NOTICE OF A
REGULAR MEETING OF THE
CALOPTIMA BOARD OF DIRECTORS

THURSDAY, NOVEMBER 2, 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. Executive Team
   b. Quality Recognition
   c. Program of All-Inclusive Care for the Elderly (PACE)
   d. Behavioral Health Transition
   e. California Children's Services
   f. Funding Distributions
   g. Intergovernmental Transfers
   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 September 7, 2017 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the May 18, 2017 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the May 22, 2017 Special Meeting of the CalOptima Board of Directors' Quality Assurance Committee, the July 13, 2017 Meeting of the CalOptima Board of Directors' Member Advisory Committee

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

4. Consider Approval of Revised Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 2017-18 for Member and Provider Incentives

5. Consider Approval of Proposed Fiscal Year 2019 (Measurement Year 2018) Pay for Value Programs for Medi-Cal and OneCare Connect

6. Consider Authorizing Additional Expenditures Related to the OneCare and OneCare Connect Sales Incentive Program

7. Consider Appointment of CalOptima Treasurer

8. **Acting as the CalOptima Foundation:** Consider Appointment of CalOptima Foundation Chief Financial Officer

REPORTS

9. Consider Accepting and Receiving and Filing Fiscal Year 2017 CalOptima Audited Financial Statements

10. **Acting as the CalOptima Foundation:** Consider Accepting and Receiving and Filing CalOptima Foundation Fiscal Year 2017 Audited Financial Statements

11. Consider Adoption of Resolution Approving Updated Human Resources Policies

12. Consider Medi-Cal Health Network Rate Adjustment for the Provision of the Screening, Brief Interventions, and Referral to Treatment Services

13. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium (PHC) Health Network Physician Contracts for AMVI Care Health Network, Family Choice Network, and Orange County Advantage Medical Group to Modify the Professional Capitation Rate

14. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium (PHC) Health Network Physician Contract for CHOC Physicians Network to Modify the Professional Capitation Rate

15. Consider Authorizing Amendment of the CalOptima Medi-Cal Full-Risk Health Network Contracts for Heritage Provider Network, Inc., Monarch Family Healthcare and Prospect Medical Group to Modify the Professional Capitation Rate

16. Consider Authorizing Amendment of the CalOptima Medi-Cal Shared Risk Group (SRG) Health Network Contracts for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Network to Modify the Professional Capitation Rate

17. Consider Recommended Appