to Labor Code, Section 230.2, to attend judicial proceedings related to that crime. A copy of the official notice to the victim of each scheduled legal, or judicial, proceeding, or documentation substantiating the employee's attendance at a judicial proceeding is required for this leave. The employee can elect to use accrued PTO for the absence.

13. Volunteer Civil Service Leave: A Civil Service LOA for an unlimited duration may be granted for employees who are required to perform emergency duty as a volunteer firefighter, a reserve police officer, or emergency rescue personnel. An employee who performs duty as a volunteer firefighter, a reserve peace officer, or as emergency rescue personnel is also permitted to take a LOA, not to exceed an aggregate of fourteen (14) scheduled ~~work days~~workdays per calendar years for the purpose of fire, law enforcement, or emergency rescue training. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

14. Civil Air Patrol Leave: Employees who have been employed for at least ninety (90) calendar days may request a maximum total of ten (10) scheduled ~~work days~~workdays per calendar year (three (3) scheduled work days maximum for a single emergency operational mission, unless otherwise authorized by HR) for Civil Air Patrol duty. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

E. Except as required by federal or state law, or as necessary to protect the employee's safety in the workplace, CalOptima management and HR shall reasonably maintain the confidentiality, to the extent possible under the circumstances, of any employee requesting time off pursuant to a LOA described herein.

F. Other Leaves: Please refer to CalOptima Policy ~~-~~GA.8038: Personal Leave of Absence.

G. To the extent that this policy conflicts with CalOptima Policies GA.8038: Personal Leave of Absence, GA.8039: Pregnancy Disability Leave, or GA.8040: Family and Medical Leave Act and California Family Rights Act Leave, those specific policies shall supersede. To the extent this policy conflicts with the CalOptima Employee Handbook, this policy shall supersede.

III. PROCEDURE

A. Reinstatement: When an employee is placed on a LOA, CalOptima shall make an effort to hold the employee's position open for the period of the approved leave, with the exception of Personal LOAs in which there is no guarantee of reinstatement. However, to meet business needs, CalOptima may need to fill such positions. If an employee's former position is unavailable when the employee returns promptly to work upon the expiration of an approved LOA, CalOptima shall make every effort to place the employee in a comparable position for which the employee is qualified. If such a position is not available, the employee will be offered the next suitable position for which the employee is qualified that becomes available. In addition, CalOptima will attempt to reasonably accommodate employees who are released for partial or modified duty. An employee who does not accept a position offered by CalOptima is considered to have voluntarily terminated employment, effective the day such refusal is made. Employees returning from a LOA related to the employee's own medical condition must obtain a release to return to work from his or her health care provider (where applicable) stating that he or she is able to resume work. CalOptima also reserves the right to require employees to participate in a fitness for duty examination at the expense of CalOptima prior to return to work.

B. Paid Time Off (PTO) accruals: PTO only accrues during the time period an employee is on active duty, or utilizing PTO for an approved LOA. Once an employee elects not to use PTO accruals or exhausts all PTO accruals, the remaining time off for an approved LOA shall not be considered time worked for purposes of accruing PTO hours.

C. Holidays: If a paid holiday occurs during the period an employee is on a LOA, the employee may be eligible for the holiday pay if PTO is being used for the LOA the day before and the day after the holiday and the holiday pay will be prorated based on the ~~PTO hours used the day preceding and following the holiday.~~employee's full-time or part-time status as it was in effect prior to the LOA. If a holiday falls on a day in which the employee would have been regularly scheduled to work, the holiday will count against the employee's LOA entitlement.

D. Documentation: Failure to provide all the required information and/or documentation within the requested or required timeframe may result in: a delay in CalOptima's approval of the LOA request; CalOptima's denial of the employee's request for a LOA; an impact to the employee's ability to take a LOA as requested; and/or disciplinary action, up to and including termination.

E. Failure to return promptly: If an employee fails to return to work upon the expiration of an approved LOA and has not obtained an extension from HR prior to such expiration date, the employee will be considered to have voluntarily resigned.

F. Misrepresentations: Misrepresenting reasons for applying for a LOA will result in disciplinary action, up to and including termination.

G. Health benefits for PDL, FMLA, CFRA, Military Service or Workers' Compensation Leaves of Absence: Employer payments towards health benefits (medical, vision, and dental) for PDL, FMLA, CFRA, Military Service, or Workers' Compensation LOAs, will not continue beyond the FMLA/CFRA covered period pursuant to CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave. Employees may elect to purchase continuation of such health benefits coverage through COBRA. When an employee returns to work, the eligibility and accrual dates for such benefits may be adjusted to reflect the period of the LOA.

H. Other benefits: All other benefits not specified herein provided by CalOptima shall be administered according to HR procedures.

I. Eligibility and Specific Leave Requirements: Refer to specific CalOptima policies listed below for detailed information about eligibility and other leave requirements:

1. CalOptima Policy GA.8018: Paid Time Off (PTO);

2. CalOptima Policy GA.8038: Personal Leave of Absence;

3. CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence;

4. CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave; and/or

5. CalOptima Policy GA.8041: Workers' Compensation.

IV. ATTACHMENTS

A. Leave of Absence Request Form

V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8018: Paid Time Off (PTO)
C. CalOptima Policy GA.8038: Personal Leave of Absence
D. CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence
E. CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave
F. Government Code, §12945.1 *et seq*. (CFRA)
G. Labor Code, §230 *et seq*. (Jury service and other leaves)
H. Military & Veterans Code, §395.10 (Military Service Leave)
I. Title 2, California Code of Regulations (C.C.R.), §7291.2 *et seq.* (Pregnancy Regulations)
J. Title 2, California Code of Regulations (C.C.R.), §7293.5 *et seq*. (Disability Regulations)
K. Title 29, Code of Federal Regulations (C.F.R.), Part 825 (FMLA Regulations)
L. Title 29, United States Code (U.S.C.), §2601 *et seq.* (FMLA)
M. Title 38, United States Code (U.S.C.), §4301 *et seq*. (USSERA)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. ~~05/04~~08/03/17: Regular Meeting of the CalOptima Board of Directors
B. 08/07/14: Regular Meeting of the CalOptima Board of Directors
C. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8037	Leave of Absence	Administrative
Revised	02/01/2014	GA.8037	Leave of Absence	Administrative
Revised	~~05/04~~08/03/2017	GA.8037	Leave of Absence	Administrative

IX. GLOSSARY

Term	Definition
Child-Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of his or her child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima.
Leave of Absence	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.

Policy #: GA.8037
Title: **Leave of Absence**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader

Effective Date: 01/05/12
Last Review Date: 08/03/17
Last Revised Date: 08/03/17

I. PURPOSE

This policy outlines the general rules and restrictions applicable to a Leave of Absence.

II. POLICY

A. Granting a Leave of Absence: CalOptima will grant a Leave of Absence (LOA) to eligible employees in accordance with CalOptima's respective policies and procedures. For leaves specified herein, an employee must submit an LOA request form to the Human Resources (HR) Department.

B. An employee's manager may approve up to five (5) scheduled workdays of excused absences for an illness or pre-planned surgery; however, absences of more than five (5) scheduled workdays for illnesses or pre-planned surgery, must be submitted to and approved by HR. Use of PTO time for pre-planned vacations does not require HR approval.

C. If an employee requires additional time off work beyond the amount of time authorized herein, and his or her manager and HR grant Personal LOA pursuant to CalOptima Policy GA.8038: Personal Leave of Absence, the Personal LOA will start on the first day after the termination of the LOA granted pursuant to one (1) of the leaves authorized herein.

D. Types of LOA:

1. Pregnancy Disability Leave (PDL): Under California Pregnancy Regulations, employers must provide up to four (4) months (calculated based on number of days or hours the employee would normally work within four (4) calendar months) of unpaid disability leave per pregnancy to women requiring time off work because of a disability caused by an employee's pregnancy, childbirth, or a related medical condition as described in CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence.

2. Family and Medical Leave: Under the Family and Medical Leave Act (FMLA), employers must provide eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per twelve (12) month period. In most circumstances, FMLA leave will run at the same time as Pregnancy Disability Leave or California Family Rights Act (CFRA) leave (see below), where applicable, and is not in addition to those leaves, as outlined in CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and CFRA Leaves of Absence.

3. California Family Rights Leave: The California Family Rights Act (CFRA) provides eligible employees with up to twelve (12) weeks of unpaid, job-protected leave per twelve (12) month

period, as detailed in CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence.

4. Military Family Leave: Eligible employees may take an unpaid leave of absence under FMLA and CFRA to care for a spouse, child, or parent who is on covered active duty or has been notified of an impending call or order to active duty. FMLA also includes a special leave entitlement for eligible employees to take up to twenty-six (26) weeks of unpaid leave to care for a covered service-member with a qualifying serious injury or illness during a single twelve (12) month period, as outlined in CalOptima Policy GA.8040: Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) Leaves of Absence.

5. Military Service Leave: The Uniformed Services Employment and Reemployment Rights Act (USERRA) is a Federal law that provides a cumulative of five (5) years of leave (with certain exceptions) and re-employment rights for veterans and members of the National Guard and Reserve following qualifying military service. USERRA requires that a person re-employed under its provisions be given credit for any months he or she would have been employed but for the military service in determining eligibility for FMLA leave. A person re-employed following military service should be given credit for the period of military service towards the months-of-employment eligibility requirement.

    a. Salary and Compensation for First Thirty (30) Calendar Days for Military Service LOA: Pursuant to Military and Veterans Code, Sections 395.01 and 395.05, an employee may be entitled to his or her full salary, or compensation, including all appropriate benefits, for the first thirty (30) calendar days of his or her absence while he or she is engaged in the performance of ordered duty, active military training, inactive duty training, encampment, naval cruises, special exercises, or like activity. Pay under this provision is limited to not more than thirty (30) calendar days in any given fiscal year.

    b. Supplemental Compensation and Continuation of Benefits for Military Service LOA resulting from the National Emergency declared as a Result of the War on Terror: Upon the exhaustion of pay and benefits for the first thirty (30) calendar days, an employee called to active duty or active training duty with the U.S. Armed Forces or National Guard as a result of the National Emergency, may receive supplemental pay in an amount equal to the difference between the amount of the employee's military pay, including any allotments or additional allowances paid to their families, as calculated at the beginning of the employee's leave, and the amount the employee earned as base salary at CalOptima in the month prior to the leave of absence, assuming the amount the employee earned at CalOptima is greater than his or her military pay. The employee is also authorized to receive a continuation of appropriate benefits, including CalOptima's payment of the employer cost for applicable health insurance premiums for employees and, if applicable, their dependents. In the event the employee's military pay is greater than their CalOptima base salary, CalOptima will continue the employee's eligible benefits, if elected, and pay for the employee's cost of such benefits without seeking reimbursement. In instances where training or service with the U.S. Armed Forces is not mandatory and is not covered by state, or federal law, the leave of absence will be unpaid.

6. Military Spouse Leave: Pursuant to Military & Veterans Code, Section 395.10, eligible employees may take up to ten (10) scheduled workdays of unpaid leave when their spouse is on leave from active duty in the U.S. Armed forces, Reserves or National Guard. Employee may use accrued paid time off (PTO) if sufficient PTO is accrued or may take this time as unpaid.

7. Workers' Compensation: In accordance with state law, CalOptima provides Workers' Compensation insurance coverage for employees in case of work-related injury. CalOptima may grant a leave of absence subject to any limitations permitted by law for work-related injuries, in accordance with CalOptima Policy GA.8041: Workers' Compensation Leave of Absence.

8. Jury or Witness Duty Leave: Employees may be granted a LOA with regular pay for those hours that coincide with the employee's regularly-scheduled working hours for jury duty, provided they remit the jury fee, excluding payments for mileage, to CalOptima. CalOptima may grant an employee a LOA with pay to appear as a witness in court, other than as a litigant, or to respond to an official order from another governmental jurisdiction for reasons not brought about through the connivance or misconduct of the employee. On days employees are not required to report to court, or on days when the court either dismisses the employee early or requests that the employee report at a later time, whenever practical, the employee must report to work to perform regular duties prior to or after completing jury duty or appearing as a witness, unless the employee's manager approves that the remaining work time is less than reasonable travel time to court and work location. Employees are expected to work with and coordinate with their manager to ensure that their time away from work does not adversely impact business needs, their coworkers, or CalOptima's members.

9. Parental School Attendance: Pursuant to Labor Code, Section 230.8, employees can take time off up to eight (8) hours in one (1) month or forty (40) hours each year to participate in Child-Related Activities, subject to limitations under applicable laws. Pursuant to Labor Code, Section 230.7, employees can take time off to appear in the school pursuant to a request made under Education Code, Section 48900.1 (suspension of pupil), subject to limitations under applicable laws. Accrued paid time off (PTO) shall automatically be used for time-off for Child-Related Activities and/or to appear in a pupil's school, subject to the limitations under applicable laws. Otherwise, the Employee may take this time as unpaid if there is not enough accrued PTO available in accordance with CalOptima Policy GA.8018: Paid Time Off (PTO) and the CalOptima Employee Handbook under Time Off to Appear in Pupil's School.

10. Bereavement Leave: With approval of an employee's manager, an employee may take up to three (3) scheduled workdays off with pay (maximum of twenty-four (24) hours) in the event of a death of an employee's: current spouse; registered domestic partner; biological, adopted, step or foster child; biological, adopted, step or foster parent; legal guardian; siblings, including step brother and step sister; grandparent; grandchild; parents-in-law; siblings-in-law; or child-in-law. Supporting documentation for bereavement leave must be submitted to Payroll within thirty (30) calendar days of leave. The employee's manager may approve additional time off of up to five (5) scheduled work days to be taken as either PTO, or unpaid time off. An employee must submit a LOA request form to HR and request a Personal LOA pursuant to CalOptima Policy GA.8038: Personal Leave of Absence if the employee plans to take additional unpaid time off exceeding five (5) scheduled workdays.

11. Victims of Domestic Violence, Sexual Assault or Stalking Leave: Subject to the requirements under Labor Code, Sections 230 and 230.1, an employee who is a victim of domestic violence, sexual assault, or stalking, may, with reasonable advance notice, unless the advance notice is not feasible, request a LOA. Employees may elect to use accrued PTO, if available, when a LOA is granted; however, the PTO cannot be used to adjust the start date and will count as part of the LOA. After an employee exhausts his or her PTO accruals, if elected, the remaining time off will be unpaid. LOAs under this paragraph may be granted for any of the following:

a. To seek medical attention for injuries caused by domestic violence, sexual assault, or stalking;

b. To obtain services from a domestic violence shelter, program, or rape crisis center as a result of domestic violence, sexual assault, or stalking;

c. To obtain psychological counseling related to an experience of domestic violence, sexual assault, or stalking;

d. To participate in safety planning and take other actions to increase safety from future domestic violence, sexual assault, or stalking, including temporary or permanent relocation; and/or

e. To obtain relief, including, but not limited to, a temporary restraining order, restraining order, or other injunctive relieve, to help ensure the health, safety, or welfare of the employee, or his or her child.

12. Victims of Crime Leave: An employee who is a victim of a crime or whose immediate family member(s) is/are a crime victim may take time off subject to the procedural conditions imposed pursuant to Labor Code, Section 230.2, to attend judicial proceedings related to that crime. A copy of the official notice to the victim of each scheduled legal, or judicial, proceeding, or documentation substantiating the employee's attendance at a judicial proceeding is required for this leave. The employee can elect to use accrued PTO for the absence.

13. Volunteer Civil Service Leave: A Civil Service LOA for an unlimited duration may be granted for employees who are required to perform emergency duty as a volunteer firefighter, a reserve police officer, or emergency rescue personnel. An employee who performs duty as a volunteer firefighter, a reserve peace officer, or as emergency rescue personnel is also permitted to take a LOA, not to exceed an aggregate of fourteen (14) scheduled workdays per calendar years for the purpose of fire, law enforcement, or emergency rescue training. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

14. Civil Air Patrol Leave: Employees who have been employed for at least ninety (90) calendar days may request a maximum total of ten (10) scheduled workdays per calendar year (three (3) scheduled work days maximum for a single emergency operational mission, unless otherwise authorized by HR) for Civil Air Patrol duty. LOAs under this paragraph can be unpaid unless the employee elects to use accrued PTO. However, an employee cannot use PTO to adjust the start date of the LOA authorized under this paragraph, and the time covered by the PTO will be counted towards the LOA.

E. Except as required by federal or state law, or as necessary to protect the employee's safety in the workplace, CalOptima management and HR shall reasonably maintain the confidentiality, to the extent possible under the circumstances, of any employee requesting time off pursuant to a LOA described herein.

F. Other Leaves: Please refer to CalOptima Policy GA.8038: Personal Leave of Absence.

G. To the extent that this policy conflicts with CalOptima Policies GA.8038: Personal Leave of Absence, GA.8039: Pregnancy Disability Leave, or GA.8040: Family and Medical Leave Act and California Family Rights Act Leave, those specific policies shall supersede. To the extent this policy conflicts with the CalOptima Employee Handbook, this policy shall supersede.

III. PROCEDURE

A. Reinstatement: When an employee is placed on a LOA, CalOptima shall make an effort to hold the employee's position open for the period of the approved leave, with the exception of Personal LOAs in which there is no guarantee of reinstatement. However, to meet business needs, CalOptima may need to fill such positions. If an employee's former position is unavailable when the employee returns promptly to work upon the expiration of an approved LOA, CalOptima shall make every effort to place the employee in a comparable position for which the employee is qualified. If such a position is not available, the employee will be offered the next suitable position for which the employee is qualified that becomes available. In addition, CalOptima will attempt to reasonably accommodate employees who are released for partial or modified duty. An employee who does not accept a position offered by CalOptima is considered to have voluntarily terminated employment, effective the day such refusal is made. Employees returning from a LOA related to the employee's own medical condition must obtain a release to return to work from his or her health care provider (where applicable) stating that he or she is able to resume work. CalOptima also reserves the right to require employees to participate in a fitness for duty examination at the expense of CalOptima prior to return to work.

B. Paid Time Off (PTO) accruals: PTO only accrues during the time period an employee is on active duty, or utilizing PTO for an approved LOA. Once an employee elects not to use PTO accruals or exhausts all PTO accruals, the remaining time off for an approved LOA shall not be considered time worked for purposes of accruing PTO hours.

C. Holidays: If a paid holiday occurs during the period an employee is on a LOA, the employee may be eligible for the holiday pay if PTO is being used for the LOA the day before and the day after the holiday and the holiday pay will be prorated based on the employee's full-time or part-time status as it was in effect prior to the LOA. If a holiday falls on a day in which the employee would have been regularly scheduled to work, the holiday will count against the employee's LOA entitlement.

D. Documentation: Failure to provide all the required information and/or documentation within the requested or required timeframe may result in: a delay in CalOptima's approval of the LOA request; CalOptima's denial of the employee's request for a LOA; an impact to the employee's ability to take a LOA as requested; and/or disciplinary action, up to and including termination.

E. Failure to return promptly: If an employee fails to return to work upon the expiration of an approved LOA and has not obtained an extension from HR prior to such expiration date, the employee will be considered to have voluntarily resigned.

F. Misrepresentations: Misrepresenting reasons for applying for a LOA will result in disciplinary action, up to and including termination.

G. Health benefits for PDL, FMLA, CFRA, Military Service or Workers' Compensation Leaves of Absence: Employer payments towards health benefits (medical, vision, and dental) for PDL, FMLA, CFRA, Military Service, or Workers' Compensation LOAs, will not continue beyond the FMLA/CFRA covered period pursuant to CalOptima Policy GA.8040: Family and Medical Leave

Act and California Family Rights Act Leave. Employees may elect to purchase continuation of such health benefits coverage through COBRA. When an employee returns to work, the eligibility and accrual dates for such benefits may be adjusted to reflect the period of the LOA.

H. Other benefits: All other benefits not specified herein provided by CalOptima shall be administered according to HR procedures.

I. Eligibility and Specific Leave Requirements: Refer to specific CalOptima policies listed below for detailed information about eligibility and other leave requirements:

1. CalOptima Policy GA.8018: Paid Time Off (PTO);

2. CalOptima Policy GA.8038: Personal Leave of Absence;

3. CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence;

4. CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave; and/or

5. CalOptima Policy GA.8041: Workers' Compensation.

IV. ATTACHMENTS

A. Leave of Absence Request Form

V. REFERENCES

A. CalOptima Employee Handbook
B. CalOptima Policy GA.8018: Paid Time Off (PTO)
C. CalOptima Policy GA.8038: Personal Leave of Absence
D. CalOptima Policy GA.8039: Pregnancy Disability Leave of Absence
E. CalOptima Policy GA.8040: Family and Medical Leave Act and California Family Rights Act Leave
F. Government Code, §12945.1 *et seq*. (CFRA)
G. Labor Code, §230 *et seq*. (Jury service and other leaves)
H. Military & Veterans Code, §395.10 (Military Service Leave)
I. Title 2, California Code of Regulations (C.C.R.), §7291.2 *et seq*. (Pregnancy Regulations)
J. Title 2, California Code of Regulations (C.C.R.), §7293.5 *et seq*. (Disability Regulations)
K. Title 29, Code of Federal Regulations (C.F.R.), Part 825 (FMLA Regulations)
L. Title 29, United States Code (U.S.C.), §2601 *et seq*. (FMLA)
M. Title 38, United States Code (U.S.C.), §4301 *et seq*. (USSERA)

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 08/03/17: Regular Meeting of the CalOptima Board of Directors
B. 08/07/14: Regular Meeting of the CalOptima Board of Directors

C. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/05/2012	GA.8037	Leave of Absence	Administrative
Revised	02/01/2014	GA.8037	Leave of Absence	Administrative
Revised	08/03/2017	GA.8037	Leave of Absence	Administrative

IX. GLOSSARY

Term	Definition
Child-Related Activities	Participation in activities at child's school or day care facility as permitted under Labor Code section 230.8, which includes: finding, enrolling, or reenrolling a child in a school or with a licensed child care provider; child care provider or school, emergency; request for child to be picked up from school/child care or an attendance policy that prohibits the child from attending or requires the child to be picked up from the school or child care provider; behavioral/discipline problems; closure or unexpected unavailability of school (excluding planned holidays); a natural disaster; or to participate in activities of the school or licensed child care provider of his or her child, if the employee, prior to taking the time off, gives reasonable notice to CalOptima.
Leave of Absence	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.

CalOptima
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LEAVE OF ABSENCE REQUEST FORM

SECTION I – EMPLOYEE'S STATEMENT Contact Phone Number:_____

Employee Name: _____ Employee ID #: _____

Department: _____ Position: _____

Requested dates of absence: First day off work ____/____/____ Expected Return Date: ____/____/____

Is Illness/Injury Work Related?

☐ Yes ☐ No

REASON FOR LEAVE

☐ **Employee Medical (FMLA/CFRA)** - Attach Medical Certification

☐ **Pregnancy Disability (PDL)** - Attach Medical Certification

☐ **Family Medical (FMLA/CFRA) -** Attach Medical Certification

☐ **Military Leave (FMLA or Spouse Leave)** - Attach Supporting Documentation

☐ ***Baby Bonding** (within 1 year of birth or placement of adoption/foster care)

☐ **Personal Leave –** Must be approved by Manager/Director

☐ **Other** - _____ (Attach Supporting Documentation)

Note: Additional documentation regarding types of leaves of absence can be found on the Human Resources page of the Infonet.

EXPLANATION: _____

_____

(FOR UNPAID LEAVE REQUESTS) To continue employee paid Health Insurance you should contact Human Resources to make arrangements for payment in advance

Employee's Signature: _____ Date: ____/____/____

SECTION II – MANAGER OR DIRECTOR ACKNOWLEDGMENT (CONTACT HUMAN RESOURCES TO DISCUSS OPTIONS)

Manager/Director Signature: _____Date: ____/____/____

HUMAN RESOURCES USE ONLY

SECTION III – HUMAN RESOURCES REVIEW

You are ☐ eligible ☐ not eligible for leave under the FMLA/CFRA FMLA/CFRA Hours Balance Available _____

Last Day Worked _____ Return from Leave Date _____

Human Resources Signature: _____ Date: ____/____/____

COMMENTS_____

Rev: 092116

Back to Agenda

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	~~06/01~~08/03/17
Last Revised Date:	~~06/01~~08/03/17

~~*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 ~~06/01~~08/03/17)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 08/03/17: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 06/01/17: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 05/04/17: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 03/02/17: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 12/01/16: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 11/03/16: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 10/06/16: Regular Meeting of the CalOptima Board of Directors
~~G.~~H. 09/01/16: Regular Meeting of the CalOptima Board of Directors
~~H.~~I. 08/04/16: Regular Meeting of the CalOptima Board of Directors
~~I.~~J. 06/02/16: Regular Meeting of the CalOptima Board of Directors
~~J.~~K. 03/03/16: Regular Meeting of the CalOptima Board of Directors
~~K.~~L. 12/03/15: Regular Meeting of the CalOptima Board of Directors
~~L.~~M. 10/01/15: Regular Meeting of the CalOptima Board of Directors
~~M.~~N. 06/04/15: Regular Meeting of the CalOptima Board of Directors

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VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08//03/2017	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

Policy #: GA.8058
Title: **Salary Schedule**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _____

Effective Date: 05/01/14
Last Review Date: 08/03/17
Last Revised Date: 08/03/17

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).

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IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of 08/03/17)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 08/03/17: Regular Meeting of the CalOptima Board of Directors
B. 06/01/17: Regular Meeting of the CalOptima Board of Directors
C. 05/04/17: Regular Meeting of the CalOptima Board of Directors
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VIII. REVIEW/REVISION HISTORY

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Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
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Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
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Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
Revised	03/02/2017	GA.8058	Salary Schedule	Administrative
Revised	05/04/2017	GA.8058	Salary Schedule	Administrative
Revised	06/01/2017	GA.8058	Salary Schedule	Administrative
Revised	08//03/2017	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised August 3, 2017
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	634	$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	
	Associate Director Provider Network	O	647	$82,576	$107,328	$131,976	
	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 Manager	M	TBD	$62,400	$81,120	$99,840	New Position
	Care Transition Intervention Coach (RN)	N	417	$71,760	$93,184	$114,712	
	Certified Coder	K	399	$47,112	$61,360	$75,504	
	Certified Coding Specialist	K	639	$47,112	$61,360	$75,504	
	Certified Coding Specialist Sr	L	640	$54,288	$70,512	$86,736	
	Change Control Administrator	L	499	$54,288	$70,512	$86,736	
	Change Control Administrator Int	M	500	$62,400	$81,120	$99,840	
	Change Management Analyst Sr	N	465	$71,760	$93,184	$114,712	
**	Chief Counsel	T	132	$197,704	$266,968	$336,024	
**	Chief Executive Officer	V	138	$319,740	$431,600	$543,600	
**	Chief Financial Officer	U	134	$237,224	$320,216	$403,312	
**	Chief Information Officer	T	131	$197,704	$266,968	$336,024	
**	Chief Medical Officer	U	137	$237,224	$320,216	$403,312	
**	Chief Operating Officer	U	136	$237,224	$320,216	$403,312	
	Claims - Lead	J	574	$40,976	$53,352	$65,624	
	Claims Examiner	H	9	$33,696	$42,224	$50,648	
	Claims Examiner - Lead	J	236	$40,976	$53,352	$65,624	
	Claims Examiner Sr	I	20	$37,128	$46,384	$55,640	
	Claims QA Analyst	I	28	$37,128	$46,384	$55,640	
	Claims QA Analyst Sr.	J	540	$40,976	$53,352	$65,624	
	Claims Recovery Specialist	I	283	$37,128	$46,384	$55,640	
	Claims Resolution Specialist	I	262	$37,128	$46,384	$55,640	
	Clerk of the Board	O	59	$82,576	$107,328	$131,976	
	Clinical Auditor	M	567	$62,400	$81,120	$99,840	
	Clinical Auditor Sr	N	568	$71,760	$93,184	$114,712	
	Clinical Documentation Specialist (RN)	O	641	$82,576	$107,328	$131,976	
	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	

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CalOptima - Annual Base Salary Schedule - Revised August 3, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Community Partner	K	575	$47,112	$61,360	$75,504	
	Community Partner Sr	L	612	$54,288	$70,512	$86,736	
	Community Relations Specialist	J	288	$40,976	$53,352	$65,624	
	Community Relations Specialist Sr	K	646	$47,112	$61,360	$75,504	
	Compliance Claims Auditor	K	222	$47,112	$61,360	$75,504	
	Compliance Claims Auditor Sr	L	279	$54,288	$70,512	$86,736	
	Contract Administrator	M	385	$62,400	$81,120	$99,840	
	Contracts Manager	N	207	$71,760	$93,184	$114,712	
	Contracts Specialist	K	257	$47,112	$61,360	$75,504	
	Contracts Specialist Int	L	469	$54,288	$70,512	$86,736	
	Contracts Specialist Sr	M	331	$62,400	$81,120	$99,840	
*	Controller	Q	464	$114,400	$154,440	$194,480	
	Credentialing Coordinator	J	41	$40,976	$53,352	$65,624	
	Credentialing Coordinator - Lead	J	510	$40,976	$53,352	$65,624	
	Customer Service Coordinator	J	182	$40,976	$53,352	$65,624	
	Customer Service Rep	H	5	$33,696	$42,224	$50,648	
	Customer Service Rep - Lead	J	482	$40,976	$53,352	$65,624	
	Customer Service Rep Sr	I	481	$37,128	$46,384	$55,640	
	Data Analyst	K	337	$47,112	$61,360	$75,504	
	Data Analyst Int	L	341	$54,288	$70,512	$86,736	
	Data Analyst Sr	M	342	$62,400	$81,120	$99,840	
	Data and Reporting Analyst - Lead	O	TBD	$82,576	$107,328	$131,976	
	Data Entry Tech	F	3	$27,872	$34,840	$41,808	
	Data Warehouse Architect	O	363	$82,576	$107,328	$131,976	
	Data Warehouse Programmer/Analyst	O	364	$82,576	$107,328	$131,976	
	Data Warehouse Project Manager	O	362	$82,576	$107,328	$131,976	
	Data Warehouse Reporting Analyst	N	412	$71,760	$93,184	$114,712	
	Data Warehouse Reporting Analyst Sr	O	522	$82,576	$107,328	$131,976	
	Database Administrator	M	90	$62,400	$81,120	$99,840	
	Database Administrator Sr	O	179	$82,576	$107,328	$131,976	
**	Deputy Chief Counsel	S	160	$164,736	$222,352	$280,072	
**	Deputy Chief Medical Officer	T	561	$197,704	$266,968	$336,024	
*	Director Accounting	P	122	$95,264	$128,752	$162,032	
*	Director Applications Management	R	170	$137,280	$185,328	$233,376	
*	Director Audit & Oversight	Q	546	$114,400	$154,440	$194,480	
*	Director Behavioral Health Services	P	392	$95,264	$128,752	$162,032	
*	Director Budget and Procurement	Q	527	$114,400	$154,440	$194,480	
*	Director Business Development	P	351	$95,264	$128,752	$162,032	
*	Director Business Integration	Q	543	$114,400	$154,440	$194,480	
*	Director Case Management	Q	318	$114,400	$154,440	$194,480	
*	Director Claims Administration	P	112	$95,264	$128,752	$162,032	
*	Director Clinical Outcomes	Q	602	$114,400	$154,440	$194,480	
*	Director Clinical Pharmacy	R	129	$137,280	$185,328	$233,376	
*	Director Coding Initiatives	P	375	$95,264	$128,752	$162,032	
*	Director Communications	P	361	$95,264	$128,752	$162,032	
*	Director Community Relations	P	292	$95,264	$128,752	$162,032	
*	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	

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CalOptima - Annual Base Salary Schedule - Revised August 3, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
* 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	
* 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 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	
** Executive Director, Behavioral Health Integration	S	614	$164,736	$222,352	$280,072	
Facilities & Support Services Coord - Lead	J	631	$40,976	$53,352	$65,624	
Facilities & Support Services Coordinator	J	10	$40,976	$53,352	$65,624	
Facilities Coordinator	J	438	$40,976	$53,352	$65,624	
Financial Analyst	L	51	$54,288	$70,512	$86,736	
Financial Analyst Sr	M	84	$62,400	$81,120	$99,840	
Financial Reporting Analyst	L	475	$54,288	$70,512	$86,736	
Gerontology Resource Coordinator	M	204	$62,400	$81,120	$99,840	
Graphic Designer	M	387	$62,400	$81,120	$99,840	
Grievance & Appeals Nurse Specialist	N	226	$71,760	$93,184	$114,712	
Grievance Resolution Specialist	J	42	$40,976	$53,352	$65,624	
Grievance Resolution Specialist - Lead	L	590	$54,288	$70,512	$86,736	
Grievance Resolution Specialist Sr	K	589	$47,112	$61,360	$75,504	
Health Coach	M	556	$62,400	$81,120	$99,840	
Health Educator	K	47	$47,112	$61,360	$75,504	
Health Educator Sr	L	355	$54,288	$70,512	$86,736	
Health Network Liaison Specialist (RN)	N	524	$71,760	$93,184	$114,712	
Health Network Oversight Specialist	M	323	$62,400	$81,120	$99,840	
HEDIS Case Manager	N	443	$71,760	$93,184	$114,712	

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CalOptima - Annual Base Salary Schedule - Revised August 3, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
HEDIS Case Manager (LVN)	M	552	$62,400	$81,120	$99,840	
Help Desk Technician	J	571	$40,976	$53,352	$65,624	
Help Desk Technician Sr	K	573	$47,112	$61,360	$75,504	
HR Assistant	I	181	$37,128	$46,384	$55,640	
HR Business Partner	M	584	$62,400	$81,120	$99,840	
HR Coordinator	J	316	$40,976	$53,352	$65,624	
HR Representative	L	278	$54,288	$70,512	$86,736	
HR Representative Sr	M	350	$62,400	$81,120	$99,840	
HR Specialist	K	505	$47,112	$61,360	$75,504	
HR Specialist Sr	L	608	$54,288	$70,512	$86,736	
HRIS Analyst Sr	M	468	$62,400	$81,120	$99,840	
ICD-10 Project Manager	O	411	$82,576	$107,328	$131,976	
Infrastructure Systems Administrator	J	541	$40,976	$53,352	$65,624	
Infrastructure Systems Administrator Int	K	542	$47,112	$61,360	$75,504	
Inpatient Quality Coding Auditor	L	642	$54,288	$70,512	$86,736	
Intern	E	237	$25,272	$31,720	$37,960	
Investigator Sr	L	553	$54,288	$70,512	$86,736	
IS Coordinator	J	365	$40,976	$53,352	$65,624	
IS Project Manager	O	424	$82,576	$107,328	$131,976	
IS Project Manager Sr	P	509	$95,264	$128,752	$162,032	
IS Project Specialist	M	549	$62,400	$81,120	$99,840	
IS Project Specialist Sr	N	550	$71,760	$93,184	$114,712	
Kitchen Assistant	E	585	$25,272	$31,720	$37,960	
Legislative Program Manager	N	330	$71,760	$93,184	$114,712	
Licensed Clinical Social Worker	L	598	$54,288	$70,512	$86,736	
Litigation Support Specialist	M	588	$62,400	$81,120	$99,840	
LVN (PACE)	M	533	$62,400	$81,120	$99,840	
Mailroom Clerk	E	1	$25,272	$31,720	$37,960	
Manager Accounting	N	98	$71,760	$93,184	$114,712	
Manager Actuary	P	453	$95,264	$128,752	$162,032	
Manager Applications Management	P	271	$95,264	$128,752	$162,032	
Manager Audit & Oversight	O	539	$82,576	$107,328	$131,976	
Manager Behavioral Health	O	633	$82,576	$107,328	$131,976	
Manager Business Integration	O	544	$82,576	$107,328	$131,976	
Manager Case Management	O	270	$82,576	$107,328	$131,976	
Manager Claims	N	92	$71,760	$93,184	$114,712	
Manager Clinic Operations	O	551	$82,576	$107,328	$131,976	
Manager Clinical Pharmacist	Q	296	$114,400	$154,440	$194,480	
Manager Coding Quality	N	382	$71,760	$93,184	$114,712	
Manager Communications	N	398	$71,760	$93,184	$114,712	
Manager Community Relations	M	384	$62,400	$81,120	$99,840	
Manager Contracting	O	329	$82,576	$107,328	$131,976	
Manager Creative Branding	N	430	$71,760	$93,184	$114,712	
Manager Cultural & Linguistic	N	349	$71,760	$93,184	$114,712	
Manager Customer Service	N	94	$71,760	$93,184	$114,712	
Manager Decision Support	O	454	$82,576	$107,328	$131,976	
Manager Disease Management	O	372	$82,576	$107,328	$131,976	
Manager Electronic Business	O	422	$82,576	$107,328	$131,976	
Manager Employment Services	N	420	$71,760	$93,184	$114,712	
Manager Encounters	N	516	$71,760	$93,184	$114,712	
Manager Environmental Health & Safety	N	495	$71,760	$93,184	$114,712	
Manager Facilities	N	209	$71,760	$93,184	$114,712	
Manager Finance	N	148	$71,760	$93,184	$114,712	
Manager Financial Analysis	O	356	$82,576	$107,328	$131,976	
Manager Government Affairs	N	437	$71,760	$93,184	$114,712	
Manager Grievance & Appeals	N	426	$71,760	$93,184	$114,712	
Manager Health Education	N	173	$71,760	$93,184	$114,712	
Manager HEDIS	O	427	$82,576	$107,328	$131,976	

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	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	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 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	
	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	635	$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	

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Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Performance Analyst	L	538	$54,288	$70,512	$86,736	
Personal Care Attendant	E	485	$25,272	$31,720	$37,960	
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	
Privacy Officer	P	648	$95,264	$128,752	$162,032	
Process Excellence Manager	O	529	$82,576	$107,328	$131,976	
Program Assistant	I	24	$37,128	$46,384	$55,640	
Program Coordinator	I	284	$37,128	$46,384	$55,640	
Program Development Analyst Sr	M	492	$62,400	$81,120	$99,840	
Program Manager	M	421	$62,400	$81,120	$99,840	
Program Manager Sr	O	594	$82,576	$107,328	$131,976	
Program Specialist	J	36	$40,976	$53,352	$65,624	
Program Specialist Int	K	61	$47,112	$61,360	$75,504	
Program Specialist Sr	L	508	$54,288	$70,512	$86,736	
Program/Policy Analyst	K	56	$47,112	$61,360	$75,504	
Program/Policy Analyst Sr	M	85	$62,400	$81,120	$99,840	
Programmer	L	43	$54,288	$70,512	$86,736	
Programmer Int	N	74	$71,760	$93,184	$114,712	
Programmer Sr	O	80	$82,576	$107,328	$131,976	
Project Manager	M	81	$62,400	$81,120	$99,840	
Project Manager - Lead	M	467	$62,400	$81,120	$99,840	
Project Manager Sr	O	105	$82,576	$107,328	$131,976	
Project Specialist	K	291	$47,112	$61,360	$75,504	
Project Specialist Sr	L	503	$54,288	$70,512	$86,736	
Projects Analyst	K	254	$47,112	$61,360	$75,504	
Provider Enrollment Data Coordinator	I	12	$37,128	$46,384	$55,640	
Provider Enrollment Data Coordinator Sr	J	586	$40,976	$53,352	$65,624	
Provider Enrollment Manager	K	190	$47,112	$61,360	$75,504	
Provider Network Rep Sr	L	391	$54,288	$70,512	$86,736	
Provider Network Specialist	K	44	$47,112	$61,360	$75,504	
Provider Network Specialist Sr	L	595	$54,288	$70,512	$86,736	
Provider Office Education Manager	L	300	$54,288	$70,512	$86,736	
Provider Relations Rep	K	205	$47,112	$61,360	$75,504	
Provider Relations Rep Sr	L	285	$54,288	$70,512	$86,736	
Publications Coordinator	J	293	$40,976	$53,352	$65,624	
QA Analyst	L	486	$54,288	$70,512	$86,736	
QA Analyst Sr	N	380	$71,760	$93,184	$114,712	
QI Nurse Specialist	N	82	$71,760	$93,184	$114,712	
QI Nurse Specialist (LVN)	M	445	$62,400	$81,120	$99,840	
Receptionist	F	140	$27,872	$34,840	$41,808	
Recreational Therapist	L	487	$54,288	$70,512	$86,736	
Recruiter	L	406	$54,288	$70,512	$86,736	
Recruiter Sr	M	497	$62,400	$81,120	$99,840	
Registered Dietitian	L	57	$54,288	$70,512	$86,736	
Regulatory Affairs and Compliance Analyst	K	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	

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	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	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 Human Resources	P	649	$95,264	$128,752	$162,032	
	Sr Manager Information Services	Q	650	$114,400	$154,440	$194,480	
	Sr Manager Government Affairs	O	451	$82,576	$107,328	$131,976	
	Sr Manager Provider Network	O	651	$82,576	$107,328	$131,976	
	Staff Attorney	P	195	$95,264	$128,752	$162,032	
	Supervisor Accounting	M	434	$62,400	$81,120	$99,840	
	Supervisor Audit and Oversight	N	618	$71,760	$93,184	$114,712	
	Supervisor Budgeting	M	466	$62,400	$81,120	$99,840	
	Supervisor Case Management	N	86	$71,760	$93,184	$114,712	
	Supervisor Claims	K	219	$47,112	$61,360	$75,504	
	Supervisor Coding Initiatives	M	502	$62,400	$81,120	$99,840	
	Supervisor Customer Service	K	34	$47,112	$61,360	$75,504	
	Supervisor Data Entry	K	192	$47,112	$61,360	$75,504	
	Supervisor Day Center (PACE)	K	619	$47,112	$61,360	$75,504	
	Supervisor Dietary Services (PACE)	M	643	$62,400	$81,120	$99,840	
	Supervisor Disease Management	N	644	$71,760	$93,184	$114,712	
	Supervisor Encounters	L	253	$54,288	$70,512	$86,736	
	Supervisor Facilities	L	162	$54,288	$70,512	$86,736	
	Supervisor Finance	N	419	$71,760	$93,184	$114,712	
	Supervisor Grievance and Appeals	M	620	$62,400	$81,120	$99,840	
	Supervisor Health Education	M	381	$62,400	$81,120	$99,840	
	Supervisor Information Services	N	457	$71,760	$93,184	$114,712	
	Supervisor Long Term Support Services	N	587	$71,760	$93,184	$114,712	
	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 Pharmacist	P	610	$95,264	$128,752	$162,032	
	Supervisor Provider Enrollment	K	439	$47,112	$61,360	$75,504	
	Supervisor Provider Relations	M	652	$62,400	$81,120	$99,840	
	Supervisor Quality Analytics	M	609	$62,400	$81,120	$99,840	
	Supervisor Quality Improvement	N	600	$71,760	$93,184	$114,712	
	Supervisor Regulatory Affairs and Compliance	N	627	$71,760	$93,184	$114,712	
	Supervisor Social Work (PACE)	L	636	$54,288	$70,512	$86,736	
	Supervisor Systems Development	O	456	$82,576	$107,328	$131,976	
	Supervisor Therapy Services (PACE)	N	645	$71,760	$93,184	$114,712	
	Supervisor Utilization Management	N	637	$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	
	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.

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CalOptima - Annual Base Salary Schedule - Revised August 3, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval

** 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.

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Summary of Changes to Salary Schedule

For August 2017 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Care Manager	N/A	M	This new position is responsible for oversight and review of behavior analysis services offered to members with Autism Spectrum Disorders (ASD).	N/A	August 2017

Summary of Executive Compensation Changes

For August 2017 Board Meeting:
Pursuant to the Compensation Administration Guidelines adopted as part of CalOptima Policy GA. 8057: Compensation Program, the Board will be informed of all Chief and Executive Director compensation changes. The below changes were determined as part of the merit process and consistently administered to all employees based on the combination of performance rating and position of pay within the pay range.

Title	Salary Adjustment - Fiscal Impact (% Increase)	Effective Date
Chief Financial Officer (Interim)	The total impact for the current fiscal year is $6,367.24. (2.68%)	6/25/2017
Chief Information Officer	The total impact for the current fiscal year is $11,631.71. (4.44%)	6/25/2017
Chief Medical Officer	The total impact for the current fiscal year is $13,952.64. (3.93%)	6/25/2017
Chief Operating Officer	The total impact for the current fiscal year is $13,092.96. (4.45%)	6/25/2017
Deputy Chief Counsel	The total impact for the current fiscal year is $9,102.36. (4.02%)	6/25/2017
Deputy Chief Medical Officer	The total impact for the current fiscal year is $2,656.24 (1.07%). In addition, the employee will receive a lump sum amount of $3,025.03, which is not added to base salary.	6/25/2017
Executive Director Clinical Operations	The total impact for the current fiscal year is $4,874.45. (2.37%)	6/25/2017
Executive Director Compliance	The total impact for the current fiscal year is $9,005.21. (4.51%)	6/25/2017
Executive Director Network Operations	The total impact for the current fiscal year is $490.00. (0.23%)	6/25/2017
Executive Director Operations	The total impact for the current fiscal year is $494.67. (0.23%)	6/25/2017
Executive Director Program Implementation	The total impact for the current fiscal year is $9,115.31. (4.45%)	6/25/2017
Executive Director Public Affairs	The total impact for the current fiscal year is $6,108.00. (3.17%)	6/25/2017
Executive Director Quality Analytics	The total impact for the current fiscal year is $9,267.80. (4.44%)	6/25/2017

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Actions

1. Authorize expenditures for CalOptima's participation in the following community event:
    a. Up to $1,500 and staff participation in the World Refugee Day 2017 in Anaheim on August 26, 2017;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

Background

CalOptima has a long history of participating in community events, health and resource fairs, town halls, workshops, and other public activities in furtherance of the organization's statutory purpose. Consistent with these activities, CalOptima has offered financial participation in public activities from time to time when such participation is in the public good, in furtherance of CalOptima's mission and statutory purpose, and encourages broader participation in CalOptima's programs and services, or promotes health and wellness among the populations CalOptima serves. As a result, CalOptima has developed and cultivated a strong reputation in Orange County with community partners and key stakeholders.

Requests for participation are considered based on several factors, including: the number of current and potential CalOptima members and others the activity/event will reach, the marketing benefits accrued to CalOptima, the strength of the partnership or level of involvement with the requesting entity in serving CalOptima members, past participation, staff availability, and available budget.

Discussion

Staff recommends the authorization of expenditures for participation in this community event, as it provides an opportunity promote access to CalOptima programs and services available to members and potential members.

For the World Refugee Day 2017 in Anaheim on August 26, 2017, a $1,500 financial commitment includes an opportunity for CalOptima's Chief Executive Officer to accept a "Distinguished Refugee Forum of Orange County Award of Excellence" which will be presented by elected officials and the executive board on the day of the event and an opportunity to address attendees. Additional benefits include social media recognition, one exhibit space, and CalOptima's name and logo on stage banner and program. Employee time will be used to participate in the event. The event will raise awareness about issues refugees face while resettling in Orange County and provide resources to help refugees

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connect to available services. More than 1,000 guests are expected to attend this event. Guests will be comprised of current and potential CalOptima members, elected officials, executive board members and community members throughout Orange County. Employees will be able to interact with current and potential CalOptima members and share information about programs and services. Participation in this event will create positive visibility for CalOptima in the community and provide continued support to strengthen our existing relationship with the Refugee Forum of Orange County, which includes community-based organizations such as the American Red Cross of Orange County, County of Orange Social Services Agency, California State University, Fullerton, Orange County Health Care Agency and the Salvation Army.

CalOptima has participated in the World Refugee Day for four years: 2013 at a $500 sponsorship level, and 2014-2016 at a $1,500 sponsorship level. Staff recommends for CalOptima to continue supporting this event at $1,500 for 2017.

CalOptima staff has reviewed each request and determined that they each meet the considerations for participation including the following:

1. The number of current and potential CalOptima members and others the activity/event will reach;
2. The marketing benefits accrued to CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity in serving CalOptima members;
4. Past participation;
5. Staff availability; and
6. Available budget.

As part of its consideration of the recommended actions, approval of this item would be based on the Board making a finding that the proposed activities and expenditures are in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

Funding for the recommended action of $1,500 is included as part of the Community Events budget under the CalOptima Fiscal Year 2017-18 Operating Budget approved by the CalOptima Board of Directors on June 1, 2017.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support community activities that provide opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, or promote health and wellness.

Concurrence

Gary Crockett, Chief Counsel

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Attachment
Refugee Form of Orange County Sponsorship Request Letter dated June 9, 2017

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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June 9th, 2017

Wilbur Sham
CalOptima
505 City Parkway West
Orange, CA 92868

Dear Mr. Sham,

On behalf of the Refugee Forum of Orange County (RFOC) we would like to thank you for your continued support over the years. We are humbled to request your sponsorship for this year's annual celebration of World Refugee Day on Saturday August 26th, 2017 at the Pearson Park Amphitheatre in Anaheim. Your sponsorship will raise awareness of refugees resettling in Orange County and provide them with access to supportive resources in enhancing their quality of life locally.

Thousands of refugees originating from Iraq, Syria, Egypt, Afghanistan, Iran, and many East African and Central American countries have experienced war, famine, and political persecution. After years of adjusting to the culture and systems involved in their resettlement, they are now successfully contributing citizens of the United States of America

Your sponsorship will display your reputable partnership in celebrating and showcasing the economic, social, and civic contributions of refugees in Orange County which is the fourth largest resettlement region in California. With your sponsorship, you will have an increase in visibility within a hard-to-reach target population, as well as gain exposure in both print and electronic media associated with World Refugee Day. Expected attendance is over 1,000 guests including refugees, the general public, community leaders, and public officials that will listen to refugee stories and performances to celebrate their accomplishments.

Please contact **refugeeforumoc@gmail.com** for more information. Thank you for your support and attention to the extraordinary accomplishments of refugees resettling in Orange County.

Sincerely,

Nahla Kayali
Chair, Refugee Forum of Orange County

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Authorizing Non-Binding Agreement Between CalOptima, Inland Empire Health Plan, L.A. Care Health Plan and the Regents of the University of California to Outline General Goals for Collaboration

Contact

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

Recommended Action

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into a non-binding agreement involving CalOptima, Inland Empire Health Plan, and L.A. Care (the Plans) with the Regents of the University of California, a Constitutional Corporation, on behalf of the University of California Office of the President, UC Health and its Academic Medical and Clinical Enterprises in Southern California (UC), that outlines general goals for collaboration among the parties for a one (1) year term beginning July 1, 2017, with the option to renew for three (3) two (2) year periods.

Background/Discussion

Today, nearly one in three Californians—approximately 12.2 million people—are enrolled in Medi-Cal. As a result of the Affordable Care Act, CalOptima, Inland Empire Health Plan and L.A. Care (the Plans) have averaged membership growth of upwards of 20% in the last two years. Collectively, the Plans have approximately 4 million members; with CalOptima serving approximately 800,000 members. The growth of the Plans' enrollment has strained the operations, infrastructure, and related systems of the Plans, which have required upgrade technologies and increased staffing.

UC indicates that growth in Medi-Cal membership has significantly increased demand for UC Health services. UC has identified selected services having a greater than normal need including pediatrics, primary care and specialty services. UC also indicates that the large number of newly eligible members has resulted in an increase in the use of UC's emergency rooms, and increased demand for routine care and specialty services due in part to limited availability of timely ambulatory specialty services in the communities the Plans serve.

Representatives of the Plans and UC have met to discuss designing an improved business and policy relationship which is intended to better meet the health needs of the members the Plans serve, to address associated reimbursement challenges, and to achieve the policy expectations of publicly chartered health organizations. It is intended that a closer and more effective working relationship will provide access to resources and economies of scale that could improve the care management and quality of service provided to Plan members. A closer relationship may also facilitate achievement of a more cohesive policy voice for Medi-Cal beneficiaries in California and in Washington, DC.

The Parties have identified the following areas of focus in order to achieve greater access to and quality of patient care: a) Provision of Tertiary and Quaternary Care; b) Post-Discharge Care; c) Primary Care Collaboration; d) Physician Recruitment; e) Hospital Admission via Emergency

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Department; f) Shared Electronic Records; g) Quality Assurance; h) Payments; and i) Data Exchange. It is envisioned that additional detail regarding these areas and proposed approaches to addressing them will be addressed in separate managed care and other agreements to be authorized and negotiated in the future.

While each of the Plans have unique needs and a variety of existing relationships with providers, the proposed collaboration is intended to compliment the Plans' existing delivery systems.

Fiscal Impact
Because the recommended collaboration is non-binding and includes no financial commitment at this time, it is budget neutral. Going forward, financial analysis will be included as part of the evaluation of proposed future specific contracts between UC Health campuses and CalOptima.

Rationale for Recommendation
The proposed nonbinding agreement is focused on improving collaboration between the UC health system and public plans, identifying priority areas that all parties agree to work on together. Given our strategic priority to ensure that member health care needs are met, CalOptima is interested in further exploring this arrangement as a way of expanding the available delivery system, including for hard to access services such as tertiary and quaternary care.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
11. Consider Adoption of Resolution Approving CalOptima's Updated Policy No. AA.1217: Legal Claims and Judicial Review

Contact
Gary Crockett, Chief Counsel, (714) 246-8400

Recommended Action
Adopt Resolution No. 17-0803-02, approving CalOptima's updated Policy No. AA.1217: Legal Claims and Judicial Review, to authorize CalOptima's Chief Executive Officer ("CEO"), with the assistance of legal counsel, to compromise any pending action if the amount to be paid from CalOptima's treasury does not exceed $50,000.

Background
State law provides that CalOptima may by resolution delegate authority to an employee to perform the functions that the Board has under Part 3 of Division 3.6 of Title 1 of the California Government Code, including the allowance, compromise, or settlement of a Government Claims Act claim if the amount to be paid does not exceed $50,000. Consistent with this state law, Section 11.1 of the CalOptima Bylaws and CalOptima Policy AA.1217 delegates this authority to the CEO or his or his designee, but provides that any allowance, compromise, or settlement of any Government Claims Act claim where the amount to be paid from CalOptima's treasury exceeds $10,000 shall be approved personally by the CEO, rather than his or her designee.

State law also provides that the Board may compromise, or may delegate the authority to its attorney or an employee to compromise, any pending action (i.e., litigation) against CalOptima. This delegation of authority to resolve pending litigation allowed under Section 949, Part 4 of Division 3.6 of Title 1 of the California Government Code is separate and apart from the delegated authority to allow, settle, or compromise Government Claims Act claims in an amount not to exceed $50,000, as set forth under Part 3.

On December 4, 2014, the Board of Directors approved revisions to Policy No. AA.1217, which, among other things, provided that the Board may on a case-by-case basis authorize its attorney or an employee to compromise pending actions against CalOptima.

CalOptima legal staff periodically reviews the legal claims policy to ensure consistency with all applicable laws, regulations, and guidelines, and to ensure the claims presentation requirements and obligations, and delegated authority relating to Government Claims Act claims and lawsuits against CalOptima, are made clear for staff and any potential plaintiffs. Consistent with that practice, updates have been made to CalOptima Policy AA.1217: Legal Claims and Judicial Review.

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Discussion
Legal Affairs recommends that the Board adopt a Resolution approving updates to Policy AA.1217 that would authorize its CEO, with the assistance of legal counsel, to compromise any pending action if the amount to be paid from CalOptima's treasury does not exceed $50,000. Although CalOptima policy currently delegates authority to its CEO or his or her designee to resolve Government Claims Act claims made against CalOptima where the amount to be paid does not exceed $50,000, there is no corresponding delegated authority to resolve pending actions without a separate Board action. The Board's adoption of the Resolution and the revised policy, attached for your review, would have the effect of clarifying and making consistent the delegated settlement authority granted for both Government Claims Act claims and lawsuits filed against CalOptima. The revised policy is also consistent with a public agency's delegation of authority to compromise pending actions that is allowed under state law.

Fiscal Impact
No direct fiscal impact.

Rationale for Recommendation
The proposed revised policy will clarify and create consistencies in the delegated settlement authority granted to resolve Government Claims Act claims and lawsuits filed against CalOptima, and is consistent with the delegation of authority to resolve actions against public agencies as set forth under state law. The revised policy will also allow for greater efficiencies in investigating, processing, and resolving lawsuits filed against CalOptima, reducing the number of agenda items and time spent in closed session on such matters.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 17-0803-02, A Resolution Approving CalOptima's Updated Legal Claims and Judicial Review Policy
2. Revised CalOptima Policy: AA.1217: Legal Claims and Judicial Review (redlined and clean copies)
3. Board Action dated December 4, 2014, Consider Adoption of Resolution Approving CalOptima's Updated Policy No. AA.1217, Legal Claims and Judicial Review, and its Updated Attachment, CalOptima Claim for Damage or Injury

/s/ Michael Schrader — *7/27/2017*
Authorized Signature — **Date**

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RESOLUTION NUMBER 17-0803-02

RESOLUTION OF THE BOARD OF DIRECTORS OF ORANGE COUNTY HEALTH AUTHORITY dba CalOptima

APPROVING CALOPTIMA'S UPDATED LEGAL CLAIMS AND JUDICIAL REVIEW POLICY

WHEREAS, state law provides that a public entity may by resolution authorize an employee to perform those functions of the governing body under Part 3 of Division 3.6 of Title 1 of the California Government Code that are prescribed by the local public entity, including the allowance, compromise, or settlement of a claim against the public entity if the amount to be paid pursuant to the allowance, compromise, or settlement does not exceed $50,000; and

WHEREAS, Section 11.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, and CalOptima Policy AA.1217: Legal Claims and Judicial Review, authorizes the Chief Executive Officer or designee to perform those functions of the CalOptima Board specified in Part 3 of Division 3.6 of Title 1 of the California Government Code, including the allowance, compromise, or settlement of any claims if the amount to be paid from CalOptima's treasury does not exceed $50,000, and provides that any allowance, compromise, or settlement of any claim in which the amount to be paid from CalOptima's treasury exceeds $10,000 shall be approved personally by the Chief Executive Officer, rather than his or her designee; and

WHEREAS, pursuant to Section 949, Part 4 of Division 3.6 of Title 1 of the California Government Code, state law also provides that the Board may compromise, or may delegate the authority to its attorney or an employee to compromise, any pending action (i.e., litigation) against CalOptima, and this authority to resolve actions is separate and apart from the delegated authority to allow, compromise, or settle claims up to $50,000 as set forth in Part 3; and

WHEREAS, on December 4, 2014, the Board of Directors approved revisions to Policy No. AA.1217: Legal Claims and Judicial Review, which, among other things, provided that the

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Board may, on a case-by-case basis, authorize its attorney or a CalOptima employee to compromise any pending action against CalOptima; and

WHEREAS, the Board of Directors and CalOptima staff may review the Legal Claims and Judicial Review Policy from time to time as needed to ensure to ensure consistency with all applicable laws, regulations, and guidelines, and to clarify the obligations and requirements for the presentation and resolution of legal claims and actions against CalOptima.

NOW THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated CalOptima Policy No. AA.1217: Legal Claims and Judicial Review, and its Attachment.

Section 2. That these actions are effective upon the date of adoption of this Resolution.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, dba CalOptima, this 3rd day of August 2017.

AYES:

NOES:

ABSENT:

ABSTAIN:

/s/_____
Title: Chair, Board of Directors

Printed Name and Title: Paul Yost, M.D., Chair, CalOptima Board of Directors

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

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Policy #:	AA.1217
Title:	**Legal Claims and Judicial Review**
Department:	Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	~~4/6~~04/06/
Last Review Date:	99
Last Revision Date:	~~12/1/15~~ ~~12/4/14~~08 /03/17 08/03/17

I. PURPOSE

To set forth the process for the presentation of Legal Claims to CalOptima in compliance with this Policy, Division 3.6 of Title 1 of the California Government Code, and all applicable statutes and regulations. Section 1094.6 of the California Code of Civil Procedure shall govern cases involving judicial review.

~~II. DEFINITIONS~~

~~Not Applicable~~

~~III.~~II. POLICY

A. General: As a public agency, CalOptima is subject to Division 3.6 of Title 1 of the California Government Code, pertaining to claims against public agencies. Any claims against CalOptima for money or damages, which are not governed by any other statutes or regulations expressly relating thereto, shall be presented in accordance with Title 1, Division 3.6, Part 3, Chapter 1 (commencing with Section 900) and Chapter 2 (commencing with Section 910) of the California Government Code, prior to initiating suit thereon.

B. Claims Presentation: Except as provided above in Section III.A, any action presented to CalOptima, which has the potential to be litigated, shall be handled in accordance with this Policy. Those actions include but are not limited to Verified Claims, Notice of Intent to Sue, Summons and Complaints, and all documents which have the potential to meet the criteria for a claim against a public entity as defined in Government Code Sections 910 and 910.2.

C. Excepted Claims: In accordance with the authority set forth in California Government Code Section 935, the claims procedures for those claims against CalOptima for money or damages, which are excepted from the claims presentation requirement by Government Code Section 905 and not governed by other statutes or regulations expressly relating thereto, are governed by the procedures set forth in this Policy. Notwithstanding any exceptions contained in Section 905 of the California Government Code, no action based on a claim or demand for money or damages shall be brought against CalOptima, or any of CalOptima's Board members, officers, employees, or agents, unless presented to, and acted upon by, the Board, as provided herein.

D. Timeliness: All claims shall be presented within the time limitations and in the manner prescribed by Sections 910 through 915.2 of the California Government Code. Such claims shall further be

subject to the provisions of Section 945.4 of the California Government Code relating to the prohibition of suits in the absence of presentation of claims and action thereon by the Board.

E. Late and Insufficient Claims

1. If the Chief Executive Officer (CEO), or his or her designee upon the CEO's unavailability, determines that a claim fails to comply substantially with the presentation requirements of Government Code Sections 910 and 910.2, or with the requirements of a form provided under Government Code Section 910.4 if a claim is presented thereto, he or she may give written notice of its insufficiency in accordance with Government Code Sections 910.8 and 915.4.

2. When a claim is not presented within the time limits prescribed in Government Code Section 911.2, the CEO, or his or her designee upon the CEO's unavailability, is authorized to return the claim without further action, in accordance with Government Code Section 911.3 for claims required to be filed within six months, or reject the claim in accordance with Government Code Section 913 for all other claims.

F. Small Claims: In the cases of small claims actions brought against CalOptima which personally name an individual who has no personal knowledge of the claim (CEO, Chair of Board, etc.), it is permissible to substitute a representative with more personal knowledge for purposes of court appearances.

G. Delegated Functions of the Board and Settlement Authority

1. Claims Against CalOptima

i. The CEO, or his or her designee upon the CEO's unavailability, is authorized to perform the functions of the Board which are specified in Part 3 of Division 3.6 of Title 1 of the California Government Code.

ii. Such delegation includes the allowance, compromise, or settlement of any claims if the amount to be paid from CalOptima's treasury does not exceed $50,000. Notwithstanding the foregoing, any allowance, compromise, or settlement of any claim in which the amount to be paid from CalOptima's treasury exceeds $10,000 shall be approved personally by the CEO, rather than his or her designee.

iii. The CEO or his or her designee shall periodically report such actions to the Board of Directors.

2. Actions Against CalOptima: Consistent with Section 949 of Part 4 of Division 3.6 of Title 1 of the California Government Code~~, the Board may on a case-by-case basis authorize its attorney or a CalOptima employee to compromise any pending action.~~:

i. The CEO, with the assistance of legal counsel, is authorized to compromise any pending action if the amount to be paid from CalOptima's treasury does not exceed $50,000.

ii. The Board may on a case-by-case basis authorize its CEO, with the assistance of legal counsel, to compromise any pending action where the amount to be paid from CalOptima's treasury exceeds $50,000.

H. Judicial Review: In compliance with Section 1094.6 of the California Code of Civil Procedure, petitions for judicial review of any decision made by CalOptima must be filed within ninety (90) days after the action is final.

I. Claim Form: In accordance with California Government Code Section 910.4, CalOptima shall maintain and provide a claim form for the public's use, which form is attached hereto as Exhibit "A." All claims presented to CalOptima must be submitted on CalOptima's claim form pursuant to Government Code Section 910.4, or in a form that substantially complies with the claims requirements of California Government Code Sections 910 and 910.2. The CEO shall have the authority to revise the claim form from time to time as he or she deems necessary.

J. Exhaustion of Administrative Remedies: Nothing herein is intended to diminish, eliminate, or waive any legal or contractual obligation to exhaust CalOptima's administrative remedies prior to the presentation of a claim pursuant to this Policy.

~~IV.~~III. PROCEDURE

Not Applicable

~~V.~~IV. ATTACHMENTS

A. CalOptima - Claim for Damage or Injury

~~VI.~~V. REFERENCES

A. California Code of Civil Procedure, Section 1094.6
B. California Government Code, Title 1, Division 3.6, Sections 900-915.2, 935, 935.4, 945.4, and 949, and all applicable statutes and regulations.

~~VII.~~VI. REGULATORY APPROVALS

None to Date

~~VIII.~~VII. BOARD ACTION

~~A. 12/4/14~~08/03/17: Regular ~~CalOptima Board of Directors~~ Meeting
~~B.~~A. ~~8/5/03: Regular~~ of the CalOptima Board of Directors ~~Meeting~~
B. ~~6/4/02~~12/04/14: Regular Meeting of the CalOptima Board of Directors
C. 08/05/03: Regular Meeting of the CalOptima Board of Directors ~~Meeting~~
D. ~~4/6/99~~06/04/02: Regular Meeting of the CalOptima Board of Directors ~~Meeting~~
E. 04/06/99: Regular Meeting of the CalOptima Board of Directors

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

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	04/06/1999	AA.1217	Legal Claims and Judicial Review	Administrative

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
~~Revision Date 1~~Revised	06/04/2002	AA.1217	Legal Claims and Judicial Review	Administrative
~~Revision Date 2~~Revised	08/05/2003	AA.1217	Legal Claims and Judicial Review	Administrative
~~Revision Date 3~~Revised	01/2004	AA.1217	Legal Claims and Judicial Review	Administrative
~~Revision Date 4~~Revised	12/04/2014	AA.1217	Legal Claims and Judicial Review	Administrative
~~Review Date~~Reviewed	12/01/2015	AA.1217	Legal Claims and Judicial Review	Administrative
Revised	08/03/2017	AA.1217	Legal Claims and Judicial Review	Administrative

IX. GLOSSARY

Not Applicable

Policy #:	AA.1217
Title:	**Legal Claims and Judicial Review**
Department:	Administration
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	04/06/99
Last Review Date:	08/03/17
Last Revision Date:	08/03/17

I. PURPOSE

To set forth the process for the presentation of Legal Claims to CalOptima in compliance with this Policy, Division 3.6 of Title 1 of the California Government Code, and all applicable statutes and regulations. Section 1094.6 of the California Code of Civil Procedure shall govern cases involving judicial review.

II. POLICY

A. General: As a public agency, CalOptima is subject to Division 3.6 of Title 1 of the California Government Code, pertaining to claims against public agencies. Any claims against CalOptima for money or damages, which are not governed by any other statutes or regulations expressly relating thereto, shall be presented in accordance with Title 1, Division 3.6, Part 3, Chapter 1 (commencing with Section 900) and Chapter 2 (commencing with Section 910) of the California Government Code, prior to initiating suit thereon.

B. Claims Presentation: Except as provided above in Section III.A, any action presented to CalOptima, which has the potential to be litigated, shall be handled in accordance with this Policy. Those actions include but are not limited to Verified Claims, Notice of Intent to Sue, Summons and Complaints, and all documents which have the potential to meet the criteria for a claim against a public entity as defined in Government Code Sections 910 and 910.2.

C. Excepted Claims: In accordance with the authority set forth in California Government Code Section 935, the claims procedures for those claims against CalOptima for money or damages, which are excepted from the claims presentation requirement by Government Code Section 905 and not governed by other statutes or regulations expressly relating thereto, are governed by the procedures set forth in this Policy. Notwithstanding any exceptions contained in Section 905 of the California Government Code, no action based on a claim or demand for money or damages shall be brought against CalOptima, or any of CalOptima's Board members, officers, employees, or agents, unless presented to, and acted upon by, the Board, as provided herein.

D. Timeliness: All claims shall be presented within the time limitations and in the manner prescribed by Sections 910 through 915.2 of the California Government Code. Such claims shall further be subject to the provisions of Section 945.4 of the California Government Code relating to the prohibition of suits in the absence of presentation of claims and action thereon by the Board.

E. Late and Insufficient Claims

1. If the Chief Executive Officer (CEO), or his or her designee upon the CEO's unavailability, determines that a claim fails to comply substantially with the presentation requirements of Government Code Sections 910 and 910.2, or with the requirements of a form provided under

Government Code Section 910.4 if a claim is presented thereto, he or she may give written notice of its insufficiency in accordance with Government Code Sections 910.8 and 915.4.

2. When a claim is not presented within the time limits prescribed in Government Code Section 911.2, the CEO, or his or her designee upon the CEO's unavailability, is authorized to return the claim without further action, in accordance with Government Code Section 911.3 for claims required to be filed within six months, or reject the claim in accordance with Government Code Section 913 for all other claims.

F. Small Claims: In the cases of small claims actions brought against CalOptima which personally name an individual who has no personal knowledge of the claim (CEO, Chair of Board, etc.), it is permissible to substitute a representative with more personal knowledge for purposes of court appearances.

G. Delegated Functions of the Board and Settlement Authority

1. Claims Against CalOptima

i. The CEO, or his or her designee upon the CEO's unavailability, is authorized to perform the functions of the Board which are specified in Part 3 of Division 3.6 of Title 1 of the California Government Code.

ii. Such delegation includes the allowance, compromise, or settlement of any claims if the amount to be paid from CalOptima's treasury does not exceed $50,000. Notwithstanding the foregoing, any allowance, compromise, or settlement of any claim in which the amount to be paid from CalOptima's treasury exceeds $10,000 shall be approved personally by the CEO, rather than his or her designee.

iii. The CEO or his or her designee shall periodically report such actions to the Board of Directors.

2. Actions Against CalOptima: Consistent with Section 949 of Part 4 of Division 3.6 of Title 1 of the California Government Code:

i. The CEO, with the assistance of legal counsel, is authorized to compromise any pending action if the amount to be paid from CalOptima's treasury does not exceed $50,000.

ii. The Board may on a case-by-case basis authorize its CEO, with the assistance of legal counsel, to compromise any pending action where the amount to be paid from CalOptima's treasury exceeds $50,000.

H. Judicial Review: In compliance with Section 1094.6 of the California Code of Civil Procedure, petitions for judicial review of any decision made by CalOptima must be filed within ninety (90) days after the action is final.

I. Claim Form: In accordance with California Government Code Section 910.4, CalOptima shall maintain and provide a claim form for the public's use, which form is attached hereto as Exhibit "A." All claims presented to CalOptima must be submitted on CalOptima's claim form pursuant to Government Code Section 910.4, or in a form that substantially complies with the claims

requirements of California Government Code Sections 910 and 910.2. The CEO shall have the authority to revise the claim form from time to time as he or she deems necessary.

J. Exhaustion of Administrative Remedies: Nothing herein is intended to diminish, eliminate, or waive any legal or contractual obligation to exhaust CalOptima's administrative remedies prior to the presentation of a claim pursuant to this Policy.

III. PROCEDURE

Not Applicable

IV. ATTACHMENTS

A. CalOptima - Claim for Damage or Injury

V. REFERENCES

A. California Code of Civil Procedure, Section 1094.6
B. California Government Code, Title 1, Division 3.6, Sections 900-915.2, 935, 935.4, 945.4, and 949, and all applicable statutes and regulations.

VI. REGULATORY APPROVALS

None to Date

VII. BOARD ACTION

A. 08/03/17: Regular Meeting of the CalOptima Board of Directors
B. 12/04/14: Regular Meeting of the CalOptima Board of Directors
C. 08/05/03: Regular Meeting of the CalOptima Board of Directors
D. 06/04/02: Regular Meeting of the CalOptima Board of Directors
E. 04/06/99: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Effective	04/06/1999	AA.1217	Legal Claims and Judicial Review	Administrative
Revised	06/04/2002	AA.1217	Legal Claims and Judicial Review	Administrative
Revised	08/05/2003	AA.1217	Legal Claims and Judicial Review	Administrative
Revised	01/2004	AA.1217	Legal Claims and Judicial Review	Administrative
Revised	12/04/2014	AA.1217	Legal Claims and Judicial Review	Administrative

Version	Version Date	Policy Number	Policy Title	Line(s) of Business
Reviewed	12/01/2015	AA.1217	Legal Claims and Judicial Review	Administrative
Revised	08/03/2017	AA.1217	Legal Claims and Judicial Review	Administrative

IX. GLOSSARY

Not Applicable

CalOptima
A Public Agency
Better. Together.

FOR CALOPTIMA'S USE ONLY
(Date Claim Received by CalOptima Clerk of the Board)

Received via: ☐ U.S. Mail ☐Interoffice ☐ Hand Delivery

CLAIM FOR DAMAGE OR INJURY

INSTRUCTIONS:

1. Answer all sections on both pages of this form completely and attach any additional information as necessary to support your claim.

2. Return this original signed and dated claim form and any attachments **to the attention of the Clerk of the Board** at the address below, in person or by mail.

3. Claims that are not submitted in compliance with the presentation requirements under California Government Code Section 915(a) will not be processed or handled as government claims.

4. See California Government Code Section 900 et seq. and CalOptima Policy No. AA.1217 for more information regarding presenting a claim against CalOptima. **Please note the following timeframes:**

   - Claims for death or for injury to person or to personal property must be presented not later than six (6) months after the accrual of the cause of action (Gov. Code Sec. 911.2(a)).

   - Claims relating to any other cause of action must be presented not later than one (1) year after the accrual of the cause of action (Gov. Code Sec. 911.2(a)).

[ATTACH SEPARATE SHEETS, IF NECESSARY, TO GIVE FULL DETAILS]

_____ _____
Name of Claimant | Member Identification Number of Claimant (if Claimant is a CalOptima member)

_____ (_____) _____
Home Address of Claimant | Home Telephone No.

_____
City State Zip

_____ (_____) _____
Business Address of Claimant | Business Telephone No.

_____
City State Zip

ADDRESS TO WHICH CLAIMANT DESIRES NOTICES OR COMMUNICATIONS SENT REGARDING THIS CLAIM (if different from an address listed above):

_____

_____

WHEN did damage or injury occur? _____

WHERE did damage or injury occur? _____

HOW and under what circumstances did damage or injury occur? _____

_____

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Main: 714. 246. 8400 | Fax: 714. 246. 8492 | TDD/TTY: 714. 246. 8523

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WHAT particular action or omission by CalOptima, or its employees, caused the alleged damage or injury? (Include names of employees, if known)

_____

_____

_____

WHAT amount do you claim? Include the estimated amount of any prospective loss, insofar as it may be known at the time of the presentation of this claim, together with the basis of computation of the amount claimed.

(Attach copies of all documentation in support of the total amount claimed.)

_____ $_____

_____ $_____

_____ $_____

Total Amount Claimed $_____

If the total amount claimed exceeds $10,000, indicate whether your claim would be a:

Limited Civil Case ($25,000 or less) ☐ Unlimited Civil Case (more than $25,000) ☐

NAMES, addresses and telephone numbers of all persons known to have information about this claim: (Use attachment if necessary)

_____

_____

_____

I HAVE READ THE FOREGOING CLAIM, INCLUDING ATTACHMENTS, IF ANY, AND KNOW THE CONTENTS THEREOF, AND CERTIFY THAT THE SAME IS TRUE ON MY OWN KNOWLEDGE, EXCEPT AS TO THOSE MATTERS WHICH ARE HEREIN STATED UPON MY INFORMATION AND BELIEF, AND AS TO THOSE MATTERS I BELIEVE THEM TO BE TRUE. I CERTIFY (OR DECLARE) UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

_____ _____

Signature of Claimant or Agent acting on behalf of Claimant

Type or Print Name Date

_____

Relationship to Claimant

NOTE: You must provide all information necessary for CalOptima to consider the claim and as required by law for the claim to be deemed sufficient. (See, Government Code Sections 910, 910.2, 910.4, and 910.8.) Submit the original signed claim form and back-up documentation **to the attention of the Clerk of the Board** at the address below.

WARNING: It is a criminal offense to file a false claim. (See California Penal Code Section 72).

505 City Parkway West | Orange, CA 92868 | www.caloptima.org
Main: 714. 246. 8400 | Fax: 714. 246. 8492 | TDD/TTY: 714. 246. 8523

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

VI. F. Consider Adoption of Resolution Approving CalOptima's Updated Policy No. AA.1217, Legal Claims and Judicial Review, and its Updated Attachment, CalOptima Claim for Damage or Injury

Contact

Gary Crockett, Chief Counsel, (714) 246-8400

Recommended Action

Consider adoption of Resolution No. 14-1204-03, approving CalOptima's updated Policy No. AA.1217, Legal Claims and Judicial Review, and its updated Attachment, CalOptima Claim for Damage or Injury.

Background

As a governmental entity, CalOptima enjoys certain protections from lawsuits, such as those set forth in Government Code Section 900, *et seq*. (sometimes referred to as the "Government Claims Act"). One of these protections is the requirement that a potential plaintiff must present a written claim to CalOptima before initiating a lawsuit for money or damages against CalOptima.

Certain types of claims are exempted from this presentation requirement under Government Code Section 905. However, state law allows a local public agency to adopt a procedure to govern those excepted claims, and the procedure may include a requirement that a claim be presented and acted upon as a prerequisite to initiating a lawsuit against the public agency. Section 11.3 of the CalOptima Bylaws provides that notwithstanding any exceptions contained in Government Code Section 905, no action based on a claim shall be brought against CalOptima unless presented in accordance with certain Government Code sections that are applicable to non-excepted claims.

State law also provides that CalOptima may by resolution delegate authority to an employee to perform the functions that the Board has under Part 3 of Division 3.6 of Title 1 of the California Government Code, including the allowance, compromise, or settlement of a claim if the amount to be paid does not exceed $50,000. Consistent with this state law, Section 11.1 of the CalOptima Bylaws delegates this authority to the Chief Executive Officer or his or his designee, but provides that any allowance, compromise, or settlement of any claim where the amount to be paid from CalOptima's treasury exceeds $10,000 shall be approved personally by the Chief Executive Officer, rather than his or her designee.

On April 6, 1999, the Board of Directors adopted Resolution No. 99-0406, which adopted a Claims (Verified) and Judicial Review Policy that, among other things, delegated to the Chief Executive Officer, or the Chief Operations Officer upon the Chief Executive Officer's unavailability, the authority to perform the functions of the Board described above. This delegated authority included the authority to allow, compromise, or settle claims if the amount to be paid from CalOptima's treasury does not exceed $50,000. The Board of Directors later approved revisions to the Legal

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Claims and Judicial Review Policy No.1217 on June 4, 2002, to require the presentation of claims otherwise exempt under Government Code Section 905, and on August 5, 2003, to require the presentation of claims on a standardized form adopted by CalOptima and to authorize the Chief Executive Officer to revise the form as needed.

CalOptima legal staff periodically reviews the claims policy and its attached claim form to ensure consistency with all applicable laws, regulations, and guidelines, and to ensure the claims presentation requirements and obligations relating to claims against CalOptima are made clear for staff and any potential plaintiffs. Consistent with that practice, updates have been made to CalOptima Policy AA.1217, Legal Claims and Judicial Review, and its Attachment A, CalOptima Claim for Injury or Damage.

Fiscal Impact
No direct fiscal impact.

Rationale for Recommendation
The proposed revised policy and claim form will clarify the obligations and requirements applicable to claims presented to and acted on by CalOptima, and will provide updated language that will assist in the processing of claims presented to CalOptima.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 14-1204-03, A Resolution Approving CalOptima's Updated Legal Claims and Judicial Review Policy
2. Revised CalOptima Policy: AA. 1217: Legal Claims and Judicial Review – with Attachment

/s/ Michael Schrader — *11/26/2014*
Authorized Signature — **Date**

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RESOLUTION NUMBER 14-1204-03

RESOLUTION OF THE BOARD OF DIRECTORS OF ORANGE COUNTY HEALTH AUTHORITY dba CalOptima

APPROVING CALOPTIMA'S UPDATED LEGAL CLAIMS AND JUDICIAL REVIEW POLICY

WHEREAS, state law provides that except for certain claims excepted from the presentations requirement under California Government Code Section 905, all claims against local public entities for money or damages shall be presented in accordance with Chapter 1 and Chapter 2 of Part 3 of Division 3.6 of Title 1 of the California Government Code, prior to initiating a lawsuit against the public entity; and

WHEREAS, state law provides that a local public entity may adopt a procedure to govern claims that are excepted under California Government Code Section 905, and such procedure may include a requirement that a claim be presented and acted upon as a prerequisite to a lawsuit thereon; and

WHEREAS, state law provides that a public entity may by resolution authorize an employee to perform those functions of the governing body under Part 3 of Division 3.6 of Title 1 of the California Government Code that are prescribed by the local public entity, including the allowance, compromise, or settlement of a claim against the public entity if the amount to be paid pursuant to the allowance, compromise, or settlement does not exceed $50,000; and

WHEREAS, Section 11.1 of the Bylaws of the Orange County Health Authority, dba CalOptima, authorizes the Chief Executive Officer or designee to perform those functions of the CalOptima Board specified in Part 3 of Division 3.6 of Title 1 of the California Government Code, including the allowance, compromise, or settlement of any claims if the amount to be paid from CalOptima's treasury does not exceed $50,000, and provides that any allowance, compromise, or settlement of any claim in which the amount to be paid from CalOptima's

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treasury exceeds $10,000 shall be approved personally by the Chief Executive Officer, rather than his or her designee; and

WHEREAS, Section 11.3 of the Bylaws of the Orange County Health Authority, dba CalOptima, provides that notwithstanding any exceptions contained in Section 905 of the California Government Code, no action based on a claim shall be brought against CalOptima unless presented to CalOptima within the time limitations and in the manner prescribed by Sections 910 through 915.2 of the Government Code, and that such claims shall be further subject to Section 945.4 of the Government Code; and

WHEREAS, in 1999, the Board of Directors approved and adopted Resolution No. 99-0406, which adopted the Claims (Verified) and Judicial Review Policy that, among other things, delegated to the Chief Executive Officer, or the Chief Operations Officer upon the Chief Executive Officer's unavailability, the authority to perform those functions of the CalOptima Board under Part 3 of Division 3.6 of Title 1 of the Government Code, including the allowance, compromise, or settlement of a claim against CalOptima if the amount to be paid from CalOptima's treasury does not exceed $50,000; and

WHEREAS, in 2002, the Board of Directors approved revisions to Policy No. AA.1217, Legal Claims and Judicial Review, which, among other things, required the presentation of claims otherwise excepted under Government Code Section 905 prior to filing a lawsuit against CalOptima; and

WHEREAS, in 2003, the Board of Directors approved revisions to Policy No. AA.1217, Legal Claims and Judicial Review, to require the presentation of claims on a standardized form adopted by CalOptima as set forth in the newly enacted Government Code Section 910.4, and to authorize the Chief Executive Officer to revise the CalOptima claim form as needed; and

WHEREAS, the Board of Directors and CalOptima staff may review the Legal Claims and Judicial Review Policy from time to time as needed to ensure to ensure consistency with all

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applicable laws, regulations, and guidelines, and to clarify the obligations and requirements for the presentation of legal claims against CalOptima.

NOW THEREFORE, BE IT RESOLVED:

Section 1. That the Board of Directors hereby approves and adopts the attached updated CalOptima Policy No. AA.1217, Legal Claims and Judicial Review, and its updated Attachment.

Section 2. That these actions are effective upon the date of adoption of this Resolution.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, dba CalOptima, this 4th day of December 2014.

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 #:	AA.1217
Title:	**Legal Claims and Judicial Review**
Department:	Administation
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	4/6/99
Last Review Date:	12/4/14
Last Revision Date:	12/4/14

I. PURPOSE

To set forth the process for the presentation of Legal Claims to CalOptima ~~responding to all Legal Claims in a prompt and appropriate manner and~~ in compliance with this Policy, Division 3.6 of Title 1~~I~~ of the California Government Code, and all applicable statutes and regulations. Section 1094.6 of the California Code of Civil Procedure shall govern cases involving judicial review.

II. POLICY

A. General: As a public agency, CalOptima is subject to Division 3.6 of Title 1 of the California Government Code, pertaining to claims against public agencies. Any claims against CalOptima for money or damages, which are not governed by any other statutes or regulations expressly relating thereto, shall be presented in accordance with Title 1, Division 3.6, Part 3, Chapter 1 (commencing with Section 900) and Chapter 2 (commencing with Section 910) of the California Government Code, prior to initiating suit thereon.

~~A.~~B. Claims Presentation: Except as provided above in Section II.A, ~~A~~any action presented to CalOptima, which has the potential to be litigated, shall be handled in accordance with this ~~p~~Policy. Those actions include but are not limited to Verified Claims, Notice of Intent to Sue, Summons and Complaints, and all documents which have the potential to meet the criteria for a claim against a public entity as defined in Government Code Sections 910 and 910.2.

~~B.~~C. Excepted Claims: In accordance with the authority set forth in California Government Code Section 935, ~~T~~the claims procedures for those claims against CalOptima for money or damages, which are excepted from the claims presentation requirement by Government Code Section 905 and not governed by other statutes or regulations expressly relating thereto, are ~~set forth in this Paragraph~~governed by the procedures set forth in this Policy. Notwithstanding any exceptions contained in Section 905 of the California Government Code, no action based on a claim or demand for money or damages shall be brought against CalOptima, or any of CalOptima's Board members, officers, employees, or agents, unless presented to, and acted upon by, the Board, as provided herein.

~~1. Notwithstanding any exceptions contained in Section 905 of the California Government Code, no action based on a claim or demand for money or damages shall be brought against CalOptima, or any of CalOptima's Board members, officers, employees, or agents, unless presented to, and acted upon by, the Board, as provided in Paragraph B.2. below.~~

~~2. All claims shall be presented within the time limitations and in the manner prescribed by Sections 910 through 915.2 of the California Government Code. Such claims shall further be subject to the provisions of Section 945.4 of the California Government Code relating to the prohibition of suits in the absence of presentation of claims and action thereon by the Board.~~

Policy #: AA.1217
Title: Legal Claims and Judicial Review Revised Date: 12/4/14~~5/1/13~~

D. Timeliness: All claims shall be presented within the time limitations and in the manner prescribed by Sections 910 through 915.2 of the California Government Code. Such claims shall further be subject to the provisions of Section 945.4 of the California Government Code relating to the prohibition of suits in the absence of presentation of claims and action thereon by the Board.

~~C.~~E. Late and Insufficient Claims

1. If the Chief Executive Officer (CEO), or his or her designee upon the CEO's unavailability, determines that a claim fails to comply substantially with the presentation requirements of Government Code Sections 910 and 910.2, or with the requirements of a form provided under Government Code Section 910.4 if a claim is presented thereto, he or she may give written notice of its insufficiency in accordance with Government Code Sections 910.8 and 915.4.

2. When a claim is not presented within the time limits prescribed in Government Code Section 911.2, the CEO, or his or her designee upon the CEO's unavailability, is authorized to return the claim without further action, in accordance with Government Code Section 911.3 for claims required to be filed within six months, or reject the claim in accordance with Government Code Section 913 for all other claims.

~~D.~~F. Small Claims: In the cases of small claims actions brought against CalOptima which personally name an individual who has no personal knowledge of the claim (CEO, Chair of Board, etc.), it is permissible to substitute a representative with more personal knowledge for purposes of court appearances.

G. Delegated Functions of the Board and Settlement Authority~~:~~

1. Claims Against CalOptima

i. The ~~Chief Executive Officer (~~CEO~~),~~ or his or her designee~~the Chief Operations Officer (COO)~~ upon the CEO's unavailability, is authorized to perform the functions of the Board which are specified in Part 3 of Division 3.6 of Title 1 of the California Government Code.~~.~~

ii. Such delegation includes~~ing~~ the allowance, compromise, or settlement of any claims if the amount to be paid from CalOptima's treasury does not exceed $50,000. Notwithstanding the foregoing, any allowance, compromise, or settlement of any claim in which the amount to be paid from CalOptima's treasury exceeds $10,000 shall be approved personally by the CEO, rather than his or her designee.

iii. The CEO~~hief Executive Officer~~ or his or her designee shall periodically report such actions to the Board of Directors~~ at its next meeting~~.

~~E.~~2. Actions Against CalOptima: Consistent with Section 949 of Part 4 of Division 3.6 of Title 1 of the California Government Code, the Board may on a case-by-case basis authorize its attorney or a CalOptima employee to compromise any pending action.

~~F.~~H. Judicial Review: In compliance with Section 1094.6 of the California Code of Civil Procedure, petitions for judicial review of any decision made by CalOptima must be filed within ninety (90) days after the action is final.

Policy #: AA.1217
Title: Legal Claims and Judicial Review Revised Date: 12/4/14~~5/1/13~~

I. Claim Form: In accordance with California Government Code Section 910.4, CalOptima shall maintain and provide a claim form for the public's use, which form is attached hereto as Exhibit "A." All claims presented to CalOptima must be submitted on ~~the~~ CalOptima's claim form ~~attached hereto as Exhibit "A",~~ pursuant to Government Code Section 910.4, or in a form that substantially complies with the claims requirements of California Government Code Sections 910 and 910.2. The ~~Chief Executive Officer (~~CEO~~)~~ shall have the authority to revise the claim form from time to time as he or she deems necessary.

~~G.~~J. Exhaustion of Administrative Remedies: Nothing herein is intended to diminish, eliminate, or waive any legal or contractual obligation to exhaust CalOptima's administrative remedies prior to the presentation of a claim pursuant to this Policy.

III. PROCEDURE

Not Applicable

IV. ATTACHMENTS

A. CalOptima - Claim for Damage or Injury

V. REFERENCES

A. California Code of Civil Procedure~~s~~, Section 1094.6
~~B. California Government Code, Section 910.4~~
~~C.~~B. California Government Code, Title 1, Division 3.6, Sections 900~~5~~-915.2, 935, 935.4, 945.4, and 949~~, and title I, Division 6~~ and all applicable statutes and regulations.

VI. APPROVALS OR BOARD ACTION

~~Not Applicable~~
A. 12/4/14: Regular CalOptima Board of Directors Meeting
B. 8/5/03: Regular CalOptima Board of Directors Meeting
C. 6/4/02: Regular CalOptima Board of Directors Meeting
D. 4/6/99: Regular CalOptima Board of Directors Meeting

VII. REVISION HISTORY

A. 12/4/14: AA.1217: Legal Claims and Judicial Review
~~A.~~B. 1/04: AA.1217: Legal Claims and Judicial Review
~~B.~~C. 8/5/03: AA.1217: Legal Claims and Judicial Review
D. 6/4/02: AA.1217: Legal Claims and Judicial Review
~~C.~~E. 4/6/99: AA.1217: Legal Claims and Judicial Review

~~VIII. KEYWORDS~~

~~Legal~~
~~Claims~~
~~Judical~~
~~Review~~

Attachment to August 3, 2017 Board of Directors Meeting - Agenda Item 11

FOR CALOPTIMA'S USE ONLY
(Date Claim Rec'd by CalOptima)

Received via: ☐ U.S. Mail ☐Interoffice ☐ Hand Delivery

FILE NUMBER:

CALOPTIMA
CLAIM FOR DAMAGE OR INJURY

INSTRUCTIONS:

Answer all sections on both pages of this form completely and attach any additional information as necessary to support your claim. Return this original signed and dated claim form and any attachments to the Clerk of the Board at the address below, in person or by mail. See California Government Code Section 900 et seq. and CalOptima Policy No. AA.1217 for more information regarding presenting a claim against CalOptima. ~~When properly completed, this form satisfies the requirements for filing a claim against CalOptima under the Government Claims Act and CalOptima's Legal Claims and Judicial Review Policy, Policy Number AA.1217.~~ **Please note the following timeframes:**

1. Claims for death~~,~~ or for injury to person~~,~~ or to personal property must be ~~filed~~ presented not later than six (6) months after the accrual of the cause of action~~occurrence~~ (Gov. Code Sec. 911.2(a)).

2. Claims relating to any other cause of action must be ~~filed~~ presented not later than one (1) year after the accrual of the cause of action~~occurrence~~ (Gov. Code Sec. 911.2(a)).

TO: **Clerk of the Board**
CalOptima
505 City Parkway West
Orange, CA 92868

[ATTACH SEPARATE SHEETS, IF NECESSARY, TO GIVE FULL DETAILS]

Name of Claimant

Member Identification Number of Claimant
(if Claimant is a CalOptima member)

Home ~~a~~Address of Claimant

( ) Home Telephone No.

City State Zip

Business Address of Claimant

( ) Business Telephone No.

City State Zip

ADDRESS TO WHICH CLAIMANT DESIRES NOTICES OR COMMUNICATIONS SENT REGARDING THIS CLAIM
(i~~I~~f different from an address listed above):

WHEN did damage or injury occur? _____

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WHERE did damage or injury occur? _____

HOW and under what circumstances did damage or injury occur? _____

_____

_____

WHAT particular action or omission by CalOptima, or its employees, caused the alleged damage or injury?
(Include names of employees, if known)

_____

_____

_____

WHAT ~~sum~~ amount do you claim? Include the estimated amount of any prospective loss, insofar as it may be known at the time of the presentation of this claim, together with the basis of computation of the amount claimed.~~:~~

(Attach copies of all documentation in support of the total amount claimed~~, if any~~.)

_____ $_____

_____ $_____

_____ $_____

Total Amount Claimed $_____

If the total amount claimed exceeds $10,000, indicate whether your claim would be a:

Limited Civil Case ($25,000 or less) ☐ Unlimited Civil Case (more than $25,000) ☐

NAMES, addresses and telephone numbers of all persons known to have information about this claim:
(Use attachment if necessary)

_____

_____

_____

I HAVE READ THE FOREGOING CLAIM, INCLUDING ATTACHMENTS, IF ANY, AND KNOW THE CONTENTS THEREOF, AND CERTIFY THAT THE SAME IS TRUE ON MY OWN KNOWLEDGE, EXCEPT AS TO THOSE MATTERS WHICH ARE HEREIN STATED UPON MY INFORMATION AND BELIEF, AND AS TO THOSE MATTERS I BELIEVE THEM TO BE TRUE. I CERTIFY (OR DECLARE) UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

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Signature of Claimant or Agent ~~acting on~~ Date

Type or Print Name

acting on ~~B~~behalf of Claimant

Relationship to Claimant

NOTE: Provide all information you wish CalOptima to consider and submit original signed claim form and back-up documentation to the Clerk of the Board at the address above on page 1.

WARNING: It is a criminal offense to file a false claim. (See California Penal Code Section 72).

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 3, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item
12. Consider Actions Related to the Provision of Behavioral Health Services for CalOptima Medi-Cal Members

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

Recommended Actions
1. Authorize the Chief Executive Officer (CEO) to:
    a. Amend, with the assistance of legal counsel, the Medi-Cal Contract with the existing managed behavioral health organization to transition to a percent of premium basis for compensation of ABA services as part of a 180-day wind down period ending on December 31, 2017~~;~~
    ~~b. Integrate Medi-Cal covered Behavioral Health (BH), which includes Mental Health (MH) and Applied Behavior Analysis (ABA) services, within CalOptima internal operations;~~
    ~~c. Establish a standard CalOptima provider fee schedule for MH and ABA services;~~
    ~~d. Enter into contracts, with the assistance of legal counsel, with MH and ABA providers;~~
    e. ~~Enter into an agreement, with the assistance of legal counsel, for after-hour coverage for CalOptima's behavioral health call center and triage services obtained in accordance with CalOptima's Procurement Policy;~~

Continued to 9/7/2017 Board Meeting

~~2. Authorize reallocation of budgeted funds not to exceed $4.1 million from Medi-Cal administrative expenses for purchased services approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, to Medi-Cal medical and administrative expenses; and~~
~~3. Authorize unbudgeted expenditures of up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses.~~

Background

Medi-Cal MH/ABA Benefits. Behavioral Health services include MH, substance use disorder, and autism spectrum disorder behavioral health treatment (which includes ABA services). Outpatient mild-to-moderate MH services became a covered benefit for Medi-Cal managed care plans as of January 1, 2014. Beginning in September 2014, CalOptima started providing ABA services to Medi-Cal beneficiaries under the age of 21 under the Early and Periodic Screening, Diagnostic, and Treatment benefit. Like many Medi-Cal managed care plans, CalOptima has contracted with Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of behavioral health benefits, including ABA. CalOptima currently contracts with Human Affairs International of California, Inc., dba Magellan Healthcare (Magellan) as its MBHO serving Medi-Cal, OneCare, and OneCare Connect members.

Medi-Cal MH/ABA MBHO. Between January 1, 2014 and December 31, 2016, CalOptima contracted with College Health IPA (CHIPA) and its subcontractor Beacon Health Options as its Medi-Cal

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MBHO. Effective January 1, 2017, the Medi-Cal MH/ABA services were transitioned to Magellan. Magellan was selected as the new MBHO through a 2016 request for proposal (RFP) process that focused on identifying a delivery model that could cover Behavioral Health services for CalOptima's Medi-Cal, OneCare, and OneCare Connect members. On September 1, 2016, the Board authorized a contract with Magellan, effective January 1, 2017, for the full scope Medi-Cal covered mild to moderate mental health and ABA services. Specialty mental health services, including inpatient psychiatric services, remain the responsibility of the Orange County Health Care Agency. In addition, substance use disorder treatment services remain as a carve-out benefit under Drug Medi-Cal. CalOptima provides the coordination of care and service across levels of care (including participating on interdisciplinary care teams), quality initiatives, and oversight. The Board also authorized a separate contract with Magellan for Medicare Behavioral Health services for CalOptima's Medicare Advantage (OneCare) and Cal-MediConnect (OneCare Connect) members.

Magellan Contract. The CalOptima-Magellan contract includes a provision allowing for the reset of reimbursement rates for ABA services based on changes to the Medi-Cal membership or the penetration rate for ABA services. In accordance with the contract, Magellan requested an adjustment to the ABA rates based on the increased Medi-Cal member utilization trends. The parties were unable to reach an agreement when on June 28, 2017, CalOptima received a rescission notice from Magellan asserting the right to rescind the Medi-Cal MBHO Contract effective June 30, 2017, rather than providing the 180-notice of termination provided for in the contract. Subsequently, Magellan entered into a "Settlement Agreement and Order" with the Department of Managed Health Care under which Magellan agreed to provide MBHO as set forth in the Medi-Cal Contract from July 1, 2017 through August 30, 2017.

Discussion

CalOptima staff assessed various options for providing MH and ABA services to Medi-Cal members after the transition date with the intent of keeping the provider network intact to mitigate disruptions to services. The network includes over 530 provider contracts that comprises over 800 MH and 300 ABA providers.

These options included considering contracting with another MBHO who responded to the 2016 RFP, issuing a new RFP, contracting with the previous MBHO, outsourcing certain services, or integrating MH and ABA services into CalOptima operations. After considering these options, staff recommends implementing a model in which coordination and management of MH and ABA services are integrated into CalOptima operations rather than utilizing a vendor/partner for Medi-Cal MH/ABA services as the approach that will best mitigate disruption to Medi-Cal members. At this time, no recommendation is being made on the separate contract with Magellan for services for CalOptima's OneCare and OneCare Connect members, though staff may return with further recommendations on this contract at a future date.

Magellan and CalOptima continued discussions on options for moving forward, with the proposal that Magellan transition to a percent of premium arrangement from CalOptima for the ABA services during a July 1, 2017 through December 31, 2017 transition period. Staff is recommending that your Board authorize integration of administration of Medi-Cal MH and ABA services within CalOptima internal operations and authorize the amendment of the Magellan Contract for the percent of premium

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arrangement from July 1, 2017 through the December 31, 2017 transition end date. While the proposal is to bring administration of this benefit in-house, services will continue to be provided by private sector providers.

Transition Plan to Incorporate MH and ABA Services into CalOptima Operations. In order to transition MH and ABA services into its operations, CalOptima staff developed a clinical and operational work plan. New infrastructure and resources are necessary to meet this timeframe as well ensure compliance with the Mental Health Parity and Addiction Equity Act, and other regulatory and accreditation requirements. The transition plan includes:

1. Development of a MH and ABA provider network that meets all credentialing and access and availability standards:
    - Establish a MH services provider network to include psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists;
    - Establish an ABA provider network to include Qualified Autism Service (QAS) providers, including Board Certified Behavioral Analysts (BCBAs), and other licensed professionals in the field;
2. Rely on Magellan's credentialing files in accordance with the National Committee for Quality Assurance (NCQA) guidelines and re-credential the practitioner when they are due.
3. Build infrastructure (staff and systems) to support the following areas:
    - Expand Customer Service to include BH and triage services:
        - Contract with an external vendor, with the assistance of legal counsel, that has experience with behavioral health services for 24/7/365 referral and after-hours call center support;
    - Ensure adequate resources to process claims timely due to the anticipated increased volume of MH/ABA claims received after the transition period;
    - Incorporate handling of behavior health services provider complaints into existing system;
    - Implement Clinical Operations for BH Utilization Management and Case Management:
        - Perform initial MH screening, determine level of care needs, routine appointment assistance and participation in interdisciplinary care teams;
        - Develop authorization processes for ABA services and psychological testing;
    - Integrate MH and ABA treatment protocols and clinical guidelines into the electronic clinical support system and operations to support decisions;
    - Expand BHI resources for ABA services:
        - Implement process to review prior authorizations for ABA services; and
        - Conduct clinical case management and progress reports;
    - Implement MH/ABA Quality Improvement processes and complete impact analysis of MH/ABA transition on NCQA Accreditation.
4. Hire and train additional clinical and operational staff required to support MH/ABA member needs.
5. Implement reporting and analytic capabilities to meet operational, regulatory and accreditation requirements.

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Continued Implementation Efforts. CalOptima staff will continue to identify and develop or revise policies and procedures, quality program descriptions, and utilization management program descriptions. Further transition plans as developed as well as policies and programs requiring CalOptima Board approval or ratification will be presented at subsequent meetings.

Fiscal Impact

Magellan Medi-Cal Contract Amendment for ABA Services

There is no fiscal impact based on the recommended action to transition to a percent of premium agreement for ABA services for the period of July 1, 2017, through December 31, 2017. Under the CalOptima FY 2017-18 Operating Budget approved on June 1, 2017, Staff budgeted for the increased ABA provider capitation expenses. Staff anticipates the budgeted funds will be sufficient to transition to the proposed payment methodology with Magellan.

BH Services Integration

The fiscal impact for the recommended actions to fund the cost to integrate Medi-Cal covered MH and ABA services internally is projected to be ~~$5.5~~ $6.6 million. Management proposes to make a reallocation of budgeted funds approved in the CalOptima FY 2017-18 Operating Budget on June 1, 2017. Funding not to exceed $4.1 million will be reallocated from Medi-Cal administrative costs for Purchased Services to:

Rev. 8/3/17

- $1.2 million to Medical Management; and
- $2.9 million to Administrative Costs.

In addition, Management requests up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses among the following budget categories: Medical Management, Salaries, Wages and Benefits, Professional Fees, Purchased Services, Printing, Postage and Other Operating Expenses.

Rationale for Recommendation

Upon receipt of the notice of rescission from Magellan, it was critical to ensure continuity of care and access to services for CalOptima members with behavioral health needs. CalOptima staff reviewed multiple options and concluded that, based on the available solutions, the best option was to integrate administration of MH and ABA services into CalOptima operations, with the services continuing to be provided by private sector providers. With the proposed wind-down period extending through December 2017, the transition team, consisting of all affected areas' leadership continues to believe that transitioning administration of the behavioral health benefit into CalOptima operations is the best option to minimize any further disruption to members' care. This approach will allow CalOptima to organize care around the needs of our members and work closely with the provider community to provide members with appropriate care.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. PowerPoint Presentation: Consider Actions Related to the Provision of Behavioral Health Services for Medi-Cal Members
2. Board Action dated September 1, 2016, 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

/s/ Michael Schrader *08/01/2017*

Authorized Signature **Date**

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12. Consider Actions Related to the Provision of Behavioral Health Services for Medi-Cal Members

Board of Directors Meeting

August 3, 2017

Richard Helmer, M.D., Chief Medical Officer

Ladan Khamseh, Chief Operating Officer

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Agenda

- Background
- Current State
- Considerations and Recommendations
- Implementation Planning
- Recommended Actions

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Background

- CalOptima is responsible for Behavioral Health (BH) services for Medi-Cal, OneCare, and OneCare Connect
- BH services include:
  - Mental Health (MH)
  - Substance Use Disorder (SUD)
  - Autism Spectrum Disorder or Applied Behavioral Analysis (ABA)
- CalOptima responsible for:
  - Mental health health benefits since January 1, 2014
  - Autism Spectrum Disorder Behavioral Health Treatment benefit beginning September 15, 2014
- Orange County Health Care Agency responsible for specialty MH services and SUD through Drug Medi-Cal

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Background (Cont.)

- Primary care providers and community resources for mild to moderate behavioral health issues and to support self-management and early identification

- Use of Managed Behavioral Health Organizations (MBHO) to provide mild to moderate BH services to members:
  - September 2014 – December 2016: CHIPA/Beacon (Medi-Cal only)
  - January 2017 – Present: Magellan (all populations including OneCare and OneCare Connect)

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Status of Magellan Contract

- Contract includes provision allowing reset of reimbursement rates for ABA services based on:
  - Changes to Medi-Cal membership; or
  - Penetration rate for ABA services
- Magellan requested adjustment to the ABA rates; parties could not reach agreement
- Magellan subsequently agreed to provide MBHO services through December 31, 2017

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Considerations and Recommendations

- Contingency strategies considered for transition effective January 1, 2018:
  1. Contract with an MBHO who responded to RFP in 2016
  2. Issue a new RFP
  3. Contract with the previous MBHO

- Average number of members receiving services:
  - BH Services = 6,700 members per month
  - ABA Services = 1,800 members per month

- Previous transition for ABA in last two years
  - RCOC to CalOptima
  - Beacon
  - Magellan

- Recommendation to mitigate member disruption:
  - Integrate administration of MH and ABA services into CalOptima operations with services continuing to be provided by network of private sector providers

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Transition Implementation Planning

- Clinical and operational workplan developed
- Workgroups have been in place to ensure services during July 1 – December 31, 2017 transition:

Network Development	Operations
Provider Contracting	Claims
Credentialing	Customer Service
Provider Directory	Grievance and Appeals
Rate Development	Utilization & Care Management
	Reporting (internal, regulatory, accreditation)

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Fiscal Impact

- Total estimated cost: Not to exceed $6.6 million
  - $4.1 million: Funded through budget reallocation under FY 2017-18 Medi-Cal Operating Budget

$4.1 million: Administrative Expenses – Purchased Services

$1.2 million: Medical Management
$2.9 million: Administrative Expenses

  - $2.5 million: Unbudgeted expenditures funded from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses
    - Distributed among the following budget categories: Medical Management, Salaries, Wages and Benefits, Professional Fees, Purchased Services, Printing, Postage, Other Operating Expenses

Rationale to Integrate MH and ABA Services

- Utilize existing CalOptima capabilities
  - Network contracting and relations
  - Customer service
  - Behavioral Health Integration Department
  - Claims
  - Quality improvement
  - Grievance and appeals
- Minimize disruption to members that would occur with new vendor
- Provide increased opportunities to integrate BH services with medical care in the future

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Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to:
   a. Amend, with the assistance of legal counsel, the Medi-Cal Contract with the existing managed behavioral health organization to transition to a percent of premium basis for compensation of ABA services as part of a 180-day wind down period ending on December 31, 2017;
   b. Integrate Medi-Cal covered Behavioral Health (BH), which includes Mental Health (MH) and Applied Behavior Analysis (ABA) services, within CalOptima internal operations;
   c. Establish a standard CalOptima provider fee schedule for MH and ABA services;
   d. Enter into contracts, with the assistance of legal counsel, with MH and ABA providers; and
   e. Enter into an agreement, with the assistance of legal counsel, for after-hour coverage for CalOptima's behavioral health call center and triage services obtained in accordance with CalOptima's Procurement Policy;

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Recommended Actions (Cont.)

2. Authorize reallocation of budgeted funds not to exceed $4.1 million from Medi-Cal administrative expenses for purchased services approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, to Medi-Cal medical and administrative expenses; and

3. Authorize unbudgeted expenditures of up to $2.5 million from existing reserves for one-time transition-related contingency funds for Medi-Cal medical and administrative expenses.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:
    a. 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.
    b. Contract with a consultant(s) in an amount not to exceed $50,000, to assist with the implementation of the Behavioral Health MBHO contract.
    c. 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.

Background

Like many managed care plans, CalOptima has used Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of behavioral health benefits. Behavioral Health is a covered benefit for CalOptima's Medi-Cal and managed Medicare beneficiaries. CalOptima also provides Behavioral Health Treatment (BHT) services to Medi-Cal beneficiaries under the age of 21 under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. CalOptima currently contracts with CHIPA for the provision of Medi-Cal Managed Care Plan covered behavioral health and BHT services. This contract commenced January 1, 2014, was amended September 15, 2014 to include BHT services, and currently expires on December 31, 2016.

In addition, CalOptima contracts with Windstone to provide behavioral health services for members enrolled in CalOptima's OneCare and OneCare Connect programs. The OneCare contract with Windstone commenced January 1, 2007 and has been extended four times (January 1, 2010, January 1, 2013, January 1, 2014, and January 1, 2015). On May 7, 2015, the CalOptima Board of Directors authorized a contract with Windstone for the OneCare Connect program for the period July 1, 2015 through June 30, 2016, and extension of the Windstone OneCare contract through December 31, 2016. In addition, the CalOptima Board recommended a RFP process for future coverage, to ensure that the best available behavioral health services are obtained for CalOptima members in a most cost effective manner.

All CalOptima behavioral health contracts have been aligned to have the same expiration date. This change was made in part to minimize the possibility of confusion for members new to OneCare

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Connect. On February 4, 2016, the CalOptima Board approved the extension of the OneCare Connect contract through December 31, 2016, thereby aligning all behavioral health contracts termination dates. The Board also authorized the use of a consultant to assist with required activities related to the issuance, scoring and awarding of the RFP for MBHO services.

Discussion

On April 1, 2016, CalOptima contracted with Health Management Associates (HMA) to help conduct a thorough search of potential Behavioral Health vendors and assist in the evaluation process to select the a vendor to provide best practice treatment to members. HMA's scope of work for MBHO RFP included providing assistance in the development of the proposal, creation of the proposal scoring tool, assessment of proposals, and selection of vendor.

On June 1, 2016, CalOptima released the Behavioral Health Request for Proposal (RFP) via BidSync. The CalOptima Procurement Department also contacted identified MBHOs nationwide notifying them about the RFP. Vendors had six weeks to submit their proposals. They also had two opportunities to submit questions to CalOptima about the RFP.

The responses to the RFP were reviewed by an evaluation team consisting of the Executive Director of Clinical Operations, Director of Behavioral Health Services, Behavioral Health Medical Director, and members of the Provider Advisory and Member Advisory Committees. Staff representatives from Claims, Information Services, and Finance scored sections related to their respective technical areas. The evaluation team also met with Subject Matter Experts (SMEs), including Customer Service, Quality Improvement, Grievances and Appeals, Compliance, Case Management, Utilization Management, and Behavioral Health, to discuss the strengths and weaknesses of each proposal.

Selection criteria used for scoring the proposals included:

- Experience in managed care
- Accreditation with the National Committee for Quality Assurance (NCQA)
- Corporate capabilities
- Information processing system
- Financial management
- Proposed staffing and project organization
- Ownership
- Outsourced services
- Provider network management
- Operations
- Utilization management
- Claim processing
- Grievances and Appeals
- Care management
- Cultural competency
- Quality improvement
- Information technology, data management
- Business intelligence

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- Compliance program
- Implementation plan
- Innovation program and services

Based on the evaluation team's scoring, the results for the RFP were as follows:

Vendor	Score
Magellan	4.41
Envolve	4.00
CHIPA	3.54
Optum	3.28
Windstone	2.80

As the table indicates, Magellan finished with the highest score at 4.41 out of 5.

As part of the final review, the evaluation team invited the top two finalists, Magellan and Envolve, to an on-site presentation/interview. In the on-site portion of the evaluation, Magellan finished first with a score of 4.36. Envolve received a score of 2.67 for the on-site portion.

Based on the review of each vendor's capabilities, references, contract requirements and financial costs, the evaluation team is recommending that the Board authorize the CEO to contract with Magellan as the new MBHO. However, in the event that final contract terms cannot be reached within 30 days, staff plans to return to the Board with further recommendations.

Assuming contract terms are reached, the implementation phase will begin as soon as agreement with Magellan has been reached; implementation is calendared to be completed by December 31, 2016. However, if it is identified that additional time is needed for thorough implementation, the team is requesting authorization to extend the existing CHIPA and Windstone proposed to ensure no gap in coverage of behavioral health services. This process includes the winding down of current contracts with CHIPA and Windstone and the transition to the Magellan. Staff also recommends that the Board also authorize a contract with a consultant(s) in an amount not to exceed $50,000 to facilitate this implementation process.

Both CHIPA and Windstone have indicated that they are willing to extend their current contracts in the event that the implementation of the new MBHO contract is not fully completed within the aggressive timeline that is outlined.

Fiscal Impact

Management has included expenses for behavioral health benefits in the CalOptima Fiscal Year (FY) 2016-17 Operating Budget, which is sufficient to fund the projected costs of the new MBHO contract for the period of January 1, 2017, through June 30, 2017. Based on projected enrollment and the proposed rates, Staff estimates the total annual cost of the new MBHO contract will be approximately $41 million.

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In the event CalOptima will need to extend the CHIPA and Windstone contracts, Management will execute an amendment to extend the termination date of the existing contract. No additional expenses will be incurred due to the contract extensions, since there will not be an overlap in dates for when the CHIPA and Windstone contracts expire and the effective date of the new MBHO contract.

The recommended action to authorize the CEO to contract with a consultant to assist with the implementation of the Behavioral Health MBHO contract is unbudgeted and will not exceed $50,000 through June 30, 2017. An allocation of $50,000 from existing reserves will fund this action.

Rationale for Recommendation

CalOptima staff believes contracting with the selected MBHO will allow CalOptima to continue to provide a comprehensive provider network and Behavioral Health and Autism Spectrum Disorder services for CalOptima's Medi-Cal and Duals programs. The evaluation team reviewed qualified MBHO responses and identified the candidate believed to best meet CalOptima's needs for integration of care, regulatory compliance, operational efficiency, administrative simplification, best practices, as well as overall reasonableness of price. The recommended MBHO is expected to be able to provide all delegated functions related to Behavioral Health Benefits including, but not limited to, customer service, care management, utilization management, credentialing, quality improvement, claims processing and payment, and provider dispute resolution. Moreover, the recommended MBHO will help CalOptima organize care around the needs of our members to achieve efficient and effective assessment, diagnosis, care planning, strength based and person centered treatment implementation, support services and outcomes evaluation.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Actions referenced:
    a. Board Action dated December 5, 2013, Contract with College Health Independent Practice Association for the Provision of Medi-Cal Outpatient Mental Health Services Beginning on January 1, 2014
    b. Board Actions dated October 2, 2014:
        i. Amendments to the Primary Agreement between DHCS and CalOptima to Implement Behavioral Health Therapy Benefit
        ii. Amend CalOptima's Contract with College Health Independent Association to Include Behavioral Health Therapy Services to meet DHCS Requirements
    c. Board Action dated May 7, 2015 Authorizing Contract for Behavioral Health Services with Windstone Behavioral Health
    d. Board Action dated February 4, 2016 Authorizing the Extension of the Contract with Windstone Behavioral Health for Behavioral Health Services
2. Behavioral Health Services PowerPoint Presentation

/s/ Michael Schrader — *8/25/2016*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Consent Calendar

V. F. Authorize the Chief Executive Officer (CEO) to Contract with College Health Independent Practice Association (CHIPA) for the Provision of Medi-Cal Outpatient Mental Health Services Beginning on January 1, 2014

Contact

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

Recommended Action

Authorize the CEO, with the assistance of legal counsel, to enter into a contract with CHIPA for the provision of Medi-Cal outpatient mental health services, as defined by the Department of Health Care Services (DHCS), effective January 1, 2014 for a one year term with two one year extension options, exercisable at CalOptima's discretion.

Background

At its September 5, 2013 meeting, the CalOptima Board of Directors authorized the CEO to contract with Beacon Health Strategies, LLC (Beacon) to provide outpatient mental health services effective January 1, 2014 based legislative changes requiring Medi-Cal managed care plans to provide these services. Excluded from this arrangement are benefits provided by county mental health plans under the Specialty Mental Health Services Waiver, which CalOptima administers under a separate contract with the Orange County Health Care Agency (OCHCA), and also contracts with Beacon for the provision of administrative services organization (ASO) services under the CalOptima contract with the OCHCA. Separately, CHIPA has a Master Service Agreement with Beacon.

Discussion

As CalOptima prepares to provide all Medi-Cal members with mental health benefits beginning on January 1, 2014, it has been determined that Beacon is neither Knox-Keene licensed in CalOptima's service area nor a professional corporation. Consequently, Beacon cannot be fully delegated for the medical management of the program. Instead, under CalOptima's National Committee Quality Improvement (NCQA) accreditation for the Medi-Cal program, the contract for the medical management of the mental health program must be directly with the delegated entity performing the utilization management for the program. Although Beacon can function as the Management Services Organization (MSO), it cannot perform the full delegation required by CalOptima. As a result, staff recommends that CalOptima instead contract directly with CHIPA, which in turn, has an existing management services agreement with Beacon.

Operational

By contracting with CHIPA, CalOptima will be positioned to continue to leverage Beacon's expertise, experience with the Medi-Cal program, and substantial provider network, as well as meet the NCQA delegation requirements. Additionally, based on CalOptima's experience with Beacon staff co-located at CalOptima's facility for the last three years, CHIPA and Beacon are integrated into CalOptima's operational processes. This is particularly important given the aggressive timeline for implementation of the new benefit.

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Member Experience
With the implementation of the new benefit, CalOptima's goal is to ensure that members' continue to have a seamless experience of care. CalOptima's relationship with Beacon through CHIPA will allow staff to leverage the existing services and processes that Beacon has in place.

In summary, staff proposes contracting with CHIPA for the provision of the new Medi-Cal managed care mental health benefit. Having a contract in place with CHIPA prior to the implementation date of the new benefit will allow CalOptima staff to respond quickly to the requirements associated with implementing this mandatory new benefit. Staff believes that this recommendation will result in optimal member care and allow CalOptima to leverage existing resources and operational processes to the fullest extent.

Fiscal Impact
The recommended action to provide Medi-Cal mental health services will result in revenue neutrality for CalOptima. Management believes that DHCS will apply an adjustment to Medi-Cal capitation rates through a forthcoming contract amendment in an amount equivalent to the benefit expense plus an administrative load. Management will operate the program within the confines of this revenue allocation.

Rationale for Recommendation
A contract with CHIPA for the delivery of this new Medi-Cal mental health benefit will allow CalOptima to maintain the NCQA standards for delegation and leverage existing Beacon resources and operational processes to the fullest extent. Additionally, CalOptima must be prepared to provide this benefit to all Medi-Cal members beginning January 1, 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachment
None

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. A. Authorize and Direct the Chairman of the Board of Directors to Execute Amendments to the Primary Agreement between the California Department of Health Care Services (DHCS) and CalOptima to Implement the Behavioral Health Therapy (BHT) Benefit

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

Recommended Action
Authorize and direct the Chairman of the Board of Directors to execute Amendments to the Primary Agreement between the California DHCS and CalOptima (Primary Agreement) to implement the Behavioral Health Therapy (BHT) Benefit.

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

Discussion
On August 29, 2014, DHCS notified Medi-Cal Managed Care Plans (Plans) that effective September 15, 2014, Plans' responsibility for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services will extend to coverage of Behavioral Health Therapy (BHT). Through the same notification, DHCS provided draft interim policy guidance regarding BHT services to include Applied Behavioral Analysis (ABA).

On September 15, 2014, DHCS released the final interim policy guidance pertaining to BHT services in Medi-Cal managed care for children and adolescents 0 to 21 years of age diagnosed with Autism Spectrum Disorder (ASD). The final interim guidance includes information regarding recipient criteria, covered services and limitations.

DHCS is beginning the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with health plans and stakeholders. DHCS committed to Plans to develop rates, which will be retroactive to September 15, 2014. DHCS will also engage stakeholders to further define eligibility criteria, provider participation criteria, utilization controls, and the delivery system for ABA services.

At this time, CalOptima staff requests your approval of amendments necessary with DHCS to implement the BHT benefit, subject to the terms being consistent with the requirements of the benefit and the rates being satisfactory to provide the services. While the State has not yet provided any amendments to CalOptima for execution, management understands that the State will present them in

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the near future and require prompt execution. There is a separate staff report and recommended action for your Board's consideration related to the administration of the BHT benefit by College Health Independent Practice Association (CHIPA)

Fiscal Impact
At this time, the fiscal impact of the BHT benefit is unknown.

Rationale for Recommendation
The approval of amendments will make language changes consistent with EPSDT requirements and ensure CalOptima will receive funding for the benefit.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to Primary Agreement with DHCS

/s/ Michael Schrader — *9/26/2014*
Authorized Signature — **Date**

APPENDIX TO AGENDA ITEM VII. A.

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012
A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. B. Ratify Amendment of CalOptima's Contract with College Health Independent Practice Association (CHIPA) to Include Behavioral Health Therapy (BHT) Services, Including Applied Behavioral Analysis (ABA) Services, to Meet Department of Health Care Services (DHCS) Requirements; Authorize the Development of Policies and Procedures as Necessary to Implement the BHT Benefit

Contact

Donald Sharps, M.D., Medical Director, (714) 246-8400

Recommended Actions

1. Ratify amendment of CalOptima's contract with College Health Independent Practice Association (CHIPA) to implement the Behavioral Health Therapy (BHT), including ABA services, effective September 15, 2014 for Medi-Cal beneficiaries aged 0 to 21 years diagnosed with Autism Spectrum Disorder (ASD); and
2. Authorize the Chief Executive Officer (CEO) to develop and implement required policies and procedures as required to implement the BHT benefit as required by the Department of Health Care Services (DHCS).

Background

Behavioral Health Treatment Benefit for Autism
On August 29, 2014, the Department of Health Care Services (DHCS) released a draft All Plan Letter (APL) to provide interim policy guidance for Medi-Cal Managed Care Plans' (Plans) coverage of Behavioral Health Treatment (BHT) for children diagnosed with Autism Spectrum Disorder (ASD).

CalOptima was informed at that time of DHCS's intent to provide BHT services as a covered Medi-Cal benefit for individuals 0 to 21 years of age with ASD to the extent required by the federal government under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. DHCS is currently seeking federal approval to provide BHT as it is defined by Section 1374.73 of the California Health and Safety Code. DHCS has begun the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with health plans and stakeholders. DHCS released a subsequent APL on this topic dated September 15, 2014. Based on this guidance:

- Effective September 15, 2014, Plans' responsibility for the provision of EPSDT services for beneficiaries 0 to 21 years of age were further defined to include medically necessary BHT services such as ABA and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD. Plans (including CalOptima) are obligated to ensure that appropriate EPSDT services are initiated in accordance with timely access standards; and

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- Continuity of Care under the following circumstances:
  - Plan members 0 to 21 years diagnosed with ASD who, as of September 14, 2014 were receiving BHT services including ABA services through a Regional Center will continue to receive these services through the Regional Center until such time that the department and the Department of Developmental Services develop a plan for transition.
  - For a Plan's Medi-Cal members receiving BHT services outside of the Plan's network for Medi-Cal services, the Plan is obligated to ensure continuity of care for up to 12 months in accordance with existing contract requirements.
    - DHCS also detailed the requirements for out-of-network providers
  - Plans shall not discontinue BHT services during a continuity of care evaluation.

- Rates:
  - Per the APL, DHCS has committed to working with Plans to develop capitation rates for the costs associated with the provision of ABA services. Any rate adjustments will be retroactively applied to September 15, 2014.
  - On and after September 15, 2014, beneficiaries must receive ABA services from the Plan unless they are receiving their ABA services from a Regional Center.

- DHCS has also provided:
  - Recipient Criteria For ABA-Based Therapy Services
  - Defined Covered Services under Welfare & Institutions Code section 14059.5.
  - Limitations for services to include discontinuation when treatment goals and objectives are achieved or are no longer appropriate

CalOptima's Behavoral Health Intergration unit has been working with our contracted Medi-Cal Behavioral Health Vendor CHIPA/Beacon to gain a better understanding of the population of CalOptima members who may ultimately access ABA services. CalOptima has approximately 314,000 members age 18 and under, with an estimated incidence of autism at approximately 1.0 percent, or roughly 3,140 children. From that group, it is estimated, based on experience with similar populations they service, that approximately 20 percent may use ABA services, or 628 members. Beacon projects approximately half of those children will continue to receive ABA services through the Regional Center of Orange County, which is allowed until the state develops its transition plan. It is anticipated that CalOptima will serve approximately 314 members under this new benefit. However these figures may vary depending on a number of factors, including whether members' parent or guardian wish to continue receiving these services through the Regional Center.

Discussion

CalOptima is currently contracted with CHIPA for the medical management of the Medi-Cal mental health program, which in turn, has an existing management services agreement with Beacon.

Operational
By amending the current contract with CHIPA, CalOptima will be positioned to continue to leverage Beacon's experience with the mental health benefit included in the Medi-Cal program and also meet both DHCS regulatory and National Committee for Quality Assurance (NCQA) accreditation requirements.

Member Experience
With the implementation of the new benefit, CalOptima's goal is to ensure that members continue to have a seamless experience of care. CalOptima's relationship with Beacon through CHIPA allows staff to leverage the existing services and processes that Beacon currently has in place.

Clinical Expertise
Autism Service Group (ASG) has been fully integrated with CHIPA/Beacon for the last four years. Beacon ASG administers autism benefits on behalf of a number of health plans. Services that Beacon ASG provides include Network Management, ASD diagnosis validation, a comprehensive assessment and intake process, Care Management, Claims, and Reporting.
CalOptima and other Plans can expect that DHCS:

- Will require them to undergo a readiness review with DHCS. In the coming weeks, both the DHCS and the Department of Managed Health Care (DMHC) will issue a readiness review checklist. This checklist is expected to include submission timelines which will mirror each other when both Departments are collecting the same information. Both Departments are also working to draft template Evidence of Coverage (EOC) language. This language is expected to be shared with Plans in the near future.

- Will update APL 13-023, *Continuity of Care for Medi-Cal Beneficiaries who Transition from Fee-For-Service Medi-Cal into Medi-Cal Managed Care*, to include the new benefit. These new requirements are expected to include:
    - New noticing requirements when continuity of care: 1) are approved, and 2) approvals are 30 days from ending;
    - Retroactive coverage in certain situations;
    - Utilization management requirements for qualified providers; and
    - Timelines for approving requests when more immediate attention is needed and when there is a risk of harm.

In summary, management requests ratification of an amendment to the current CalOptima-CHIPA contract to include the provision of BHT services related to ASD as required by DHCS.

Fiscal Impact
As proposed, Beacon will be paid via capitation, at a rate of $0.14 per member per month (PMPM) for the period prior to the Regional Center of Orange County transition (September 15, 2014), and $0.25 PMPM for the period after the transition. Based on the projected total costs of ABA services, these rates result in administrative loads of 7.1% and 6.4% respectively for Beacon. As indicated, based on

APL 14-011, management anticipates that the DHCS will work with Plans including CalOptima to ensure that the new capitation rates are sufficient to cover the cost of providing this enhanced benefit.

Rationale for recommendation
The proposed changes are intended to ensure that, within the parameters delineated by the DHCS, CalOptima Medi-Cal beneficiaries have access to this newly added Medi-Cal mental health benefit.

Concurrence
Gary Crockett, Chief Counsel

Attachment
DHCS All Plan Letter 14-011

/s/ Michael Schrader — *9/26/2014*
Authorized Signature — **Date**

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State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: September 15, 2014

All Plan Letter 14-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: INTERIM POLICY FOR THE PROVISION OF BEHAVIORAL HEALTH TREATMENT COVERAGE FOR CHILDREN DIAGNOSED WITH AUTISM SPECTRUM DISORDER

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with interim policy guidance for providing Behavioral Health Therapy (BHT) services to Medi-Cal children and adolescent beneficiaries 0 to 21 years of age diagnosed with Autism Spectrum Disorder (ASD).

BACKGROUND:
ASD is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called ASD[1]. Currently, the Centers for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD.

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance regarding the coverage of BHT services pursuant to section 1905(a)(4)(B) of the Social Security Act (the Act) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to provide coverage to individuals eligible for the EPSDT benefit for any Medicaid covered service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to ensure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and

[1] See Diagnostic and Statistical Manual (DSM) V.

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1501 Capitol Avenue, P.O. Box 997413, MS 4400
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treated as early as possible. When medically necessary, States may not impose limits on EPSDT services and must cover services listed in section 1905(a) of the Act regardless of whether or not they have been approved under a State Plan Amendment.

All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. When a screening examination indicates the need for further evaluation of a child's health, the child must be appropriately referred for medically necessary diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to ensure children receive the health care they need, when they need it.

The Department of Health Care Services (DHCS) intends to include BHT services, including Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD, as a covered Medi-Cal benefit for individuals 0 to 21 years of age with ASD to the extent required by the federal government. DHCS will seek federal approval to provide BHT as it is defined by Section 1374.73 of the Health and Safety (H&S) Code.

Pursuant to Section 14132.56 of the Welfare & Institutions Code (WIC), DHCS is beginning the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT as defined by H&S code section 1374.73, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with stakeholders. In consultation with stakeholders, DHCS will further develop and define eligibility criteria, provider participation criteria, utilization controls, and the delivery system for BHT services, subject to the limitations allowed under federal law, and provide final policy guidance to MCPs upon federal approval.

PROGRAM DESCRIPTION AND PURPOSE:
BHT means professional services and treatment programs, including but not limited to ABA and other evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services are services based on reliable evidence and are not experimental.

INTERIM POLICY:
In accordance with existing contracts, MCPs are responsible for the provision of EPSDT services for members 0 to 21 years of age, including those who have special health care needs. MCPs shall: (1) inform members that EPSDT services are available for beneficiaries 0 to 21 years of age, (2) provide comprehensive screening and prevention

services, (including, but not limited to, a health and developmental history, a comprehensive physical examination, appropriate immunizations, lab tests, lead toxicity screening, etc.), and (3) provide diagnosis and treatment for all medically necessary services, including but not limited to, BHT.

Effective September 15, 2014, the MCP responsibility for the provision of EPSDT services for beneficiaries 0 to 21 years of age includes medically necessary BHT services such as ABA and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD. MCPs shall ensure that appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the MCP's contracts.

CONTINUITY OF CARE:
MCP beneficiaries 0 to 21 years diagnosed with ASD who are receiving BHT services through a Regional Center on September 14, 2014, will automatically continue to receive all BHT services through the Regional Center until such time that DHCS and the Department of Developmental Services (DDS) develop a plan for transition. Until DHCS and DDS develop a plan for transition and communicate this transition plan to Regional Centers and to MCPs (through a forthcoming APL), Regional Centers will continue to provide BHT services for Medi-Cal beneficiaries and reimburse providers for BHT services provided in accordance with existing federal approvals, unless the parent or guardian requests that the MCP provide BHT services to the beneficiary prior to the development and/or implementation of the transition plan. Beneficiaries presenting for BHT services at a Regional Center on or after September 15, 2014, should be referred to the MCP for services.

For Medi-Cal beneficiaries receiving BHT services outside of a Regional Center or the MCPs' network, upon parental or guardian request, the MCPs shall ensure continuity of care for up to 12 months in accordance with existing contract requirements and All Plan Letter (APL) 13-023, unless the parent or guardian requests that the MCP change the service provider to an MCP BHT in-network provider prior to the end of the 12 month period.

BHT services will not be discontinued during a continuity of care evaluation. Pursuant to Health & Safety Code section 1373.96, BHT services must continue until MCPs have established a treatment plan.

An MCP shall offer continuity of care with an out-of-network provider to beneficiaries if all of the following circumstances exist:

- The beneficiary has an existing relationship with a qualified autism service provider. An existing relationship means a beneficiary has seen an out-of-network provider at least twice during the 12 months prior to September 15, 2014;

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- The provider is willing to accept payment from the MCP based on the current Medi-Cal fee schedule; and

- The MCP does not have any documented quality of care concerns that would cause it to exclude the provider from its network.

HEALTH PLAN READINESS:
DHCS and the Department of Managed Health Care (DMHC) will coordinate efforts to conduct readiness reviews of MCPs for purposes of ensuring that MCPs are providing timely medically necessary BHT services. DHCS and DMHC will engage in joint decision making processes when considering the content of any licensing filing submitted to either department. The departments will work together to issue template language to MCPs, as needed.

Guidance pertaining to MCPs' readiness review requirements will be provided to MCPs separate from this APL.

DELEGATION OVERSIGHT:
MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements, as well as DHCS guidance, including APLs.

REIMBURSEMENT:
DHCS will engage in discussions with the MCPs in order to develop capitation rates for the costs associated with the provision of BHT services as soon as possible. Any rate adjustments for BHT services will be retroactively applied to September 15, 2014, subject to federal approval.

To the extent Medi-Cal beneficiaries received BHT services from licensed providers between July 7, 2014, and up to and including September 14, 2014, and incurred out-of-pocket expenditures for such services, these expenditures shall be submitted to the Fiscal Intermediary for reimbursement of expenditures through the existing *Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan)* process (http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_Conlan.aspx). On and after September 15, 2014, Medi-Cal beneficiaries that are not receiving BHT services from a Regional Center or an out-of-network provider must receive all BHT services from a MCP.

CRITERIA FOR BHT SERVICES:
In order to be eligible for BHT services, a Medi-Cal beneficiary must meet all of the following coverage criteria. The recipient must:

1. Be 0 to 21 years of age and have a diagnosis of ASD;
2. Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to, aggression, self-injury, elopement, and/or social interaction, independent living, play and/or communication skills, etc.);

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3. Be medically stable and without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID);
4. Have a comprehensive diagnostic evaluation[2] that indicates evidence-based BHT services are medically necessary and recognized as therapeutically appropriate; and
5. Have a prescription for BHT services ordered by a licensed physician or surgeon or developed by a licensed psychologist.

COVERED SERVICES AND LIMITATIONS:

Medi-Cal covered BHT services must be:

1. Medically necessary as defined by Welfare & Institutions Code Section 14132(v).
2. Prior authorized by the MCP or its designee; and
3. Delivered in accordance with the beneficiary's MCP approved treatment plan.

Services must be provided and supervised under an MCP approved treatment plan developed by a contracted and MCP-credentialed "qualified autism service provider" as defined by Health & Safety Code Section 1374.73(c)(3). Treatment services may be administered by one of the following:

1. A qualified autism service provider as defined by H&S Code section 1374.73(c)(3).
2. A qualified autism service professional as defined by H&S Code section 1374.73(c)(4) who is supervised and employed by the qualified autism services provider.
3. A qualified autism service paraprofessional as defined by H&S Code section 1374.73(c)(5) who is supervised and employed by a qualified autism service provider.

BHT services must be based upon a treatment plan that is reviewed no less than every six months by a qualified autism service provider and prior authorized by the MCP for a time period not to exceed 180 days. Services provided without prior authorization shall not be considered for payment or reimbursement except in the case of retroactive Medi-Cal eligibility.

BHT services shall be rendered in accordance with the beneficiary's treatment plan. The treatment plan shall:

1. Be person-centered and based upon individualized goals over a specific timeline;
2. Be developed by a qualified autism service provider for the specific beneficiary being treated;
3. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors;

[2] MCPs shall obtain a diagnostic evaluation of no more than four hours in duration that includes:

- A clinical history with informed parent/guardian, inclusive of developmental and psychosocial history;
- Direct observation;
- Review of available records; and
- Standardized measures including ASD core features, general psychopathology, cognitive abilities, and adaptive functioning using published instruments administered by qualified members of a diagnostic team.

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4. Identify long, intermediate, and short-term goals and objectives that are specific, behaviorally defined, measurable, and based upon clinical observation;
5. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives;
6. Utilize evidence-based practices with demonstrated clinical efficacy in treating ASD, and are tailored to the beneficiary;
7. Ensure that interventions are consistent with evidenced-based BHT techniques.
8. Clearly identify the service type, number of hours of direct service and supervision, and parent or guardian participation needed to achieve the plan's goals and objectives, the frequency at which the beneficiary's progress is reported, and identifies the individual providers responsible for delivering the services;
9. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
10. Include parent/caregiver training, support, and participation.

BHT Service Limitations:

1. Services must give consideration to the child's age, school attendance requirements, and other daily activities as documented in the treatment plan.
2. Services must be delivered in a home or community-based settings, including clinics.
3. BHT services shall be discontinued when the treatment goals and objectives are achieved or are no longer medically necessary.
4. MCPs will comply with current contract requirements relating to coordination of care with Local Education Agencies to ensure the delivery of medically necessary BHT services.

The following services do not meet medical necessity criteria, nor qualify as Medi-Cal covered BHT services for reimbursement:

1. Therapy services rendered when continued clinical benefit is not expected;
2. Services that are primarily respite, daycare or educational in nature and are used to reimburse a parent for participating in the treatment program;
3. Treatment whose purpose is vocationally or recreationally-based;
4. Custodial care
   a. for purposes of BHT services, custodial care:
      i. shall be defined as care that is provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating, and maintaining personal hygiene and safety;
      ii. is provided primarily for maintaining the recipient's or anyone else's safety; and
      iii. could be provided by persons without professional skills or training.
5. Services, supplies, or procedures performed in a non-conventional setting including, but not limited to:
   a. resorts;
   b. spas; and
   c. camps.

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6. Services rendered by a parent, legal guardian, or legally responsible person.

For questions about this APL, contact your Medi-Cal Managed Care Division Contract Manager.

Sincerely,

Original Signed by Sarah C. Brooks

Sarah C. Brooks
Program Monitoring and Medical Policy Branch Chief
Medi-Cal Managed Care Division
Department of Health Care Services

Attachments

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State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

What to Expect if You Suspect or You Have Been Told Your Child has Autism Spectrum Disorder

If you have a concern about how your child is communicating, interacting or behaving, or your child has been diagnosed with autism spectrum disorder (ASD) but you have been unable to access services to treat your child, you are likely wondering what to expect now that Behavioral Health Treatment services to treat children with ASD are available in Medi-Cal.

The following guidance is provided to share information about obtaining an evaluation of your child's development and treatment options, if needed, and the approximate amount of time it will take to obtain evaluations and medically necessary treatment.

1. If you have concerns about your child's development or your child has been diagnosed with ASD, call your Health Plan's Call Center and/or make an appointment to see your child's doctor. Your child's doctor should offer you an appointment within 10 business days. The evaluation and approval processes for your child to receive Behavioral Health Treatment services could take approximately 60 to 90 days to complete.

2. At the appointment with your child's doctor, share your concerns about your child, noting how your child is different from other children the same age, or provide any documents you may have from a health care provider that state your child has been diagnosed with autism spectrum disorder.

3. Your child's doctor will listen to your concerns, review documents that you share, examine your child, and may conduct a developmental screening. The doctor may ask you questions or talk or play with your child during the examination to see how your child learns, speaks, behaves, and moves. This screening provides useful information to identify if your child is developing differently from other children.

4. As a result of this visit with the doctor, your child may be referred to a specialist who will meet with you and your child, conduct further tests/exams of your child, and then prepare a report. The specialist should offer you an appointment within 15 business days after your appointment with your child's doctor.

5. The specialist will submit his/her report to your child's Health Plan for review and approval of medically necessary services, if deemed necessary.

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State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

6. Your child's Health Plan will notify you of its determination whether or not to provide Behavioral Health Treatment services to your child in accordance with the recommendations of the specialist.

7. If the Health Plan determines that Behavioral Health Treatment services are medically necessary, your child will be referred to a qualified autism service provider who will meet with you and your child and develop a treatment plan. The qualified autism service provider should offer to meet with you within 15 business days after your Health Plan makes its determination.

8. The proposed treatment plan will be submitted by the qualified autism service provider to the Health Plan and reviewed by your Health Plan to determine whether or not the Behavioral Health Treatment services recommended by the qualified autism service provider are medically necessary.

9. Your child's Health Plan will notify you of its determination whether or not to provide Behavioral Health Treatment services to your child in accordance with the treatment plan developed by the qualified autism service provider.

10. If the Health Plan determines that Behavioral Health Treatment services recommended by the qualified autism service provider are medically necessary, your child will be referred back to the qualified autism service provider who will meet with you and your child in your home or another community setting, such as a community clinic, to describe the treatment plan and specific services your child will receive. The qualified autism provider should offer you an appointment within 15 days after your Health Plan makes its determination.

11. You have the right to make complaints about your child's covered services or care. This includes the right to:

    a) File a complaint or grievance or appeal certain decisions made by the Health Plan or health plan provider. For more information on filing a complaint, grievance, or appeal, contact your Health Plan.

    b) Ask for an Independent Medical Review (IMR) of the medical necessity of Medi-Cal Services or terms that are medical in nature from the California Department of Managed Health Care (DMHC). For more information on asking for an IMR, contact DMHC's Help Center at 1-888-466-2219 or (TDD) 1-877-688-9891 or online at http://www.dmhc.ca.gov/FileaComplaint/ConsumerIndependentMedicalReviewComplaint.aspx

State of California—Health and Human Services Agency
Department of Health Care Services

TOBY DOUGLAS
DIRECTOR

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c) Ask for a State Fair Hearing (SFH) from the California Department of Social Services (DSS). You can request a SFH over the phone by contacting DSS at 1-800-952-5253 or (TDD) 1-800-952-8349, by faxing DSS at 916-651-5210 or 916-651-2789, or by sending a letter to DSS. Additional information on the SFH process can be accessed at: http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx

12. The qualified autism service provider will meet with you and your child and describe the behavioral health treatment service type, the number of hours of direct service and the supervision of the service provider, parent or guardian participation needed, the frequency of reporting progress, and identify the individual providers responsible for delivering services to your child. Services will be scheduled at the location and in the frequency approved by the Health Plan.

13. The qualified autism service provider will provide a description of care coordination involving parents, guardians or caregivers, school, state disability programs, and others. The provider will also describe parent, guardian or caregiver training, support and participation that will be required.

14. The effectiveness of Behavioral Health Treatment is dramatically improved when parents or guardians receive training and are actively participating in their child's treatment. Your participation will ensure the best long term outcomes from the treatments your child is receiving.

15. If you have any questions or concerns about obtaining services for your child at any point in the process, call your Health Plan's Call Center or your child's doctor for assistance.

16. If you are concerned about what you can do when your child is not receiving services, the federal government and the Association for Children and Families has put together a guide to help parents facilitate development every day. This guide can be found at www.acf.hhs.gov/ecd/ASD. Themes include:

    a. Engaging your child in play through joint attention
    b. Using your child's interests in activities
    c. Using a shared agenda in daily routines
    d. Using visual cues
    e. Sharing objects and books
    f. Teaching your children to play with each other
    g. Using predictable routines and predictable spaces for your child.

DEPARTMENT OF HEALTH & HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

CMCS Informational Bulletin

DATE: July 7, 2014

FROM: Cindy Mann, Director
Center for Medicaid and CHIP Services

SUBJECT: **Clarification of Medicaid Coverage of Services to Children with Autism**

In response to increased interest and activity with respect to services available to children with autism spectrum disorder (ASD), CMS is providing information on approaches available under the federal Medicaid program for providing services to eligible individuals with ASD.

Background

Autism spectrum disorder is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called autism spectrum disorder. Currently, the Center for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD. [1]

Treatments for children with ASD can improve physical and mental development. Generally these treatments can be categorized in four categories: 1) behavioral and communication approaches; 2) dietary approaches; 3) medications; and 4) complementary and alternative medicine. [2] While much of the current national discussion focuses on one particular treatment modality called Applied Behavioral Analysis (ABA), there are other recognized and emerging treatment modalities for children with ASD, including those described in the ASD Services, Final Report on Environmental Scan (see link below)[3]. This bulletin provides information related to services available to individuals with ASD through the federal Medicaid program.

The federal Medicaid program may reimburse for services to address ASD through a variety of authorities. Services can be reimbursed through section 1905(a) of the Social Security Act (the Act), section 1915(i) state plan Home and Community-Based Services, section 1915(c) Home

[1] http://www.cdc.gov/ncbddd/autism/facts.html
[2] http://www.cdc.gov/ncbddd/autism/treatment.html
[3] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/Autism-Spectrum-Disorders.pdf

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and Community-Based Services (HCBS) waiver programs and section 1115 research and demonstration programs.

State Plan Authorities

Under the Medicaid state plan, services to address ASD may be covered under several different section 1905(a) benefit categories. Those categories include: section 1905(a)(6) - services of other licensed practitioners; section 1905(a)(13)(c) - preventive services; and section 1905(a)(10) - therapy services. States electing these services may need to update the Medicaid state plan in order to ensure federal financial participation (FFP) is available for expenditures for these services. In addition, for children, as discussed below, states must cover services that could otherwise be covered at state option under these categories consistent with the provisions at 1905(a)(4)(B) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Below is information on these coverage categories for services to address ASD. Under these section 1905(a) benefit categories all other state Medicaid plan requirements such state-wideness and comparability must also be met.

Other Licensed Practitioner Services

Other Licensed Practitioner services (OLP) services, defined at 42 CFR 440.60, are "medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law." If a state licenses practitioners who furnish services to address ASD, the state may elect to cover those providers under this section of their state plan even if the providers are not covered under other sections of the plan (e.g., physical therapist, occupational therapist, etc.). A state would need to submit a state plan amendment (SPA) to add the new licensed provider to their Medicaid plan. The SPA must describe the provider's qualifications and include a reimbursement methodology for paying the provider.

In addition, services that are furnished by non-licensed practitioners under the supervision of a licensed practitioner could be covered under the OLP benefit if the criteria below are met:

- Services are furnished directly by non-licensed practitioners who work under the supervision of the licensed practitioners;
- The licensed provider is able to furnish the service being provided;
- The state's Scope of Practice Act for the licensed practitioners specifically allows the licensed practitioners to supervise the non-licensed practitioners who furnish the service;
- The state's Scope of Practice Act also requires the licensed practitioners to assume professional responsibility for the patient and the service furnished by the unlicensed practitioner under their supervision; and
- The licensed practitioners bill for the service;

Preventive Services

Preventive Services, defined at 42 CFR 440.130(c) are "services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to—

(1) Prevent disease, disability, and other health conditions or their progression;
(2) Prolong life; and
(3) Promote physical and mental health and efficiency"

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A regulatory change that took effect January 1, 2014, permits coverage of preventive services furnished by non-licensed practitioners who meet the qualifications set by the state, to furnish services under this state plan benefit as long at the services are recommended by a physician or other licensed practitioner. Under the preventive services benefit, in the state plan, the state must 1) list the services to be provided to ensure that services meet the definition of preventive services as stated in section 4385 of the State Medicaid Manual (including the requirement for the service to involve direct patient care); 2) identify the type(s) of non-licensed practitioners who may furnish the services; and 3) include a summary of the state's provider qualifications that make these practitioners qualified to furnish the services, including any required education, training, experience, credentialing, supervision, oversight and/ or registration.

Therapy Services

Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit at 42 CFR 440.110. Physical and occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law and provided to a beneficiary by or under the direction of a qualified therapist. Services for individuals with speech, hearing and language disorders mean diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

States would need to include an assurance in the state plan that the state furnishes the therapy in accordance with 42 CFR 440.110. States would also need to describe the supervisory arrangements if a practitioner is furnishing the therapy under the direction of a qualified therapist. Finally, for audiology services, the state plan must reflect the supervision requirements as set forth at 42 CFR 440.110(c)(3).

Section 1915(i) of the Social Security Act

States can offer a variety of services under a section 1915(i) state plan Home and Community-Based Services (HCBS) benefit. The benefit may be targeted to one or more specific populations including individuals with ASD and can provide services and supports above and beyond those included in section 1905(a). Participants must meet state-defined criteria based on need and typically receive a combination of acute-care medical services (like dental services, skilled nursing services) and other long-term services such as respite care, supported employment, habilitative supports, and environmental modifications.

Other Medicaid Authorities

There are several other Medicaid authorities that may be used to provide services to address ASD. Below is a discussion of each of those authorities:

Section 1915 (c) of the Social Security Act

The section 1915(c) Home and Community-Based Services waiver program allows states to provide a combination of medical services and long-term services and supports. Services include

but are not limited to adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. Participants must meet an institutional level of care but are served in the community. Section 1915(c) waiver programs also require that services be furnished in home and community-based settings. For individuals under the age of 21 who are eligible for EPSDT services, an HCBS waiver could provide services and supports for ASD that are above and beyond services listed in section 1905(a), such as respite care. Additionally, for individuals who are receiving state plan benefits as part of EPSDT that are not available to adults under the state plan, waiver services may be used to help these individuals transition into adulthood and not lose valuable necessary services and supports.

Section 1115 Research and Demonstration Waiver

Section 1115 of the Act provides the Secretary of the Department of Health and Human Services broad authority to authorize experimental, pilot, or demonstration programs that promote the objectives of the Medicaid program. Flexibility under section 1115 is sufficiently broad to allow States to test substantially new ideas, including benefit design or delivery system reform, of policy merit. The Secretary can approve an 1115 demonstration for up to five years, and states may submit extension requests to continue the program for additional periods of time. Demonstrations must be "budget neutral" over the life of the program, meaning they cannot be expected to cost the Federal government more than it would cost without the demonstration.

EPSDT Benefit Requirements

Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. Good clinical practice requires ruling out any additional medical issues and not assuming that a behavioral manifestation is always attributable to the ASD. EPSDT also requires medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to assure that children get the health care they need, when they need it – the right care to the right child at the right time in the right setting.

The role of states is to make sure all covered services are available as well as to assure that families of enrolled children, including children with ASD, are aware of and have access to a broad range of services to meet the individual child's needs; that is, all services that can be covered under section 1905(a), including licensed practitioners' services; speech, occupational,

and physical therapies; physician services; private duty nursing; personal care services; home health, medical equipment and supplies; rehabilitative services; and vision, hearing, and dental services.

If a service, supply or equipment that has been determined to be medically necessary for a child is not listed as covered (for adults) in a state's Medicaid State Plan, the state will nonetheless need to arrange for and cover it for the child as long as the service or supply is included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act. This longstanding coverage design is intended to ensure a comprehensive, high-quality health care benefit for eligible individuals under age 21, including for those with ASD, based on individual determinations of medical necessity.

Implications for Existing Section 1915(c), Section 1915 (i) and Section 1115 Programs

In states with existing 1915(c) waivers that provide services to address ASD, this 1905(a) policy clarification may impact on an individual's eligibility for the waiver. Waiver services are separated into two categories: waiver services and extended state plan services. Extended state plan services related to section 1905(a) services are not available to individuals under the age of 21 (individuals eligible for EPSDT) because of the expectation that EPSDT will meet the individual's needs. There are therefore a limited number of services that can be provided to this age group under 1915 (c) waivers, primarily respite, and/or environmental/vehicle modifications.

For states that currently provide waiver services to individuals under age 21 to address ASD, the ability to provide services under the 1905(a) state plan may have the effect of making these individuals ineligible for the waiver unless another waiver service is provided. This implication is especially important for individuals with ASD who may not otherwise be eligible for Medicaid absent the (c) waiver. States need to ensure that these individuals are receiving a waiver service, not coverable under section 1905(a), to ensure that they do not lose access to all Medicaid services by losing waiver eligibility. Individuals age 21 and older may continue to receive services to address ASD through the waiver if a state does not elect to provide these services to adults under its Medicaid state plan.

The same issues arise for children under the 1915(i) authority, which allows for services above and beyond section 1905(a) to be provided under the state plan. CMS is available to provide technical assistance to states that currently have approved waivers or state plans that may be impacted by this clarification. Similarly, states with existing 1115 demonstrations authorizing reimbursement for services provided to children with autism should contact CMS to ensure that EPSDT requirements are met.

We hope this information is helpful. If you have questions please send them to AutismServicesQuestions@cms.hhs.gov.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. C. Authorize Contract for Behavioral Health Services with Windstone Behavioral Health for Cal MediConnect/OneCare Connect, and Extend the Current OneCare Contract

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

Recommended Actions
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel to:

1. Enter into a contract with Windstone Behavioral Health (Windstone) for the Cal MediConnect/OneCare Connect program for the period July 1, 2015 through ~~December 31~~, June 30, 2016. ~~with the option to renew for one additional year at CalOptima's sole discretion.~~ Revised 5/7/15
2. Amend the OneCare contract to extend it for one additional year (through calendar 2016), with the option to renew for one additional year at CalOptima's sole discretion. The current OneCare contract expires December 31, 2015.

Background and Discussion
Behavioral Health is a Medicare covered benefit for OneCare and OneCare Connect members. CalOptima currently contracts with Windstone to provide Medicare covered behavioral health services for the OneCare program. Windstone has been contracted with OneCare for behavioral health since January 1, 2007. The current contract is set to expire December 31, 2015, based on the previous contract extensions.

CalOptima's medical management and behavioral health staff have reviewed the utilization performance of this provider and also evaluated the access needs of CalOptima members, and determined that Windstone adequately meets CalOptima's requirements for the current OneCare program and future OneCare Connect program. At its January 2013 meeting, the CalOptima Board authorized the CEO to leverage the OneCare provider network as the basis for the Duals Delivery system. Therefore, staff recommends initiating a new contract for the OneCare Connect program, and renewing the current OneCare contract as indicated above.

Renewal of the OneCare contract will support the stability of CalOptima's contracted provider network should CalOptima decide to renew the OneCare program for 2016. The new contract for OneCare Connect will initiate a stable network with an already established provider. Contract language does not guarantee any particular volume and allows for CalOptima and the provider to terminate the contracts with or without cause.

Fiscal Impact
Based on forecasted OneCare and OneCare Connect enrollment for the extended contract periods, the fiscal impact of the recommended action is approximately $650,000 for OneCare and $2 million for OneCare Connect. Funding for the recommended actions will be included in the upcoming Fiscal Year 2015-16 CalOptima Consolidated Operating Budget.

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Rationale for Recommendation

CalOptima staff recommends authorizing an extension to OneCare's contract with Windstone to ensure that OneCare members continue to have access to covered services, and extending a new contract for the OneCare Connect program so that these members will also receive the same quality level of service.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *5/1/2015*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

7. Authorize Extension of the Cal MediConnect/OneCare Connect Contract with Windstone Behavioral Health for Behavioral Health Services; Authorize Contract for Consulting Services Related to Request for Proposal (RFP) Development and Delivery Model Optimization for the Behavioral Health Benefit

Contact

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

Recommended Action

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:
    a. Extend the CalOptima-Windstone Behavioral Health Cal MediConnect/OneCare Connect contract for a six month period, through December 31, 2016, with the option to renew for one additional year (or two consecutive six month periods) exercisable at CalOptima's sole discretion; and
    b. Contract for up to $150,000 to hire a consultant through a Request for Proposal (RFP) process to determine the delivery model optimization for the behavioral health benefit and for the development of an RFP for contracted services, as appropriate.
2. Authorize budget allocation of $150,000 from the Medical Management department to the Behavioral Health Integration department.

Background/Discussion

Behavioral Health is a Medicare covered benefit for both OneCare and OneCare Connect members. In actions taken on May 7, 2015, the CalOptima Board of Directors authorized CalOptima staff to:

1. Enter into a contract with Windstone Behavioral Health (Windstone) for the Cal MediConnect/OneCare Connect program for the period July 1, 2015, through June 30, 2016, with direction that CalOptima staff would conduct a Request for Proposal (RFP) process by March 2016, to ensure that the best services are obtained for our members in a cost efficient manner; and
2. Extend the contract with CalOptima-OneCare Windstone for remaining OneCare members through December 31, 2016, with the option to renew for one additional year at CalOptima's sole discretion.

During the process of developing the RFP's Scope of Work for a Managed Care Behavioral Health Organization (MBHO), staff noted that the separate timing for implementation and transition of two MBHO contracts would potentially increase disruption of services for CalOptima OneCare and OneCare Connect members. Additionally, since the CalOptima Medi-Cal contract with CHIPA / Beacon Health Strategies expires on December 31, 2016, there is an opportunity to issue a single MBHO RFP that would potentially allow a single vendor to respond for OneCare, OneCare Connect, and Medi-Cal.

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In order to minimize disrupting services with multiple MBHO implementations and transitions for OneCare and OneCare Connect members, Staff recommends that the Board authorize extending the current OneCare Connect contract with Windstone through December 31, 2016 (a six month extension) to align with the OneCare and Medi-Cal contracts. Aligning these contract expiration dates would allow time to include the Medi-Cal MBHO in the RFP. In addition, Staff believes that it would be prudent to have the option of renewing the Windstone OneCare Connect contract for one additional year (or two consecutive six month periods) at CalOptima's sole discretion, should additional time be required to complete the selection process.

Extending the current contract will support the stability of CalOptima's contracted provider network and ensure continued services without disruption to OneCare Connect members until the RFP process has been completed. Contract language does not guarantee any particular volume and allows for CalOptima and the provider to terminate the contract with or without cause.

To assist in developing an RFP and determining how best to administer the behavioral health benefit, management proposes to engage a consultant. The consultant, to be selected consistent with CalOptima's Board-approved procurement policy, will help with the development of the RFP and to assist staff in evaluating the advisability and feasibility of building internal capacity to perform some or all of the behavioral health benefit functions. Activities in which the consultant would assist staff include, but are not limited to:

- Development/ refinement of an RFP
- Identifying organizations with the capacity to respond to the RFP
- Developing proposed scoring tool(s)
- Assessing proposals, panel review management
- Assisting in the selection process for a vendor
- Make recommendations on activities that should (or should not) be delegated to the proposed vendor(s)
- Provide support in the contract negotiation process

As future plans for the OneCare and OneCare Connect programs are finalized, staff will return to the Board to request authority to enter into future contracts/contract extensions for behavioral health and or consulting services as appropriate.

Fiscal Impact

Staff assumes the capitation rate included in the OneCare Connect Contract with Windstone Behavioral Health will remain unchanged under the contract extension, and will therefore be budget neutral to CalOptima. Funding for the recommended action will be included in the forthcoming Fiscal Year 2016-17 CalOptima Consolidated Operating Budget.

The recommended action to hire a consultant through an RFP process to determine the delivery model optimization for the behavioral health benefit and for the development an RFP for contracted services, as appropriate, is an unbudgeted item, and will be funded in an amount not to exceed

$150,000 of budgeted funds from the Medical Management department to the Behavioral Health Integration department.

Rationale for Recommendation

CalOptima staff recommends authorizing an extension to the OneCare Connect contract with Windstone to ensure that OneCare Connect members continue to have access to covered services, and to authorize contracting with a consultant to assist in optimizing the administration of the behavioral health benefit.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Previous Board action dated May 7, 2015

/s/ Michael Schrader *01/29/2016*
Authorized Signature **Date**

Attachment to:
February 4, 2016
Agenda Item 7

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Attachment to:
2/4/16, Agenda Item 7

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. C. Authorize Contract for Behavioral Health Services with Windstone Behavioral Health for Cal MediConnect/OneCare Connect, and Extend the Current OneCare Contract

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel to:

1. Enter into a contract with Windstone Behavioral Health (Windstone) for the Cal MediConnect/OneCare Connect program for the period July 1, 2015 through ~~December 31~~, June 30, 2016. ~~with the option to renew for one additional year at CalOptima's sole discretion.~~ Revised 5/7/15
2. Amend the OneCare contract to extend it for one additional year (through calendar 2016), with the option to renew for one additional year at CalOptima's sole discretion. The current OneCare contract expires December 31, 2015.

Background and Discussion

Behavioral Health is a Medicare covered benefit for OneCare and OneCare Connect members. CalOptima currently contracts with Windstone to provide Medicare covered behavioral health services for the OneCare program. Windstone has been contracted with OneCare for behavioral health since January 1, 2007. The current contract is set to expire December 31, 2015, based on the previous contract extensions.

CalOptima's medical management and behavioral health staff have reviewed the utilization performance of this provider and also evaluated the access needs of CalOptima members, and determined that Windstone adequately meets CalOptima's requirements for the current OneCare program and future OneCare Connect program. At its January 2013 meeting, the CalOptima Board authorized the CEO to leverage the OneCare provider network as the basis for the Duals Delivery system. Therefore, staff recommends initiating a new contract for the OneCare Connect program, and renewing the current OneCare contract as indicated above.

Renewal of the OneCare contract will support the stability of CalOptima's contracted provider network should CalOptima decide to renew the OneCare program for 2016. The new contract for OneCare Connect will initiate a stable network with an already established provider. Contract language does not guarantee any particular volume and allows for CalOptima and the provider to terminate the contracts with or without cause.

Fiscal Impact

Based on forecasted OneCare and OneCare Connect enrollment for the extended contract periods, the fiscal impact of the recommended action is approximately $650,000 for OneCare and $2 million for OneCare Connect. Funding for the recommended actions will be included in the upcoming Fiscal Year 2015-16 CalOptima Consolidated Operating Budget.

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Rationale for Recommendation
CalOptima staff recommends authorizing an extension to OneCare's contract with Windstone to ensure that OneCare members continue to have access to covered services, and extending a new contract for the OneCare Connect program so that these members will also receive the same quality level of service.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

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Behavioral Health Integration - Managed Behavioral Healthcare Organization (MBHO) Vendor Selection

Board of Directors Meeting

September 1, 2016

Richard Helmer, M.D., Chief Medical Officer

Donald Sharps, M.D., Medical Director

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Today's Agenda

- Behavioral Health Services at CalOptima
- MBHO Functions
- BH Request for Proposal
- Evaluation Team
- Selection Criteria
- Evaluation Process
- Evaluation Result
- Next Step

Back to Agenda

Behavioral Health Services at CalOptima

- OneCare (Medicare Duals Special Needs)
  - ➢Benefits began on January 1, 2007
- Medi-Cal Managed Care Plan
  - ➢Behavioral health benefits began on January 1, 2014
  - ➢Autism Spectrum Disorder Behavioral Health Treatment benefit began on September 15, 2014
- OneCare Connect (Duals Demonstration Project)
  - ➢Benefit began on July 1, 2015

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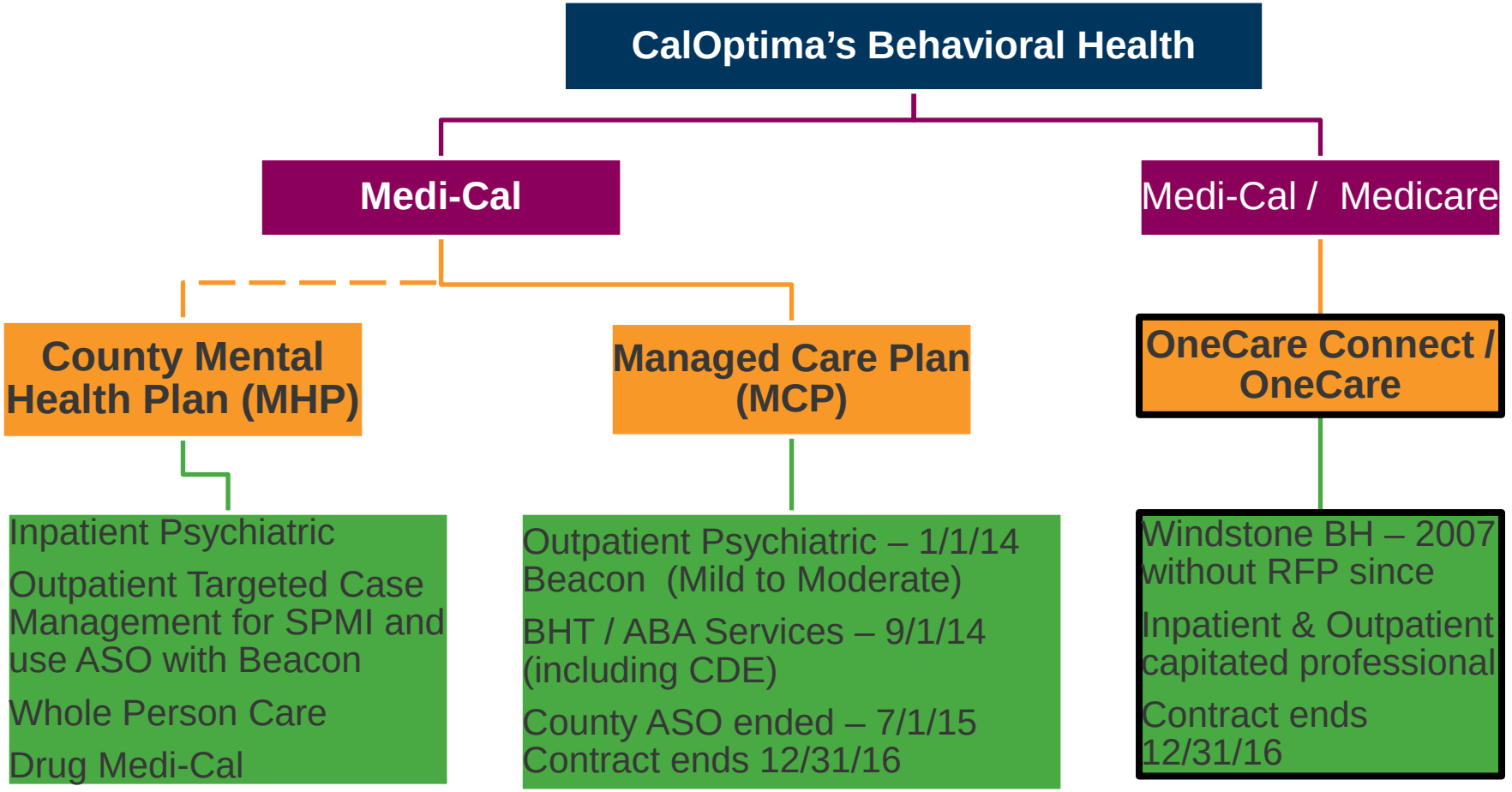
Behavioral Health Services at CalOptima



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Behavioral Health Services at CalOptima

- Behavioral Health (BH) services include services to address both mental health and substance use disorder conditions

- CalOptima is responsible for behavioral health services for all of its lines of business

- CalOptima has an opportunity to enhance the overall health of its members through the effective management of its behavioral health benefits

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Behavioral Health Services at CalOptima

- Like many managed care plans, CalOptima has used Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of BH benefits

Line of Business	Current Vendor
OneCare	Windstone Behavioral Health
OneCare Connect	Windstone Behavioral Health
Medi-Cal	CHIPA

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MBHO Functions

- MBHOs can support managed care plans by providing efficiency and subject matter expertise with:
  - BH Provider Network and Provider Relations
  - BH specific Credentialing
  - Call Center management
  - Eligibility verification
  - Level of care determinations
  - Claims payment and processing
  - Utilization management
  - Care management
  - Quality Improvement
  - Value based payment management

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BH Request for Proposal Timeline

Date	Key Steps
06/01/16	RFP released
06/29/16	Questions submitted from bidders*
07/15/16	Five bidders submitted proposal by deadline
07/20/16	RFP evaluation team met with CalOptima SME's
08/04/16	Completed scoring of written proposals
08/10/16	Bidder presentations to RFP evaluation team

* "CalOptima is requesting an at-risk (i.e. capitated) pricing model for each line of business"

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MBHO RFP Status - Evaluation Team

Proposals were evaluated by a collaborative team including CalOptima staff and HMA:

- Executive Director of Clinical Operations
- Behavioral Health Medical Director
- Director of Behavioral Health Services
- MAC member
- MAC OCC member
- PAC member

Additionally, only CalOptima staff scored specific sections of technical nature

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MBHO Selection Criteria – 21 Elements

- Experience in managed care
- Accreditation
- Corporate capabilities
- Information processing system*
- Financial management*
- Proposed staffing and project organization
- Ownership
- Outsourced services
- Provider network management and credentialing
- Operations
- Utilization management
- Claim processing*
- Grievances and appeals
- Care management
- Cultural competency
- Quality improvement
- Information technology, data management*
- Business intelligence*
- Compliance program
- Implementation plan
- Innovative program and services

* Technical Sections scored only by CalOptima staff

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MBHO Selection Process – Written Proposal

- The scoring tool contained 171 questions in 21 sections
  - Each question is scored on a scale of 1 to 5
- CalOptima Subject Matter Experts (SMEs) provided the evaluation team qualitative feedback
- CalOptima Staff also provided the evaluation team quantitative scores for the technical sections
- Weighted average score was calculated for each proposal

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MBHO Written Proposal Scores

Bidder Final Score Summary	Magellan	Envolve	CHIPA	Optum	Windstone
TOTAL Weighted	4.41	4.00	3.54	3.28	2.80
1.0 Experience and References	4.5	4.2	3.7	4.1	3.8
2.0 Accreditation	4.3	3.8	4.1	3.7	2.0
3.0 Corporate Capabilities	4.2	3.8	3.6	3.1	3.5
4.0 Information Processing System*	5.0	4.0	3.0	2.0	1.0
5.0 Financial Management*	4.0	4.0	3.0	4.0	2.0
6.0 Proposed Staffing and Project Organization	4.4	4.0	3.7	3.9	2.5
7.0 Ownership	3.7	3.1	2.9	3.7	3.0
8.0 Outsourced Services	N/A	N/A	3.5	2.3	N/A
9.0 Provider Network Management / Credentialing	4.6	4.7	3.8	3.5	3.6
10.0 Operations	4.2	4.0	3.0	2.7	2.7
11.0 Utilization Management	5.1	4.6	3.5	3.5	3.6
12.0 Claims Processing*	3.4	3.5	3.0	3.3	3.0
13.0 Grievances and Appeals	4.0	3.3	2.9	2.5	2.8
14.0 Care Management / Coordination	4.5	4.4	3.4	3.2	3.4
15.0 Cultural Competency	4.2	4.6	3.7	3.2	3.3
16.0 Quality Improvement	5.1	4.6	3.7	3.3	3.3
17.0 IT, Data Management, Electronic Data Exchange, and Health Information Exchange*	5.1	4.5	3.7	2.8	1.2
18.0 Business Intelligence*	4.6	4.4	4.4	4.4	1.3
19.0 Compliance Program	3.6	2.0	3.9	3.1	2.8
20.0 Implementation Plan	4.7	4.0	4.0	3.2	2.8
21.0 Innovative Programs & Services	4.7	4.5	4.2	3.4	4.4

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* Technical Sections scored only by CalOptima staff

MBHO Selection Process – Presentation

- The two bidders with highest written proposal scores, also
  1) Submitted bids for both Medi-Cal and Duals
  2) Had reasonableness of price
  3) Submitted bids with an at-risk (i.e. capitated) pricing model for each line of business
- Additional questions were submitted to these two bidders by the evaluation team and asked to present in person on 8/10/16

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MBHO Presentation Scores

Additional areas with follow-up questions from Evaluation Team	Magellan	ENVOLVE
1. Accreditation	3.71	1.00
2. Provider Network	4.14	3.33
3. Operations	4.71	3.50
4. Utilization Management	4.29	3.33
5. Grievances and Appeals	4.29	2.17
6. Care Management / Coordination	4.43	3.17
7. Quality Improvement	4.14	2.50
8. Reporting	5.00	2.20
9. Claims	4.57	2.83
Overall Average Score	4.36	2.67

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MBHO Selection Process – Additional Steps

- **Contract Language**
  - ➢Proposed changes reviewed
- **References**
  - ➢Reference checks completed and support the RFP scoring
- **Financial Review**
  - ➢Magellan and Envolve proposals were reviewed with Finance and determined to have a reasonable pricing model

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Rationale for Recommendation

- The evaluation team reviewed qualified MBHO responses and identified the candidate believed to best meet CalOptima's needs for:
  - Integration of care, regulatory compliance, operational efficiency, administrative simplification, best practices, as well as overall reasonableness of price
  - All delegated functions related to the Behavioral Health benefits: Customer Service, Care Management, Utilization Management, Credentialing, Quality Improvement, Claims Processing and Payment, Provider Dispute Resolution, Compliance and first level Provider Appeals

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Rationale for Recommendation

- CalOptima staff believes contracting with Magellan will meet CalOptima's goal of continuing to provide a comprehensive provider network and Behavioral Health and ASD services for CalOptima's Medi-Cal and Duals programs with:
  - Efficient and effective assessment, diagnosis, integrated care planning, strength based and person centered treatment implementation, support services and outcomes evaluation
  - Cultural responsiveness to our diverse membership, to develop a full picture of the various needs of the person and support goals and strategies to help members achieve and maintain recovery

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Next Steps

- Authorize the CEO to:
  - Enter into contract within 30 days with Magellan Health Inc.
  - Contract with a consultant(s) for up to $50,000 to assist with implementation
  - Extend the current CHIPA and Windstone contracts for up to six months, if necessary, to ensure no gap in coverage during the transition
- Direct CEO to return to the Board with further recommendations if contract is not finalized with Magellan within 30 days.

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CalOptima's Mission

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

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AGENDA ITEM 13 TO FOLLOW CLOSED SESSION

Consider Chief Executive Officer and Chief Counsel Performance Reviews and Compensation

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Board of Directors Meeting
August 3, 2017

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

At the June 22, 2017 OneCare Connect Member Advisory Committee (OCC MAC) meeting, OCC MAC received the following informational presentations. Pshyra Jones, Director, Health Education and Disease Management, presented highlights from the Group Needs Assessment that was conducted to identify members' health needs and health risks, evaluate cultural and linguistic needs and identify gaps in services. Albert Cardenas, Associate Director, Customer Service, presented an overview of OCC Eligibility Aid Codes, which was a request from OCC MAC members to better understand OCC qualifying aid codes. Belinda Abeyta, Director, Customer Service, provided an overview of the Veteran's Administration Coordination of Health Care Benefits. Ana Aranda, Manager, GARS, provided a follow up on the Member Trend Report, outlining the trend rate for complaints (appeals/grievances) for the CalOptima Community Network.

Member Christine Chow presented an overview of the Orange County Strategic Plan on Aging Initiative, noting its purpose is to prepare Orange County for the issues facing the growing number of older adults. Ms. Chow explained that this initiative brings together cities, the county, non-profits, foundations, and corporate entities to evaluate the concerns faced by seniors and to create a structure to address those issues.

Also at the June meeting, OCC MAC members received the following updates from CalOptima's executive staff, including the Chief Executive Officer update, Chief Medical Officer update and the State and Federal Legislative update.

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

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Board of Directors Meeting
August 3, 2017

Member Advisory Committee Update

At the July 13, 2017 Member Advisory Committee (MAC) meeting, MAC received the following informational updates. Dr. Sharps, Medical Director, Behavioral Health, presented on CalOptima's new initiative for screening of depression in adolescents. Utilizing a modified depression screening tool, pediatricians will screen members 12 years of age. Claudia Hernandez, Manager, Strategic Development, provided an overview of CalOptima's three-pronged approach to community engagement: 1) create programs and information that help the community access quality healthcare; 2) maintain strong relationships with our stakeholders; and 3) provide grants, as well as community events and free services, such as health education and other informational events.

Member Carlos Robles presented an overview of ResCare Workforce Services. ResCare, a subcontractor for the Social Services Agency, provides CalWORKs' recipients with job services and welfare to work activities, such as job readiness workshops, resume preparation and employment support services. Member Robles provided MAC members with a brief demonstration of what workshop participants experience and learn during the job search workshop.

Also at the July MAC meeting, CalOptima's executive staff, including the Chief Executive Officer, Chief Medical Officer, Chief Operating Officer, Executive Director of Network Operations and the Executive Director of Government Affairs, provided updates on items that impact CalOptima. The items included the status of behavioral health services under Magellan, the impact of California's Budget Act of 2017 on CalOptima and the potential fiscal impacts of the Better Care Reconciliation Act (H.R. 1628), currently under consideration in the United States Senate. Following considerable discussion about Magellan, CalOptima assured MAC that we are working diligently to prevent disruption of services to members. CalOptima will keep MAC apprised of developments. In addition, MAC members discussed ways to more effectively present issues affecting members. This item will be considered at the next MAC meeting.

On July 13, 2017, Vice Chair Patty Mouton and Member Christine Tolbert met with representatives of the Provider Advisory Committee (PAC) to determine an agenda for the Joint MAC/PAC meeting scheduled for September 14, 2017. The focus of September's joint meeting will be on homelessness.

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

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Board of Directors Meeting
August 3, 2017

Provider Advisory Committee (PAC) Update

June 8, 2017 PAC Meeting

Eleven (11) PAC members were in attendance at the May PAC meeting.

Richard Helmer, M.D., Chief Medical Officer, presented the CalOptima Community Network's (CCN) Performance: Quality and Financial Analysis. Dr. Helmer discussed the background of CalOptima Direct (COD) and CCN, the membership growth of CCN as well as performance on quality measures. This elicited much discussion among the PAC members and CalOptima staff regarding the overlap of physicians from both the networks and CCN. PAC members will be soliciting feedback from their constituents and share the comments with CalOptima staff.

CalOptima staff provided a legislative update on Prop 56 and the potential impact to FY 17-18 State Budget and CalOptima. PAC also discussed the impact of the Children's Health Insurance Program (CHIP) reallocation of funding between the Federal and State governments. The PAC recognizes that Medi-Cal funding is being challenged from all fronts, and it is important we support one another.

Cheryl Meronk, Director, Strategic Planning, provided an overview of CalOptima's Community Engagement, and Intergovernmental Transfer (IGT) funds. She also noted that CalOptima staff will engage the Member Advisory Committee and the PAC for input in developing strategic community grant initiatives to address the identified needs.

PAC also received the following updates from CalOptima executive staff at the June 8, 2017 PAC meeting: review of the April 2017 financial statements, Network Operations update, and the 2016 Group Needs Assessment results.

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

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Financial Summary

June 2017

Board of Directors Meeting

August 3, 2017

Nancy Huang

Interim Chief Financial Officer

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FY 2016-17: Consolidated Enrollment

- June 2017 MTD:
  - Overall enrollment was 789,066 member months
    - Actual lower than budget by 22,220 or 2.7%
      - Medi-Cal: unfavorable variance of 16,262 members
        - Medi-Cal Expansion (MCE) favorable variance of 11,555 members
        - SPD favorable variance of 3,771 members
        - Offset by TANF unfavorable variance of 32,224 members
      - OneCare Connect: unfavorable variance of 5,949 members
    - 0.1% or 1,047 decrease from prior month
      - Medi-Cal: decrease of 587 from May
      - OneCare Connect: decrease of 268 from May
      - OneCare: decrease of 199 from May
      - PACE: increase of 7 from May

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FY 2016-17: Consolidated Enrollment

- June 2017 YTD:
  - Overall enrollment was 9,543,816 member months
    - Actual lower than budget by 112,188 or 1.2%
      - Medi-Cal: unfavorable variance of 52,848 members
        - MCE favorable variance of 124,060 members
        - SPD favorable variance of 53,401 members due to less than anticipated dual eligible members transferring to OneCare Connect
        - Offset by TANF unfavorable variance of 237,131 members
      - OneCare Connect: unfavorable variance of 59,914 members or 22.9%
      - OneCare: favorable variance of 616 members or 4.3%
      - PACE: unfavorable variance of 36 members or 1.6%

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FY 2016-17: Consolidated Revenues

- June 2017 MTD:
  - Actual higher than budget by $120.7 million or 42.6%
    - Medi-Cal: favorable to budget by $104.8 million or 44.1%
      - Unfavorable volume variance of $4.9 million
      - Favorable price variance of $109.7 million due to:
        - $56.5 million of Fiscal Year (FY) 2016 and 2017 Coordinated Care Initiative (CCI) revenue for rate adjustments received in June 2017
        - $56.3 million of FY 2016 LTC related revenue recognized for members with Non-LTC aid codes
        - Offset by a $16 million unfavorable MCE revenue adjustment
    - OneCare Connect: favorable to budget by $14.8 million or 34.5%
      - Unfavorable volume variance of $11.9 due to lower enrollment
      - Favorable price variance of $26.8 million due to:
        - $12.1 million of fiscal year 2016 and 2017 CCI rate adjustment revenue
        - $21.2 million related to CMS mid-year adjustments

FY 2016-17: Consolidated Revenues (con't.)

- June 2017 YTD:
  - Actual higher than budget by $164.0 million or 4.8%
    - Medi-Cal: favorable to budget by $323.0 million or 11.4%
      - Unfavorable volume variance of $15.9 million
      - Favorable price variance of $338.9 million due to:
        - $49.2 million from CCI revenue for rate adjustments
        - $77.0 million from Medi-Cal LTC related revenue recognized for members with Non-LTC aid codes
        - $178.6 million related to prior year LTC related revenue and CCI revenue; includes increase in IHSS expenses discussed in Medical Expense
        - Additional favorable variance from rate increase

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FY 2016-17: Consolidated Revenues (con't.)

- OneCare Connect: unfavorable to budget by $161.5 million or 30.3%
  - Unfavorable volume variance of $122.0 million
  - Unfavorable price variance of $39.5 million due to:
    - ➢ $22.6 million unfavorable Medicare variance due mostly to rate decrease
    - ➢ $17.0 million unfavorable Medi-Cal variance related to prior year CCI rate adjustment
- OneCare: favorable to budget by $1.8 million or 11.0%
- PACE: favorable to budget by $0.7 million or 4.6%

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FY 2016-17: Consolidated Medical Expenses

- June 2017 MTD:
  - ➢ Actual higher than budget by $106.5 million or 39.2%
    - Medi-Cal: unfavorable variance of $96.1 million
      - MLTSS unfavorable variance of $43.4 million
        - ➢ LTC unfavorable variance of $46.8 million due to higher claim expense and a $35.0 million adjustment of IHSS expense
        - ➢ Nursing facility favorable variance of $4.0 million
      - Provider Capitation unfavorable variance of $31.6 million due to shared risk group move to HMO model in February
      - Facilities expenses unfavorable variance of $17.7 million
        - ➢ $23.4 unfavorable variance for hospital shared risk pool
        - ➢ Offset by favorable variance due to shared risk group move to HMO
    - OneCare Connect: unfavorable variance of $10.1 million
      - Favorable volume variance of $11.4 million
      - Unfavorable price variance of $21.5 million
        - ➢ $12.4 million for CMS mid-year adjustments
        - ➢ $10.3 million for LTC expenses

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FY 2016-17: Consolidated Medical Expenses (Cont.)

- June 2017 YTD:
  - Actual higher than budget by $159.6 million or 4.9%
    - Medi-Cal: unfavorable variance of $308.8 million
      - Favorable volume variance of $15.2 million
      - Unfavorable price variance of $324.0 million
        - IHSS estimated expense $156.5 million higher than budget
        - LTC expense $57.2 million higher than budget
        - Provider Capitation $81.5 million higher than budget due to unbudgeted conversion of ASO contract to capitation
    - OneCare Connect: favorable variance of $148.9 million
      - Favorable volume variance of $115.3 million
      - Favorable price variance of $33.6 million

- Medical Loss Ratio (MLR):
  - June 2017 MTD: Actual: 93.6% Budget: 95.9%
  - June 2017 YTD: Actual: 95.8% Budget: 95.7%

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FY 2016-17: Consolidated Administrative Expenses

- June 2017 MTD:
  - Actual lower than budget by $5.8 million or 50.4%
    - Salaries and Benefits: favorable variance of $7.0 million
      - Favorable variance of $5.0 million for YTD true-up of pension
    - Other categories: unfavorable variance of $1.2 million

- June 2017 YTD:
  - Actual lower than budget by $27.4 million or 19.7%
    - Salaries and Benefits: favorable variance of $19.9 million driven by lower than budgeted FTE
    - Other categories: favorable variance of $7.5 million

- Administrative Loss Ratio (ALR):
  - June 2017 MTD: Actual: 1.4% Budget: 4.1%
  - June 2017 YTD: Actual: 3.2% Budget: 4.1%

FY 2016-17: Change in Net Assets

- June 2017 MTD:
  - $21.3 million surplus
  - $21.1 million favorable to budget
    - Higher than budgeted revenue of $120.7 million
    - Higher than budgeted medical expenses of $106.5 million
    - Lower than budgeted administrative expenses of $5.8 million
    - Higher than budgeted investment and other income of $1.1 million

- June 2017 YTD:
  - $51.9 million surplus
  - $45.1 million favorable to budget
    - Higher than budgeted revenue of $164.0 million
    - Higher than budgeted medical expenses of $159.6 million
    - Lower than budgeted administrative expenses of $27.4 million
    - Higher than budgeted investment and other income of $13.3 million

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Enrollment Summary: June 2017

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
60,593	56,498	4,095	7.2%	Aged	709,595	667,555	42,040	6.3%
624	681	(57)	(8.4%)	BCCTP	7,471	8,136	(665)	(8.2%)
46,941	47,208	(267)	(0.6%)	Disabled	580,494	568,468	12,026	2.1%
325,827	346,313	(20,486)	(5.9%)	TANF Child	3,974,383	4,105,299	(130,916)	(3.2%)
96,462	108,200	(11,738)	(10.8%)	TANF Adult	1,203,054	1,309,269	(106,215)	(8.1%)
3,395	2,759	636	23.1%	LTC	39,392	32,569	6,823	20.9%
238,386	226,831	11,555	5.1%	MCE	2,810,300	2,686,240	124,060	4.6%
772,228	**788,490**	**(16,262)**	**(2.1%)**	**Medi-Cal**	**9,324,689**	**9,377,537**	**(52,848)**	**(0.6%)**
15,505	**21,454**	**(5,949)**	**(27.7%)**	**OneCare Connect**	**202,010**	**261,930**	**(59,920)**	**(22.9%)**
212	**220**	**(8)**	**(3.6%)**	**PACE**	**2,274**	**2,310**	**(36)**	**(1.6%)**
1,121	**1,122**	**(1)**	**(0.1%)**	**OneCare**	**14,843**	**14,227**	**616**	**4.3%**
789,066	**811,286**	**(22,220)**	**(2.7%)**	**CalOptima Total**	**9,543,816**	**9,656,004**	**(112,188)**	**(1.2%)**

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Financial Highlights: June 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
789,066	811,286	(22,220)	(2.7%)	Member Months	9,543,816	9,656,004	(112,188)	(1.2%)
404,326,084	283,636,230	120,689,854	42.6%	Revenues	3,549,461,861	3,385,447,657	164,014,205	4.8%
378,513,279	271,965,394	(106,547,885)	(39.2%)	Medical Expenses	3,400,677,061	3,241,033,953	(159,643,108)	(4.9%)
5,744,547	11,587,651	5,843,104	50.4%	Administrative Expenses	111,847,488	139,207,122	27,359,634	19.7%
20,068,258	**83,185**	**19,985,073**	**24024.8%**	**Operating Margin**	**36,937,312**	**5,206,582**	**31,730,730**	**609.4%**
1,200,428	134,753	1,065,675	790.8%	Non Operating Income (Loss)	14,994,031	1,663,750	13,330,281	801.2%
21,268,686	**217,938**	**21,050,748**	**9659.0%**	**Change in Net Assets**	**51,931,343**	**6,870,332**	**45,061,011**	**655.9%**
93.6%	95.9%	2.3%		Medical Loss Ratio	95.8%	95.7%	(0.1%)	
1.4%	4.1%	2.7%		Administrative Loss Ratio	3.2%	4.1%	1.0%	
5.0%	0.0%	4.9%		Operating Margin Ratio	1.0%	0.2%	0.9%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: June (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
14.4	0.5	13.8	Medi-Cal	40.4	6.4	33.9
0.7	0.1	0.6	OneCare	1.0	0.3	0.6
5.2	(0.4)	5.6	OCC	(4.1)	0.9	(5.1)
(0.3)	(0.2)	(0.1)	PACE	(0.4)	(2.5)	2.1
20.1	**0.1**	**20.0**	**Operating**	**36.9**	**5.2**	**31.6**
1.2	0.1	1.1	Inv./Rental Inc, MCO tax	15.1	1.7	13.5
1.2	**0.1**	**1.1**	**Non-Operating**	**15.1**	**1.7**	**13.5**
21.3	**0.2**	**21.1**	**TOTAL**	**51.9**	**6.9**	**45.1**

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Consolidated Revenue & Expense: June 2017 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	533,842	238,386	772,228	1,121	15,505	212	789,066
REVENUES							
Capitation Revenue	$ 212,950,638	$ 129,417,793	$ 342,368,431	$ 2,752,881	$ 57,941,634	$ 1,263,137	$ 404,326,084
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	212,950,638	129,417,793	342,368,431	2,752,881	57,941,634	1,263,137	404,326,084
MEDICAL EXPENSES							
Provider Capitation	49,239,473	58,402,525	107,641,998	933,901	15,381,826	-	123,957,724
Facilities	36,934,814	38,148,881	75,083,695	252,873	12,454,586	138,088	87,929,241
Ancillary	-	-	-	56,761	792,619	-	849,380
Skilled Nursing	-	-	-	25,341	-	-	25,341
Professional Claims	8,344,473	9,798,536	18,143,009	-	-	412,542	18,555,550
Prescription Drugs	17,926,760	18,088,379	36,015,139	514,415	4,130,587	119,805	40,779,946
Long-term Care Facility Payments	74,980,546	5,532,570	80,513,116	-	17,668,337	16,957	98,198,409
Medical Management	6,760,094	-	6,760,094	71,552	687,348	442,132	7,961,126
Reinsurance & Other	(1,453,092)	1,372,727	(80,365)	129	101,186	235,612	256,561
Total Medical Expenses	192,733,066	131,343,618	324,076,685	1,854,971	51,216,488	1,365,135	378,513,279
Medical Loss Ratio	**90.5%**	**101.5%**	**94.7%**	**67.4%**	**88.4%**	**108.1%**	**93.6%**
GROSS MARGIN	**20,217,572**	**(1,925,825)**	**18,291,747**	**897,910**	**6,725,146**	**(101,998)**	**25,812,805**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			(235,653)	26,256	798,250	86,810	675,663
Professional fees			(6,076)	30,013	108,558	20,300	152,796
Purchased services			1,127,008	(1,523)	336,450	2,183	1,464,118
Printing and Postage			479,497	10,102	101,862	1,596	593,057
Depreciation and Amortization			359,073	-	-	2,244	361,317
Other expenses			2,052,611	(18)	60,904	37,509	2,151,005
Indirect cost allocation, Occupancy expense			107,517	118,655	114,657	5,762	346,591
Total Administrative Expenses			3,883,976	183,486	1,520,681	156,404	5,744,547
Admin Loss Ratio			**1.1%**	**6.7%**	**2.6%**	**12.4%**	**1.4%**
INCOME (LOSS) FROM OPERATIONS			14,407,770	714,424	5,204,465	(258,402)	20,068,258
INVESTMENT INCOME			-	-	-	-	1,207,149
NET RENTAL INCOME			-	-	-	-	3,863
NET GRANT INCOME			(10,629)	-	-	-	(10,629)
OTHER INCOME			45	-	-	-	45
CHANGE IN NET ASSETS			**$ 14,397,186**	**$ 714,424**	**$ 5,204,465**	**$ (258,402)**	**$ 21,268,686**
BUDGETED CHANGE IN ASSETS			548,826	75,836	(379,848)	(161,629)	217,938
VARIANCE TO BUDGET - FAV (UNFAV)			13,848,360	638,589	5,584,313	(96,773)	21,050,748

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Consolidated Revenue & Expense: June 2017 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	6,514,389	2,810,300	9,324,689	14,843	202,010	2,274	9,543,816
REVENUES							
Capitation Revenue	$ 1,845,537,761	$ 1,298,475,164	$ 3,144,012,925	$ 18,615,729	$ 371,630,947	$ 15,202,259	$ 3,549,461,861
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	1,845,537,761	1,298,475,164	3,144,012,925	18,615,729	371,630,947	15,202,259	3,549,461,861
MEDICAL EXPENSES							
Provider Capitation	440,679,712	544,496,880	985,176,591	5,321,478	99,042,019	-	1,089,540,088
Facilities	343,752,741	348,285,555	692,038,296	4,330,317	96,936,316	3,403,291	796,708,220
Ancillary	-	-	-	553,194	9,411,853	-	9,965,047
Skilled Nursing	-	-	-	512,533	-	-	512,533
Professional Claims	103,413,024	107,888,823	211,301,847	-	-	3,068,533	214,370,380
Prescription Drugs	218,027,101	203,467,595	421,494,696	5,312,486	58,653,614	1,189,940	486,650,735
Long-term Care Facility Payments	621,518,492	38,594,893	660,113,386	-	78,116,621	71,746	738,301,753
Medical Management	38,820,658	-	38,820,658	331,765	11,766,329	4,877,936	55,796,688
Reinsurance & Other	(6,857,800)	12,780,801	5,923,001	62,480	1,298,487	1,547,650	8,831,617
Total Medical Expenses	1,759,353,928	1,255,514,548	3,014,868,476	16,424,251	355,225,238	14,159,096	3,400,677,061
Medical Loss Ratio	**95.3%**	**96.7%**	**95.9%**	**88.2%**	**95.6%**	**93.1%**	**95.8%**
GROSS MARGIN	**86,183,834**	**42,960,616**	**129,144,450**	**2,191,478**	**16,405,710**	**1,043,163**	**148,784,800**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			62,633,657	263,342	9,305,962	1,100,825	73,303,786
Professional Fees			532,325	204,934	426,673	77,484	1,241,416
Purchased services			8,803,609	250,443	1,871,003	41,512	10,966,567
Printing and Postage			2,953,510	118,338	679,834	19,036	3,770,719
Depreciation and Amortization			4,023,152			24,847	4,048,000
Other expenses			13,644,426	2,333	486,232	137,722	14,270,713
Indirect cost allocation, Occupancy expense			(3,941,610)	385,919	7,770,338	31,639	4,246,287
Total Administrative Expenses			88,649,070	1,225,310	20,540,042	1,433,065	111,847,488
Admin Loss Ratio			**2.8%**	**6.6%**	**5.5%**	**9.4%**	**3.2%**
INCOME (LOSS) FROM OPERATIONS			40,495,380	966,168	(4,134,333)	(389,902)	36,937,312
INVESTMENT INCOME			-	-	-	-	15,064,815
NET RENTAL INCOME			-	-	-	-	57,462
NET GRANT INCOME			(129,643)	-	-	-	(129,643)
OTHER INCOME			1,397	-	-	-	1,397
CHANGE IN NET ASSETS			**$ 40,367,133**	**$ 966,168**	**$ (4,134,333)**	**$ (389,902)**	**$ 51,931,344**
BUDGETED CHANGE IN ASSETS			6,420,321	326,512	937,405	(2,477,655)	6,870,332
VARIANCE TO BUDGET - FAV (UNFAV)			33,946,813	639,655	(5,071,737)	2,087,753	45,061,011

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CalOptima A Public Agency Better. Together.

Balance Sheet: As of June 2017

ASSETS			LIABILITIES & FUND BALANCES		
Current Assets			Current Liabilities		
	Operating Cash	$496,077,478		Accounts payable	$39,891,295
	Catastrophic Reserves	10,770,209		Medical claims liability	1,266,624,804
	Investments	1,082,765,356		Accrued payroll liabilities	9,858,588
	Capitation receivable	689,218,521		Deferred revenue	236,130,600
	Receivables - Other	21,084,090		Deferred lease obligations	197,123
	Prepaid Expenses	5,654,647		Capitation and withholds	595,252,382
	Total Current Assets	**2,305,570,301**		**Total Current Liabilities**	**2,147,954,790**
Capital Assets	Furniture and equipment	33,437,912	Other employment benefits liability		30,562,755
	Leasehold improvements	5,882,676			
	505 City Parkway West	49,422,364	Net Pension Liabilities		15,430,763
		88,742,952	Long Term Liabilities		100,000
	Less: accumulated depreciation	(34,441,925)			
	Capital assets, net	**54,301,026**	**TOTAL LIABILITIES**		**2,194,048,309**
Other Assets	Restricted deposit & Other	300,000	Deferred inflows of Resources - Excess Earnings		-
			Deferred inflows of Resources - Changes in Assumptions		1,340,010
	Board-designated assets				
	Cash and cash equivalents	17,716,161	Tangible net equity (TNE)		98,445,479
	Long term investments	517,422,213	Funds in excess of TNE		613,053,043
	Total Board-designated Assets	535,138,374			
	Total Other Assets	**535,438,374**	**Net Assets**		**711,498,522**
	Deferred outflows of Resources - Pension Contributions	5,234,198			
	Deferred outflows of Resources - Difference in Experience	1,072,771			
	Deferred outflows of Resources - Excess Earnings	5,270,171			
TOTAL ASSETS & OUTFLOWS		**2,906,886,841**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**		**2,906,886,841**

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CalOptima A Public Agency Better. Together.

Board Designated Reserve and TNE Analysis As of June 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,225,298				
	Tier 1 - Logan Circle	145,997,548				
	Tier 1 - Wells Capital	145,964,635				
Board-designated Reserve		438,187,482	305,408,833	478,489,252	132,778,649	(40,301,770)
TNE Requirement	Tier 2 - Logan Circle	96,950,892	98,445,479	98,445,479	(1,494,587)	(1,494,587)
	Consolidated:	**535,138,374**	**403,854,312**	**576,934,731**	**131,284,062**	**(41,796,357)**
	Current reserve level	*1.86*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

June 2017

Preliminary Report as of July 20, 2017

Subject to change following the financial audit

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CalOptima - Consolidated
Financial Highlights
For the Twelve Months Ended June 30, 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
789,066	811,286	(22,220)	(2.7%)	Member Months	9,543,816	9,656,004	(112,188)	(1.2%)
404,326,084	283,636,230	120,689,854	42.6%	Revenues	3,549,461,861	3,385,447,657	164,014,205	4.8%
378,513,279	271,965,394	(106,547,885)	(39.2%)	Medical Expenses	3,400,677,061	3,241,033,953	(159,643,108)	(4.9%)
5,744,547	11,587,651	5,843,104	50.4%	Administrative Expenses	111,847,488	139,207,122	27,359,634	19.7%
20,068,258	**83,185**	**19,985,073**	**24024.8%**	**Operating Margin**	**36,937,312**	**5,206,582**	**31,730,730**	**609.4%**
1,200,428	134,753	1,065,675	790.8%	Non Operating Income (Loss)	14,994,031	1,663,750	13,330,281	801.2%
21,268,686	**217,938**	**21,050,748**	**9659.0%**	**Change in Net Assets**	**51,931,343**	**6,870,332**	**45,061,011**	**655.9%**
93.6%	95.9%	2.3%		Medical Loss Ratio	95.8%	95.7%	(0.1%)	
1.4%	4.1%	2.7%		Administrative Loss Ratio	3.2%	4.1%	1.0%	
5.0%	0.0%	4.9%		Operating Margin Ratio	1.0%	0.2%	0.9%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima
Financial Dashboard
For the Twelve Months Ended June 30, 2017

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	772,228	788,490	(16,262)	(2.1%)
OneCare	1,121	1,122	(1)	(0.1%)
OneCare Connect	15,505	21,454	(5,949)	(27.7%)
PACE	212	220	(8)	(3.6%)
Total	789,066	811,286	(22,220)	(2.7%)

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 14,397	$ 549	$ 13,848	2523.3%
OneCare	714	76	639	842.1%
OneCare Connect	5,204	(380)	5,584	1470.1%
PACE	(258)	(162)	(97)	(59.9%)
505 Bldg.	4	(74)	77	105.3%
Investment Income & Other	1,207	208	999	479.4%
Total	$ 21,269	$ 218	$ 21,051	9659.0%

MLR

	Actual	Budget	% Point Var
Medi-Cal	94.7%	96.0%	1.3
OneCare	67.4%	89.2%	21.8
OneCare Connect	88.4%	95.5%	7.1

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 3,884	$ 9,048	$ 5,164	57.1%
OneCare	183	102	(81)	(79.9%)
OneCare Connect	1,521	2,312	792	34.2%
PACE	156	126	(31)	(24.6%)
Total	$ 5,745	$ 11,588	$ 5,843	50.4%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	877	887	10
OneCare	4	3	(1)
OneCare Connect	230	239	9
PACE	47	61	13
Total	1,158	1,190	31

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	880	889	(8)
OneCare	281	374	(93)
OneCare Connect	68	90	(22)
PACE	4	4	1
Total	1,233	1,356	(123)

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	9,324,689	9,377,537	(52,848)	(0.6%)
OneCare	14,843	14,227	616	4 3%
OneCare Connect	202,010	261,930	(59,920)	(22 9%)
PACE	2,274	2,310	(36)	(1.6%)
Total	9,543,816	9,656,004	(112,188)	(1 2%)

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 40,367	$ 6,420	$ 33,947	528.7%
OneCare	966	327	640	195 9%
OneCare Connect	(4,134)	937	(5,072)	(541 0%)
PACE	(390)	(2,478)	2,088	84 3%
505 Bldg.	57	(836)	894	106 9%
Investment Income & Other	15,065	2,500	12,565	502.6%
Total	$ 51,931	$ 6,870	$ 45,061	655 9%

MLR

	Actual	Budget	% Point Var
Medi-Cal	95 9%	95.9%	0.0
OneCare	88 2%	90.6%	2.4
OneCare Connect	95.6%	94.6%	(1.0)

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 88,649	$ 108,495	$ 19,846	18 3%
OneCare	1,225	1,254	28	2 3%
OneCare Connect	20,540	28,008	7,468	26.7%
PACE	1,433	1,450	17	1 2%
Total	$ 111,847	$ 139,207	$ 27,360	19.7%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	10,202	10,631	429
OneCare	45	36	(9)
OneCare Connect	2,732	2,863	131
PACE	522	696	174
Total	13,379	14,226	847

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	914	882	32
OneCare	327	395	(68)
OneCare Connect	74	91	(18)
PACE	4	3	1
Total	1,320	1,372	(53)

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CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended June 30, 2017

	Month					
	Actual		Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	789,066		811,286		(22,220)	
Revenues						
Medi-Cal	$ 342,368,431	$ 443.35	$ 237,523,868	$ 301.24	$ 104,844,563	$ 142.11
OneCare	2,752,881	2,455.74	1,640,403	1,462.03	1,112,478	993.70
OneCare Connect	57,941,634	3,736.96	43,094,678	2,008.70	14,846,956	1,728.26
PACE	1,263,137	5,958.20	1,377,281	6,260.37	(114,144)	(302.17)
Total Operating Revenue	404,326,084	512.41	283,636,230	349.61	120,689,854	162.80
Medical Expenses						
Medi-Cal	324,076,685	419.66	227,927,084	289.07	(96,149,601)	(130.60)
OneCare	1,854,971	1,654.75	1,462,576	1,303.54	(392,395)	(351.20)
OneCare Connect	51,216,488	3,303.22	41,162,328	1,918.63	(10,054,160)	(1,384.59)
PACE	1,365,135	6,439.32	1,413,406	6,424.57	48,272	(14.74)
Total Medical Expenses	378,513,279	479.70	271,965,394	335.23	(106,547,885)	(144.47)
Gross Margin	25,812,805	32.71	11,670,836	14.39	14,141,969	18.33
Administrative Expenses						
Salaries and Benefits	675,663	0.86	7,717,998	9.51	7,042,335	8.66
Professional fees	152,796	0.19	445,418	0.55	292,623	0.36
Purchased services	1,464,118	1.86	1,031,674	1.27	(432,444)	(0.58)
Printing and Postage	593,057	0.75	475,813	0.59	(117,244)	(0.17)
Depreciation and Amortization	361,317	0.46	385,117	0.47	23,801	0.02
Other	2,151,005	2.73	1,104,325	1.36	(1,046,680)	(1.36)
Indirect cost allocation, Occupancy expense	346,591	0.44	427,305	0.53	80,714	0.09
Total Administrative Expenses	5,744,547	7.28	11,587,651	14.28	5,843,104	7.00
Income (Loss) From Operations	20,068,258	25.43	83,185	0.10	19,985,073	25.33
Investment income						
Interest income	2,027,569	2.57	208,333	0.26	1,819,236	2.31
Realized gain/(loss) on investments	(212,933)	(0.27)	-	-	(212,933)	(0.27)
Unrealized gain/(loss) on investments	(607,487)	(0.77)	-	-	(607,487)	(0.77)
Total Investment Income	1,207,149	1.53	208,333	0.26	998,816	1.27
Net Rental Income	3,863	0.00	(73,579)	(0.09)	77,442	0.10
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(10,629)	(0.01)	-	-	(10,629)	(0.01)
QAF/IGT	-	-	-	-	-	-
Other Income	45	0.00	-	-	45	0.00
Change In Net Assets	**21,268,686**	**26.95**	**217,938**	**0.27**	**21,050,748**	**26.69**
Medical Loss Ratio	**93.6%**		**95.9%**		**2.3%**	
Administrative Loss Ratio	**1.4%**		**4.1%**		**2.7%**	

* 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 Twelve Months Ended June 30, 2017

	Year to Date					
	Actual		Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	9,543,816		9,656,004		(112,188)	
Revenues						
Medi-Cal	$ 3,144,012,925	$ 337.17	$ 2,821,016,503	$ 300.83	$ 322,996,422	$ 36.34
OneCare	18,615,729	1,254.18	16,771,979	1,178.88	1,843,750	75.29
OneCare Connect	371,630,947	1,839.67	533,118,659	2,035.35	(161,487,712)	(195.68)
PACE	15,202,259	6,685.25	14,540,515	6,294.60	661,744	390.65
Total Operating Revenue	3,549,461,861	371.91	3,385,447,657	350.61	164,014,205	21.31
Medical Expenses						
Medi-Cal	3,014,868,476	323.32	2,706,100,756	288.57	(308,767,720)	(34.75)
OneCare	16,424,251	1,106.53	15,191,738	1,067.81	(1,232,513)	(38.72)
OneCare Connect	355,225,238	1,758.45	504,173,683	1,924.84	148,948,445	166.39
PACE	14,159,096	6,226.52	15,567,776	6,739.30	1,408,679	512.78
Total Medical Expenses	3,400,677,061	356.32	3,241,033,953	335.65	(159,643,108)	(20.67)
Gross Margin	148,784,800	15.59	144,413,704	14.96	4,371,096	0.63
Administrative Expenses						
Salaries and Benefits	73,303,786	7.68	93,158,686	9.65	19,854,900	1.97
Professional fees	1,241,416	0.13	5,080,523	0.53	3,839,107	0.40
Purchased services	10,966,567	1.15	11,799,978	1.22	833,411	0.07
Printing and Postage	3,770,719	0.40	5,624,402	0.58	1,853,683	0.19
Depreciation and Amortization	4,048,000	0.42	4,621,407	0.48	573,407	0.05
O her	14,270,713	1.50	13,789,618	1.43	(481,095)	(0.07)
Indirect cost allocation, Occupancy expense	4,246,287	0.44	5,132,508	0.53	886,221	0.09
Total Administrative Expenses	111,847,488	11.72	139,207,122	14.42	27,359,634	2.70
Income (Loss) From Operations	36,937,312	3.87	5,206,582	0.54	31,730,730	3.33
Investment income						
Interest income	19,806,293	2.08	2,500,000	0.26	17,306,293	1.82
Realized gain/(loss) on investments	(527,657)	(0.06)	-	-	(527,657)	(0.06)
Unrealized gain/(loss) on investments	(4,213,822)	(0.44)	-	-	(4,213,822)	(0.44)
Total Investment Income	15,064,815	1.58	2,500,000	0.26	12,564,815	1.32
Net Rental Income	57,462	0.01	(836,250)	(0.09)	893,713	0.09
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(129,643)	(0)	-	-	(129,643)	(0)
QAF/IGT	-	-	-	-	-	-
Other Income	1,397	0.00	-	-	1,397	0.00
Change In Net Assets	**51,931,344**	**5.44**	**6,870,332**	**0.71**	**45,061,011**	**4.73**
Medical Loss Ratio	**95.8%**		**95.7%**		**(0.1%)**	
Administrative Loss Ratio	**3.2%**		**4.1%**		**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 June 30, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	533,842	238,386	772,228	1,121	15,505	212	789,066
REVENUES							
Capitation Revenue	$ 212,950,638	$ 129,417,793	$ 342,368,431	$ 2,752,881	$ 57,941,634	$ 1,263,137	$ 404,326,084
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	212,950,638	129,417,793	342,368,431	2,752,881	57,941,634	1,263,137	404,326,084
MEDICAL EXPENSES							
Provider Capitation	49,239,473	58,402,525	107,641,998	933,901	15,381,826	-	123,957,724
Facilities	36,934,814	38,148,881	75,083,695	252,873	12,454,586	138,088	87,929,241
Ancillary	-	-	-	56,761	792,619	-	849,380
Skilled Nursing	-	-	-	25,341	-	-	25,341
Professional Claims	8,344,473	9,798,536	18,143,009	-	-	412,542	18,555,550
Prescription Drugs	17,926,760	18,088,379	36,015,139	514,415	4,130,587	119,805	40,779,946
Long-term Care Facility Payments	74,980,546	5,532,570	80,513,116	-	17,668,337	16,957	98,198,409
Medical Management	6,760,094	-	6,760,094	71,552	687,348	442,132	7,961,126
Reinsurance & Other	(1,453,092)	1,372,727	(80,365)	129	101,186	235,612	256,561
Total Medical Expenses	192,733,066	131,343,618	324,076,685	1,854,971	51,216,488	1,365,135	378,513,279
Medical Loss Ratio	**90.5%**	**101.5%**	**94.7%**	**67.4%**	**88.4%**	**108.1%**	**93.6%**
GROSS MARGIN	**20,217,572**	**(1,925,825)**	**18,291,747**	**897,910**	**6,725,146**	**(101,998)**	**25,812,805**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			(235,653)	26,256	798,250	86,810	675,663
Professional fees			(6,076)	30,013	108,558	20,300	152,796
Purchased services			1,127,008	(1,523)	336,450	2,183	1,464,118
Printing and Postage			479,497	10,102	101,862	1,596	593,057
Depreciation and Amortization			359,073	-	-	2,244	361,317
Other expenses			2,052,611	(18)	60,904	37,509	2,151,005
Indirect cost allocation, Occupancy expense			107,517	118,655	114,657	5,762	346,591
Total Administrative Expenses			3,883,976	183,486	1,520,681	156,404	5,744,547
Admin Loss Ratio			**1.1%**	**6.7%**	**2.6%**	**12.4%**	**1.4%**
INCOME (LOSS) FROM OPERATIONS			14,407,770	714,424	5,204,465	(258,402)	20,068,258
INVESTMENT INCOME			-	-	-	-	1,207,149
NET RENTAL INCOME			-	-	-	-	3,863
NET GRANT INCOME			(10,629)	-	-	-	(10,629)
OTHER INCOME			45	-	-	-	45
CHANGE IN NET ASSETS			**$ 14,397,186**	**$ 714,424**	**$ 5,204,465**	**$ (258,402)**	**$ 21,268,686**
BUDGETED CHANGE IN ASSETS			548,826	75,836	(379,848)	(161,629)	217,938
VARIANCE TO BUDGET - FAV (UNFAV)			13,848,360	638,589	5,584,313	(96,773)	21,050,748

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Twelve Months Ended June 30, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	6,514,389	2,810,300	9,324,689	14,843	202,010	2,274	9,543,816
REVENUES							
Capitation Revenue	$ 1,845,537,761	$ 1,298,475,164	$ 3,144,012,925	$ 18,615,729	$ 371,630,947	$ 15,202,259	$ 3,549,461,861
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	1,845,537,761	1,298,475,164	3,144,012,925	18,615,729	371,630,947	15,202,259	3,549,461,861
MEDICAL EXPENSES							
Provider Capitation	440,679,712	544,496,880	985,176,591	5,321,478	99,042,019	-	1,089,540,088
Facilities	343,752,741	348,285,555	692,038,296	4,330,317	96,936,316	3,403,291	796,708,220
Ancillary	-	-	-	553,194	9,411,853	-	9,965,047
Skilled Nursing	-	-	-	512,533	-	-	512,533
Professional Claims	103,413,024	107,888,823	211,301,847	-	-	3,068,533	214,370,380
Prescription Drugs	218,027,101	203,467,595	421,494,696	5,312,486	58,653,614	1,189,940	486,650,735
Long-term Care Facility Payments	621,518,492	38,594,893	660,113,386	-	78,116,621	71,746	738,301,753
Medical Management	38,820,658	-	38,820,658	331,765	11,766,329	4,877,936	55,796,688
Reinsurance & Other	(6,857,800)	12,780,801	5,923,001	62,480	1,298,487	1,547,650	8,831,617
Total Medical Expenses	1,759,353,928	1,255,514,548	3,014,868,476	16,424,251	355,225,238	14,159,096	3,400,677,061
Medical Loss Ratio	**95.3%**	**96.7%**	**95.9%**	**88.2%**	**95.6%**	**93.1%**	**95.8%**
GROSS MARGIN	**86,183,834**	**42,960,616**	**129,144,450**	**2,191,478**	**16,405,710**	**1,043,163**	**148,784,800**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			62,633,657	263,342	9,305,962	1,100,825	73,303,786
Professional Fees			532,325	204,934	426,673	77,484	1,241,416
Purchased services			8,803,609	250,443	1,871,003	41,512	10,966,567
Printing and Postage			2,953,510	118,338	679,834	19,036	3,770,719
Depreciation and Amortization			4,023,152			24,847	4,048,000
Other expenses			13,644,426	2,333	486,232	137,722	14,270,713
Indirect cost allocation, Occupancy expense			(3,941,610)	385,919	7,770,338	31,639	4,246,287
Total Administrative Expenses			88,649,070	1,225,310	20,540,042	1,433,065	111,847,488
Admin Loss Ratio			**2.8%**	**6.6%**	**5.5%**	**9.4%**	**3.2%**
INCOME (LOSS) FROM OPERATIONS			40,495,380	966,168	(4,134,333)	(389,902)	36,937,312
INVESTMENT INCOME			-	-	-	-	15,064,815
NET RENTAL INCOME			-	-	-	-	57,462
NET GRANT INCOME			(129,643)	-	-	-	(129,643)
OTHER INCOME			1,397	-	-	-	1,397
CHANGE IN NET ASSETS			**$ 40,367,133**	**$ 966,168**	**$ (4,134,333)**	**$ (389,902)**	**$ 51,931,344**
BUDGETED CHANGE IN ASSETS			6,420,321	326,512	937,405	(2,477,655)	6,870,332
VARIANCE TO BUDGET - FAV (UNFAV)			33,946,813	639,655	(5,071,737)	2,087,753	45,061,011

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SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $21.3 million, $21.1 million favorable to budget
- Operating surplus is $20.1 million with a surplus in non-operating of $1.2 million

YEARLY RESULTS:

- Change in Net Assets is $51.9 million, $45.1 million favorable to budget
- Operating surplus is $36.9 million with a surplus in non-operating of $15.1 million

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
14.4	0.5	13.8	Medi-Cal	40.4	6.4	33.9
0.7	0.1	0.6	OneCare	1.0	0.3	0.6
5.2	(0.4)	5.6	OCC	(4.1)	0.9	(5.1)
(0.3)	(0.2)	(0.1)	PACE	(0.4)	(2.5)	2.1
20.1	**0.1**	**20.0**	**Operating**	**36.9**	**5.2**	**31.6**
1.2	0.1	1.1	Inv./Rental Inc, MCO tax	15.1	1.7	13.5
1.2	**0.1**	**1.1**	**Non-Operating**	**15.1**	**1.7**	**13.5**
21.3	**0.2**	**21.1**	**TOTAL**	**51.9**	**6.9**	**45.1**

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CalOptima

Enrollment Summary

For the Twelve Months Ended June 30, 2017

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
60,593	56,498	4,095	7.2%	Aged	709,595	667,555	42,040	6.3%
624	681	(57)	(8.4%)	BCCTP	7,471	8,136	(665)	(8.2%)
46,941	47,208	(267)	(0.6%)	Disabled	580,494	568,468	12,026	2.1%
325,827	346,313	(20,486)	(5.9%)	TANF Child	3,974,383	4,105,299	(130,916)	(3.2%)
96,462	108,200	(11,738)	(10.8%)	TANF Adult	1,203,054	1,309,269	(106,215)	(8.1%)
3,395	2,759	636	23.1%	LTC	39,392	32,569	6,823	20.9%
238,386	226,831	11,555	5.1%	MCE	2,810,300	2,686,240	124,060	4.6%
772,228	**788,490**	**(16,262)**	**(2.1%)**	**Medi-Cal**	**9,324,689**	**9,377,537**	**(52,848)**	**(0.6%)**
15,505	**21,454**	**(5,949)**	**(27.7%)**	**OneCare Connect**	**202,010**	**261,930**	**(59,920)**	**(22.9%)**
212	**220**	**(8)**	**(3.6%)**	**PACE**	**2,274**	**2,310**	**(36)**	**(1.6%)**
1,121	**1,122**	**(1)**	**(0.1%)**	**OneCare**	**14,843**	**14,227**	**616**	**4.3%**
789,066	**811,286**	**(22,220)**	**(2.7%)**	**CalOptima Total**	**9,543,816**	**9,656,004**	**(112,188)**	**(1.2%)**

Enrollment (By Network)

136,615	50,804	85,811	168.9%	HMO	1,024,077	584,671	439,406	75.2%
222,736	237,565	(14,829)	(6.2%)	PHC	2,724,020	2,826,619	(102,599)	(3.6%)
238,095	340,600	(102,505)	(30.1%)	Shared Risk Group	3,582,623	4,085,503	(502,880)	(12.3%)
174,782	159,521	15,261	9.6%	Fee for Service	1,993,969	1,880,744	113,225	6.0%
772,228	**788,490**	**(16,262)**	**(2.1%)**	**Medi-Cal**	**9,324,689**	**9,377,537**	**(52,848)**	**(0.6%)**
15,505	**21,454**	**(5,949)**	**(27.7%)**	**OneCare Connect**	**202,010**	**261,930**	**(59,920)**	**(22.9%)**
212	**220**	**(8)**	**(3.6%)**	**PACE**	**2,274**	**2,310**	**(36)**	**(1.6%)**
1,121	**1,122**	**(1)**	**(0.1%)**	**OneCare**	**14,843**	**14,227**	**616**	**4.3%**
789,066	**811,286**	**(22,220)**	**(2.7%)**	**CalOptima Total**	**9,543,816**	**9,656,004**	**(112,188)**	**(1.2%)**

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CalOptima
Enrollment Trend by Network Type
Fiscal Year 2017

Network Type	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	MMs
HMO													
Aged	351	350	355	368	363	381	379	3,103	3,062	3,050	3,031	3,039	17,832
BCCTP	1	1	1	(8)	2	1	1	1	1	1	-	2	4
Disabled	1,799	1,797	1,813	1,866	1,853	1,858	1,875	5,780	5,752	5,697	5,597	5,490	41,177
TANF Child	24,211	24,455	24,733	24,928	24,987	25,083	24,928	53,811	53,432	52,933	52,852	52,904	439,257
TANF Adult	7,929	7,872	7,914	7,850	8,029	7,967	7,871	25,446	25,155	24,830	24,776	24,731	180,370
LTC	-	-	-	-	-	-	-	3	4	3	4	5	19
MCE	12,989	13,224	13,464	14,034	13,897	14,116	14,200	49,527	49,627	49,825	50,071	50,444	345,418
	47,280	47,699	48,280	49,038	49,131	49,406	49,254	137,671	137,033	136,339	136,331	136,615	1,024,077
PHC													
Aged	1,495	1,464	1,488	1,458	1,427	1,419	1,408	1,439	1,420	1,416	1,418	1,472	17,324
BCCTP	-	-	-	1	-	-	-	-	-	-	-	-	1
Disabled	7,903	7,872	7,862	7,865	7,804	7,779	7,783	7,751	7,741	7,647	7,494	7,345	92,846
TANF Child	169,358	168,529	169,733	169,714	168,615	168,294	165,979	164,330	163,343	162,600	162,489	163,115	1,996,099
TANF Adult	15,260	14,945	14,649	14,593	14,161	13,880	13,457	13,195	13,019	12,782	12,739	12,707	165,387
LTC	-	-	-	4	-	-	-	-	-	-	1	1	6
MCE	38,002	38,200	37,601	38,070	37,874	37,886	37,361	37,214	37,122	37,260	37,671	38,096	452,357
	232,018	231,010	231,333	231,705	229,881	229,258	225,988	223,929	222,645	221,705	221,812	222,736	2,724,020
Shared Risk Group													
Aged	7,658	7,627	7,635	7,726	7,528	7,546	7,501	4,834	4,813	4,800	4,805	4,799	77,272
BCCTP	-	-	-	8	1	-	-	-	-	-	-	-	9
Disabled	14,428	14,307	14,189	14,253	14,073	14,084	14,005	10,083	10,022	9,861	9,635	9,422	148,362
TANF Child	118,748	118,149	118,421	117,922	116,971	116,744	114,746	84,105	83,246	82,334	81,854	81,785	1,235,025
TANF Adult	63,849	62,814	62,579	62,266	61,355	60,893	59,355	40,848	40,247	39,602	39,265	39,085	632,158
LTC	-	-	-	3	3	3	5	3	5	5	-	1	28
MCE	140,640	140,811	137,172	139,776	139,565	140,094	138,165	103,233	102,694	102,173	102,443	103,003	1,489,769
	345,323	343,708	339,996	341,954	339,496	339,364	333,777	243,106	241,027	238,775	238,002	238,095	3,582,623
Fee for Service (Dual)													
Aged	43,684	45,173	45,173	45,522	46,007	46,233	46,592	46,682	46,856	47,201	46,986	47,001	553,110
BCCTP	27	26	24	23	23	23	25	27	27	28	28	25	306
Disabled	19,790	20,086	20,071	20,264	20,375	20,497	20,471	20,510	20,662	20,528	20,324	20,087	243,665
TANF Child	3	2	2	3	4	3	3	2	2	3	4	4	35
TANF Adult	1,179	1,162	1,184	1,197	1,181	1,216	1,220	1,200	1,211	1,217	1,197	1,219	14,383
LTC	2,868	2,910	2,941	2,906	2,940	2,914	2,914	2,913	2,887	2,963	2,977	3,014	35,147
MCE	2,960	2,975	2,721	2,750	2,822	2,893	2,818	2,842	2,852	2,789	2,808	2,805	34,035
	70,511	72,334	72,116	72,665	73,352	73,779	74,043	74,176	74,497	74,729	74,324	74,155	880,681
Fee for Service (Non-Dual)													
Aged	3,746	2,850	3,183	3,608	3,450	3,667	3,600	3,761	3,794	4,058	4,058	4,282	44,057
BCCTP	606	608	598	589	594	595	587	590	589	593	605	597	7,151
Disabled	4,533	4,269	4,390	4,368	4,488	4,548	4,567	4,569	4,643	4,771	4,701	4,597	54,444
TANF Child	22,710	23,011	22,504	23,069	23,658	23,949	25,193	25,695	28,202	29,119	28,838	28,019	303,967
TANF Adult	15,792	16,253	16,501	17,109	17,090	17,340	17,949	17,668	18,603	18,927	18,804	18,720	210,756
LTC	368	370	362	314	334	328	357	338	353	365	329	374	4,192
MCE	35,946	36,543	37,812	36,999	38,607	39,499	42,203	41,903	44,495	45,665	45,011	44,038	488,721
	83,701	83,904	85,350	86,056	88,221	89,926	94,456	94,524	100,679	103,498	102,346	100,627	1,113,288
MEDI-CAL TOTAL													
Aged	56,934	57,464	57,834	58,682	58,775	59,246	59,480	59,819	59,945	60,525	60,298	60,593	709,595
BCCTP	634	635	623	613	620	619	613	618	617	622	633	624	7,471
Disabled	48,453	48,331	48,325	48,616	48,593	48,766	48,701	48,693	48,820	48,504	47,751	46,941	580,494
TANF Child	335,030	334,146	335,393	335,636	334,235	334,073	330,849	327,943	328,225	326,989	326,037	325,827	3,974,383
TANF Adult	104,009	103,046	102,827	103,015	101,816	101,296	99,852	98,357	98,235	97,358	96,781	96,462	1,203,054
LTC	3,236	3,280	3,303	3,227	3,277	3,245	3,276	3,257	3,249	3,336	3,311	3,395	39,392
MCE	230,537	231,753	228,770	231,629	232,765	234,488	234,747	234,719	236,790	237,712	238,004	238,386	2,810,300
	778,833	778,655	777,075	781,418	780,081	781,733	777,518	773,406	775,881	775,046	772,815	772,228	9,324,689
PACE	177	179	179	180	183	183	184	194	197	201	205	212	2,274
OneCare	1,171	1,164	1,192	1,220	1,228	1,275	1,304	1,281	1,278	1,289	1,320	1,121	14,843
OneCare Connect	18,902	18,245	17,727	17,352	17,067	16,810	16,346	16,222	16,086	15,975	15,773	15,505	202,010
TOTAL	799,083	798,243	796,173	800,170	798,559	800,001	795,352	791,103	793,442	792,511	790,113	789,066	9,543,816

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ENROLLMENT:

Overall MTD enrollment was 789,066

- Unfavorable to budget by 22,220
- Decreased 1,047 or 0.1% from prior month
- Decreased 18,405 or 2.3% from prior year (June 2016)

Medi-Cal enrollment was 772,228

- Unfavorable to budget by 16,262
    - TANF unfavorable by 32,224
    - Expansion favorable by 11,555
    - SPD favorable by 3,771
    - LTC favorable by 636
- Decreased 587 from prior month

OneCare Connect enrollment was 15,505

- Unfavorable to budget by 5,949
- Decreased 268 from prior month

OneCare enrollment was 1,121

- Unfavorable to budget by 1
- Decreased 199 from prior month

PACE enrollment at 212

- Unfavorable to budget by 8
- Increased 7 from prior month

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CalOptima - Medi-Cal Total
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
772,228	788,490	(16,262)	(2.1%)	Member Months	9,324,689	9,377,537	(52,848)	(0.6%)
				Revenues				
342,368,431	237,523,868	104,844,563	44.1%	Capitation revenue	3,144,012,925	2,821,016,503	322,996,422	11.4%
342,368,431	237,523,868	104,844,563	44.1%	Total Operating Revenues	3,144,012,925	2,821,016,503	322,996,422	11.4%
				Medical Expenses				
107,641,998	76,008,238	(31,633,760)	(41.6%)	Provider capitation	985,176,591	903,684,046	(81,492,545)	(9.0%)
75,083,695	57,406,063	(17,677,632)	(30.8%)	Facilities	692,038,296	680,539,139	(11,499,157)	(1.7%)
18,143,009	18,258,740	115,731	0.6%	Professional Claims	211,301,847	210,134,387	(1,167,460)	(0.6%)
36,015,139	34,593,958	(1,421,181)	(4.1%)	Prescription drugs	421,494,696	412,580,077	(8,914,619)	(2.2%)
80,513,116	37,064,495	(43,448,621)	(117.2%)	MLTSS	660,113,386	445,038,862	(215,074,523)	(48.3%)
6,760,094	4,578,924	(2,181,170)	(47.6%)	Medical Management	38,820,658	53,924,244	15,103,587	28.0%
(80,365)	16,667	97,032	582.2%	Reinsurance & other	5,923,001	200,000	(5,723,002)	(2,861.5%)
324,076,685	227,927,084	(96,149,601)	(42.2%)	Total Medical Expenses	3,014,868,476	2,706,100,756	(308,767,720)	(11.4%)
18,291,747	9,596,784	8,694,962	90.6%	Gross Margin	129,144,450	114,915,748	14,228,702	12.4%
				Administrative Expenses				
(235,653)	6,647,963	6,883,617	103.5%	Salaries, wages & employee benefits	62,633,657	80,380,170	17,746,513	22.1%
(6,076)	329,612	335,687	101.8%	Professional fees	532,325	3,816,877	3,284,552	86.1%
1,127,008	830,052	(296,956)	(35.8%)	Purchased services	8,803,609	9,335,791	532,182	5.7%
479,497	311,420	(168,076)	(54.0%)	Printing and postage	2,953,510	3,746,523	793,013	21.2%
359,073	383,061	23,988	6.3%	Depreciation & amortization	4,023,152	4,596,733	573,580	12.5%
2,052,611	1,086,552	(966,059)	(88.9%)	Other operating expenses	13,644,426	13,102,910	(541,517)	(4.1%)
107,517	(540,702)	(648,219)	(119.9%)	Indirect cost allocation	(3,941,610)	(6,483,576)	(2,541,966)	(39.2%)
3,883,976	9,047,958	5,163,982	57.1%	Total Administrative Expenses	88,649,070	108,495,427	19,846,357	18.3%
				Operating Tax				
9,952,919	8,931,363	(1,021,556)	(11.4%)	Tax Revenue	137,975,273	106,277,305	(31,697,968)	(29.8%)
9,952,919	0	(9,952,919)	0.0%	Premium tax expense	122,405,394	0	(122,405,394)	0.0%
0	8,931,363	8,931,363	100.0%	Sales tax expense	15,569,879	106,277,305	90,707,426	85.3%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
75,000	287,500	(212,500)	(73.9%)	Grant Revenue	700,213	3,450,000	(2,749,788)	(79.7%)
63,750	250,000	186,250	74.5%	Grant expense - Service Partner	576,938	3,000,000	2,423,063	80.8%
21,879	37,500	15,621	41.7%	Grant expense - Administrative	252,918	450,000	197,082	43.8%
(10,629)	0	(10,629)	0.0%	Total Net Grant Income	(129,643)	0	(129,643)	0.0%
45	0	45	0.0%	Other income	1,397	0	1,397	0.0%
14,397,186	548,826	13,848,359	2,523.3%	Change in Net Assets	40,367,134	6,420,321	33,946,814	528.7%
94.7%	96.0%	1 3%	1.4%	Medical Loss Ratio	95.9%	95.9%	0 0%	0.0%
1.1%	3.8%	2.7%	70.2%	Admin Loss Ratio	2.8%	3.8%	1 0%	26.7%

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MEDI-CAL INCOME STATEMENT – JUNE MONTH:

REVENUES of $342.4 million are favorable to budget by $104.8 million, driven by:

- Unfavorable volume related variance of: $4.9 million
- Favorable price related variance of $109.7 million due to:
  - $56.5 million of fiscal year 2016 and 2017 Coordinated Care Initiative (CCI) revenue for rate adjustments received in June
  - $56.3 million of fiscal year 2016 LTC related revenue recognized for members with Non-LTC aid codes
  - $16.0 million unfavorable MCE revenue adjustment

MEDICAL EXPENSES: Overall $324.1 million, unfavorable to budget by $96.1 million due to:

- **Long term care claim payments (MLTSS)** are unfavorable to budget $43.4 million due to:
  - LTC unfavorable variance of $46.8 million driven mainly by higher LTC claim expense due to less than anticipated members enrolling in OneCare Connect and $35.0 million adjustment of IHSS expense corresponding with the favorable CCI revenue variance above
  - Nursing facility favorable variance of $4.0 million
- **Provider Capitation** is unfavorable $31.6 million due to shared risk group move to HMO model beginning February
- **Facilities** expenses are unfavorable to budget $17.7 million due to:
  - Unfavorable variance of $23.4 for Hospital Shared Risk pool
  - Favorable variance due to shared risk group move to HMO model beginning February

ADMINISTRATIVE EXPENSES are $3.9 million, favorable to budget $5.2 million, driven by:

- Salary & Benefits: $6.9 million favorable to budget due to open positions
- Non-Salary: $1.7 million unfavorable to budget

CHANGE IN NET ASSETS is $14.4 million for the month, favorable to budget by $13.8

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
15,505	21,454	(5,949)	(27.7%)	Member Months	202,010	261,930	(59,920)	(22.9%)
				Revenues				
18,623,469	11,373,361	7,250,108	63.7%	Medi-Cal Capitation revenue	91,829,630	141,076,871	(49,247,241)	(34.9%)
39,318,165	31,721,317	7,596,848	23.9%	Medicare Capitation revenue	279,801,318	392,041,788	(112,240,470)	(28.6%)
57,941,634	43,094,678	14,846,956	34.5%	Total Operating Revenue	371,630,947	533,118,659	(161,487,712)	(30.3%)
				Medical Expenses				
15,381,826	9,490,799	(5,891,027)	(62.1%)	Provider capitation	99,042,019	117,399,837	18,357,818	15.6%
12,454,586	11,058,483	(1,396,103)	(12.6%)	Facilities	96,936,316	135,860,504	38,924,188	28.7%
792,619	671,304	(121,315)	(18.1%)	Ancillary	9,411,853	8,195,744	(1,216,109)	(14.8%)
17,668,337	10,134,050	(7,534,287)	(74.3%)	Long Term Care	78,116,621	123,723,434	45,606,813	36.9%
4,130,587	7,922,580	3,791,993	47.9%	Prescription drugs	58,653,614	96,469,980	37,816,366	39.2%
687,348	1,267,249	579,901	45.8%	Medical management	11,766,329	14,980,878	3,214,549	21.5%
101,186	617,864	516,678	83.6%	Other medical expenses	1,298,487	7,543,305	6,244,819	82.8%
51,216,488	41,162,328	(10,054,160)	(24.4%)	Total Medical Expenses	355,225,238	504,173,683	148,948,445	29.5%
6,725,146	1,932,350	4,792,796	248.0%	Gross Margin	16,405,710	28,944,976	(12,539,266)	(43.3%)
				Administrative Expenses				
798,250	955,043	156,793	16.4%	Salaries, wages & employee benefits	9,305,962	11,405,360	2,099,398	18.4%
108,558	86,521	(22,037)	(25.5%)	Professional fees	426,673	958,646	531,973	55.5%
336,450	181,261	(155,189)	(85.6%)	Purchased services	1,871,003	2,159,607	288,604	13.4%
101,862	148,972	47,110	31.6%	Printing and postage	679,834	1,698,930	1,019,096	60.0%
60,904	2,910	(57,994)	(1,993.0%)	Other operating expenses	486,232	535,140	48,908	9.1%
114,657	937,491	822,834	87.8%	Indirect cost allocation, Occupancy Expense	7,770,338	11,249,888	3,479,550	30.9%
1,520,681	2,312,198	791,517	34.2%	Total Administrative Expenses	20,540,042	28,007,571	7,467,529	26.7%
				Operating Tax				
151,380	0	151,380	0.0%	Tax Revenue	(314,720)	0	(314,720)	0.0%
151,380	0	(151,380)	0.0%	Sales tax expense	(314,720)	0	314,720	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
5,204,465	(379,848)	5,584,313	1,470.1%	Change in Net Assets	(4,134,333)	937,405	(5,071,737)	(541.0%)
88.4%	95.5%	7.1%	7.5%	Medical Loss Ratio	95.6%	94.6%	-1.0%	-1.1%
2.6%	5.4%	2.7%	51.1%	Admin Loss Ratio	5.5%	5.3%	-0.3%	-5.2%

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ONECARE CONNECT INCOME STATEMENT – JUNE MONTH:

REVENUES of $57.9 million are favorable to budget by $14.8 million driven by:

- Volume related unfavorable variance of $11.9 million due to lower enrollment
- Price related favorable variance of $26.8 million due to:
  - $12.1 million of fiscal year 2016 and 2017 Coordinated Care Initiative (CCI) revenue for rate adjustments
  - $21.2 million from CMS' mid-year adjustments

MEDICAL EXPENSES are unfavorable to budget $10.1 million due to:

- Price related unfavorable variance of $21.5 million driven by:
  - $12.4 million of expenses corresponding to the CMS's mid-year HCC review
  - $10.3 million for LTC driven mainly by IHSS expense corresponding with the favorable CCI revenue variance above
- Volume related favorable variance of $11.4 million due to lower enrollment

ADMINISTRATIVE EXPENSES are favorable to budget by $0.8 million

CHANGE IN NET ASSETS is $5.2 million, $5.6 million favorable to budget

CalOptima - OneCare
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,121	1,122	(1)	(0.1%)	Member Months	14,843	14,227	616	4.3%
				Revenues				
2,752,881	1,640,403	1,112,478	67 8%	Capitation revenue	18,615,729	16,771,979	1,843,750	11.0%
2,752,881	1,640,403	1,112,478	67 8%	Total Operating Revenue	18,615,729	16,771,979	1,843,750	11.0%
				Medical Expenses				
933,901	485,583	(448,318)	(92.3%)	Provider capitation	5,321,478	4,604,863	(716,615)	(15.6%)
252,873	443,169	190,296	42 9%	Inpa ient	4,330,317	3,808,631	(521,686)	(13.7%)
56,761	43,498	(13,263)	(30.5%)	Ancillary	553,194	558,987	5,793	1.0%
25,341	20,637	(4,704)	(22.8%)	Skilled nursing facilities	512,533	265,572	(246,961)	(93.0%)
514,415	428,395	(86,020)	(20.1%)	Prescription drugs	5,312,486	5,436,159	123,673	2.3%
71,552	50,848	(20,704)	(40.7%)	Medical management	331,765	464,245	132,480	28.5%
129	(9,554)	(9,683)	(101.3%)	Other medical expenses	62,480	53,281	(9,198)	(17.3%)
1,854,971	1,462,576	(392,395)	(26.8%)	Total Medical Expenses	16,424,251	15,191,738	(1,232,513)	(8.1%)
897,910	177,827	720,083	404 9%	Gross Margin	2,191,478	1,580,241	611,237	38.7%
				Administrative Expenses				
26,256	21,707	(4,549)	(21.0%)	Salaries, wages & employee benefits	263,342	257,952	(5,391)	(2.1%)
30,013	17,619	(12,394)	(70.3%)	Professional fees	204,934	190,000	(14,934)	(7 9%)
(1,523)	19,373	20,896	107 9%	Purchased services	250,443	292,580	42,137	14.4%
10,102	13,710	3,608	26 3%	Prin ing and postage	118,338	158,211	39,873	25.2%
(18)	89	107	120.6%	Other operating expenses	2,333	1,063	(1,270)	(119.4%)
118,655	29,494	(89,161)	(302.3%)	Indirect cost allocation, Occupancy Expense	385,919	353,923	(31,996)	(9 0%)
183,486	101,991	(81,494)	(79.9%)	Total Administrative Expenses	1,225,310	1,253,728	28,418	2.3%
714,424	75,836	638,589	842.1%	Change in Net Assets	966,168	326,512	639,655	195.9%
67.4%	89.2%	21.8%	24.4%	Medical Loss Ra io	88.2%	90.6%	2.4%	2.6%
6.7%	6.2%	-0.4%	-7 2%	Admin Loss Ra io	6.6%	7.5%	0.9%	11.9%

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CalOptima - PACE
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
212	220	(8)	(3.6%)	Member Months	2,274	2,310	(36)	(1.6%)
				Revenues				
1,049,415	985,695	63,719	6.5%	Medi-Cal capitation revenue	11,669,779	10,341,308	1,328,472	12.8%
213,723	391,586	(177,863)	(45.4%)	Medicare capitation revenue	3,532,480	4,199,208	(666,728)	(15.9%)
1,263,137	1,377,281	(114,144)	(8.3%)	Total Operating Revenues	15,202,259	14,540,515	661,744	4.6%
				Medical Expenses				
333,214	428,907	95,693	22.3%	Clinical salaries & benefits	3,657,495	4,859,854	1,202,359	24.7%
0	0	0	0.0%	Pace Center Support salaries & benefits	0	0	0	0.0%
138,088	277,170	139,083	50.2%	Claims payments to hospitals	3,403,291	2,948,926	(454,365)	(15.4%)
412,542	299,688	(112,854)	(37.7%)	Professional Claims	3,068,533	3,145,241	76,708	2.4%
119,805	143,086	23,281	16.3%	Prescription drugs	1,189,940	1,598,041	408,101	25.5%
16,957	28,387	11,430	40.3%	Long-term care facility payments	71,746	302,022	230,275	76.2%
104,090	88,118	(15,972)	(18.1%)	Patient Transportation	1,015,633	937,520	(78,112)	(8.3%)
53,858	49,349	(4,509)	(9.1%)	Depreciation & amortization	596,336	592,188	(4,148)	(0.7%)
37,655	37,214	(441)	(1.2%)	Occupancy expenses	453,009	446,568	(6,441)	(1.4%)
17,256	13,833	(3,423)	(24.7%)	Utilities & Facilities Expense	169,608	165,996	(3,612)	(2.2%)
150	323	173	53.6%	Purchased Services	1,489	3,435	1,946	56.7%
100,640	24,547	(76,093)	(310.0%)	Indirect Allocation	306,361	294,564	(11,797)	(4.0%)
0	0	0	0.0%	Reinsurance	0	0	0	0.0%
30,881	22,785	(8,096)	(35.5%)	Other Expenses	225,656	273,421	47,765	17.5%
1,365,135	1,413,406	48,272	3.4%	Total Medical Expenses	14,159,096	15,567,776	1,408,679	9.0%
(101,998)	(36,125)	(65,872)	(182.3%)	Gross Margin	1,043,163	(1,027,260)	2,070,423	201.5%
				Administrative Expenses				
86,810	93,285	6,475	6.9%	Salaries, wages & employee benefits	1,100,825	1,115,205	14,380	1.3%
20,300	11,667	(8,633)	(74.0%)	Professional fees	77,484	115,000	37,516	32.6%
2,183	988	(1,195)	(120.9%)	Purchased services	41,512	12,000	(29,512)	(245.9%)
1,596	1,710	114	6.7%	Printing and postage	19,036	20,738	1,702	8.2%
2,244	2,056	(188)	(9.1%)	Depreciation & amortization	24,847	24,674	(173)	(0.7%)
37,509	14,775	(22,734)	(153.9%)	Other operating expenses	137,722	150,505	12,783	8.5%
5,762	1,023	(4,740)	(463.4%)	Indirect cost allocation, Occupancy Expense	31,639	12,273	(19,367)	(157.8%)
156,404	125,504	(30,901)	(24.6%)	Total Administrative Expenses	1,433,065	1,450,395	17,329	1.2%
				Operating Tax				
0	0	0	0.0%	Tax Revenue	14,215	0	14,215	0.0%
0	0	0	0.0%	Premium tax expense	14,215	0	(14,215)	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
(258,402)	(161,629)	(96,773)	(59.9%)	Change in Net Assets	(389,902)	(2,477,655)	2,087,753	84.3%
108.1%	102 6%	-5.5%	-5.3%	Medical Loss Ratio	93.1%	107.1%	13.9%	13.0%
12.4%	9.1%	-3.3%	-35.9%	Admin Loss Ratio	9.4%	10 0%	0.5%	5.5%

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CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
24,056	21,285	2,772	13.0%	Rental income	289,576	255,419	34,157	13.4%
24,056	21,285	2,772	13.0%	Total Operating Revenue	289,576	255,419	34,157	13.4%
				Administrative Expenses				
1,525	2,085	560	26.8%	Professional fees	17,724	25,020	7,296	29.2%
29,523	22,405	(7,118)	(31.8%)	Purchase services	357,879	268,857	(89,022)	(33.1%)
159,641	210,141	50,500	24.0%	Depreciation & amortization	1,900,304	2,521,689	621,385	24.6%
14,913	14,300	(613)	(4.3%)	Insurance expense	188,744	171,603	(17,141)	(10.0%)
107,279	198,033	90,754	45.8%	Repair and maintenance	1,267,316	2,329,698	1,062,383	45.6%
54,850	0	(54,850)	0.0%	Other Operating Expense	494,933	0	(494,933)	0.0%
(347,539)	(352,100)	(4,561)	(1.3%)	Indirect allocation, Occupancy Expense	(3,994,786)	(4,225,198)	(230,412)	(5.5%)
20,193	94,864	74,671	78.7%	Total Administrative Expenses	232,113	1,091,669	859,556	78.7%
3,863	(73,579)	77,442	105.3%	Change in Net Assets	57,462	(836,250)	893,713	106.9%

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OTHER STATEMENTS – JUNE MONTH:

ONECARE INCOME STATEMENT

REVENUES of $2.8 million, $1.1 million favorable to budget

MEDICAL EXPENSES are $1.9 million, $0.4 million unfavorable to budget

CHANGE IN NET ASSETS is $0.7 million, $0.6 million favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS for the month is ($0.3) million, $0.1 million unfavorable to budget

505 CITY PARKWAY BUILDING INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $3.9 thousand; $77.4 thousand favorable to budget

CalOptima
BALANCE SHEET
June 30, 2017

ASSETS			**LIABILITIES & FUND BALANCES**		
Current Assets			Current Liabilities		
	Operating Cash	$496,077,478		Accounts payable	$39,891,295
	Catastrophic Reserves	10,770,209		Medical claims liability	1,266,624,804
	Investments	1,082,765,356		Accrued payroll liabilities	9,858,588
	Capitation receivable	689,218,521		Deferred revenue	236,130,600
	Receivables - Other	21,084,090		Deferred lease obligations	197,123
	Prepaid Expenses	5,654,647		Capitation and withholds	595,252,382
	Total Current Assets	**2,305,570,301**		**Total Current Liabilities**	**2,147,954,790**
Capital Assets	Furniture and equipment	33,437,912	Other employment benefits liability		30,562,755
	Leasehold improvements	5,882,676			
	505 City Parkway West	49,422,364	Net Pension Liabilities		15,430,763
		88,742,952	Long Term Liabilities		100,000
	Less: accumulated depreciation	(34,441,925)			
	Capital assets, net	54,301,026	**TOTAL LIABILITIES**		**2,194,048,309**
Other Assets	Restricted deposit & Other	300,000	Deferred inflows of Resources - Excess Earnings		-
			Deferred inflows of Resources - Changes in Assumptions		1,340,010
	Board-designated assets				
	Cash and cash equivalents	17,716,161	Tangible net equity (TNE)		98,445,479
	Long term investments	517,422,213	Funds in excess of TNE		613,053,043
	Total Board-designated Assets	535,138,374			
	Total Other Assets	**535,438,374**	**Net Assets**		**711,498,522**
	Deferred outflows of Resources - Pension Contributions	5,234,198			
	Deferred outflows of Resources - Difference in Experience	1,072,771			
	Deferred outflows of Resources - Excess Earnings	5,270,171			
TOTAL ASSETS & OUTFLOWS		**2,906,886,841**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**		**2,906,886,841**

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CalOptima
Board Designated Reserve and TNE Analysis
as of June 30, 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,225,298				
	Tier 1 - Logan Circle	145,997,548				
	Tier 1 - Wells Capital	145,964,635				
Board-designated Reserve		438,187,482	305,408,833	478,489,252	132,778,649	(40,301,770)
TNE Requirement	Tier 2 - Logan Circle	96,950,892	98,445,479	98,445,479	(1,494,587)	(1,494,587)
	Consolidated:	**535,138,374**	**403,854,312**	**576,934,731**	**131,284,062**	**(41,796,357)**
	Current reserve level	*1.86*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
June 30, 2017

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	21,268,686	51,931,343
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	520,957	5,948,304
Changes in assets and liabilities:		
Prepaid expenses and other	398,840	1,129,600
Catastrophic reserves		
Capitation receivable	(338,139,353)	(223,551,604)
Medical claims liability	37,043,613	667,929,946
Deferred revenue	3,931,255	(354,572,041)
Payable to providers	58,759,012	193,426,080
Accounts payable	12,086,629	32,502,812
Other accrued liabilities	252,866	11,598,005
Net cash provided by/(used in) operating activities	(203,877,494)	386,342,446
GASB 68 CalPERS Adjustments	(5,670,365)	(7,388,653)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	255,006,335	(63,500,724)
Purchase of property and equipment	(560,150)	(5,253,766)
Change in Board designated reserves	20,126	(59,303,009)
Net cash provided by/(used in) investing activities	254,466,311	(128,057,498)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	44,918,452	250,896,294
CASH AND CASH EQUIVALENTS, beginning of period	$461,929,236	255,951,393
CASH AND CASH EQUIVALENTS, end of period	**$ 506,847,687**	**$ 506,847,687**

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BALANCE SHEET:

ASSETS increased $128.9 million from May

- **Net Capitation Receivables** increased $337.0 million based upon payment receipt timing and receivables
- **Short-term Investments** decreased $255.0 million due to payment receipt timing and cash funding requirements
- **Cash and Cash Equivalents** increased by $45.0 million based upon payment receipt timing and receivables

LIABILITIES increased $112.1 million from May

- **Medical Claims Liability** by line of business increased $37.0 million due to increase medical liability relating to Coordinated Care Initiative (CCI)
- **Capitation Payable** increased $58.8million driven by timing of Capitation payments
- **Accrued Expenses** increased $13.6 million based on the timing of sales tax payments and an earlier fiscal year-end processing cut-off

NET ASSETS are $711.5

CalOptima Foundation
Statement of Revenues and Expenses
For the Twelve Months Ended June 30, 2017
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	2,265	(2,265)	(100.0%)	Income - Grant	27,164	27,174	(10)	(0.0%)
(22,916)	0	(22,916)	0.0%	In Kind Revenue - HITEC Grant	53,665	0	53,665	0.0%
(22,916)	2,265	(25,181)	(1111.6%)	Total Operating Revenue	80,829	27,174	53,655	197.5%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	27,195	74,210	47,016	63.4%
0	2,985	2,985	100.0%	Taxes and Benefits	26,240	35,818	9,578	26.7%
0	0	0	0.0%	Travel	(3)	0	3	0.0%
0	0	0	0.0%	Supplies	7,009	10,000	2,991	29.9%
0	0	0	0.0%	Contractual	20,388	17,174	(3,214)	(18.7%)
2,084	232,066	229,982	99.1%	Other	26,706	2,784,783	2,758,077	99.0%
2,084	241,235	239,151	99.1%	Total Operating Expenditures	107,536	2,921,985	2,814,450	96.3%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
(25,000)	(238,970)	(213,970)	(89.5%)	Program Income	(26,706)	(2,894,811)	(2,868,105)	(99.1%)

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CalOptima Foundation
Balance Sheet
June 30, 2017

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,893,139	Accounts payable-Current	0
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	25,000
Total Current Assets	**2,893,139**	Grants-Foundation	0
		Total Current Liabilities	25,000
		Total Liabilities	**25,000**
		Net Assets	**2,868,139**
TOTAL ASSETS	**2,893,139**	**TOTAL LIABILITIES & NET ASSETS**	**2,893,139**

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CALOPTIMA FOUNDATION – JUNE MONTH

INCOME STATEMENT:

Revenues

- Revenues from Health Information Technology for Economic and Clinical Health Act (HITECH) and in-kind contributions from CalOptima
- The Foundation recognized $80,829 FY17 YTD in total operating revenues
    - HITECH Grant revenue totaled $27,164 YTD which leaves $0 remaining in HITECH Grant funding as of June 2017
    - CalOptima in-kind contribution totaled $53,665 YTD
- Revenue budget variances attributed to:
    - YTD CalOptima grant budget is $0, as the ONC grant funding was to have ended in the previous fiscal year. The grant was extended through September 26, 2016
    - CalOptima in-kind revenue was not included in FY17 budget

Expenses

- Operating expenses were $107,536 for grant related activities incurred YTD FY17
- Expense categories include staff services, travel and miscellaneous supplies
    - $2.8 million 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 transfer of $3.0 million from CalOptima for grants and programs in support of providers and the community

Liabilities

- $25 thousand relating to audit fees

Budget Allocation Changes

Reporting Changes as of June 2017

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,	$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 Equipment	$20,400	Re-allocate funds to cover costs of DocuSign, Box, and Primal Script 2016	2017
August	Medi-Cal	Claims Administration - Purchased Services	Claims Administration - Office Supplies, Training & Seminars, Printing	$15,000	Re-allocate funds from Purchased Services (Integration of Claim Editing Software & Inventory Management Forecasting) to Office Supplies, Training & Seminars, and Printing to better meet department's needs	2017
September	Medi-Cal	Health Education & Disease Management - Professional Fees	Health Education & Disease Management - Other Operating Expenses	$30,000	Re-allocate funds from Professional Fees (Childhood Obesity Program Design & Evaluation) to Member & Provider Incentives to support incentives for the Group Needs Assessment (GNA) and other Health Education / Disease Management	2017
October	Capital	Facilities - Relocate Trash Enclosure	Facilities - 505 Sound Recording System	$50,555	Re-allocate from Relocate Trash Enclosure project for additional funds that are needed for the 505 Sound Recording System project.	2017
October	Medi-Cal	IS-Infrastructure - Professional Fees - Enterprise Identity Access Management	IS-Infrastructure - HW/SW Maintenance - Information Security Data Loss Prevention Solution	$21,041	Re-allocate from Professional Services for an Enterprise Identity Access Management to HW/SW Maintenance for Information Security Data Loss Prevention Solution Annual Maintenance on additional funds that are needed.	2017
October	Medi-Cal	Facilities - Computer Supply/Minor Equipment - Office Furniture & Equipment	Facilities - Computer Supply/Minor Equipment - Other Articles of Minor Equipment	$27,000	Repurpose funds in Comp supply/minor equipment for re-upholstering chairs in the member service lobby and other minor equipment expenses to better meet the Department's need.	2017
December	Medi-Cal	Human Resources - Professional Fees - Executive Coaching	Human Resources - Professional Fees - Consultant Fees	$20,000	Repurpose from Executive Coaching for interim director of HR consultant fees	2017
December	Medi-Cal	Health Education & Disease Management - Medical Management Activities	Health Education & Disease Management - Medical Management Activities	$75,000	Repurpose funds for the department printing and postage needs	2017
January	Medi-Cal	IS-Application Development - Finance Reporting Tool to Great Plains	IS-Application Development - Great Plains Software Upgrade	$20,000	Re-allocate funds from Finance Reporting Software for Great Plains budget to Great Plains Software Upgrade budget for additional funds are needed to complete the project.	2017
February	Medi-Cal	IS-Application Management - Purchased Services	IS-Application Development - Purchased Services	$19,320	Re-allocate funds from IS Application Management Purchased Services budget for direct placement fee needed in the Department.	2017
February	Medi-Cal	IS-Application Management - Comp supply/Minor Equip	IS-Infrastructure - Subscriptions	$30,000	Re-allocate funds from Computer Supply/Minor Equipment for Gartner Subscription needed in the Department.	2017
February	Medi-Cal	IS-Infrastructure - Training & Seminars	IS-Infrastructure - Subscriptions	$30,000	Re-allocate funds from Training & Seminars for Gartner Subscription needed in the Department.	2017
February	Medi-Cal	IS-Application Management - Training & Seminars	IS-Infrastructure - Subscriptions	$10,741	Re-allocate funds from Training & Seminars for Gartner Subscription needed in the Department.	2017
February	Medi-Cal	Accounting - Professional Fees	Facilities - Professional Fees	$17,000	Re-allocate funds from Accounting Financial Audit budget to Facilities Professional Fees budget for consulting services related to restacking and other Facilities projects.	2017
February	Capital	IS-Application Development - Data Warehouse Enterprise Infrastructure Expansion	IS-Application Development - K2 Business Application Workflow Upgrade	$47,300	Re-allocate funds from Data Warehouse Enterprise Infrastructure Expansion to K2 Business Application Workflow Upgrade for additional funds needed to complete the project.	2017
March	Medi-Cal	IS - Infrastructure - Telephone	IS-Application Management - Maintenance HW/SW	$29,000	Re-allocate funds from Telephone Budget to HW/SW Maintenance budget for funds needed on Claim Editor Annual Renewal	2017
March	Medi-Cal	IS - Infrastructure - Professional Fees	IS - Infrastructure - Professional Fees	$14,000	Repurpose funds from miscellaneous consulting/professional services at the Cal Optima Data Center to support upcoming Microsoft 2016 upgrade.	2017
April	Medi-Cal	IS - Application Management - Purchased Services	Cultural & Linguistic Services - Purchased Services	$85,000	Re-allocate funds from Purchased Services in IS Application Management to Purchased Services in Cultural & Linguistic Services for funds needed in translation/interpreting services.	2017
April	Medi-Cal	Quality Improvement (Medical Management)- Public Activities, Telephone, Minor Equipment/Computer Supplies	Quality Improvement (Medical Management) - Subscriptions	$11,410	Re-allocate funds to Quality Improvement Subscriptions budget for additional funds needed for AMA subscriptions.	2017
May	Medi-Cal	Human Resources - Purchased Services	Human Resources - Advertising	$50,000	Re-allocate funds from general Purchased Services to Advertising to cover expenses for recruitment advertising.	2017
May	Medi-Cal	Accounting - Purchased Services	Accounting - Purchased Services	$34,000	Re-allocate funds from Purchased Services - Business Banking to general Purchased Services to cover expenses for Change Healthcare.	2017
May	Medi-Cal	Facilities - Computer Supply/Minor Equipment	Facilities - R&M - Building	$35,000	Re-allocate funds from Computer Supply/Minor Equipment to Building Repair & Maintenance in Facilities to cover expenses for various building maintenance services.	2017
May	Medi-Cal	Facilities - Rent - Equipment	Facilities - Rent - Storage	$30,000	Reallocate funds from Rent - Equipment to Rent - Storage in Facities to cover expenses for storage service with Corovan.	2017
May	Capital	Facilities - Exterior Stair & Patio Lighting, Parking Lot Cameras & Relocate Trash Enclosure	Facilities - 1st Floor Tenant Improvement (Mailroom, Kitchenette, Exterior Stairs)	$65,345	Reallocate funds from Exterior Stair & Patio Lighting, Parking Log Cameras and Trash Enclosure projects to 1st Floor Tenant Improvement (Mailroom, Kitchenette, Exterior Stairs) for additional funds needed.	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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Financial Summary

May 2017

Board of Directors Meeting

August 3, 2017

Nancy Huang

Interim Chief Financial Officer

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FY 2016-17: Consolidated Enrollment

- May 2017 MTD:
  - Overall enrollment was 790,113 member months
    - Actual lower than budget by 19,700 or 2.4%
      - Medi-Cal: unfavorable variance 14,144 members
        - Medi-Cal Expansion (MCE) favorable to budget by 11,973 members
        - SPD enrollment is favorable to budget by 4,426
        - TANF unfavorable variance 31,103 members
      - OneCare Connect: unfavorable variance of 5,734 members
    - 0.3% or 2,398 decrease from prior month
      - Medi-Cal: decrease of 2,231 from April
      - OneCare Connect: decrease of 202 from April
      - OneCare: increase of 31 from April
      - PACE: increase of 4 from April

FY 2016-17: Consolidated Enrollment

- May 2017 YTD:
  - Overall enrollment was 8,754,750 member months
    - Actual lower than budget by 89,968 or 1.0%
      - Medi-Cal: unfavorable variance of 36,586 members
        - Medi-Cal Expansion (MCE) growth higher than budget by 112,505
        - SPD enrollment higher than budget by 49,630 due to less than anticipated dual eligible members transferring to OneCare Connect
        - Offset by lower than budget TANF enrollment of 204,907
      - OneCare Connect: unfavorable variance of 53,971 members or 22.4%
      - PACE: unfavorable variance of 28 members or 1.3%
      - OneCare: favorable variance of 617 members or 4.7%

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FY 2016-17: Consolidated Revenues

- May 2017 MTD:
  - Actual lower than budget by $6.2 million or 2.2%
    - Medi-Cal: favorable to budget by $11.7 million or 4.9%
      - Price related favorable variance of $16.0 million due to:
        - $9.4 million of fiscal year 2017 relating to rate adjustment
        - $4.1 million for prior year related to member month adjustments
        - Remaining from member mix difference versus budget
      - Volume related unfavorable variance of $4.3 million
    - OneCare Connect: unfavorable variance of $18.0 million or 41.7%
      - Unfavorable volume variance of $11.5 million due to lower enrollment
      - Unfavorable price variance of $6.5 million due to CMC Medicare Part A and B rate decrease due to base rate and RAF score change

FY 2016-17: Consolidated Revenues (con't.)

- May 2017 YTD:
  - ➢ Actual higher than budget by $43.3 million or 1.4%
    - Medi-Cal: favorable to budget by $218.2 million or 8.4%
      - IHSS favorable revenue of $139.8 million
      - LTC favorable revenue of $65.4 million
    - OneCare Connect: unfavorable variance of $176.3 million or 36.0%
      - Medicare revenue unfavorable $119.8 million
      - Medi-Cal revenue unfavorable $56.5 million
    - OneCare: favorable $0.7 million or 4.8%
    - PACE: favorable $0.8 million or 5.9%

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FY 2016-17: Consolidated Medical Expenses

- May 2017 MTD:
  - Actual lower than budget by $10.2 million or 3.7%
    - Medi-Cal: unfavorable variance of $9.7 million
      - MLTSS unfavorable variance $11.8 million
        - LTC unfavorable variance of $8.1 million due to unbudgeted capitation
        - Nursing facility unfavorable variance of $2.2 million
      - Provider Capitation unfavorable variance of $12.4 million
        - Shared risk group move to HMO model in February
      - Facilities expenses favorable variance of $11.1 million
        - Shared risk group move to HMO model in February
        - Current month claim estimated adjustment relating to prior periods
    - OneCare Connect: favorable variance of $20.0 million
      - Favorable volume variance of $11.1 million
      - Favorable price variance of $8.9 million
        - $3.1 million for claim adjustments relating to prior periods
        - $1.9 million adjustment for shared risk pool estimates

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FY 2016-17: Consolidated Medical Expenses (Cont.)

- May 2017 YTD:
  - Actual higher than budget by $53.1 million or 1.8%
    - Medi-Cal: unfavorable variance of $212.6 million
      - Unfavorable price variance of $223.2 million
        - IHSS estimated expense $109.6 million higher than budget
        - Long Term Care expense $58.8 million higher than budget
        - Provider capitation unfavorable variance of $60.0 million for unbudgeted conversion of ASO contract to capitation
      - Favorable volume variance of $10.6 million
    - OneCare Connect: favorable variance of $159.0 million
      - Favorable volume variance of $103.9 million
      - Favorable price variance of $55.1 million

- Medical Loss Ratio (MLR):
  - May 2017 MTD: Actual: 95.7% Budget: 97.2%
  - May 2017 YTD: Actual: 96.1% Budget: 95.7%

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FY 2016-17: Consolidated Administrative Expenses

- May 2017 MTD:
  - Actual lower than budget by $3.2 million or 27.8%
    - Salaries and Benefits: favorable variance of $2.1 million
    - Other categories: favorable variance of $1.1 million

- May 2017 YTD:
  - Actual lower than budget by $21.5 million or 16.9%
    - Salaries and Benefits: favorable variance of $12.8 million driven by lower than budgeted FTE
    - Other categories: favorable variance of $8.7 million

- Administrative Loss Ratio (ALR):
  - May 2017 MTD: Actual: 3.0% Budget: 4.1%
  - May 2017 YTD: Actual: 3.4% Budget: 4.1%

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FY 2016-17: Change in Net Assets

- May 2017 MTD:
  - $5.9 million surplus
  - $9.5 million favorable to budget
    - Lower than budgeted revenue of $6.2 million
    - Lower than budgeted medical expenses of $10.2 million
    - Lower than budgeted administrative expenses of $3.2 million
    - Higher than budgeted investment and other income of $2.2 million

- May 2017 YTD:
  - $30.7 million surplus
  - $24.0 million favorable to budget
    - Higher than budgeted revenue of $43.3 million
    - Higher than budgeted medical expenses of $53.1 million
    - Lower than budgeted administrative expenses of $21.5 million
    - Higher than budgeted investment and other income of $12.3 million

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Enrollment Summary: May 2017

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
60,298	56,337	3,961	7.0%	Aged	649,002	611,057	37,945	6.2%
633	681	(48)	(7.0%)	BCCTP	6,847	7,455	(608)	(8.2%)
47,751	47,238	513	1.1%	Disabled	533,553	521,260	12,293	2.4%
326,037	345,542	(19,505)	(5.6%)	TANF Child	3,648,556	3,758,986	(110,430)	(2.9%)
96,781	108,379	(11,598)	(10.7%)	TANF Adult	1,106,592	1,201,069	(94,477)	(7.9%)
3,311	2,751	560	20.4%	LTC	35,997	29,810	6,187	20.8%
238,004	226,031	11,973	5.3%	MCE	2,571,914	2,459,409	112,505	4.6%
772,815	**786,959**	**(14,144)**	**(1.8%)**	**Medi-Cal**	**8,552,461**	**8,589,047**	**(36,586)**	**(0.4%)**
15,773	**21,507**	**(5,734)**	**(26.7%)**	**OneCare Connect**	**186,505**	**240,476**	**(53,971)**	**(22.4%)**
205	**215**	**(10)**	**(4.7%)**	**PACE**	**2,062**	**2,090**	**(28)**	**(1.3%)**
1,320	**1,132**	**188**	**16.6%**	**OneCare**	**13,722**	**13,105**	**617**	**4.7%**
790,113	**809,813**	**(19,700)**	**(2.4%)**	**CalOptima Total**	**8,754,750**	**8,844,718**	**(89,968)**	**(1.0%)**

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CalOptima A Public Agency Better. Together.

Financial Highlights: May 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
790,113	809,813	(19,700)	(2.4%)	Member Months	8,754,750	8,844,718	(89,968)	(1.0%)
276,676,079	282,863,820	(6,187,741)	(2.2%)	Revenues	3,145,135,777	3,101,811,427	43,324,351	1.4%
264,818,857	274,987,146	10,168,290	3.7%	Medical Expenses	3,022,163,783	2,969,068,559	(53,095,224)	(1.8%)
8,360,153	11,584,965	3,224,812	27.8%	Administrative Expenses	106,102,941	127,619,471	21,516,530	16.9%
3,497,069	**(3,708,291)**	**7,205,361**	**194.3%**	**Operating Margin**	**16,869,054**	**5,123,397**	**11,745,657**	**229.3%**
2,378,076	134,754	2,243,322	1664.8%	Non Operating Income (Loss)	13,793,603	1,528,996	12,264,606	802.1%
5,875,145	**(3,573,537)**	**9,448,682**	**264.4%**	**Change in Net Assets**	**30,662,657**	**6,652,394**	**24,010,263**	**360.9%**
95.7%	97.2%	1.5%		Medical Loss Ratio	96.1%	95.7%	(0.4%)	
3.0%	4.1%	1.1%		Administrative Loss Ratio	3.4%	4.1%	0.7%	
1.3%	(1.3%)	2.6%		Operating Margin Ratio	0.5%	0.2%	0.4%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima A Public Agency Better. Together.

Consolidated Performance Actual vs. Budget: May (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
1.7	(2.8)	4.5	Medi-Cal	26.0	5.9	20.1
0.1	0.0	0.1	OneCare	0.3	0.3	0.0
1.9	(0.8)	2.6	OCC	(9.3)	1.3	(10.7)
(0.2)	(0.2)	0.0	PACE	(0.1)	(2.3)	2.2
3.5	**(3.7)**	**7.2**	**Operating**	**16.8**	**5.1**	**11.6**
2.4	0.1	2.3	Inv./Rental Inc, MCO tax	13.9	1.5	12.4
2.4	**0.1**	**2.3**	**Non-Operating**	**13.9**	**1.5**	**12.4**
5.9	**(3.6)**	**9.4**	**TOTAL**	**30.7**	**6.7**	**24.0**

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Consolidated Revenue & Expense: May 2017 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	534,811	238,004	772,815	1,320	15,773	205	790,113
REVENUES							
Capitation Revenue	$ 144,364,534	$ 104,344,281	$ 248,708,815	$ 1,538,035	$ 25,164,363	$ 1,264,866	$ 276,676,079
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	144,364,534	104,344,281	248,708,815	1,538,035	25,164,363	1,264,866	276,676,079
MEDICAL EXPENSES							
Provider Capitation	39,052,638	49,164,203	88,216,841	381,140	7,976,679	-	96,574,661
Facilities	24,070,418	23,129,223	47,199,641	502,925	1,098,293	324,413	49,125,271
Ancillary	-	-	-	81,905	540,408	-	622,314
Skilled Nursing	-	-	-	(10,163)	-	-	(10,163)
Professional Claims	6,692,092	8,271,860	14,963,952	-	-	335,125	15,299,077
Prescription Drugs	18,675,034	18,126,444	36,801,479	350,361	4,759,682	121,319	42,032,841
Long-term Care Facility Payments	47,549,597	2,118,333	49,667,930	-	5,907,911	(4,494)	55,571,346
Medical Management	3,121,378	-	3,121,378	34,997	1,149,047	450,155	4,755,575
Reinsurance & Other	(632,708)	1,134,534	501,825	15,215	211,171	119,724	847,935
Total Medical Expenses	138,528,448	101,944,597	240,473,045	1,356,380	21,643,191	1,346,242	264,818,857
Medical Loss Ratio	**96.0%**	**97.7%**	**96.7%**	**88.2%**	**86.0%**	**106.4%**	**95.7%**
GROSS MARGIN	**5,836,086**	**2,399,684**	**8,235,770**	**181,655**	**3,521,172**	**(81,375)**	**11,857,222**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			4,848,121	26,144	629,753	87,730	5,591,748
Professional fees			(826,893)	10,078	(1)	10,250	(806,566)
Purchased services			739,612	7,329	219,341	226	966,509
Printing and Postage			485,574	21,358	25,362	8,598	540,892
Depreciation and Amortization			355,049	-	-	2,069	357,118
Other expenses			1,289,989	0	45,609	12,219	1,347,817
Indirect cost allocation, Occupancy expense			(394,117)	25,447	728,917	2,388	362,634
Total Administrative Expenses			6,497,336	90,355	1,648,982	123,480	8,360,153
Admin Loss Ratio			**2.6%**	**5.9%**	**6.6%**	**9.8%**	**3.0%**
INCOME (LOSS) FROM OPERATIONS			1,738,435	91,300	1,872,190	(204,856)	3,497,069
INVESTMENT INCOME			-	-	-	-	2,388,013
NET RENTAL INCOME			-	-	-	-	3,143
NET GRANT INCOME			(13,160)	-	-	-	(13,160)
OTHER INCOME			79	-	-	-	79
CHANGE IN NET ASSETS			**$ 1,725,354**	**$ 91,300**	**$ 1,872,190**	**$ (204,856)**	**$ 5,875,145**
BUDGETED CHANGE IN ASSETS			(2,786,070)	20,207	(750,445)	(191,983)	(3,573,537)
VARIANCE TO BUDGET - FAV (UNFAV)			4,511,424	71,093	2,622,635	(12,872)	9,448,682

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Consolidated Revenue & Expense: May 2017 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	5,980,547	2,571,914	8,552,461	13,722	186,505	2,062	8,754,750
REVENUES							
Capitation Revenue	$ 1,632,587,123	$ 1,169,057,371	$ 2,801,644,494	$ 15,862,848	$ 313,689,313	$ 13,939,122	$ 3,145,135,777
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	1,632,587,123	1,169,057,371	2,801,644,494	15,862,848	313,689,313	13,939,122	3,145,135,777
MEDICAL EXPENSES							
Provider Capitation	391,440,239	486,094,355	877,534,593	4,387,577	83,660,193	-	965,582,363
Facilities	306,817,927	310,136,675	616,954,602	4,077,444	84,481,730	3,265,204	708,778,980
Ancillary	-	-	-	496,433	8,619,234	-	9,115,667
Skilled Nursing	-	-	-	487,191	-	-	487,191
Professional Claims	95,068,552	98,090,287	193,158,839	-	-	2,655,991	195,814,830
Prescription Drugs	200,100,341	185,379,216	385,479,557	4,798,071	54,523,027	1,070,135	445,870,790
Long-term Care Facility Payments	546,537,947	33,062,323	579,600,270	-	60,448,284	54,790	640,103,344
Medical Management	32,060,564	-	32,060,564	260,213	11,078,981	4,435,804	47,835,562
Reinsurance & Other	(5,404,708)	11,408,075	6,003,367	62,351	1,197,301	1,312,038	8,575,057
Total Medical Expenses	1,566,620,861	1,124,170,930	2,690,791,791	14,569,280	304,008,750	12,793,961	3,022,163,783
Medical Loss Ratio	**96.0%**	**96.2%**	**96.0%**	**91.8%**	**96.9%**	**91.8%**	**96.1%**
GROSS MARGIN	**65,966,262**	**44,886,441**	**110,852,703**	**1,293,568**	**9,680,563**	**1,145,161**	**122,971,995**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			62,869,310	237,086	8,507,712	1,014,015	72,628,122
Professional Fees			538,400	174,921	318,114	57,184	1,088,620
Purchased services			7,676,602	251,966	1,534,553	39,329	9,502,450
Printing and Postage			2,474,014	108,236	577,972	17,440	3,177,661
Depreciation and Amortization			3,664,080			22,603	3,686,683
Other expenses			11,591,815	2,351	425,328	100,213	12,119,708
Indirect cost allocation, Occupancy expense			(4,049,127)	267,264	7,655,682	25,877	3,899,696
Total Administrative Expenses			84,765,093	1,041,825	19,019,362	1,276,661	106,102,941
Admin Loss Ratio			**3.0%**	**6.6%**	**6.1%**	**9.2%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			26,087,609	251,743	(9,338,798)	(131,501)	16,869,054
INVESTMENT INCOME			-	-	-	-	13,857,666
NET RENTAL INCOME			-	-	-	-	53,599
NET GRANT INCOME			(119,014)	-	-	-	(119,014)
OTHER INCOME			1,352	-	-	-	1,352
CHANGE IN NET ASSETS			**$ 25,969,947**	**$ 251,743**	**$ (9,338,798)**	**$ (131,501)**	**$ 30,662,657**
BUDGETED CHANGE IN ASSETS			5,871,494	250,676	1,317,253	(2,316,026)	6,652,394
VARIANCE TO BUDGET - FAV (UNFAV)			20,098,453	1,067	(10,656,051)	2,184,525	24,010,264

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CalOptima A Public Agency Better. Together.

Balance Sheet: As of May 2017

ASSETS		
Current Assets		
	Operating Cash	$451,044,353
	Catastrophic Reserves	10,884,883
	Investments	1,337,771,690
	Capitation receivable	352,244,397
	Receivables - Other	19,918,861
	Prepaid Expenses	6,053,486
	Total Current Assets	**2,177,917,671**
Capital Assets	Furniture and equipment	33,437,912
	Leasehold improvements	5,268,668
	505 City Parkway West	49,422,364
		88,128,944
	Less: accumulated depreciation	(33,867,110)
	Capital assets, net	**54,261,834**
Other Assets	Restricted deposit & Other	300,000
	Board-designated assets	
	Cash and cash equivalents	19,982,082
	Long term investments	515,176,417
	Total Board-designated Assets	535,158,500
	Total Other Assets	**535,458,500**
	Deferred outflows of Resources - Pension Contributions	9,133,218
	Deferred outflows of Resources - Difference in Experience	1,215,473
	Deferred outflows of Resources - Excess Earnings	-
TOTAL ASSETS & OUTFLOWS		**2,777,986,695**

LIABILITIES & FUND BALANCES		
Current Liabilities		
	Accounts payable	$26,246,617
	Medical claims liability	1,229,581,191
	Accrued payroll liabilities	11,416,636
	Deferred revenue	232,199,345
	Deferred lease obligations	203,482
	Capitation and withholds	536,493,370
	Total Current Liabilities	**2,036,140,641**
Other employment benefits liability		30,303,530
Net Pension Liabilities		15,430,763
Long Term Liabilities		100,000
TOTAL LIABILITIES		**2,081,974,934**
Deferred inflows of Resources - Excess Earnings		4,130,286
Deferred inflows of Resources - changes in Assumptions		1,651,640
Tangible net equity (TNE)		95,741,735
Funds in excess of TNE		594,488,101
Net Assets		**690,229,836**
TOTAL LIABILITIES, INFLOWS & FUND BALANCES		**2,777,986,695**

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CalOptima A Public Agency Better. Together.

Board Designated Reserve and TNE Analysis As of May 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,217,605				
	Tier 1 - Logan Circle	145,957,299				
	Tier 1 - Wells Capital	145,971,498				
Board-designated Reserve		438,146,402	296,331,304	464,362,606	141,815,098	(26,216,204)
TNE Requirement	Tier 2 - Logan Circle	97,012,098	95,741,735	95,741,735	1,270,363	1,270,363
	Consolidated:	**535,158,500**	**392,073,038**	**560,104,341**	**143,085,461**	**(24,945,841)**
	Current reserve level	*1.91*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

May 2017

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CalOptima
Financial Dashboard
For the Eleven Months Ended May 31, 2017

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	772,815	786,959	(14,144)	(1.8%)
OneCare	1,320	1,132	188	16.6%
OneCare Connect	15,773	21,507	(5,734)	(26.7%)
PACE	205	215	(10)	(4.7%)
Total	790,113	809,813	(19,700)	(2.4%)

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 1,725	$ (2,786)	$ 4,511	161.9%
OneCare	91	20	71	351.8%
OneCare Connect	1,872	(750)	2,623	349.5%
PACE	(205)	(192)	(13)	(6.7%)
505 Bldg.	3	(74)	77	104.3%
Investment Income & Other	2,388	208	2,180	1046.2%
Total	$ 5,875	$ (3,574)	$ 9,449	264.4%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.7%	97.4%	0.7
OneCare	88.2%	90.7%	2.5
OneCare Connect	86.0%	96.4%	10.4

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 6,497	$ 9,047	$ 2,549	28.2%
OneCare	90	102	11	11.3%
OneCare Connect	1,649	2,311	662	28.6%
PACE	123	125	2	1.6%
Total	$ 8,360	$ 11,585	$ 3,225	27.8%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	860	886	26
OneCare	4	3	(1)
OneCare Connect	234	239	5
PACE	48	61	13
Total	1,145	1,188	43

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	899	888	11
OneCare	329	377	(48)
OneCare Connect	67	90	(23)
PACE	4	4	1
Total	1,300	1,359	(59)

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	8,552,461	8,589,047	(36,586)	(0.4%)
OneCare	13,722	13,105	617	4.7%
OneCare Connect	186,505	240,476	(53,971)	(22.4%)
PACE	2,062	2,090	(28)	(1 3%)
Total	8,754,750	8,844,718	(89,968)	(1 0%)

Change in Net Assets ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 25,970	$ 5,871	$ 20,098	342 3%
OneCare	252	251	1	0.4%
OneCare Connect	(9,339)	1,317	(10,656)	(809 0%)
PACE	(132)	(2,316)	2,185	94 3%
505 Bldg.	54	(763)	816	107 0%
Investment Income & Other	13,858	2,292	11,566	504.7%
Total	$ 30,663	$ 6,652	$ 24,010	360 9%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96 0%	95.9%	(0.1)
OneCare	91 8%	90.7%	(1.1)
OneCare Connect	96 9%	94.5%	(2.4)

Administrative Cost ($000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 84,765	$ 99,447	$ 14,682	14 8%
OneCare	1,042	1,152	110	9 5%
OneCare Connect	19,019	25,695	6,676	26 0%
PACE	1,277	1,325	48	3.6%
Total	$ 106,103	$ 127,619	$ 21,517	16 9%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	9,311	9,745	434
OneCare	41	33	(8)
OneCare Connect	2,502	2,625	123
PACE	475	634	159
Total	12,207	13,036	829

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	919	881	37
OneCare	332	397	(65)
OneCare Connect	75	92	(17)
PACE	4	3	1
Total	1,329	1,373	(44)

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CalOptima - Consolidated
Financial Highlights
For the Eleven Months Ended May 31, 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
790,113	809,813	(19,700)	(2.4%)	Member Months	8,754,750	8,844,718	(89,968)	(1.0%)
276,676,079	282,863,820	(6,187,741)	(2.2%)	Revenues	3,145,135,777	3,101,811,427	43,324,351	1.4%
264,818,857	274,987,146	10,168,290	3.7%	Medical Expenses	3,022,163,783	2,969,068,559	(53,095,224)	(1.8%)
8,360,153	11,584,965	3,224,812	27.8%	Administrative Expenses	106,102,941	127,619,471	21,516,530	16.9%
3,497,069	**(3,708,291)**	**7,205,361**	**194.3%**	**Operating Margin**	**16,869,054**	**5,123,397**	**11,745,657**	**229.3%**
2,378,076	134,754	2,243,322	1664.8%	Non Operating Income (Loss)	13,793,603	1,528,996	12,264,606	802.1%
5,875,145	**(3,573,537)**	**9,448,682**	**264.4%**	**Change in Net Assets**	**30,662,657**	**6,652,394**	**24,010,263**	**360.9%**
95.7%	97.2%	1.5%		Medical Loss Ratio	96.1%	95.7%	(0.4%)	
3.0%	4.1%	1.1%		Administrative Loss Ratio	3.4%	4.1%	0.7%	
1.3%	(1.3%)	2.6%		Operating Margin Ratio	0.5%	0.2%	0.4%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended May 31, 2017

	Month					
	Actual		Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	790,113		809,813		(19,700)	
Revenues						
Medi-Cal	$ 248,708,815	$ 321.82	$ 236,999,235	$ 301.16	$ 11,709,580	$ 20.66
OneCare	1,538,035	1,165.18	1,317,397	1,163.78	220,638	1.40
OneCare Connect	25,164,363	1,595.41	43,200,520	2,008.67	(18,036,157)	(413.27)
PACE	1,264,866	6,170.08	1,346,668	6,263.57	(81,801)	(93.49)
Total Operating Revenue	276,676,079	350.17	282,863,820	349.30	(6,187,741)	0.88
Medical Expenses						
Medi-Cal	240,473,045	311.17	230,738,547	293.20	(9,734,498)	(17.96)
OneCare	1,356,380	1,027.56	1,195,349	1,055.96	(161,031)	28.40
OneCare Connect	21,643,191	1,372.17	41,640,063	1,936.12	19,996,872	563.95
PACE	1,346,242	6,567.03	1,413,188	6,572.97	66,946	5.93
Total Medical Expenses	264,818,857	335.17	274,987,146	339.57	10,168,290	4.40
Gross Margin	11,857,222	15.01	7,876,673	9.73	3,980,549	5.28
Administrative Expenses						
Salaries and Benefits	5,591,748	7.08	7,718,413	9.53	2,126,665	2.45
Professional fees	(806,566)	(1.02)	445,419	0.55	1,251,984	1.57
Purchased services	966,509	1.22	1,031,208	1.27	64,700	0.05
Printing and Postage	540,892	0.68	475,927	0.59	(64,965)	(0.10)
Depreciation and Amortization	357,118	0.45	385,117	0.48	27,999	0.02
Other	1,347,817	1.71	1,101,575	1.36	(246,242)	(0.35)
Indirect cost allocation, Occupancy expense	362,634	0.46	427,305	0.53	64,671	0.07
Total Administrative Expenses	8,360,153	10.58	11,584,965	14.31	3,224,812	3.72
Income (Loss) From Operations	3,497,069	4.43	(3,708,291)	(4.58)	7,205,361	9.01
Investment income						
Interest income	2,091,427	2.65	208,333	0.26	1,883,093	2.39
Realized gain/(loss) on investments	(126,461)	(0.16)	-	-	(126,461)	(0.16)
Unrealized gain/(loss) on investments	423,047	0.54	-	-	423,047	0.54
Total Investment Income	2,388,013	3.02	208,333	0.26	2,179,680	2.77
Net Rental Income	3,143	0.00	(73,579)	(0.09)	76,723	0.09
Total Net Grant Income	(13,160)	(0.02)	-	-	(13,160)	(0.02)
Other Income	79	0.00	-	-	79	0.00
Change In Net Assets	**5,875,145**	**7.44**	**(3,573,537)**	**(4.41)**	**9,448,682**	**11.85**
Medical Loss Ratio	**95.7%**		**97.2%**		**1.5%**	
Administrative Loss Ratio	**3.0%**		**4.1%**		**1.1%**	

* 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 Eleven Months Ended May 31, 2017

	Year to Date					
	Actual		Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	8,754,750		8,844,718		(89,968)	
Revenues						
Medi-Cal	$ 2,801,644,494	$ 327.58	$ 2,583,492,635	$ 300.79	$ 218,151,859	$ 26.79
OneCare	15,862,848	1,156.02	15,131,576	1,154.64	731,272	1.37
OneCare Connect	313,689,313	1,681.94	490,023,981	2,037.73	(176,334,668)	(355.79)
PACE	13,939,122	6,760.00	13,163,234	6,298.20	775,888	461.80
Total Operating Revenue	3,145,135,777	359.25	3,101,811,427	350.70	43,324,351	8.55
Medical Expenses						
Medi-Cal	2,690,791,791	314.62	2,478,173,672	288.53	(212,618,119)	(26.09)
OneCare	14,569,280	1,061.75	13,729,163	1,047.63	(840,118)	(14.12)
OneCare Connect	304,008,750	1,630.03	463,011,355	1,925.40	159,002,605	295.37
PACE	12,793,961	6,204.64	14,154,369	6,772.43	1,360,408	567.79
Total Medical Expenses	3,022,163,783	345.20	2,969,068,559	335.69	(53,095,224)	(9.51)
Gross Margin	122,971,995	14.05	132,742,868	15.01	(9,770,873)	(0.96)
Administrative Expenses						
Salaries and Benefits	72,628,122	8.30	85,440,688	9.66	12,812,565	1.36
Professional fees	1,088,620	0.12	4,635,104	0.52	3,546,484	0.40
Purchased services	9,502,450	1.09	10,768,304	1.22	1,265,855	0.13
Printing and Postage	3,177,661	0.36	5,148,589	0.58	1,970,928	0.22
Depreciation and Amortization	3,686,683	0.42	4,236,290	0.48	549,607	0.06
Other	12,119,708	1.38	12,685,292	1.43	565,585	0.05
Indirect cost allocation, Occupancy expense	3,899,696	0.45	4,705,203	0.53	805,507	0.09
Total Administrative Expenses	106,102,941	12.12	127,619,471	14.43	21,516,530	2.31
Income (Loss) From Operations	16,869,054	1.93	5,123,397	0.58	11,745,657	1.35
Investment income						
Interest income	17,778,724	2.03	2,291,667	0.26	15,487,057	1.77
Realized gain/(loss) on investments	(314,723)	(0.04)	-	-	(314,723)	(0.04)
Unrealized gain/(loss) on investments	(3,606,335)	(0.41)	-	-	(3,606,335)	(0.41)
Total Investment Income	13,857,666	1.58	2,291,667	0.26	11,565,999	1.32
Net Rental Income	53,599	0.01	(762,671)	(0.09)	816,270	0.09
Total Net Grant Income	(119,014)	(0)	-	-	(119,014)	(0)
Other Income	1,352	0.00	-	-	1,352	0.00
Change In Net Assets	**30,662,657**	**3.50**	**6,652,394**	**0.75**	**24,010,264**	**2.75**
Medical Loss Ratio	**96.1%**		**95.7%**		**(0.4%)**	
Administrative Loss Ratio	**3.4%**		**4.1%**		**0.7%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment

** Includes MSSP

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended May 31, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	534,811	238,004	772,815	1,320	15,773	205	790,113
REVENUES							
Capitation Revenue	$ 144,364,534	$ 104,344,281	$ 248,708,815	$ 1,538,035	$ 25,164,363	$ 1,264,866	$ 276,676,079
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	144,364,534	104,344,281	248,708,815	1,538,035	25,164,363	1,264,866	276,676,079
MEDICAL EXPENSES							
Provider Capitation	39,052,638	49,164,203	88,216,841	381,140	7,976,679	-	96,574,661
Facilities	24,070,418	23,129,223	47,199,641	502,925	1,098,293	324,413	49,125,271
Ancillary	-	-	-	81,905	540,408	-	622,314
Skilled Nursing	-	-	-	(10,163)	-	-	(10,163)
Professional Claims	6,692,092	8,271,860	14,963,952	-	-	335,125	15,299,077
Prescription Drugs	18,675,034	18,126,444	36,801,479	350,361	4,759,682	121,319	42,032,841
Long-term Care Facility Payments	47,549,597	2,118,333	49,667,930	-	5,907,911	(4,494)	55,571,346
Medical Management	3,121,378	-	3,121,378	34,997	1,149,047	450,155	4,755,575
Reinsurance & Other	(632,708)	1,134,534	501,825	15,215	211,171	119,724	847,935
Total Medical Expenses	138,528,448	101,944,597	240,473,045	1,356,380	21,643,191	1,346,242	264,818,857
Medical Loss Ratio	**96.0%**	**97.7%**	**96.7%**	**88.2%**	**86.0%**	**106.4%**	**95.7%**
GROSS MARGIN	**5,836,086**	**2,399,684**	**8,235,770**	**181,655**	**3,521,172**	**(81,375)**	**11,857,222**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			4,848,121	26,144	629,753	87,730	5,591,748
Professional fees			(826,893)	10,078	(1)	10,250	(806,566)
Purchased services			739,612	7,329	219,341	226	966,509
Printing and Postage			485,574	21,358	25,362	8,598	540,892
Depreciation and Amortization			355,049	-	-	2,069	357,118
Other expenses			1,289,989	0	45,609	12,219	1,347,817
Indirect cost allocation, Occupancy expense			(394,117)	25,447	728,917	2,388	362,634
Total Administrative Expenses			6,497,336	90,355	1,648,982	123,480	8,360,153
Admin Loss Ratio			**2.6%**	**5.9%**	**6.6%**	**9.8%**	**3.0%**
INCOME (LOSS) FROM OPERATIONS			1,738,435	91,300	1,872,190	(204,856)	3,497,069
INVESTMENT INCOME			-	-	-	-	2,388,013
NET RENTAL INCOME			-	-	-	-	3,143
NET GRANT INCOME			(13,160)	-	-	-	(13,160)
OTHER INCOME			79	-	-	-	79
CHANGE IN NET ASSETS			**$ 1,725,354**	**$ 91,300**	**$ 1,872,190**	**$ (204,856)**	**$ 5,875,145**
BUDGETED CHANGE IN ASSETS			(2,786,070)	20,207	(750,445)	(191,983)	(3,573,537)
VARIANCE TO BUDGET - FAV (UNFAV)			4,511,424	71,093	2,622,635	(12,872)	9,448,682

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Eleven Months Ended May 31, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	5,980,547	2,571,914	8,552,461	13,722	186,505	2,062	8,754,750
REVENUES							
Capitation Revenue	$ 1,632,587,123	$ 1,169,057,371	$ 2,801,644,494	$ 15,862,848	$ 313,689,313	$ 13,939,122	$ 3,145,135,777
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	1,632,587,123	1,169,057,371	2,801,644,494	15,862,848	313,689,313	13,939,122	3,145,135,777
MEDICAL EXPENSES							
Provider Capitation	391,440,239	486,094,355	877,534,593	4,387,577	83,660,193	-	965,582,363
Facilities	306,817,927	310,136,675	616,954,602	4,077,444	84,481,730	3,265,204	708,778,980
Ancillary	-	-	-	496,433	8,619,234	-	9,115,667
Skilled Nursing	-	-	-	487,191	-	-	487,191
Professional Claims	95,068,552	98,090,287	193,158,839	-	-	2,655,991	195,814,830
Prescription Drugs	200,100,341	185,379,216	385,479,557	4,798,071	54,523,027	1,070,135	445,870,790
Long-term Care Facility Payments	546,537,947	33,062,323	579,600,270	-	60,448,284	54,790	640,103,344
Medical Management	32,060,564	-	32,060,564	260,213	11,078,981	4,435,804	47,835,562
Reinsurance & Other	(5,404,708)	11,408,075	6,003,367	62,351	1,197,301	1,312,038	8,575,057
Total Medical Expenses	1,566,620,861	1,124,170,930	2,690,791,791	14,569,280	304,008,750	12,793,961	3,022,163,783
Medical Loss Ratio	**96.0%**	**96.2%**	**96.0%**	**91.8%**	**96.9%**	**91.8%**	**96.1%**
GROSS MARGIN	**65,966,262**	**44,886,441**	**110,852,703**	**1,293,568**	**9,680,563**	**1,145,161**	**122,971,995**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			62,869,310	237,086	8,507,712	1,014,015	72,628,122
Professional Fees			538,400	174,921	318,114	57,184	1,088,620
Purchased services			7,676,602	251,966	1,534,553	39,329	9,502,450
Printing and Postage			2,474,014	108,236	577,972	17,440	3,177,661
Depreciation and Amortization			3,664,080			22,603	3,686,683
Other expenses			11,591,815	2,351	425,328	100,213	12,119,708
Indirect cost allocation, Occupancy expense			(4,049,127)	267,264	7,655,682	25,877	3,899,696
Total Administrative Expenses			84,765,093	1,041,825	19,019,362	1,276,661	106,102,941
Admin Loss Ratio			**3.0%**	**6.6%**	**6.1%**	**9.2%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			26,087,609	251,743	(9,338,798)	(131,501)	16,869,054
INVESTMENT INCOME			-	-	-	-	13,857,666
NET RENTAL INCOME			-	-	-	-	53,599
NET GRANT INCOME			(119,014)	-	-	-	(119,014)
OTHER INCOME			1,352	-	-	-	1,352
CHANGE IN NET ASSETS			**$ 25,969,947**	**$ 251,743**	**$ (9,338,798)**	**$ (131,501)**	**$ 30,662,657**
BUDGETED CHANGE IN ASSETS			5,871,494	250,676	1,317,253	(2,316,026)	6,652,394
VARIANCE TO BUDGET - FAV (UNFAV)			20,098,453	1,067	(10,656,051)	2,184,525	24,010,264

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SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $5.9 million, $9.4 million favorable to budget
- Operating surplus is $3.5 million with a surplus in non-operating of $2.4 million

YEARLY RESULTS:

- Change in Net Assets is $30.7 million, $24.0 million favorable to budget
- Operating surplus is $16.8 million with a surplus in non-operating of $13.9 million

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
1.7	(2.8)	4.5	Medi-Cal	26.0	5.9	20.1
0.1	0.0	0.1	OneCare	0.3	0.3	0.0
1.9	(0.8)	2.6	OCC	(9.3)	1.3	(10.7)
(0.2)	(0.2)	0.0	PACE	(0.1)	(2.3)	2.2
3.5	**(3.7)**	**7.2**	**Operating**	**16.8**	**5.1**	**11.6**
2.4	0.1	2.3	Inv./Rental Inc, MCO tax	13.9	1.5	12.4
2.4	**0.1**	**2.3**	**Non-Operating**	**13.9**	**1.5**	**12.4**
5.9	**(3.6)**	**9.4**	**TOTAL**	**30.7**	**6.7**	**24.0**

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CalOptima

Enrollment Summary

For the Eleven Months Ended May 31, 2017

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
60,298	56,337	3,961	7.0%	Aged	649,002	611,057	37,945	6.2%
633	681	(48)	(7.0%)	BCCTP	6,847	7,455	(608)	(8.2%)
47,751	47,238	513	1.1%	Disabled	533,553	521,260	12,293	2.4%
326,037	345,542	(19,505)	(5.6%)	TANF Child	3,648,556	3,758,986	(110,430)	(2.9%)
96,781	108,379	(11,598)	(10.7%)	TANF Adult	1,106,592	1,201,069	(94,477)	(7.9%)
3,311	2,751	560	20.4%	LTC	35,997	29,810	6,187	20.8%
238,004	226,031	11,973	5.3%	MCE	2,571,914	2,459,409	112,505	4.6%
772,815	**786,959**	**(14,144)**	**(1.8%)**	**Medi-Cal**	**8,552,461**	**8,589,047**	**(36,586)**	**(0.4%)**
15,773	**21,507**	**(5,734)**	**(26.7%)**	**OneCare Connect**	**186,505**	**240,476**	**(53,971)**	**(22.4%)**
205	**215**	**(10)**	**(4.7%)**	**PACE**	**2,062**	**2,090**	**(28)**	**(1.3%)**
1,320	**1,132**	**188**	**16.6%**	**OneCare**	**13,722**	**13,105**	**617**	**4.7%**
790,113	**809,813**	**(19,700)**	**(2.4%)**	**CalOptima Total**	**8,754,750**	**8,844,718**	**(89,968)**	**(1.0%)**
				Enrollment (By Network)				
136,331	50,418	85,913	170.4%	HMO	887,462	533,867	353,595	66.2%
221,812	237,197	(15,385)	(6.5%)	PHC	2,501,284	2,589,054	(87,770)	(3.4%)
238,002	340,293	(102,291)	(30.1%)	Shared Risk Group	3,344,528	3,744,903	(400,375)	(10.7%)
176,670	159,051	17,619	11.1%	Fee for Service	1,819,187	1,721,223	97,964	5.7%
772,815	**786,959**	**(14,144)**	**(1.8%)**	**Medi-Cal**	**8,552,461**	**8,589,047**	**(36,586)**	**(0.4%)**
15,773	**21,507**	**(5,734)**	**(26.7%)**	**OneCare Connect**	**186,505**	**240,476**	**(53,971)**	**(22.4%)**
205	**215**	**(10)**	**(4.7%)**	**PACE**	**2,062**	**2,090**	**(28)**	**(1.3%)**
1,320	**1,132**	**188**	**16.6%**	**OneCare**	**13,722**	**13,105**	**617**	**4.7%**
790,113	**809,813**	**(19,700)**	**(2.4%)**	**CalOptima Total**	**8,754,750**	**8,844,718**	**(89,968)**	**(1.0%)**

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CalOptima
Enrollment Trend by Network Type
Fiscal Year 2017

Network Type	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	MMs
HMO													
Aged	351	350	355	368	363	381	379	3,103	3,062	3,050	3,031	-	14,793
BCCTP	1	1	1	(8)	2	1	1	1	1	1	-	-	2
Disabled	1,799	1,797	1,813	1,866	1,853	1,858	1,875	5,780	5,752	5,697	5,597	-	35,687
TANF Child	24,211	24,455	24,733	24,928	24,987	25,083	24,928	53,811	53,432	52,933	52,852	-	386,353
TANF Adult	7,929	7,872	7,914	7,850	8,029	7,967	7,871	25,446	25,155	24,830	24,776	-	155,639
LTC	-	-	-	-	-	-	-	3	4	3	4	-	14
MCE	12,989	13,224	13,464	14,034	13,897	14,116	14,200	49,527	49,627	49,825	50,071	-	294,974
	47,280	47,699	48,280	49,038	49,131	49,406	49,254	137,671	137,033	136,339	136,331	-	887,462
PHC													
Aged	1,495	1,464	1,488	1,458	1,427	1,419	1,408	1,439	1,420	1,416	1,418	-	15,852
BCCTP	-	-	-	1	-	-	-	-	-	-	-	-	1
Disabled	7,903	7,872	7,862	7,865	7,804	7,779	7,783	7,751	7,741	7,647	7,494	-	85,501
TANF Child	169,358	168,529	169,733	169,714	168,615	168,294	165,979	164,330	163,343	162,600	162,489	-	1,832,984
TANF Adult	15,260	14,945	14,649	14,593	14,161	13,880	13,457	13,195	13,019	12,782	12,739	-	152,680
LTC	-	-	-	4	-	-	-	-	-	-	1	-	5
MCE	38,002	38,200	37,601	38,070	37,874	37,886	37,361	37,214	37,122	37,260	37,671	-	414,261
	232,018	231,010	231,333	231,705	229,881	229,258	225,988	223,929	222,645	221,705	221,812	-	2,501,284
Shared Risk Group													
Aged	7,658	7,627	7,635	7,726	7,528	7,546	7,501	4,834	4,813	4,800	4,805	-	72,473
BCCTP	-	-	-	8	1	-	-	-	-	-	-	-	9
Disabled	14,428	14,307	14,189	14,253	14,073	14,084	14,005	10,083	10,022	9,861	9,635	-	138,940
TANF Child	118,748	118,149	118,421	117,922	116,971	116,744	114,746	84,105	83,246	82,334	81,854	-	1,153,240
TANF Adult	63,849	62,814	62,579	62,266	61,355	60,893	59,355	40,848	40,247	39,602	39,265	-	593,073
LTC	-	-	-	3	3	3	5	3	5	5	-	-	27
MCE	140,640	140,811	137,172	139,776	139,565	140,094	138,165	103,233	102,694	102,173	102,443	-	1,386,766
	345,323	343,708	339,996	341,954	339,496	339,364	333,777	243,106	241,027	238,775	238,002	-	3,344,528
Fee for Service (Dual)													
Aged	43,684	45,173	45,173	45,522	46,007	46,233	46,592	46,682	46,856	47,201	46,986	-	506,109
BCCTP	27	26	24	23	23	23	25	27	27	28	28	-	281
Disabled	19,790	20,086	20,071	20,264	20,375	20,497	20,471	20,510	20,662	20,528	20,324	-	223,578
TANF Child	3	2	2	3	4	3	3	2	2	3	4	-	31
TANF Adult	1,179	1,162	1,184	1,197	1,181	1,216	1,220	1,200	1,211	1,217	1,197	-	13,164
LTC	2,868	2,910	2,941	2,906	2,940	2,914	2,914	2,913	2,887	2,963	2,977	-	32,133
MCE	2,960	2,975	2,721	2,750	2,822	2,893	2,818	2,842	2,852	2,789	2,808	-	31,230
	70,511	72,334	72,116	72,665	73,352	73,779	74,043	74,176	74,497	74,729	74,324	-	806,526
Fee for Service (Non-Dual)													
Aged	3,746	2,850	3,183	3,608	3,450	3,667	3,600	3,761	3,794	4,058	4,058	-	39,775
BCCTP	606	608	598	589	594	595	587	590	589	593	605	-	6,554
Disabled	4,533	4,269	4,390	4,368	4,488	4,548	4,567	4,569	4,643	4,771	4,701	-	49,847
TANF Child	22,710	23,011	22,504	23,069	23,658	23,949	25,193	25,695	28,202	29,119	28,838	-	275,948
TANF Adult	15,792	16,253	16,501	17,109	17,090	17,340	17,949	17,668	18,603	18,927	18,804	-	192,036
LTC	368	370	362	314	334	328	357	338	353	365	329	-	3,818
MCE	35,946	36,543	37,812	36,999	38,607	39,499	42,203	41,903	44,495	45,665	45,011	-	444,683
	83,701	83,904	85,350	86,056	88,221	89,926	94,456	94,524	100,679	103,498	102,346	-	1,012,661
MEDI-CAL TOTAL													
Aged	56,934	57,464	57,834	58,682	58,775	59,246	59,480	59,819	59,945	60,525	60,298	-	649,002
BCCTP	634	635	623	613	620	619	613	618	617	622	633	-	6,847
Disabled	48,453	48,331	48,325	48,616	48,593	48,766	48,701	48,693	48,820	48,504	47,751	-	533,553
TANF Child	335,030	334,146	335,393	335,636	334,235	334,073	330,849	327,943	328,225	326,989	326,037	-	3,648,556
TANF Adult	104,009	103,046	102,827	103,015	101,816	101,296	99,852	98,357	98,235	97,358	96,781	-	1,106,592
LTC	3,236	3,280	3,303	3,227	3,277	3,245	3,276	3,257	3,249	3,336	3,311	-	35,997
MCE	230,537	231,753	228,770	231,629	232,765	234,488	234,747	234,719	236,790	237,712	238,004	-	2,571,914
	778,833	778,655	777,075	781,418	780,081	781,733	777,518	773,406	775,881	775,046	772,815	-	8,552,461
PACE	177	179	179	180	183	183	184	194	197	201	205	-	2,062
OneCare	1,171	1,164	1,192	1,220	1,228	1,275	1,304	1,281	1,278	1,289	1,320	-	13,722
OneCare Connect	18,902	18,245	17,727	17,352	17,067	16,810	16,346	16,222	16,086	15,975	15,773	-	186,505
TOTAL	799,083	798,243	796,173	800,170	798,559	800,001	795,352	791,103	793,442	792,511	790,113	-	8,754,750

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ENROLLMENT:

Overall MTD enrollment was 790,113

- Unfavorable to budget by 19,700
- Decreased 2,398 or 0.3% from prior month
- Increased 5,351 or 0.7% from prior year (May 2016)

Medi-Cal enrollment was 772,815

- Unfavorable to budget by 14,144
    - Expansion favorable by 11,973
    - SPD favorable by 4,426
    - LTC favorable by 560
    - TANF unfavorable by 31,103
- Decreased 2,231 from prior month

OneCare Connect enrollment was 15,773

- Unfavorable to budget by 5,734
- Decreased 202 from prior month

OneCare enrollment was 1,320

- Favorable to budget by 188
- Increased 31 from prior month

PACE enrollment at 205

- Unfavorable to budget by 10
- Increased 4 from prior month

CalOptima - Medi-Cal Total
Statement of Revenues and Expenses
For the Eleven Months Ended May 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
772,815	786,959	(14,144)	(1.8%)	Member Months	8,552,461	8,589,047	(36,586)	(0.4%)
				Revenues				
248,708,815	236,999,235	11,709,580	4.9%	Capitation revenue	2,801,644,494	2,583,492,635	218,151,859	8.4%
248,708,815	236,999,235	11,709,580	4.9%	Total Operating Revenues	2,801,644,494	2,583,492,635	218,151,859	8.4%
				Medical Expenses				
88,216,841	75,834,312	(12,382,530)	(16.3%)	Provider capitation	877,534,593	827,675,808	(49,858,785)	(6.0%)
47,199,641	58,348,426	11,148,785	19.1%	Facilities	616,954,602	623,133,076	6,178,474	1.0%
14,963,952	18,513,346	3,549,394	19.2%	Professional Claims	193,158,839	191,875,647	(1,283,191)	(0.7%)
36,801,479	35,589,656	(1,211,823)	(3.4%)	Prescription drugs	385,479,557	377,986,119	(7,493,438)	(2.0%)
49,667,930	37,855,915	(11,812,015)	(31.2%)	MLTSS	579,600,270	407,974,367	(171,625,903)	(42.1%)
3,121,378	4,580,227	1,458,849	31.9%	Medical Management	32,060,564	49,345,321	17,284,757	35.0%
501,825	16,667	(485,158)	(2,911.0%)	Reinsurance & other	6,003,367	183,333	(5,820,033)	(3,174.6%)
240,473,045	230,738,547	(9,734,498)	(4.2%)	Total Medical Expenses	2,690,791,791	2,478,173,672	(212,618,119)	(8.6%)
8,235,770	6,260,688	1,975,082	31.5%	Gross Margin	110,852,703	105,318,963	5,533,740	5.3%
				Administrative Expenses				
4,848,121	6,650,011	1,801,890	27.1%	Salaries, wages & employee benefits	62,869,310	73,732,206	10,862,897	14.7%
(826,893)	329,612	1,156,504	350.9%	Professional fees	538,400	3,487,265	2,948,865	84.6%
739,612	829,632	90,020	10.9%	Purchased services	7,676,602	8,505,739	829,138	9.7%
485,574	312,092	(173,482)	(55.6%)	Printing and postage	2,474,014	3,435,103	961,089	28.0%
355,049	383,061	28,012	7.3%	Depreciation & amortization	3,664,080	4,213,672	549,592	13.0%
1,289,989	1,083,051	(206,937)	(19.1%)	Other operating expenses	11,591,815	12,016,358	424,543	3.5%
(394,117)	(540,702)	(146,585)	(27.1%)	Indirect cost allocation	(4,049,127)	(5,942,874)	(1,893,747)	(31.9%)
6,497,336	9,046,758	2,549,422	28.2%	Total Administrative Expenses	84,765,093	99,447,469	14,682,376	14.8%
				Operating Tax				
10,162,027	8,913,214	(1,248,812)	(14.0%)	Tax Revenue	128,022,354	97,345,942	(30,676,411)	(31.5%)
10,162,202	0	(10,162,202)	0.0%	Premium tax expense	112,452,475	0	(112,452,475)	0.0%
(175)	8,913,214	8,913,389	100.0%	Sales tax expense	15,569,879	97,345,942	81,776,063	84.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
75,000	287,500	(212,500)	(73.9%)	Grant Revenue	625,213	3,162,500	(2,537,288)	(80.2%)
63,750	250,000	186,250	74.5%	Grant expense - Service Partner	513,188	2,750,000	2,236,813	81.3%
24,410	37,500	13,090	34.9%	Grant expense - Administrative	231,039	412,500	181,461	44.0%
(13,160)	0	(13,160)	0.0%	Total Net Grant Income	(119,014)	0	(119,014)	0.0%
79	0	79	0.0%	Other income	1,352	0	1,352	0.0%
1,725,354	(2,786,070)	4,511,424	161.9%	Change in Net Assets	25,969,948	5,871,494	20,098,454	342.3%
96.7%	97.4%	0.7%	0.7%	Medical Loss Ratio	96.0%	95.9%	-0.1%	-0.1%
2.6%	3.8%	1 2%	31.6%	Admin Loss Ratio	3.0%	3.8%	0 8%	21.4%

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MEDI-CAL INCOME STATEMENT – MAY MONTH:

REVENUES of $248.7 million are favorable to budget by $11.7 million, driven by:

- Price related favorable variance of $16.0 million due to:
  - $9.4 million of fiscal year 2017 relating to rate adjustment
  - $4.1 million for prior year related to member month adjustments
  - Remaining from member mix

- Volume related unfavorable variance of: $4.3 million

MEDICAL EXPENSES: Overall $240.5 million, unfavorable to budget by $9.7 million due to:

- **Provider Capitation** is unfavorable $12.4 million due to shared risk group move to HMO model beginning February

- **Long term care claim payments (MLTSS)** are unfavorable to budget $11.8 million due to:

  - LTC unfavorable variance of $8.1 million driven mainly by higher LTC claim expense due to less than anticipated members enrolling in OneCare Connect with $1.9 million due to true-up to county IHSS expense data

  - Nursing facility unfavorable variance of $2.2 million

- **Facilities** expenses are favorable to budget $11.1 million due to:

  - Favorable variance due to shared risk group move to HMO model beginning February
  - Favorable variance of $2.5 million for current month claim estimate adjustment relating to prior periods

ADMINISTRATIVE EXPENSES are $6.5 million, favorable to budget $2.5 million, driven by:

- Salary & Benefits: $1.8 million favorable to budget due to open positions

- Non-Salary: $0.7 million favorable to budget

CHANGE IN NET ASSETS is $1.7 million for the month, favorable to budget by $4.5

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Eleven Months Ended May 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
15,773	21,507	(5,734)	(26.7%)	Member Months	186,505	240,476	(53,971)	(22.4%)
				Revenues				
7,000,308	11,401,296	(4,400,988)	(38.6%)	Medi-Cal Capitation revenue	73,206,161	129,703,510	(56,497,349)	(43.6%)
18,164,055	31,799,224	(13,635,169)	(42.9%)	Medicare Capitation revenue	240,483,153	360,320,471	(119,837,318)	(33.3%)
25,164,363	43,200,520	(18,036,157)	(41.7%)	Total Operating Revenue	313,689,313	490,023,981	(176,334,668)	(36.0%)
				Medical Expenses				
7,976,679	9,514,112	1,537,433	16.2%	Provider capitation	83,660,193	107,909,038	24,248,845	22.5%
1,098,293	11,192,357	10,094,064	90.2%	Facilities	84,481,730	124,802,021	40,320,291	32.3%
540,408	672,952	132,544	19.7%	Ancillary	8,619,234	7,524,440	(1,094,794)	(14.5%)
5,907,911	10,158,939	4,251,029	41.8%	Long Term Care	60,448,284	113,589,384	53,141,100	46.8%
4,759,682	8,215,856	3,456,174	42.1%	Prescription drugs	54,523,027	88,547,400	34,024,373	38.4%
1,149,047	1,266,465	117,418	9.3%	Medical management	11,078,981	13,713,629	2,634,648	19.2%
211,171	619,381	408,210	65.9%	Other medical expenses	1,197,301	6,925,442	5,728,141	82.7%
21,643,191	41,640,063	19,996,872	48.0%	Total Medical Expenses	304,008,750	463,011,355	159,002,605	34.3%
3,521,172	1,560,457	1,960,715	125.7%	Gross Margin	9,680,563	27,012,626	(17,332,063)	(64.2%)
				Administrative Expenses				
629,753	953,601	323,848	34.0%	Salaries, wages & employee benefits	8,507,712	10,450,317	1,942,605	18.6%
(1)	86,521	86,522	100.0%	Professional fees	318,114	872,125	554,011	63.5%
219,341	181,216	(38,125)	(21.0%)	Purchased services	1,534,553	1,978,346	443,793	22.4%
25,362	148,414	123,052	82.9%	Printing and postage	577,972	1,549,958	971,986	62.7%
45,609	3,660	(41,949)	(1,146.2%)	Other operating expenses	425,328	532,230	106,902	20.1%
728,917	937,491	208,574	22.2%	Indirect cost allocation, Occupancy Expense	7,655,682	10,312,397	2,656,716	25.8%
1,648,982	2,310,902	661,920	28.6%	Total Administrative Expenses	19,019,362	25,695,373	6,676,012	26.0%
				Operating Tax				
(82)	0	(82)	0.0%	Tax Revenue	(466,100)	0	(466,100)	0.0%
(82)	0	82	0.0%	Sales tax expense	(466,100)	0	466,100	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
1,872,190	(750,445)	2,622,635	349.5%	Change in Net Assets	(9,338,798)	1,317,253	(10,656,051)	(809.0%)
86.0%	96.4%	10.4%	10.8%	Medical Loss Ratio	96.9%	94.5%	-2.4%	-2.6%
6.6%	5.3%	-1.2%	-22.5%	Admin Loss Ratio	6.1%	5.2%	-0.8%	-15.6%

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ONECARE CONNECT INCOME STATEMENT – MAY MONTH:

REVENUES of $25.2 million are unfavorable to budget by $18.0 million driven by:

- Volume related unfavorable variance of $11.5 million due to lower enrollment
- Price related unfavorable variance of $6.5 million due to CMC Medicare Part A and B rate decreases due to base rate and RAF score changes

MEDICAL EXPENSES are favorable to budget $20.0 million due to:

- Volume related favorable variance of $11.1 million across all categories related to the provider group moving to HMO in February as well as lower long term care expenses
- Price related favorable variance of $8.9 million driven by:
  - $3.1 million for current month claim estimate adjustments relating to prior periods
  - $1.9 million adjustment to shared risk pool estimates

ADMINISTRATIVE EXPENSES are favorable to budget by $0.7 million, $0.3 million from salaries

CHANGE IN NET ASSETS is $1.9 million, $2.6 million favorable to budget

CalOptima - OneCare
Statement of Revenues and Expenses
For the Eleven Months Ended May 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,320	1,132	188	16.6%	Member Months	13,722	13,105	617	4.7%
				Revenues				
1,538,035	1,317,397	220,638	16.7%	Capitation revenue	15,862,848	15,131,576	731,272	4.8%
1,538,035	1,317,397	220,638	16.7%	Total Operating Revenue	15,862,848	15,131,576	731,272	4.8%
				Medical Expenses				
381,140	359,750	(21,390)	(5.9%)	Provider capitation	4,387,577	4,119,280	(268,297)	(6 5%)
502,925	294,640	(208,285)	(70.7%)	Inpa ient	4,077,444	3,365,462	(711,982)	(21.2%)
81,905	45,254	(36,651)	(81.0%)	Ancillary	496,433	515,489	19,056	3.7%
(10,163)	21,540	31,703	147 2%	Skilled nursing facilities	487,191	244,935	(242,256)	(98.9%)
350,361	432,721	82,360	19 0%	Prescription drugs	4,798,071	5,007,764	209,693	4.2%
34,997	50,848	15,852	31 2%	Medical management	260,213	413,397	153,184	37.1%
15,215	(9,404)	(24,620)	(261.8%)	Other medical expenses	62,351	62,836	485	0.8%
1,356,380	1,195,349	(161,031)	(13.5%)	Total Medical Expenses	14,569,280	13,729,163	(840,118)	(6.1%)
181,655	122,048	59,607	48 8%	Gross Margin	1,293,568	1,402,413	(108,845)	(7 8%)
				Administrative Expenses				
26,144	21,557	(4,587)	(21.3%)	Salaries, wages & employee benefits	237,086	236,244	(842)	(0.4%)
10,078	17,619	7,542	42 8%	Professional fees	174,921	172,381	(2,541)	(1 5%)
7,329	19,373	12,043	62 2%	Purchased services	251,966	273,207	21,241	7.8%
21,358	13,710	(7,647)	(55.8%)	Prin ing and postage	108,236	144,501	36,265	25.1%
0	89	89	100 0%	Other operating expenses	2,351	974	(1,377)	(141 3%)
25,447	29,494	4,047	13.7%	Indirect cost allocation, Occupancy Expense	267,264	324,429	57,165	17.6%
90,355	101,842	11,487	11 3%	Total Administrative Expenses	1,041,825	1,151,737	109,912	9.5%
91,300	20,207	71,093	351 8%	Change in Net Assets	251,743	250,676	1,067	0.4%
88.2%	90.7%	2.5%	2 8%	Medical Loss Ra io	91.8%	90.7%	-1.1%	-1.2%
5.9%	7.7%	1.9%	24 0%	Admin Loss Ra io	6.6%	7.6%	1.0%	13.7%

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CalOptima - PACE
Statement of Revenues and Expenses
For the Eleven Months Ended May 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
205	215	(10)	(4.7%)	Member Months	2,062	2,090	(28)	(1.3%)
				Revenues				
994,874	963,165	31,710	3.3%	Medi-Cal capitation revenue	10,620,365	9,355,612	1,264,752	13.5%
269,992	383,503	(113,511)	(29.6%)	Medicare capitation revenue	3,318,757	3,807,622	(488,865)	(12.8%)
1,264,866	1,346,668	(81,801)	(6.1%)	Total Operating Revenues	13,939,122	13,163,234	775,888	5.9%
1,582 50	1,301 86			Medical Expenses				
354,369	421,251	66,883	15.9%	Clinical salaries & benefits	3,324,281	4,430,947	1,106,666	25.0%
0	0	0	0.0%	Pace Center Support salaries & benefits	0	0	0	0.0%
324,413	279,900	(44,513)	(15.9%)	Claims payments to hospitals	3,265,204	2,671,755	(593,448)	(22.2%)
335,125	301,835	(33,290)	(11.0%)	Professional Claims	2,655,991	2,845,554	189,563	6.7%
121,319	144,495	23,176	16.0%	Prescription drugs	1,070,135	1,454,955	384,820	26.4%
(4,494)	28,667	33,161	115.7%	Long-term care facility payments	54,790	273,634	218,845	80.0%
81,080	88,986	7,906	8.9%	Patient Transportation	911,543	849,402	(62,140)	(7.3%)
49,663	49,349	(314)	(0.6%)	Depreciation & amortization	542,479	542,839	360	0.1%
37,655	37,214	(441)	(1.2%)	Occupancy expenses	415,354	409,354	(6,000)	(1.5%)
8,393	13,833	5,440	39.3%	Utilities & Facilities Expense	152,352	152,163	(189)	(0.1%)
75	326	251	77.0%	Purchased Services	1,339	3,112	1,773	57.0%
19,650	24,547	4,897	19.9%	Indirect Allocation	205,720	270,017	64,297	23.8%
0	0	0	0.0%	Reinsurance	0	0	0	0.0%
18,994	22,785	3,792	16.6%	Other Expenses	194,775	250,636	55,862	22.3%
1,346,242	1,413,188	66,946	4.7%	Total Medical Expenses	12,793,961	14,154,369	1,360,408	9.6%
(81,375)	(66,520)	(14,855)	(22.3%)	Gross Margin	1,145,161	(991,135)	2,136,295	215.5%
				Administrative Expenses				
87,730	93,244	5,514	5.9%	Salaries, wages & employee benefits	1,014,015	1,021,920	7,905	0.8%
10,250	11,667	1,417	12.1%	Professional fees	57,184	103,333	46,149	44.7%
226	988	762	77.1%	Purchased services	39,329	11,012	(28,317)	(257.1%)
8,598	1,711	(6,888)	(402.6%)	Printing and postage	17,440	19,028	1,588	8.3%
2,069	2,056	(13)	(0.6%)	Depreciation & amortization	22,603	22,618	14	0.1%
12,219	14,775	2,556	17.3%	Other operating expenses	100,213	135,730	35,517	26.2%
2,388	1,023	(1,365)	(133.5%)	Indirect cost allocation, Occupancy Expense	25,877	11,250	(14,627)	(130.0%)
123,480	125,463	1,983	1.6%	Total Administrative Expenses	1,276,661	1,324,891	48,230	3.6%
				Operating Tax				
0	0	0	0.0%	Tax Revenue	14,215	0	14,215	0.0%
0	0	0	0.0%	Premium tax expense	14,215	0	(14,215)	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
(204,856)	(191,983)	(12,872)	(6.7%)	Change in Net Assets	(131,501)	(2,316,026)	2,184,525	94.3%
106.4%	104 9%	-1.5%	-1.4%	Medical Loss Ratio	91.8%	107 5%	15.7%	14.6%
9.8%	9 3%	-0.4%	-4.8%	Admin Loss Ratio	9.2%	10.1%	0.9%	9.0%

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CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Eleven Months Ended May 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
24,056	21,285	2,772	13.0%	Rental income	265,519	234,134	31,385	13.4%
24,056	21,285	2,772	13.0%	Total Operating Revenue	265,519	234,134	31,385	13.4%
				Administrative Expenses				
1,525	2,085	560	26.8%	Professional fees	16,198	22,935	6,737	29.4%
29,788	22,405	(7,384)	(33.0%)	Purchase services	328,356	246,452	(81,903)	(33.2%)
167,190	210,141	42,951	20.4%	Depreciation & amortization	1,740,664	2,311,548	570,885	24.7%
14,913	14,300	(613)	(4.3%)	Insurance expense	173,831	157,303	(16,528)	(10.5%)
136,424	198,033	61,610	31.1%	Repair and maintenance	1,160,036	2,131,665	971,629	45.6%
30,997	0	(30,997)	0.0%	Other Operating Expense	440,082	0	(440,082)	0.0%
(359,924)	(352,100)	7,825	2.2%	Indirect allocation, Occupancy Expense	(3,647,247)	(3,873,098)	(225,851)	(5.8%)
20,913	94,864	73,951	78.0%	Total Administrative Expenses	211,920	996,805	784,885	78.7%
3,143	(73,579)	76,723	104.3%	Change in Net Assets	53,599	(762,671)	816,270	107.0%

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OTHER STATEMENTS – MAY MONTH:

ONECARE INCOME STATEMENT

REVENUES of $1.5 million; $0.2 million favorable to budget

MEDICAL EXPENSES are $1.4 million, $0.2 million unfavorable to budget

CHANGE IN NET ASSETS is $0.1 million; $0.1 million favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS for the month is ($0.2) million; in line with budget

505 CITY PARKWAY BUILDING INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $3.1 thousand; $76.7 thousand favorable to budget

CalOptima
BALANCE SHEET
May 31, 2017

ASSETS				**LIABILITIES & FUND BALANCES**	
Current Assets				Current Liabilities	
	Operating Cash	$451,044,353		Accounts payable	$26,246,617
	Catastrophic Reserves	10,884,883		Medical claims liability	1,229,581,191
	Investments	1,337,771,690		Accrued payroll liabilities	11,416,636
	Capitation receivable	352,244,397		Deferred revenue	232,199,345
	Receivables - Other	19,918,861		Deferred lease obligations	203,482
	Prepaid Expenses	6,053,486		Capitation and withholds	536,493,370
				Total Current Liabilities	**2,036,140,641**
	Total Current Assets	**2,177,917,671**			
Capital Assets	Furniture and equipment	33,437,912			
	Leasehold improvements	5,268,668			
	505 City Parkway West	49,422,364		Other employment benefits liability	30,303,530
		88,128,944			
	Less: accumulated depreciation	(33,867,110)		Net Pension Liabilities	15,430,763
	Capital assets, net	**54,261,834**		Long Term Liabilities	100,000
				TOTAL LIABILITIES	**2,081,974,934**
Other Assets	Restricted deposit & Other	300,000			
				Deferred inflows of Resources - Excess Earnings	4,130,286
	Board-designated assets			Deferred inflows of Resources - changes in Assumptions	1,651,640
	Cash and cash equivalents	19,982,082			
	Long term investments	515,176,417		Tangible net equity (TNE)	95,741,735
	Total Board-designated Assets	535,158,500		Funds in excess of TNE	594,488,101
	Total Other Assets	**535,458,500**			
				Net Assets	**690,229,836**
	Deferred outflows of Resources - Pension Contributions	9,133,218			
	Deferred outflows of Resources - Difference in Experience	1,215,473			
	Deferred outflows of Resources - Excess Earnings	-			
TOTAL ASSETS & OUTFLOWS		**2,777,986,695**		**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,777,986,695**

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CalOptima
Board Designated Reserve and TNE Analysis
as of May 31, 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,217,605				
	Tier 1 - Logan Circle	145,957,299				
	Tier 1 - Wells Capital	145,971,498				
Board-designated Reserve		438,146,402	296,331,304	464,362,606	141,815,098	(26,216,204)
TNE Requirement	Tier 2 - Logan Circle	97,012,098	95,741,735	95,741,735	1,270,363	1,270,363
	Consolidated:	**535,158,500**	**392,073,038**	**560,104,341**	**143,085,461**	**(24,945,841)**
	Current reserve level	*1.91*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
May 31, 2017

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	5,875,145	30,662,657
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	524,308	5,427,347
Changes in assets and liabilities:		
Prepaid expenses and other	1,041,755	730,760
Catastrophic reserves		
Capitation receivable	(10,585,281)	114,587,749
Medical claims liability	543,173,895	630,886,333
Deferred revenue	(627,906,038)	(358,503,296)
Payable to providers	5,122,001	134,667,068
Accounts payable	10,006,000	20,416,184
Other accrued liabilities	275,609	11,345,139
Net cash provided by/(used in) operating activities	(72,472,605)	590,219,940
GASB 68 CalPERS Adjustments	-	(1,718,288)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	(22,840,185)	(318,507,058)
Purchase of property and equipment	(257,000)	(4,693,616)
Change in Board designated reserves	(962,828)	(59,323,134)
Net cash provided by/(used in) investing activities	(24,060,013)	(382,523,809)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(96,532,618)	205,977,842
CASH AND CASH EQUIVALENTS, beginning of period	$558,461,854	255,951,393
CASH AND CASH EQUIVALENTS, end of period	**$ 461,929,236**	**$ 461,929,236**

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BALANCE SHEET:

ASSETS decreased $63.5 million from April

- **Cash and Cash Equivalents** decreased by $96.4 million due to HQAF payment of $84.3 million
- **Short-term Investments** increased $22.8 million due to payment receipt timing and cash funding requirements
- **Net Capitation Receivables** increased $10.0 million based upon payment receipt timing and receivables

LIABILITIES decreased $69.3 million from April

- **Deferred Revenue** decreased $627.9 million driven by DHCS over payment reclassified to “Due to DHS” (Medical Claims Liability)
- **Capitation Payable** increased $5.1 million driven by quality incentive and risk pool reserves
- **Accrued Expenses** increased $8.8 million based on the timing of sales tax payments
- **Medical Claims Liability** by line of business increased $543.2 million due to reclassification from “Deferred Revenue”

NET ASSETS are $690.2 million

CalOptima Foundation
Balance Sheet
May 31, 2017

ASSETS		LIABILITIES & NET ASSETS	
Operating cash	2,893,139	Accounts payable-Current	0
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,893,139**	Grants-Foundation	0
		Total Current Liabilities	0
		Total Liabilities	**0**
		Net Assets	**2,893,139**
TOTAL ASSETS	**2,893,139**	**TOTAL LIABILITIES & NET ASSETS**	**2,893,139**

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CalOptima Foundation
Statement of Revenues and Expenses
For the Eleven Months Ended May 31, 2017
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	2,264	(2,264)	(100.0%)	Income - Grant	27,164	24,909	2,256	9.1%
2,084	0	2,084	0.0%	In Kind Revenue - HITEC Grant	76,581	0	76,581	0.0%
2,084	2,264	(180)	(8.0%)	Total Operating Revenue	103,745	24,909	78,837	316.5%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	27,195	68,026	40,831	60.0%
0	2,985	2,985	100.0%	Taxes and Benefits	26,240	32,833	6,593	20.1%
0	0	0	0.0%	Travel	(3)	0	3	0.0%
0	0	0	0.0%	Supplies	7,009	10,000	2,991	29.9%
0	0	0	0.0%	Contractual	20,388	17,174	(3,214)	(18.7%)
2,084	232,065	229,981	99.1%	Other	24,622	2,552,717	2,528,095	99.0%
2,084	241,234	239,150	99.1%	Total Operating Expenditures	105,452	2,680,750	2,575,299	96.1%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
0	(238,970)	(238,970)	(100.0%)	Program Income	(1,706)	(2,655,842)	(2,654,135)	(99.9%)

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CALOPTIMA FOUNDATION – MAY MONTH

INCOME STATEMENT:

Revenues

- Revenues from Health Information Technology for Economic and Clinical Health Act (HITECH) and in-kind contributions from CalOptima
- The Foundation recognized $103,745 FY17 YTD in total operating revenues
    - HITECH Grant revenue totaled $27,164 YTD which leaves $0 remaining in HITECH Grant funding as of May 2017
    - CalOptima in-kind contribution totaled $76,581 YTD
- Revenue budget variances attributed to:
    - YTD CalOptima grant budget is $0, as the ONC grant funding was to have ended in the previous fiscal year. The grant was extended through September 26, 2016
    - CalOptima in-kind revenue was not included in FY17 budget

Expenses

- Operating expenses were $105,452 for grant related activities incurred YTD FY17
- Expense categories include staff services, travel and miscellaneous supplies
    - $2.6 million 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 transfer of $3.0 million from CalOptima for grants and programs in support of providers and the community

Liabilities

- $0

Budget Allocation Changes
Reporting changes for May 2017

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 Aud t)	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 Aud t) 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 S lk 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 w thin 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 add tional 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 Productiv ty Automation	IS-Application Management - Purchased Services - Direct Hire Fees	$10,957	Re-purpose funds from Purchased Services (Healthcare Productivity Automation) to pay for Direct Hire fees	2017
August	Medi-Cal	Other Pay	IS-Application Development - Comp Supplies/Minor Equipments	$20 400	Re-allocate funds to cover costs of DocuSign, Box, and Primal Script 2016	2017
August	Medi-Cal	Claims Administration - Purchased Services	Claims Administration - Office Supplies, Training & Seminars Printing	$15 000	Re-allocate funds from Purchased Services (Integration of Claim Editing Software & Inventory Management Forecasting) to Office Supplies, Training & Seminars, and Printing to better meet department's needs	2017
September	Medi-Cal	Health Education & Disease Management - Professional Fees	Hea th Education & Disease Management - Other Operating Expenses	$30 000	Re-allocate funds from Professional Fees (Childhood Obesity Program Design & Evaluation) to Member & Provider Incentives to support incentives for the Group Needs Assessment (GNA) and other Health Education / Disease Management activ ties.	2017
October	Capital	Facilities - Relocate Trash Enclosure	Facilities - 505 Sound Recording System	$50 555	Re-allocate from Relocate Trash Enclosure project for additional funds that are needed for the 505 Sound Recording System project.	2017
October	Medi-Cal	IS-Infrastructure - Professional Fees - Enterprise Ident ty Access Management	IS-Infrastructure - HW/SW Maintenance - Information Security Data Loss Prevention Solution	$21,041	Re-allocate from Professional Services for an Enterprise Identity Access Management to HW/SW Maintenance for Information Security Data Loss Prevention Solution Annual Maintenance on additional funds that are needed.	2017
October	Medi-Cal	Facilities - Computer Supply/Minor Equipment - Office Furniture & Equipment	Facilities - Computer Supply/Minor Equipment - Other Articles of Minor Equipment	$27 000	Repurpose funds in Comp supply/minor equipment for re-upholstering chairs in the member service lobby and other minor equipment expenses to better meet the Department's need.	2017
December	Medi-Cal	Human Resources - Professional Fees - Executive Coaching	Human Resources - Professional Fees - Consultant Fees	$20 000	Repurpose from Executive Coaching for interim director of HR consultant fees	2017
December	Medi-Cal	Health Education & Disease Management - Medical Management Activities	Hea th Education & Disease Management - Medical Management Activities	$75,000	Repurpose funds for the department printing and postage needs	2017
January	Medi-Cal	IS-Application Development - Finance Reporting Tool to Great Plains	IS-Application Development - Great Plains Software Upgrade	$20 000	Re-allocate funds from Finance Reporting Software for Great Plains budget to Great Plains Software Upgrade budget for additional funds are needed to complete the project.	2017
February	Medi-Cal	IS-Application Management - Purchased Services	IS-Application Development - Purchased Services	$19,320	Re-allocate funds from IS Application Management Purchased Services budget for direct placement fee needed in the Department.	2017
February	Medi-Cal	IS-Application Management - Comp supply/Minor Equip	IS-Infrastructure - Subscriptions	$30 000	Re-allocate funds from Computer Supply/Minor Equipment for Gartner Subscription needed in the Department.	2017
February	Medi-Cal	IS-Infrastructure - Training & Seminars	IS-Infrastructure - Subscriptions	$30 000	Re-allocate funds from Training & Seminars for Gartner Subscription needed in the Department.	2017
February	Medi-Cal	IS-Application Management - Training & Seminars	IS-Infrastructure - Subscriptions	$10,741	Re-allocate funds from Training & Seminars for Gartner Subscription needed in the Department.	2017
February	Medi-Cal	Accounting - Professional Fees	Facilities - Professional Fees	$17 000	Re-allocate funds from Accounting Financial Audit budget to Facilities Professional Fees budget for consulting services related to restacking and other Facilities projects.	2017
February	Capital	IS-Application Development - Data Warehouse Enterprise Infrastructure Expansion	IS-Application Development - K2 Business App ication Workflow Upgrade	$47,300	Re-allocate funds from Data Warehouse Enterprise Infrastructure Expansion to K2 Business App ication Workflow Upgrade for additional funds needed to complete the project.	2017
March	Medi-Cal	IS - Infrastructure - Telephone	IS-Application Management - Maintenance HW/SW	$29 000	Re-allocate funds from Telephone Budget to HW/SW Maintenance budget for funds needed on Claim Editor Annual Renewal	2017
March	Medi-Cal	IS - Infrastructure - Professional Fees	IS - Infrastructure - Professional Fees	$14 000	Repurpose funds from miscellaneous consulting/professional services at the Cal Optima Data Center to support upcoming Microsoft 2016 upgrade.	2017
April	Medi-Cal	IS - App ication Management - Purchased Services	Cultural & Linguistic Services - Purchased Services	$85,000	Re-allocate funds from Purchased Services in IS Application Management to Purchased Services in Cu tural & Linguistic Services for funds needed in translation/interpreting services.	2017
April	Medi-Cal	Quality Improvement (Medical Management)- Public Activ ties, Telephone, Minor Equipment/Computer Supplies	Quality Improvement (Medical Management) - Subscriptions	$11 410	Re-allocate funds to Quality Improvement Subscriptions budget for additional funds needed for AMA subscriptions.	2017
May	Medi-Cal	Human Resources - Purchased Services	Human Resources - Advertising	$50 000	Re-allocate funds from general Purchased Services to Advertising to cover expenses for recruitment advertising.	2017
May	Medi-Cal	Accounting - Purchased Services	Accounting - Purchased Services	$34,000	Re-allocate funds from Purchased Services - Business Banking to general Purchased Services to cover expenses for Change Healthcare.	2017
May	Medi-Cal	Facilities - Computer Supply/Minor Equipment	Facilities - R&M - Building	$35 000	Re-allocate funds from Computer Supply/Minor Equipment to Building Repair & Maintenance in Faci ities to cover expenses for various building maintenance services.	2017
May	Medi-Cal	Facilities - Rent - Equipment	Facilities - Rent - Storage	$30,000	Rea locate funds from Rent - Equipment to Rent - Storage in Facil ties to cover expenses for storage service w th Corovan.	2017
May	Capital	Facilities - Exterior Stair & Patio Lighting, Parking Lot Cameras & Relocate Trash Enclosure	Facilities - 1st Floor Tenant Improvement (Mailroom, Kitchenette, Exterior Stairs)	$65,345	Rea locate funds from Exterior Stair & Patio Lighting, Parking Log Cameras and Trash Enclosure projects to 1st Floor Tenant Improvement (Mailroom, Kitchenette, Exterior Stairs) for additional funds needed.	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
August 3, 2017

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare Connect

- DMHC Audit: The Department of Managed Health Care (DMHC) audited the provision of Medicaid-based services in OneCare Connect from February 6-10, 2017. The DMHC conducted this audit on behalf of the Department of Health Care Services (DHCS) as part of an inter-agency agreement. This is the first time that the DMHC has audited CalOptima's OneCare Connect Medicaid-based services. On July 7, 2017, DHCS sent CalOptima a report regarding the audit, which identified nine (9) potential deficiencies in the areas of utilization management, continuity of care, availability and accessibility, and member rights. CalOptima has thirty (30) days to submit a corrective action plan (CAP) to DHCS regarding the potential deficiencies.

- Medicare-Medicaid Plan (MMP) Denial Letter Monitoring: On April 19, 2017, CMS' contractor, IMPAQ International (IMPAQ), notified all Medicare-Medicaid Plans (MMPs) of a new monitoring effort for MMP denial letters. This monitoring effort attempts to understand the frequency and types of errors, identify potential areas of risk to beneficiaries, capture best practices, and assess whether MMPs are implementing their plan decision letters in a manner compliant with CMS rules and regulations and three-way contracts.

  On June 2, 2017, CalOptima successfully submitted documentation for the sixty (60) samples selected by IMPAQ, including the plan denial letters and case history files. CalOptima is currently pending IMPAQ's feedback and next steps.

- Mock Audit for Medication Therapy Management (MTM) Program: In preparation for a CMS MTM program audit, CalOptima has engaged a consultant to conduct a mock audit on its MTM program using the 2017 CMS MTM audit protocols. The scope of the audit includes all OneCare Connect members who were enrolled in the MTM program during the look back period of January 1, 2016 through December 31, 2016. The mock audit is being conducted via webinar from July 11-13, 2017.

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- Medicare Data Validation Audit (DVA): On an annual basis, CMS requires all plan sponsors to engage an independent consultant to conduct a validation audit of all Medicare Parts C and D data reported for the prior calendar year. The validation audit took place from March through June 2017, and consisted of a virtual onsite audit and source documentation review for the following Medicare Parts C and D measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Medicare Therapy Management (MTM) Program
  - Special Needs Plan (SNP) Care Management

  On July 5, 2017, the consultant officially closed out the audit and CalOptima received a score of **100**% for its OneCare Connect program. The consultant is required to report these results back to CMS for oversight purposes.

- 2017 Performance Measure Validation Activity (PMV): On July 7, 2017, CalOptima received an engagement letter from CMS' contractor, Health Services Advisory Group, Inc. (HSAG), for a performance measure validation (PMV) activity of select core and state-specific reporting measures for Medicare-Medicaid Plans (MMPs). HSAG will validate the data collection and reporting processes used by the MMPs to calculate the performance measure rates required by CMS to ensure that data reported by MMPs are accurate and valid. On July 11, 2017, HSAG conducted a kick off webinar with MMPs to prepare for the PMV activity. HSAG has not set an actual date for the PMV activity yet, but it has indicated that it will occur no later than early October 2017.

2. OneCare

- Medicare Data Validation Audit (DVA): On an annual basis, CMS requires all plan sponsors to engage an independent consultant to conduct a validation audit of all Medicare Parts C and D data reported for the prior calendar year. The validation audit took place from March through June 2017, and consisted of a virtual onsite audit and source documentation review for the following Medicare Parts C and D measures:

  - Parts C and D Grievances
  - Organization Determinations and Reconsiderations
  - Coverage Determinations and Redeterminations
  - Medicare Therapy Management (MTM) Program
  - Special Needs Plan (SNP) Care Management

  On July 5, 2017, the consultant officially closed out the audit and CalOptima received a score of **98**% for its OneCare program. The consultant is required to report these results back to CMS for oversight purposes.

3. PACE

- 2016 Annual PACE Audit: On September 29, 2016, CMS issued the final audit report to CalOptima PACE, which identified three (3) findings in the following areas --- Infection Control, Internal Quality Assessment and Performance Improvement Program Activities, and Transportation Services. On November 28, 2016, CMS accepted and closed the corrective action plans (CAP) CalOptima submitted for two (2) of the findings --- Infection Control and Internal Quality Assessment and Performance Improvement Program Activities. However, CMS kept the finding related to transportation services open for further monitoring and requested monthly submissions of reports related to transportation services starting in December 2016. Between January and June 2017, there was significant improvement in the transportation vendor's performance. On July 13, 2017, CMS issued an official audit closure letter to CalOptima for the 2016 PACE audit as it has determined that CalOptima has demonstrated compliance with the requirements related to this remaining deficiency.

B. Regulatory Compliance Notices

1. CalOptima did not receive any compliance notices from its regulators for the months of May and June 2017.

C. Updates on Internal and Health Network Audits

1. Internal Audits: Medi-Cal

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
February 2017	100%	89%	85%	67%	60%	90%	97%	100%	73%	96%	0%	44%	85%
March 2017	30%	N/A	N/A	0%	80%	67%	89%	60%	73%	87%	Nothing to Report	Nothing to Report	Nothing to Report
April 2017	50%	N/A	N/A	0%	60%	67%	83%	80%	67%	88%	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 initial notification to the requesting provider (24 hours)

- The lower scores for clinical decision making were due to the following reason:
  - Failure to cite criteria for decision

- The lower letter scores were due to the following reasons:
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide an alternative direction back to primary care physician (PCP) on denial

- Medi-Cal Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2017	80%	100%	100%	90%90%
March 2017	100%	90%	100%	100%
April 2017	90%	100%	100%	100%

- The compliance rate for paid claims timeliness has decreased from 100% in March 2017 to 90% in April 2017 due to failure to pay claims within 45 business days from original date of receipt.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Letter Accuracy	Determination Timeliness	Acknowledgement Timeliness
February 2017	100%	85%	95%
March 2017	100%	95%	100%
April 2017	100%	90%	95%

- The compliance rate for determination timeliness has decreased from 95% in March 2017 to 90% in April 2017 due to failure to process provider dispute resolutions within 45 days from original date of receipt.

- The compliance rate for acknowledgement timeliness has decreased from 100% in March 2017 to 95% in April 2017 due to failure to issue the acknowledgement within 15 business days from original date of receipt.

- Medi-Cal Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	Medi-Cal Call Center	Member Liaison Call Center
February 2017	100%	100%
March 2017	100%	100%
April 2017	100%	100%

  - The compliance rate for Medi-Cal and Member Liaison call center activity has remained stable at 100% for all three (3) reported months.

2. Internal Audits: OneCare

- OneCare Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
February 2017	0%
March 2017	0%
April 2017	0%

  - No claims rejected in error from February through April 2017.

- 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
February 2017	100%
March 2017	100%
April 2017	100%

  - The compliance rate for coverage determination timeliness has remained stable at 100% for all three (3) reported months.

- OneCare Pharmacy: Coverage determinations for protected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements.

Month	Protected Drug Cases Reviewed	Protected Drug Cases Failed	Overall Compliance
February 2017	15	0	100%
March 2017	11	0	100%
April 2017	1	0	100%

- The compliance rate for coverage determinations for protected classes of drugs has remained stable at 100% for all three (3) reported months.

- OneCare Pharmacy: Coverage determinations for unprotected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements.

Month	Unprotected Drug Cases Reviewed	Unprotected Drug Cases Failed	Overall Compliance
February 2017	27	0	100%
March 2017	20	0	100%
April 2017	14	0	100%

- The compliance rate for coverage determinations for unprotected classes of drugs has remained stable at 100% for all three (3) reported months.

- OneCare Utilization Management

  - For the months of February 2017 through April 2017, there were no standard organization determinations, denials, or expedited organization determinations reported.

- OneCare Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2017	100%	100%	100%	60%
March 2017	100%	100%	100%	70%
April 2017	100%	100%	100%	80%

  - The compliance rate for denied claims accuracy has improved month over month from February through April 2017.

  - The compliance rate for paid claims timeliness, paid claims accuracy, and denied claims timeliness has remained stable at 100% from February through April 2017.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
February 2017	71%	100%	100%	100%
March 2017	100%	100%	100%	100%
April 2017	100%	100%	100%	100%

  - ➢ No significant trends to report.

- OneCare Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Customer Service
February 2017	98%
March 2017	100%
April 2017	100%

  - ➢ The compliance rate for OneCare call center activity has remained stable ranging from 98% to 100% for the three (3) reported months.

3. Internal Audits: OneCare Connect

- OneCare Connect Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
February 2017	0%
March 2017	0%
April 2017	0%

  - ➢ No claims rejected in error from February through April 2017.

- 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
February 2017	99%
March 2017	100%
April 2017	100%

  - The compliance rate for coverage determination timeliness has remained stable ranging from 99% to 100% for the three (3) reported months.

- OneCare Connect Pharmacy: Coverage determinations for protected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements.

Month	Protected Drug Cases Reviewed	Protected Drug Cases Failed	Overall Compliance
February 2017	48	0	100%
March 2017	48	0	100%
April 2017	12	0	100%

  - The compliance rate for coverage determinations for protected classes of drugs has remained stable at 100% for all three (3) reported months.

- OneCare Connect Pharmacy: Coverage determinations for unprotected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements.

Month	Unprotected Drug Cases Reviewed	Unprotected Drug Cases Failed	Overall Compliance
February 2017	72	0	100%
March 2017	72	0	100%
April 2017	48	0	100%

  - The compliance rate for coverage determinations for unprotected classes of drugs has remained stable at 100% for all three (3) reported months.

- OneCare Connect Utilization Management: Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM For Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
February 2017	Nothing to Report	Nothing To Report	Nothing To Report	78%	28%	Nothing to Report	Nothing to Report	Nothing to Report	N/A	N/A	N/A	N/A	N/A	N/A
March 2017	90%	N/A	45%	44%	28%	70%	50%	88%	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
April 2017	80%	N/A	20%	70%	35%	100%	70%	90%	Nothing to Report	Nothing to Report	Nothing to Report	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)

- The lower scores for clinical decision making were due to the following reason:
  - Failure to cite criteria for decision

- The lower scores for letter review were due to the following reasons:
  - Failure to provide letter with description of services in lay language
  - Failure to provide letter in member preferred language

- OneCare Connect Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2017	50%	90%	100%	100%
March 2017	100%	100%	100%	70%
April 2017	50%	100%	100%	80%

- The compliance rate for paid claims timeliness decreased from 100% in March 2017 to 50% in April 2017 due to failure to meet the required timeline for paying claims within 30 calendar days.

- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
February 2017	100%	95%	100%	67%
March 2017	100%	93%	100%	100%
April 2017	95%	100%	100%	100%

  - The compliance rate for determination timeliness decreased from 100% in March 2017 to 95% in April 2017 due to failure to process provider dispute resolutions within 30 days from original date of receipt.

- OneCare Connect Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Connect Customer Service
February 2017	100%
March 2017	100%
April 2017	100%

  - The compliance rate for OneCare Connect call center activity has remained stable at 100% for all three (3) reported months.

4. Internal Audits: PACE

- PACE Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2017	70%	70%	100%	100%
March 2017	100%	100%	100%	90%
April 2017	100%	100%	100%	60%

  - The compliance rate for denied claims accuracy decreased from 90% in March 2017 to 60% in April 2017 due to inappropriate denial of authorized services.

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check LAG
February 2017	100%	100%	100%	100%
March 2017	100%	100%	100%	100%
April 2017	100%	100%	100%	100%

  - The compliance rate for PDRs has remained stable at 100% for all three (3) reported months.

5. Health Network Audits: Medi-Cal, OneCare, and OneCare Connect

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgent	Clinical Decision Making (CDM) for Urgent	Letter Score for Urgent	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
February 2017	80%	100%	88%	84%	50%	89%	94%	49%	95%	100%	Nothing to Report	Nothing to Report	Nothing to Report
March 2017	88%	89%	92%	83%	65%	92%	94%	74%	78%	89%	Nothing to Report	Nothing to Report	Nothing to Report
April 2017	68%	97%	99%	94%	74%	88%	90%	80%	100%	97%	46%	81%	58%

  - The lower scores for timeliness were due to the following reasons:
    - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days)
    - Failure to meet timeframe for provider written notification (2 business days)
    - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)
    - Failure to meet timeframe for extended decision (14 calendar days)
    - Failure to meet timeframe for member delay notification (2 business days)
    - Failure to meet timeframe for provider delay notification (2 business days)

  - The lower scores for clinical decision making (CDM) were due to the following reasons:
    - Failure to obtain adequate clinical information
    - Failure to have appropriate professional make decision
    - Failure to use criteria for decision

- The lower letter scores were due to the following reasons:
  - Failure to provide information on how to file a grievance
  - Failure to provide letter in member preferred language
  - Failure to provide language assistance program (LAP) insert with approved threshold languages
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide description of services in lay language
  - Failure to provide alternative direction back to PCP on denial
  - Failure to provide name and contact information for health care professional responsible for decision to requesting provider
  - Failure to provide notification to member of delayed decision and anticipated decision date
  - Failure to provide notification to provider of delayed decision and anticipated decision date
  - Failure to provide peer-to-peer discussion with medical reviewer

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2017	99%	89%	100%	93%
March 2017	94%	92%	92%	98%
April 2017	100%	99%	99%	97%

- The compliance rate decreased from 98% in March 2017 to 97% in April 2017 for denied claims accuracy due to misclassification on the universe and incorrect denial reason utilized.

- Medi-Cal Claims: Misclassified Hospital Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
February 2017	100%	100%
March 2017	100%	100%
April 2017	100%	100%

- The compliance rate for misclassified paid and denied claims has remained stable at 100% for all three (3) reported months.

- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2017	100%	100%	100%	100%
March 2017	95%	100%	100%	100%
April 2017	100%	100%	100%	100%

- No significant trends to report.

6. Health Network Audits: OneCare

- OneCare Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making (CDM) for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	CDM for Denials	Letter Score for Denials
February 2017	67%	Nothing to Report	49%	91%	64%	100%	73%	91%
March 2017	79%	Nothing to Report	65%	89%	59%	80%	70%	92%
April 2017	82%	Nothing to Report	57%	88%	67%	80%	73%	94%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for member oral notification (Expedited – 72 hours)
  - Failure to meet timeframe for provider initial notification (Expedited – 24 hours)
  - Failure to meet timeframe for decision making (Expedited – 24 hours)

- The lower scores for clinical decision making (CDM) were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision
  - Failure to obtain adequate clinical information to deny
  - No indication that the medical reviewer was involved in the denial determination

- The lower letter scores were due to the following reasons:
  - Failure to use approved CMS letter template
  - Failure to provide description of requested services in lay language
  - Failure to use CalOptima logo

- OneCare Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
February 2017	100%	93%
March 2017	100%	89%
April 2017	100%	97%

- No significant trends to report.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2017	94%	90%	94%	94%
March 2017	100%	100%	96%	81%
April 2017	99%	100%	100%	94%

- The compliance rate for paid claims timeliness decreased from 100% in March 2017 to 99% in April 2017 due to untimely processing of claims.

7. Health Network Audits: OneCare Connect

- OneCare Connect Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
February 2017	76%	100%	58%	91%	66%	31%	79%	72%	32%	100%	95%	Nothing to Report	Nothing to Report	Nothing to Report
March 2017	87%	100%	72%	85%	63%	67%	68%	83%	25%	74%	85%	Nothing to Report	Nothing to Report	Nothing to Report
April 2017	77%	100%	77%	82%	82%	43%	78%	80%	56%	87%	96%	100%	Nothing to Report	60%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days)
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider initial notification (24 hours)
  - Failure to provide proof of successful written notification to requesting provider (2 business days)
  - Failure to meet timeframe for member delay notification (2 business days)
  - Failure to meet timeframe for provider delay notification (2 business days)

- The lower scores for clinical decision making (CDM) were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision
  - Failure to obtain adequate clinical information to deny

- The lower letter scores were due to the following reasons:
  - Failure to provide letter in member's primary language
  - Failure to provide member-specific denial reason for not meeting the criteria in lay language
  - Failure to provide letter with description of services in lay language
  - Failure to provide peer-to-peer discussion of the decision with medical reviewer
  - Failure to provide referral back to primary care provider (PCP) on denial letter
  - Failure to include name and contact information for health care professional responsible for decision to deny
  - Failure to notify enrollee of delayed decision and anticipated decision date
  - Failure to notify provider of delayed decision and anticipated decision date

- OneCare Connect Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
February 2017	99%	91%
March 2017	94%	93%
April 2017	100%	97%

  - No significant trends to report.

- OneCare Connect Claims: Professional Claims

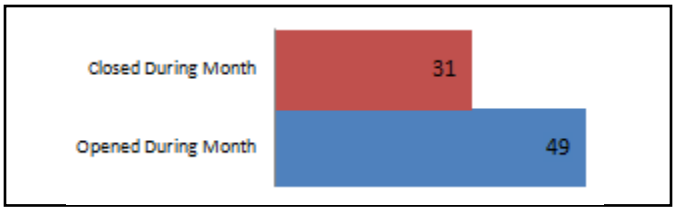
Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
February 2017	92%	80%	90%	92%
March 2017	97%	90%	100%	95%
April 2017	96%	95%	98%	100%

  - The compliance rate for paid claims timeliness decreased from 97% in March 2017 to 96% in April 2017 due to underpaid interest on claims.

  - The compliance rate for denied claims timeliness decreased from 100% in March 2017 to 98% in April 2017 due to untimely processing.

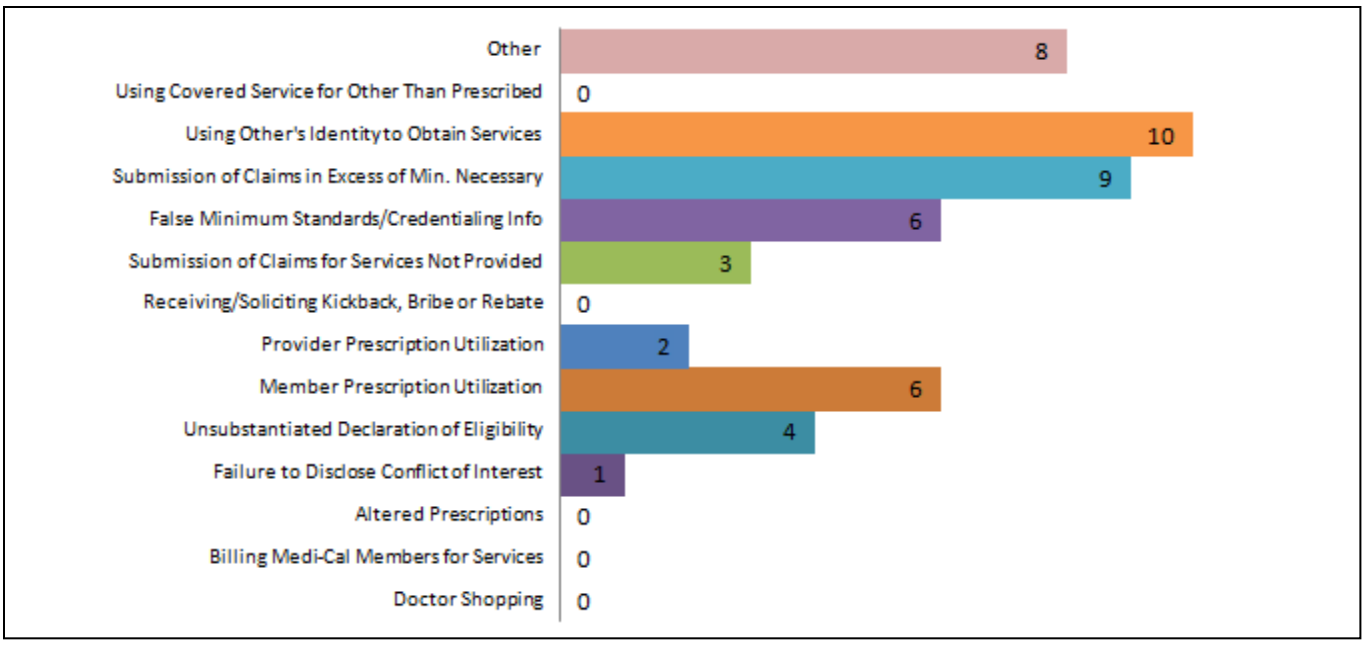
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations (May and June 2017)

Case Status
Case status at the end of May and June 2017

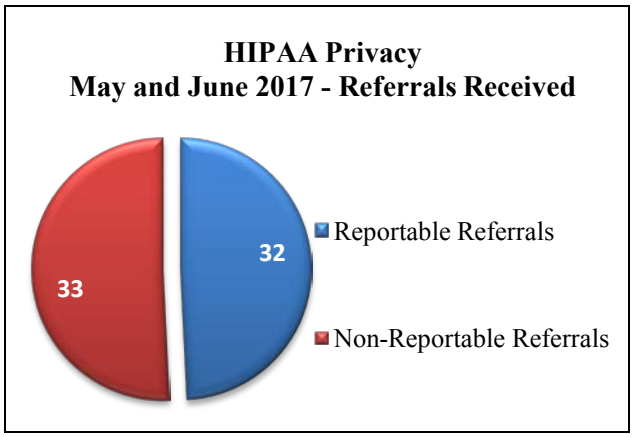


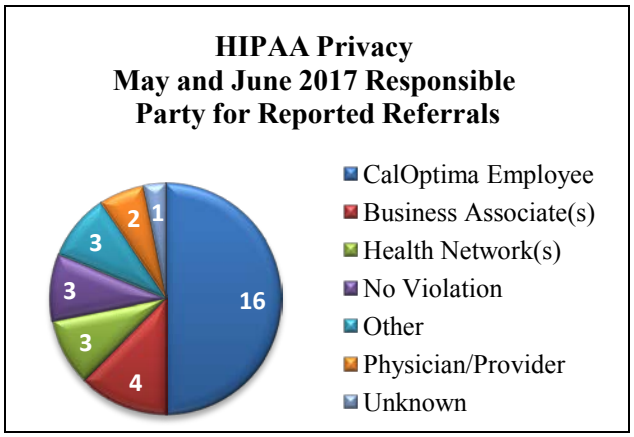
Note: Cases that are referred to DHCS or the MEDIC are not "closed" until CalOptima receives notification of case closure from the applicable government agency.

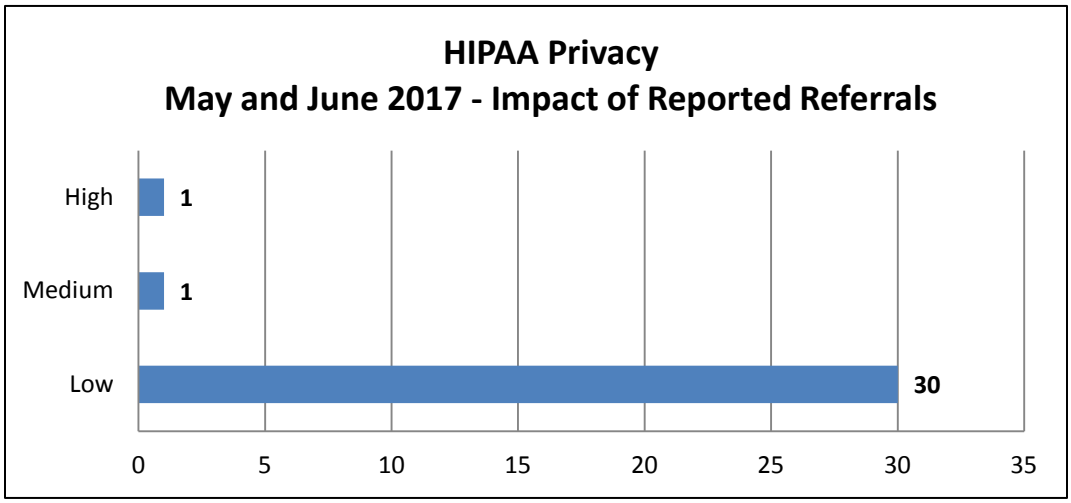
Types of FWA Cases: (Received in May and June 2017)



E. Privacy Update (May and June 2017)







PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	30
Total Number of Referrals Reported to DHCS and Office for Civil Rights (OCR)	2
Total Number of Referrals Reported	**32**

Federal & State Legislative Advocate Reports

Board of Directors Meeting

August 3, 2017

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

July 10, 2017

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: July Report

The months of June and July saw activity significantly increase in the Senate as the majority sought to build consensus within its own party on a bill to repeal and replace the Affordable Care Act. As this controversial legislation moved forward, progress on other historically bipartisan bills, such as reauthorization for the State Children's Health Insurance Program (SCHIP), stalled. The following summary of health care activity on Capitol Hill covers the end of June and July through July 10.

The Better Health Care Act (BCRA)
Senate Republicans primarily wrote their bill among themselves in working groups and over discussions at the daily Senator luncheons. In the days preceding the release of the Senate Republican bill, public reports and private conversations with relevant staff indicated that the structure of the Senate Republican bill would be quite similar to the AHCA. On June 20, 2017, CalOptima joined a letter with other Medicaid managed care organizations addressed to Senate Leaders Mitch McConnell (R-KY) and Chuck Schumer (D-NY) detailing strong concerns with that structure, concluding that "we are united in our opposition to the Medicaid policies currently debated by the Senate" and noting that the signed organizations "stand ready" to work with the Senate on "meaningful Medicaid reform." CalOptima also sent modified versions of this letter to California Senators Feinstein and Harris.

Two days later, on June 22, 2017, Senate Republicans released a discussion draft of their proposal to repeal and replace the Affordable Care Act (ACA), titled the "Better Care Reconciliation Act of 2017" (BCRA). The proposal retains a number of provisions from the House passed AHCA. Beyond the title change, there are notable differences in the Senate's bill, including a slower phase-out schedule for the Medicaid expansion, retention of the ACA's premium subsidy structure, somewhat reduced State waiver flexibility, and delayed implementations of effective dates for certain ACA tax provisions. The BCRA proposes many of the Medicaid changes included in the AHCA, such as the sunset of the essential health benefits requirements for Medicaid plans effective January 1, 2020. The BCRA also retains the conversion of Medicaid to a per capita cap system with optional block grants for certain populations, as well as the AHCA's optional work requirement. Key differences between the BCRA and the House-passed bill are:

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- *Presumptive eligibility* – Like the AHCA, the BCRA would allow state Medicaid plans to conduct eligibility determinations every 6 months and provides a 5% increase in the federal medical assistance percentage (FMAP) for states that elect this option. However, the BCRA gives states more flexibility by allowing them to make eligibility redeterminations after fewer months.

- *Medicaid expansion freeze* – The AHCA would freeze Medicaid expansion after March 1, 2017, by eliminating the state option to expand and receive enhanced FMAP payments. By contrast, the BCRA would not freeze Medicaid expansion, allowing states to enroll and cover individuals up to 133 percent FPL through December 31, 2017. States that had not expanded their programs as of March 1, 2017 could opt to do so, but would receive their regular matching rate to cover new enrollees.

- *Medicaid expansion phase-down* – Unlike the AHCA, the BCRA would provide a prolonged phaseout of enhanced federal Medicaid funding for states. Under the AHCA, states that have already expanded could keep the enhanced match for expansion enrollees until December 31, 2019, but after that would receive an enhanced FMAP only for individuals enrolled as of December 31, 2019, who do not become disenrolled for more than a month ("grandfathered expansion enrollees"). The BCRA maintains the enhanced FMAP for the Medicaid expansion population until December 31, 2020, after which enhanced funding would be phased down from 85% to 75% over three years (2021-2023). No enhanced funding would be available to states after December 31, 2023.

- *Per capita cap* – Like the AHCA, the BCRA would convert federal funding for Medicaid to a per capita cap model, unless a state chooses to receive block grant funding for children and non-expansion adult enrollees, beginning in FY 2020. The BCRA also would maintain the five enrollee categories established by the AHCA: (1) elderly; (2) blind and disabled; (3) children; (4) expansion enrollees; and (5) other non-elderly, nondisabled, non-expansion adults.

  However, the BCRA includes several key differences:
  - Medically complex children would be carved out from the cap.
  - The baseline for the cap would no longer be based on state FY2016 spending trended forward by the medical consumer price index (CPI-M) to 2019 in each enrollee category. Instead, the BCRA cap baseline is a period of 8 consecutive quarters between 2014 and the 2nd quarter of 2017 selected by the state.
  - The growth factor for the cap is altered. Under the BCRA, from FY 2020 to FY2024, the per capita cap would increase annually by the CPI-M for expansion adults,

children and other adult enrollee categories. The cap would grow annually by medical inflation plus one percent. Then, beginning in FY 2025, the per capita cap would grow more slowly for all enrollee categories at the general consumer price index rate.
    - The BCRA would impose deeper Medicaid cuts than the AHCA because it utilizes a slower annual growth rate for payments made to states.

- *Optional block grant* – Similar to the AHCA, the BCRA would give each state the option to receive block grant funding for its "other adult" and children populations in 2020. Similar to the AHCA, states would be subject to minimum requirements, but they also would retain the ability to set eligibility and minimum benefits, and general funding will remain the same. The key difference is that, under the BCRA, before the Secretary of HHS may approve a block grant proposal, it must be made public for a 30 day notice-and-comment period.

- *Provider tax* – The BCRA reduces permissible Medicaid provider taxes from 6% under the ACA in 0.2% increments beginning in 2021 to ultimately reduce the tax to 5% in FY2025. There was no such similar provision in the AHCA.

Nearly immediately following its release, the BCRA faced resistance from Republican Senators. On the afternoon of June 22, conservative Senators Ted Cruz (R-TX), Rand Paul (R-KY), Mike Lee (R-UT), and Ron Johnson (R-WI) issued a joint statement declaring that "for a variety of reasons" they were "not ready to vote for this bill." The following day, Senator Dean Heller (R-NV), the only Republican Senator up for re-election in 2018 in a state won by Hillary Clinton, held a press conference with the Republican governor of Nevada, Brian Sandoval, where he said that he "cannot support legislation that takes insurance away from millions of Americans and hundreds of thousands of Nevadans." Nevada is one of several states to expand Medicaid led by a Republican governor. The quick succession of 5 GOP Senators opposing the bill as drafted spelled trouble for a Senate Republican conference that could only afford to lose 2 of its 52 members in order to pass the bill (assuming Vice President Pence would break the tie in favor of the bill). Yet, this positioning also signaled the ways in which each Senator's concerns could be addressed before the bill was considered by the full Senate, allowing them to claim specific wins for their states or other constituencies. Senate Majority Leader Mitch McConnell established a goal of voting on the bill by Friday, June 30 – before Congress left Washington for the Fourth of July recess.

On Monday, June 26, 2017, four days following the release of the BCRA discussion draft, the Congressional Budget Office (CBO) released its cost estimate of the Senate's health care bill, projecting that the legislation would increase the number of uninsured by 22 million in 2026

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relative to the number under current law. This is slightly fewer than the 23 million uninsured estimated for the House-passed AHCA. CBO also estimates that the BCRA would reduce federal deficits by $321 billion over 10 years, $202 billion more than estimated net savings for the House bill. Under the budget reconciliation rules governing the consideration of the bill, the Senate version had to achieve at least the same amount of savings as the House bill. In other words, Senate Majority Leader McConnell could spend up to roughly $200 billion to secure the votes of GOP Senators.

When it became clear that there was insufficient support for an initial procedural vote to begin consideration of the bill, Majority Leader McConnell on Tuesday, June 27, postponed a vote on the BCRA until after the Fourth of July recess in order to give his conference more time to make changes that would address their concerns. For example, on June 28, he agreed to add $45 billion in funding to address the opioid crisis at the request of Senators Rob Portman (R-OH) and Shelley Moore Capito (R-WV).

Senate Republicans then sent several options to CBO for new cost and coverage estimates that could be used to build support for the bill among GOP Senators when they return from the Fourth of July recess the week of July 10. This next CBO score is not expected to be completed until the end of this week or the beginning of the week of July 17 – the earliest that the Senate may consider a revised BCRA.

One of the options under consideration is an amendment supported by Senators Ted Cruz (R-TX) and Mike Lee (R-UT) that would allow insurance companies to sell plans in the individual insurance market that did not comply with the ACA's consumer protections as long as that insurance company also sold ACA compliant plans. Conservative groups expressed strong support for inclusion of this amendment, but it may dissuade Senate moderates from supporting the bill if it can be painted as undermining protections for individuals with pre-existing conditions.

While Senate Republicans searched for a path forward on the BCRA, the House sought to consider other health care agenda items.

E&C CHIP Hearing
On June 23, 2017, the House Energy & Commerce Health Subcommittee held a hearing titled Examining the Extension of Safety Net Health Programs," intended to be focused on the reauthorization of the SCHIP and Federally Qualified Health Center programs. Without action from Congress by September 31, funding for SCHIP will expire. Democratic Subcommittee members primarily used their question time to criticize the impact of the AHCA on the health

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care safety net, especially Medicaid, and raise concerns about the impact of allowing SCHIP funding to expire. Republican committee leaders such as Chairman Walden and Subcommittee Chairman Burgess both expressed a desire to let the enhanced federal match for SCHIP lapse, saying that the additional federal funding "upends the traditional federal-state partnership." Little consensus emerged at the hearing, and most recognize that SCHIP will not be reauthorized until September following the August Congressional recess.

D-SNP Comment Letter
Last, the House Ways & Means Committee circulated among the special needs plan (SNP) providers a discussion draft of a bill to reauthorize SNPs, which are set to expire in 2018. The Committee's effort is intended to parallel the comprehensive work done in the Senate to draft and pass the CHRONIC Care Act, which would permanently reauthorize D-SNPs. The House discussion draft would reauthorize such plans for 5 years and add a requirement that D-SNPs close in 2022 if they do not provide long-term care and support services or Medicaid behavioral health either through the D-SNP itself or through separate MLTSS or behavioral health plans. CalOptima submitted comments to the Committee reiterating its support for permanent reauthorization of D-SNPs, but encouraging the Committee for providing a reauthorization of 5 years.

Several days later, the Committee shared a revised discussion draft with minor changes but none extending the reauthorization period beyond 5 years. The Committee plans to give its members at least one week before moving forward with a markup. The Committee staff also noted that they would also have to reach agreement with the Energy & Commerce Committee on these provisions, which has primary jurisdiction over Medicaid.

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CalOptima Legislative Report
July 10, 2017
By Don Gilbert and Trent Smith

The Legislature passed a $125 billion budget on June 15 meeting their Constitutional obligation. The new voter approved law requiring that legislation be in print at least 72 hours prior to the Legislature casting final votes created a new wrinkle to this year's budget negotiations. The Governor and Legislative leadership were required to finalize their negotiations the weekend before the scheduled Thursday, June 15 vote in order to get bills in print. In addition to the budget bill, the Legislature commonly prepares dozens of trailer bills which include changes in statute necessary to implement the budget. Those bills also had to be in print 72 hours prior to the June 15 deadline. The Legislature must forfeit their pay for each day they are late in passing the budget which seems to properly motivate them to be timely. This mandate only applies to the budget bill not the various trailer bills. Therefore, it is likely that there will be additional trailer bills considered in the last few weeks of June.

One of the last deals that the Legislature and Governor finalized was a compromise on additional Medi-Cal funding. In 2016 voters approved Proposition 56, which raised taxes on tobacco products. This proposition was sponsored by the California Medical Association (CMA). Proposition 56 was presented to voters as a means to raise revenue to enhance access to Medi-Cal care. Specifically, the new revenue would be used to increase notoriously low provider reimbursement rates.

In January when the Governor introduced his proposed State Budget, CMA and others were surprised that he allocated $1.3 billion in Proposition 56 funds to pay for new Medi-Cal enrollment. CMA argued that Proposition 56 specially prohibits the Governor and Legislature from using Proposition 56 funds to supplant funding that otherwise would have gone towards Medi-Cal. The Governor cleverly argued that the money is targeted for a new purpose because the Medi-Cal enrollees are new to the program. CMA argued that the Governor was supplanting funds because General Fund money would cover the new enrollment had it not been for the Proposition 56 funds.

Legislators from both political parties seemed to side with CMA. However, they were already boxed in by the Governor's initial budget proposal. By earmarking $1.3 billion in Proposition 56 funds for the new Medi-Cal enrollment, the Governor placed the burden on the Legislature to find $1.3 billion in General Fund money to backfill the Proposition 56 funds if they wanted to use these funds for a different purpose. In order to maintain a balanced budget, they would have to cut $1.3 billion from some other part of the State Budget to use for new Medi-Cal enrollment. For the Legislature there are no easy choices when it comes to cutting $1.3 billion from some other popular state program.

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Ultimately, the Governor and Legislature split the difference. The final budget agreement allocates $325 million in Proposition 56 revenue in 2017-18 and 2018-19 for Medi-Cal rate increases for physicians and $140 million for dentists.

The budget also approves $50 million in Proposition 56 revenue in 2017-18 and ongoing for rate increases for women's health services. In addition $27 million in Proposition 56 revenue is allocated in 2017-18 and ongoing to remove the Medi-Cal rate freeze for Intermediate Care Facilities-Developmental Disabilities (ICF-DD). Finally, the budget approves $4 million in Proposition 56 revenue in 2017-18 and ongoing to increase the Medi-Cal rates paid under the AIDS Waiver Program.

In total, $546 million of the $1.3 billion in Proposition 56 funds originally allocated by the Governor for new Medi-Cal enrollment was shifted to provider rate increase. In addition, depending on the state's fiscal condition next year, lawmakers could increase the payments to $800 million beginning July 1, 2018. However, the extra funding depends on the federal government approving the rate increases.

CMA begrudgingly accepted the compromise. In the final budget hearings many Legislators, including both Democrats and Republicans, voiced their displeasure with the fact that the will of the voters was being ignored by the fact that not all of the Proposition 56 revenue was earmarked for the intended purpose of increasing Medi-Cal provider rate increases.

In addition, there was displeasure voiced with the fact that the language allocating the provider rate increases requires that federal funds are secured for the same purposes. Normally, this would not be a big deal. However, with the uncertainty over the future of the Affordable Care Act (ACA) in Washington D.C., there is reason for concern as to whether the Proposition 56 allocations could be jeopardized if the ACA is substantially amended.

Overall, the State Budget appropriates $105.6 billion ($18.6 billion State General Fund) for 2017-18 and $89.2 billion ($18.9 billion State General Fund) for 2016-17 to support the Medi-Cal program.

The budget also approved $1,789,000 ($895,000 General Fund, $894,000 Federal Fund), and a total of 15 permanent positions to address an increase in workload to the Medi-Cal Managed Care Ombudsman Call Center. In addition, trailer bill language was adopted to require the Medi-Cal Managed Care Ombudsman Call Center to collect data on callers and calls received and requires DHCS to include this information in a quarterly report.

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This action is significant for County Organized Health Systems (COHS) because the Western Center on Law and Poverty (WCLP) continues to highlight that enrollees who call the Medi-Cal Managed Care Ombudsman Call Center face very long wait times compared to the Department of Managed Health Care (DMHC) consumer hotline. COHS enrollees rely on the Ombudsman Call center, as COHS are not required to have a Knox-Keene License (KKL) for their Medi-Cal programs and are not regulated by DMHC. The long wait time for the Ombudsman Call Center is an argument WCLP uses to push a KKL mandate on COHS. We have argued that rather than forcing COHS to obtain a KKL, the state should better fund the Ombudsman Call Center. It appears that the Legislature is taking our advice.

Other specific Medi-Cal related items of interest include:

- Trailer bill language to establish statutory authority to request federal approval to use the determination of eligibility for the CalWORKs program as a determination of eligibility for the Medi-Cal program.

- Trailer bill language to delay implementation of AB 1863 (Wood, 2016) - inclusion of marriage and family therapists as billable FQHC – and requires implementation to occur no later than July 1, 2018.

- $34.8 million (General Fund) in 2017-18 and $73 million in 2018-19 and ongoing and trailer bill language to restore the remaining uncovered optional Medi-Cal dental benefits beginning January 1, 2018.

- $12.5 million (General Fund) in 2019-20 and $26.3 million ongoing and trailer bill language to restore the Optician/Optical Lab optional Medi-Cal benefits beginning January 1, 2020.

- Trailer bill language eliminating the Newly Qualified Immigrant Affordability and Benefit Program, and authorizing DHCS to seek federal Minimum Essential Coverage designation for the existing, state-funded NQI health care coverage program.

- Federal Cures Act Opioid Targeted Response Grant of $44.7 million (federal funds) per year for two years to provide increased medication-assisted treatment for individuals with substance use disorders. Also adopts trailer bill language to exempt DHCS from certain state contract processes in order to distribute the funding as fast as possible.

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- Trailer bill language to codify the new drug ingredient reimbursement methodology and dispensing fee based on a study of outpatient pharmacy provider costs in purchasing and dispensing outpatient prescription drugs to Medi-Cal beneficiaries. This action will create state savings by lowering pharmacy reimbursement.

It is also worthy to note that trailer bill language was also adopted to reauthorize and continue the key components of the Coordinated Care Initiative (CCI), including the duals demonstration project and mandatory managed care for duals. In his January budget, the Governor suggested that counties could continue to voluntarily provide In Home Supportive Services (IHSS). However, under his proposal, counties would be required to cover more than $623 million in costs that are currently covered by the state under the CCI.

After heavy lobbying by the counties, the Governor proposed a revised plan in the May Revise. The revised proposal provides $592.2 million in state funds to help counties provide IHSS benefits. This proposal was adopted as part of the final budget.

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Congressional Health Care Reform Efforts
Chronology of Events

U.S. SENATE

Date	Senate Action	Analysis
7/26/17	**Senate Rejects "Repeal Now, Replace Later" Amendment** (Sen. Paul) Vote: 45–55	
7/25/17	**Senate Rejects BCRA With Amendments** (Sens. Cruz and Portman) Vote: 43–57	Sen. Cruz: • Allows health insurers to sell plans with limited benefits if they also offer at least one plan that complies with ACA requirements Sen. Portman: • Provides $100 billion for individuals who lose Medicaid to purchase commercial health coverage
7/25/17	**Senate Approves "Motion to Proceed" on H.R. 1628** Vote: 51–50	Sens. Murkowski (R) and Collins (R) vote no. VP Pence casts tie-breaking vote.
7/21/17	**Senate Parliamentarian Determines Certain BCRA Provisions Violate Budget Reconciliation Requirements (Byrd Rule)**	Certain BCRA provisions are found to violate the Byrd rule, including: • Cutting federal funding for Planned Parenthood • Prohibiting the use of federal subsidies to buy insurance that covers abortion services • Requiring individuals who have a lapse in insurance coverage to wait six months before obtaining coverage through a health care exchange • Ending the requirement that state's alternative benefit Medicaid plans cover the ACA's 10 essential health benefits
7/20/17	**CBO Scores BCRA** (Includes Sen. McConnell Amendment)	Beginning in 2021, the first year of Medicaid impact, a reduction of $55 billion (approximately 10%) in Medicaid spending, which may result in 10 million fewer enrollees (approximately 14%) through 2021. In 2026, a reduction of $87 billion (approximately 14%) in Medicaid spending, which may result in 15 million fewer enrollees (approximately 18%) through 2026.
7/20/17	**BCRA Amendment Offered** (Sen. McConnell)	Preserves three ACA-related taxes: • Payroll tax on individuals with annual income over $200,000 ($250,000 for couples) • Investment income tax • Provision that prevents insurance companies from writing off executive compensation Medicaid provisions remain unchanged.

Congressional Health Care Reform Efforts: *Chronology of Events*

Date	Senate Action	Analysis
7/19/17	**CBO Scores "Repeal Now, Replace Later" Bill**	Beginning in 2020, the first year of Medicaid impact, a reduction of $75 billion (approximately 13%) in Medicaid spending, which may result in 15 million fewer enrollees (approximately 20%) through 2020. In 2026, a reduction of $144 billion (approximately 23%) in Medicaid spending, which may result in 19 million fewer enrollees (approximately 23%) through 2026.
7/19/17	**Three Republican Senators Publicly Oppose "Repeal Now, Replace Later"** (Sens. Murkowski, Moore Capito and Collins)	
7/19/17	**Leader McConnell Calls for "Repeal Now, Replace Later" Vote**	This bill would eliminate the ACA's Medicaid Expansion (MCE) in 2020. No changes to Medicaid Classic.
7/18/17	**Two More Republican Senators Publicly Oppose BCRA** (Sens. Lee and Moran)	Total number of public "no" votes is four.
7/13/17	**BCRA Amendment Offered** (Sens. Cruz and Lee)	Allows health insurers to sell plans with limited benefits if they also offer at least one plan that complies with ACA requirements. Medicaid provisions remain unchanged.
7/02/17	**Leader McConnell Postpones BCRA Vote**	
6/28/17	**DHCS Releases Fiscal Analysis of BCRA**	Beginning in 2020, a reduction of $3 billion (approximately 3%) to Medi-Cal. Classic would not see any reductions in 2020, and MCE would see a $2.6 billion reduction. In 2026, a reduction of $29.3 billion to Medi-Cal: $11.3 billion in reductions for Classic and $18 billion for MCE.
6/26/17	**Two Republican Senators Publicly Oppose BCRA** (Sens. Collins and Paul)	• Susan Collins (ME) opposes due to Medicaid reductions • Rand Paul (KY) opposes due to continuation of several ACA policies
6/26/17	**CBO Scores BCRA**	Beginning in 2021, the first year of Medicaid impact, a reduction of $70 billion (approximately 13%) in Medicaid spending, which may result in 10 million fewer enrollees (approximately 14%) through 2021. In 2026, a reduction of $158 billion (approximately 25%) in Medicaid spending, which may result in 15 million fewer enrollees (approximately 18%) through 2026. In 2036, a 35% reduction in Medicaid spending.

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Congressional Health Care Reform Efforts: *Chronology of Events*

Date	Senate Action	Analysis
6/22/17	**Senate Releases Better Care Reconciliation Act (BCRA) Discussion Draft**	Medicaid Classic: • Transitions Classic 50/50 FMAP formula to per capita caps beginning in FY 2021 (AHCA: FY 2020). Establishes new per-enrollee baseline amount based on a state's Medicaid spending over eight consecutive quarters from FY 14–17 (AHCA: based on 2016 Medicaid spending). These amounts would increase by the CPI-M from FY 2021–24. In FY 2025, the growth rate would drop from CPI-M to the CPI-U. MCE: • Maintains the MCE 90/10 FMAP formula until 2021 (AHCA: 2020). Three year phase-down of MCE FMAP (85/15 in 2021, 80/20 in 2022, 75/25 in 2023. 50/50 FMAP in 2024).
6/21/17	**CalOptima Sends Letter of Concern Regarding Senate Consideration of AHCA to Sens. Feinstein and Harris**	Opposes reduced federal funding from: • Proposed per capita cap formula • MCE reductions
6/20/17	**CalOptima Signs Part of Coalition Letter (including Blue Shield, L.A. Care, Molina, and IEHP) to Senate Leaders Regarding Medicaid Reform**	• Expresses the importance of Medicaid • Opposes Medicaid provisions being debated • Offers to work with the Senate on meaningful reforms

U.S. HOUSE OF REPRESENTATIVES

Date	House Action	Analysis
5/04/17	**AHCA Passes House** Vote: 217–213	Orange County House Delegation CD 38 – Sanchez: NO CD 39 – Royce: AYE CD 45 – Walters: AYE CD 46 – Correa: NO CD 47 – Lowenthal: NO CD 48 – Rohrabacher: AYE CD 49 – Issa: AYE
5/03/17	**AHCA Amended** (Reps. MacArthur and Palmer)	Rep. MacArthur: • Through the state waiver process, allows states to set their own essential health benefits and allows commercial health insurers to charge individuals with pre-existing conditions up to five times more than healthy individuals (ACA: 3:1) Rep. Palmer: • Allocates $15 billion for high-risk pool to reduce premiums for individuals with pre-existing conditions
3/24/17	**Speaker Ryan Postpones Vote on AHCA**	
3/24/17	**CalOptima Letter Regarding AHCA to Orange County Congressional Delegation**	Shares concerns with reduced federal funding through: • Proposed per capita caps formula • MCE reductions

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Congressional Health Care Reform Efforts: *Chronology of Events*

Date	House Action	Analysis
3/21/17	**AHCA Amended** (Rep. Walden)	Changes to Medicaid: • Through state waiver process, allows states to add Medicaid work requirements and choose block grant formula vs. per capita cap formula • Increases per capita cap annual growth rate for elderly and disabled from CPI-M to CPI-M + 1%
3/21/17	**DHCS Releases Analysis of AHCA**	Beginning in 2020, the first year of Medi-Cal impact, a reduction of nearly $6 billion to Medi-Cal (approximately 5%): $680 million in reductions for Classic and $4.8 billion for MCE. In 2027, a reduction of $24 billion to Medi-Cal: $5.3 billion in reductions for Classic and $18.6 billion for MCE.
3/13/17	**CBO Scores AHCA**	Beginning in 2020, the first year of Medicaid impact, a reduction of $68 billion (approximately 12%) in Medicaid spending, which may result in 9 million fewer enrollees (approximately 12%) through 2020. In 2026, a reduction of $155 billion (approximately 25%) in Medicaid spending, which may result in 14 million fewer enrollees (approximately 17%) through 2026.
3/08/17	**AHCA Amended by Two House Committees (E&C and W&M)**	Technical, non-substantive changes. Medicaid provisions remain unchanged.
3/06/17	**American Health Care Act (AHCA)** **H.R. 1628** **Introduced in the House**	Medicaid Classic: • Transitions Classic 50/50 FMAP formula to per capita caps beginning in FY 2020. Establishes new per-enrollee baseline amount based on a state's 2016 Medicaid spending levels. These amounts would increase by the consumer price index medical (CPI-M) MCE: • Transitions MCE FMAP formula from 90/10 to 50/50 beginning January 1, 2020 • Current MCE enrollees who experience a 30-day break in coverage after January 1, 2020, funded at 50/50 FMAP

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2017–18 Legislative Tracking Matrix

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
AB 15 (Maienschein)	This bill would require DHCS to increase the Denti-Cal provider reimbursement rates to the regional commercial rates for the 15 most common dental services. While the bill does not specify a dollar amount for the increase, it does note Denti-Cal's low utilization and funding levels, citing the need for increased reimbursement rates to attract additional providers. CalOptima members who receive Denti-Cal benefits outside of CalOptima may be affected by this proposed increase in funding. This bill would take effect on January 1, 2018.	**05/26/2017** Held under submission	Watch
AB 97 (Ting)	Thill bill enacts California's Budget for FY 17-18. The bill funds state departments, projects, and programs for the upcoming fiscal year.	**06/27/2017** Signed into law	Watch
AB 120 (Ting)	This "junior budget bill" contains specific state Medi-Cal appropriations and instructions for allocating those funds. Section 3(1)1-5 of the bill requires Proposition 56 revenue to include $325 million for increased Medi-Cal physician payments and $140 million for increased Denti-Cal provider payments. Most of the remaining Proposition 56 funds will be used for general Medi-Cal expenditures. Additionally, section 1(16) of the bill requires DHCS to provide Medicare Part A recoupment amounts to plans by July 31, 2017. This is a result of a state enrollment error, where some Medi-Cal members with Medicare Part A were incorrectly enrolled as Medi-Cal expansion members and were funded at a higher federal match. DHCS must return $365 million to the federal government and will collect payments from Medi-Cal health plans, including CalOptima.	**06/27/2017** Signed into law	Watch
AB 340 (Arambula)	This bill would require the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) to include screenings for incidents of trauma that affect a child's mental or physical health. The EPSDT program is a comprehensive, preventive Medi-Cal benefit for children under the age of 21. CalOptima provides most EPSDT services, while the Orange County Health Care Agency (HCA) covers services not covered by CalOptima. Further clarification is needed in the bill to define whether trauma screening is considered a specialty mental health service offered by county mental health plans, or if Medi-Cal managed care plans would be responsible for providing these services.	**06/28/2017** Passed out of Senate Committee on Health, referred to Senate Committee on Appropriations	Watch
AB 675 (Ridley-Thomas)	This bill would appropriate $650 million of state General Fund dollars to DHCS in order to allow In-Home Supportive Services (IHSS) to continue as a Medi-Cal managed care benefit. The Coordinated Care Initiative (CCI) contained a "poison pill" that went into effect in January, meaning IHSS will no longer be a Medi-Cal managed care benefit beginning January 1, 2018. This bill aims to retain the IHSS provision of CCI by shifting dollars from the state General Fund to DHCS.	**05/26/2017** Held under submission	Watch
SB 4 (Mendoza)	This bill would codify the current seat designations on the CalOptima Board of Directors, and modify the Board member removal process.	**07/13/2017** Passed Assembly Committee on Local Government	Watch

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
SB 152 (Hernandez)	Based on the most recent guidance from DHCS, CalOptima will implement the Whole Child Model (WCM) no sooner than January 1, 2019. However, under current law, DHCS is required to submit a report to the Legislature no later than January 1, 2021 (two years after plan implementation). Since the WCM implementation date has been delayed, this bill has been introduced to allow plans the full three years to implement the WCM before DHCS submits its report to the Legislature. This bill would also allow DHCS to make this report available to the public with 90 days instead of the original 30 days.	**07/06/2017** Passed Assembly, re-referred to the Senate	Watch
SB 171/ AB 205 (Hernandez/ Wood)	This bill would implement certain provisions of the CMS Medicaid managed care rules, making changes at the state level regarding Medi-Cal managed care plans and state fair hearings, time and distance requirements for providers, medical loss ratios, and public hospital financing.	**07/11/2017** Passed Committees on Health, referred to Committees on Appropriations	Watch
SB 223 (Atkins)	This bill would require Medi-Cal managed care plans to notify members of their nondiscriminatory protections, and translate its member materials into the top 15 languages as identified by the U.S. Census. Plans are currently required to translate materials into threshold languages based on regional population. It would also require interpreters to be deemed qualified by the state and receive additional ethics, conduct, and proficiency training.	**06/28/2017** Passed Senate Committee on Health, referred to Senate Committee on Appropriations	Watch
SB 508 (Roth)	This bill would allow DHCS to create a dental health collaboration pilot program for Medi-Cal members in Riverside and San Bernardino counties. The program would coordinate efforts between health plans and DHCS to deliver more coordinated Denti-Cal services for Medi-Cal members and incentive based payment structures for Denti-Cal providers. According to the bill, this pilot program would be implemented for up to five years.	**04/24/2017** Hearing cancelled at the request of the bill author	Watch
State Budget Trailer Bill – Cal MediConnect	This trailer bill language (TBL) would extend the Cal MediConnect (CMC) program, which includes CalOptima's OneCare Connect. CMC is currently part of the Coordinated Care Initiative (CCI), which operates in seven counties and consists of both CMC, and the integration of Medi-Cal long-term services and supports, including In-Home Supportive Services (IHSS), into managed care. The FY 2017–18 state budget proposed the continuation of CMC until December 31, 2019, even as the broader CCI is discontinued as of January 1, 2018. CCI's discontinuation means that IHSS administration will be transferred back to counties from managed care plans and new state legislation will be required to authorize the CMC program past January 1, 2018.	**05/31/2017** Preliminary trailer bill language published by the Department of Finance	Watch

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
HR 1628 (Black)	The American Health Care Act (AHCA) would make sweeping changes to the national health care system. For CalOptima, the most significant changes would be 1) Changes to the Medicaid financing structure from the federal medical assistance percentage (FMAP) to a per capita cap system, 2) Decreased federal dollars for Medicaid expansion members who leave and return to the program, 3) Additional state authority to set "essential health benefit" requirements for Medicaid plans, and 4) Potentially decreased funding and additional restrictions for state waiver programs.	**05/04/2017** Passed the House	Sent letter of concern

2017–18 Legislative Tracking Matrix *(continued)*

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Position
Better Care Reconciliation Act - Draft Senate Amendment to HR 1628 (Senate Committee on the Budget)	Similar to the AHCA, the Better Care Reconciliation Act (BCRA) discussion draft legislation would also make sweeping changes to the national health care system. BCRA, however, differs from the AHCA by slowing per capita cap growth starting in FY 2025 and by excluding medically complex children. The slowed per capita cap growth would require states to either decrease benefits, modify Medicaid eligibility, or increase their contribution to maintain current Medicaid coverage. If states elect to continue the Medicaid expansion, BCRA maintains enhanced federal funding for the Medi-Cal expansion population until 2021, but gradually phases down federal funding over a three year period, eventually returning to the traditional FMAP. The bill sunsets the requirement for Medicaid plans to offer the ACA-mandated "essential health benefits", but does provide states with some flexibility and funding for state waiver programs.	**06/22/2017** Discussion draft posted on Senate Budget Committee's website	Sent letter of concern
HR 3168 (Tiberi)	This bill would make a number of reforms to the Medicare program, and most importantly for CalOptima, it would re-authorize dual eligible special needs plans (D-SNPs) for five years, including CalOptima's OneCare program. Historically, D-SNPs have been temporarily re-authorized by Congress, and are currently set to expire on December 31, 2018.	**07/06/2017** Referred to House Committee on Ways and Means and House Committee on Energy and Commerce	Watch
S 191 (Cassidy)	The Patient Freedom Act would repeal several mandates in the Affordable Care Act (ACA), such as the individual and employer mandates, as well as the essential health benefit requirements. The bill retains most of the ACA consumer protections, such as prohibiting discrimination, pre-existing conditions exclusions, and annual/lifetime limits. Once the ACA provisions are repealed, the bill would provide greater state flexibility for their Medicaid and exchange programs. Specifically, states would be given three options after the ACA provisions are repealed: 1) A state-specific health system (excluding the repealed ACA provisions) with 95 percent of current federal funding available to states prior to implementation of this bill, 2) A state-based health care system with no federal financial assistance, or 3) Continue under current system at funding no more than option 1 (state legislatures would be required to reinstate the ACA requirements and mandates repealed by S. 191).	**01/23/2017** Referred to Senate Committee on Finance	Watch
S 870 (Hatch)	This bill would make a number of reforms to the Medicare program, and most importantly for CalOptima, it would permanently re-authorize dual eligible special needs plans (D-SNPs), including CalOptima's OneCare program. Historically, D-SNPs have been temporarily re-authorized by Congress, and are currently set to expire on December 31, 2018. According to the bill author, this bill aims to improve care for individuals with multiple chronic conditions and who are enrolled in Medicare and/or Medicaid.	**05/18/2017** Passed Senate Finance Committee	Support

The CalOptima Legislative Tracking Matrix includes information regarding legislation that directly impacts CalOptima and our members. These bills are closely tracked 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.

2017 State Legislative Deadlines

January 4	Legislature reconvenes
February 17	Last day for legislation to be introduced
April 28	Last day for policy committees to hear and report bills to fiscal committees
May 12	Last day for policy committees to hear and report non-fiscal bills to the floor
May 26	Last day for fiscal committees to report fiscal bills to the floor
May 30–June2	Floor session only
June 2	Last day to pass bills out of their house of origin
June 15	Budget bill must be passed by midnight
July 21–August 21	Summer recess
September 1	Last day for fiscal committees to report bills to the floor
September 5–15	Floor session only
September 15	Last day for bills to be passed. Interim recess begins
October 15	Last day for Governor to sign or veto bills passed by the Legislature

Sources: 2017 State Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

Board of Directors Meeting
August 3, 2017

CalOptima Community Outreach Summary — June and July 2017

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.

We consider requests for sponsorship based on several factors including: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in a number of community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues. CalOptima strives to address issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Events Update

In FY 2016–2017, the Community Relations department received 233 requests for CalOptima to participate in public activities. Approximately 80 percent (183 out of 233) of the requests met at least one of the criteria required for CalOptima's participation. CalOptima participated in approximately 80 percent (142 out of the 183) of the approved public activity requests. CalOptima did not participate in approximately 40 approved public activity requests due to limited staff availability, short notice or events were cancelled.

Public activities attended range from health, literacy, housing and community resource fairs, to back-to-school events, conferences and community celebrations throughout Orange County. During these events, CalOptima interacted with current and potential members of all ages and ethnic backgrounds. Approximately 67 percent of these events provided outreach to children and families, 30 percent outreached to seniors, and 3 percent outreached to veterans and their families. The remainder of the events were educational seminars and conferences for staff development.

CalOptima also provided financial support to nearly 50 community events. A total of $41,194 was contributed to community events that provided opportunity for CalOptima staff to engage with members/potential members. CalOptima contributed $5,490 to community events that provided

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opportunity for CalOptima staff to outreach to health care professionals, non-profit organizations or policy makers. Financial support for these events included registration fees and sponsorships. Financially supporting these community events provided CalOptima opportunities to outreach to members and potential members, and to promote awareness of CalOptima in the community, CalOptima's programs and services, and long-term collaborative partnerships with requesting entities.

For additional information or questions, please contact Community Relations Manager Tiffany Kaaiakamanu at **657-235-6872** or tkaaiakamanu@caloptima.org.

Summary of Public Activities

During June and July, CalOptima participated in 72 community events, coalitions and committee meetings:

Date	Events/Meetings	Audience Reached
6/01/17	• Homeless Provider Forum	Health and Human Service Providers
	• New Partnership Meeting with Second Harvest Food Bank of Orange County	Health and Human Service Providers
	• Orange County Women's Health Policy Project Advisory Board Meeting	Health and Human Service Providers
	• Strengthening Partnership Meeting with Family Caregiver Resource Center	Health and Human Service Providers
	• Orange County Wraparound Resource Fair hosted by Wraparound Orange County and Family Support Network	Members/Potential Members
6/03/17	• Family Fun and Wellness Fair hosted by Pretend City Children's Museum (Registration Fee: $250 included one table for outreach)	Members/Potential Members
6/05/17	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting	Health and Human Service Providers
6/07/17	• Anaheim Human Services Network Meeting	Health and Human Service Providers
	• Orange County Aging Services Collaborative General Meeting	Health and Human Service Providers
	• Orange County Healthy Aging Initiative Meeting	Health and Human Service Providers
	• Safe and Healthy Summer Family Resource Fair hosted by Westminster Family Resource Center	Members/Potential Members
6/08/17	• Orange County Strategic Plan for Aging Meeting	Health and Human Service Providers
6/09/17	• Community Resource Fair hosted by City of Cypress Senior Center (Registration Fee: $50 included one table for outreach)	Members/Potential Members
6/10/17	• 17th Anniversary Celebration and Resource Fair hosted by Magnolia Park Family Resource Center	Members/Potential Members

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	• Teen and Parent Conference hosted by Minnie Street Family Resource Center, Institute for Healthcare Advancement and Human Options	Members/Potential Members
6/13/17	• Susan G. Komen Orange County — Unidos Contra el Cancer de Seno Meeting	Health and Human Service Providers
	• Orange County Strategic Plan for Aging Meeting	Health and Human Service Providers
6/14/17	• Orange County Communication Workgroup Meeting	Health and Human Service Providers
	• Vietnamese -American Human Service Providers Quarterly Networking Luncheon	Health and Human Service Providers
6/15/17	• Orange County Children's Partnership Committee	Health and Human Service Providers
6/16/17	• Orange County Care Coordination Collaborative for Kids	Health and Human Service Providers
6/17/17	• Community Resource Fair hosted by Rancho Santiago Community College District Child Development Services	Members/Potential Members
	• World Elder Abuse Awareness Day hosted by North Orange County Senior Collaborative	Members/Potential Members
6/19/17	• New Partnership Meeting with Child Abuse Prevention Center	Health and Human Service Providers
6/21/17	• Vision Y Compromiso Promotoras Meeting	Health and Human Service Providers
	• Covered Orange County Steering Committee Meeting	Health and Human Service Providers
	• Orange County Promotoras	Health and Human Service Providers
	• Minnie Street Family Resource Center Professional Roundtable	Health and Human Service Providers
	• 2017 Health Fair hosted by Project Access, Inc.	Members/Potential Members
6/22/17	• New Partnership Meeting with Palm Tree Shangha	Health and Human Service Providers
	• Disability Coalition of Orange County	Health and Human Service Providers
6/26/17	• Stanton Collaborative Meeting	Health and Human Service Providers
	• Community Health Research Exchange Meeting	Health and Human Service Providers
6/27/17	• Get Healthy Initiative Meeting	Health and Human Service Providers
	• Strengthening Partnership Meeting with Alinea Medical Imaging	Health and Human Service Providers
	• Orange County Senior Roundtable	Health and Human Service Providers

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	• Twelfth Annual Senior Expo 2017 hosted by City of Fountain Valley Recreation and Community Services (Sponsorship Fee: $1,000 included two reserved premiere booth locations, company logo displayed on street banners, during event, on event fliers, and all printed materials, website, Channel 3 television, and listed on press releases.	Members/Potential Members
6/28/17	• Orange County Human Trafficking Task Force Meeting	Health and Human Service Providers
6/29/17	• Community Walks — Walk with a Doc hosted by City of Placentia	Members/Potential Members
	• Residents and Families Picnic hosted by Living Opportunities Management Company at Community Garden Tower	Members/Potential Members
7/03/17	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting	Health and Human Service Providers
7/06/17	• Homeless Provider Forum	Health and Human Service Providers
	• Refugee Forum of Orange County	Health and Human Service Providers
7/07/17	• Covered Orange County General Meeting	Health and Human Service Providers
7/10/17	• Orange County Veterans and Military Families Collaborative	Health and Human Service Providers
	• Fullerton Collaborative Meeting	Health and Human Service Providers
7/11/17	• San Clemente Youth Wellness and Prevention Coalition Meeting	Health and Human Service Providers
	• Buena Clinton Neighborhood Coalition Meeting	Health and Human Service Providers
	• Orange County Strategic Plan for Aging	Health and Human Service Providers
	• Susan G. Komen Orange County – Unidos Contra el Cancer del Seno Coalition	Health and Human Service Providers
7/12/17	• Anaheim Homeless Collaborative Meeting	Health and Human Service Providers
	• Buena Park Collaborative Meeting	Health and Human Service Providers
7/13/17	• FOCUS Collaborative Meeting	Health and Human Service Providers
	• State Council on Development Disabilities Regional Advisory Committee Meeting	Health and Human Service Providers
	• Orange County Women's Health Policy Project Advisory Board Meeting	Health and Human Service Providers
7/14/17	• Annual Health and Resource Fair hosted by Living Opportunities Management Company at	Members/Potential Members

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	Woodbridge Manor Apartments	
7/15/17	• Summer Health and Wellness Festival hosted by City of Fullerton (Registration Fee: $50 included one table for outreach)	Members/Potential Members
7/18/17	• North Orange County Senior Collaborative Meeting	Health and Human Service Providers
	• Placentia Collaborative Meeting	Health and Human Service Providers
7/19/17	• La Habra Collaborative Meeting	Health and Human Service Providers
	• La Habra Move More Eat Healthy Planning Meeting	Health and Human Service Providers
	• Vision Y Compromiso Promotoras Meeting	Health and Human Service Providers
	• Covered Orange County Steering Committee Meeting	Health and Human Service Providers
7/20/17	• Orange County Children's Partnership Committee	Health and Human Service Providers
7/21/17	• Orange County Care Coordination Collaborative for Kids	Health and Human Service Providers
7/24/17	• Stanton Collaborative Meeting	Health and Human Service Providers
7/25/17	• Santa Ana Building Healthy Community Meeting	Health and Human Service Providers
	• Orange County Senior Roundtable	Health and Human Service Providers
7/26/17	• Orange County Human Trafficking Task Force General Meeting	Health and Human Service Providers
7/27/17	• Disability Coalition of Orange County Meeting	Health and Human Service Providers
7/29/17	• Back to School Outreach hosted by Anaheim Union High School District and Collaboration to Assist Motel Families	Members/Potential Members
	• Third Annual Trans Pride: Health for EveryBODY hosted by LGBT Center OC (Sponsorship Fee: $250 included one table for outreach, logo on marketing materials and opportunity for speaking engagement)	Members/Potential Members

CalOptima organized or convened the following 29 community stakeholder events, meetings and presentations:

Date	Event/Meeting	Audience Reached
6/06/17	• OneCare Connect Forum hosted for Living Opportunities Management Company at Triangle Terrace Affordable Senior Housing — Topic:	Members/Potential Members

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	OneCare Connect • CalOptima Health Education Workshops — Topic: Healthy Weight Healthy You (Spanish)	Members/Potential Members
6/07/17	• OneCare Connect Forum hosted for Living Opportunities Management Company at Woodbridge Manor Affordable Senior Housing — Topic: OneCare Connect	Members/Potential Members
	• CalOptima Health Education Workshops — Healthy Weight Healthy You	Members/Potential Members
6/08/17	• CalOptima Health Education Workshops — Topic: Healthy Weight Healthy You (Spanish)	Members/Potential Members
6/09/17	• County Community Service Center education seminar — Topic: Long-Term Services and Supports for Seniors and Persons with Disabilities	Members/Potential Members
	• CalOptima Informational Forum — Topic: Care Management: How CalOptima Supports Delivery of Quality, Person-Centered Care	Health and Human Service Providers
6/13/17	• CalOptima Health Education Workshops — Topic: Healthy Weight Healthy You (Spanish)	Members/Potential Members
6/14/17	• CalOptima Health Education Workshops — Topic: Promoting Lifecycle Weight Management	Health and Human Service Providers
	• CalOptima Health Education Workshops — Healthy Weight Healthy You	Members/Potential Members
	• Community Alliances Forum — Topic: Enhancing the Aging Experience Together: The Orange County Strategic Plan for Aging	Health and Human Service Providers
6/15/17	• Community-based organization presentation for Planned Parenthood of San Bernardino and Orange Counties — Topic: CalOptima Overview	Health and Human Service Providers
	• CalOptima Health Education Workshops — Topic: Healthy Weight Healthy You (Spanish)	Members/Potential Members

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6/16/17	• County Community Service Center education seminar — Topic: Long –Term Services and Supports for Seniors and Persons with Disabilities (Spanish)	Members/Potential Members
6/20/17	• CalOptima Health Education Workshops — Topic: Healthy Weight Healthy You (Spanish)	Members/Potential Members
	• OneCare Connect Town Hall for Physicians and Hospital Staff	Health and Human Service Providers
6/21/17	• CalOptima Health Education Workshops — Topic: Healthy Weight Healthy You	Members/Potential Members
6/22/17	• CalOptima Health Education Workshops — Topic: Healthy Weight Healthy You (Spanish)	Members/Potential Members
6/27/17	• CalOptima Health Education Workshops — Topic: Healthy Weight Healthy You (Spanish)	Members/Potential Members
6/28/17	• CalOptima Health Education Workshops — Topic: Healthy Weight Healthy You	Members/Potential Members
	• CalOptima Health Education Workshops — Topic: Diabetes Update	Health and Human Service Providers
6/29/17	• CalOptima New Member Orientation for Medi-Cal Members (Vietnamese)	Members/Potential Members
	• CalOptima Health Education Workshops — Topic: Healthy Weight Healthy You (Spanish)	Members/Potential Members
6/30/17	• County Community Service Center education seminar — Topic: Long-Term Services and Supports for Seniors and Persons with Disabilities (Vietnamese)	Members/Potential Members
7/06/17	• CalOptima New Member Orientation for Medi-Cal — Medicare Members (Vietnamese)	Members/Potential Members
	• CalOptima Health Education Workshops — Topic: Healthy Weight Healthy You	Members/Potential Members
7/14/17	• County Community Service Center education seminar — Topic: Understanding Diabetes (Vietnamese)	Members/Potential Members
7/27/17	• CalOptima New Member Orientation for Medi-Cal Members (Vietnamese)	Members/Potential Members
7/28/17	• County Community Service Center education seminar — Topic: Understanding Diabetes (Vietnamese)	Members/Potential Members

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CalOptima did not provide any endorsement for events during this reporting period (e.g., letters of support, program/public activity event with support, or use of name/logo).

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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.

August

Tuesday, 8/1 9:30-11am	++Collaborative to Assist Motel Families	**Steering Committee Meeting: Open to Collaborative Members**	Anaheim Downtown Center 250 E. Center St. Anaheim
Tuesday, 8/1 4:30-6pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required***	CalOptima Room 150
Wednesday, 8/2 9-10:30am	++OC Aging Services Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 8/2 10am-12pm	++Anaheim Human Services Network	**Steering Committee Meeting: Open to Collaborative Members**	Orange County Family Justice Center 150 W. Vermont Anaheim
Wednesday, 8/2 10:30am-12pm	++OC Healthy Aging Initiative	**Steering Committee Meeting: Open to Collaborative Members**	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 8/2 4:30-6pm	*Health Education Weight Control Class	**Community Presentation Open to the Public** ***Registration required***	CalOptima Room 150
Thursday, 8/3 9-11am	++Homeless Provider Forum	**Steering Committee Meeting: Open to Collaborative Members**	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 8/3 9:30-10:30am	*New Member Orientation Presentation in Vietnamese	**Community Presentation Open to the Public**	County Community Service Center 15496 Magnolia St.

+ Exhibitor/Attendee
++ Meeting Attendee

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			Westminster
Friday, 8/4 9-10:30am	++Covered Orange County General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	The Village 1505 E. 17th St. Santa Ana
Friday, 8/4 10-11am	++Help Me Grow Advisory Meeting	**Steering Committee Meeting: Open to Collaborative Members**	Help Me Grow 2500 Redhill Ave. Santa Ana
Monday, 8/7 1-4pm	++OCHCA Mental Health Services Act Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	Delhi Center 505 E. Central Ave. Santa Ana
Monday, 8/7 3:30-4:30pm	++OC Communications Workgroup	**Steering Committee Meeting: Open to Collaborative Members**	Location varies
Tuesday, 8/8 9-10:30am	++OC Strategic Plan for Aging-Social Engagement Committee	**Steering Committee Meeting: Open to Collaborative Members**	Alzheimer's OC 2515 McCabe Way Irvine
Tuesday, 8/8 11:30am-12:30pm	++Buena Clinton Neighborhood Coalition	**Steering Committee Meeting: Open to Collaborative Members**	Buena Clinton Youth and Family Center 12661 Sunswept Ave. Garden Grove
Tuesday, 8/8 2-4pm	++Susan G. Komen Orange County Unidos Contra el Cancer del Seno Coalition	**Steering Committee Meeting: Open to Collaborative Members**	Susan G. Komen OC 2817 McGaw Irvine
Tuesday, 8/8 4-5:30pm	++San Clemente Youth Wellness & Prevention Coalition	**Steering Committee Meeting: Open to Collaborative Members**	San Clemente High School 700 Avenida Pico San Clemente
Tuesday, 8/8 4:30-6pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required***	CalOptima Room 150
Wednesday, 8/9 10-11:30am	++Buena Park Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Buena Park Library 7150 La Palma Ave. Buena Park

Wednesday, 8/9 12-1:30pm	++Anaheim Homeless Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Anaheim Central Library 500 W. Broadway Anaheim
Wednesday, 8/9 10-11:30am	++Buena Park Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Buena Park Library 7150 La Palma Ave. Buena Park
Tuesday, 8/9 4:30-6pm	*Health Education Weight Control Class	**Community Presentation Open to the Public** ***Registration required***	CalOptima Room 150
Thursday, 8/10 11:30am-12:30pm	++FOCUS Collaborative Meeting	**Steering Committee Meeting: Open to Collaborative Members**	Magnolia Park Family Resource Center 11402 Magnolia Street Garden Grove
Thursday, 8/10 3-5pm	++OC Women's Health Project	**Steering Committee Meeting: Open to Collaborative Members**	The Village 1505 E. 17th St. Santa Ana
Friday, 8/11 9:30-11am	++Senior Citizen Advisory Council Meeting	**Steering Committee Meeting: Open to Collaborative Members**	Location varies
Monday, 8/14 1-2:30pm	++OC Veterans and Military Families Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 8/14 2:30-3:30pm	++Fullerton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 8/15 10-11:30am	++Placentia Community Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Placentia Presbyterian Church 849 Bradford Ave. Placentia
Tuesday, 8/15 10-11:30am	++OC Cancer Coalition	**Steering Committee Meeting: Open to Collaborative Members**	American Cancer Society 1940 E. Deere Ave. Santa Ana
Tuesday, 8/15 4:30-6pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required***	CalOptima Room 150

Wednesday, 8/16 9:15-11am	++Covered OC Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	The Village 1505 E. 17th St. Santa Ana
Wednesday, 8/16 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana
Wednesday, 8/16 1-4pm	++Orange County Promotoras	**Steering Committee Meeting: Open to Collaborative Members**	Location varies
Wednesday, 8/16 1:30-3pm	++La Habra Move More Eat Health Plan	**Steering Committee Meeting: Open to Collaborative Members**	Friends of Family Community Clinic 501 S. Idaho St. La Habra
Tuesday, 8/16 4:30-6pm	*Health Education Weight Control Class	**Community Presentation Open to the Public** ***Registration required***	CalOptima Room 150
Thursday, 8/17 8:30-10am	++Orange County Children's Partnership Committee	**Steering Committee Meeting: Open to Collaborative Members**	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 8/17 8:30-10am	++Surf City Senior Providers Network and Lunch	**Steering Committee Meeting: Open to Collaborative Members**	Central Park Senior Center 18041 Goldenwest St. Huntington Beach
Saturday, 8/19 9am-1pm	+City of Buena Park 23rd Annual Super Senior Saturday	**Health/Resource Fair Open to the Public**	Buena Park Senior Activity Center 8150 Knott Ave. Buena Park
Tuesday, 8/22 7:30-9am	++OC Senior Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	Orange Senior Center 170 S. Olive Orange
Tuesday, 8/22 3:30-4:30pm	++Santa Ana Building Healthy Communities	**Steering Committee Meeting: Open to Collaborative Members**	KidWorks 1902 W. Chestnut Ave. Santa Ana
Tuesday, 8/22 4:30-6pm	*Health Education Weight Control Class Presentation in Spanish	**Community Presentation Open to the Public** ***Registration required***	CalOptima Room 150

Wednesday, 8/23 4:30-6pm	*Health Education Weight Control Class	**Community Presentation Open to the Public *Registration required***	CalOptima Room 150
Thursday, 8/24 8:30-10am	++Disability Coalition of Orange County	**Steering Committee Meeting: Open to Collaborative Members**	Dayle McIntosh Center 501 N. Brookhurst St. Anaheim
Monday, 8/28 9-11am	++Community Health Research Exchange	**Steering Committee Meeting: Open to Collaborative Members**	Healthy Smile for Kids 2101 E. Fourth St. Santa Ana
Monday, 8/28 9-11am	++Stanton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	Stanton Civic Center 7800 Katella Ave. Stanton
Wednesday, 8/30 10:30-11:30am	++OC Human Trafficking Task Force General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	Community Service Program 1221 E. Dyer Rd. Santa Ana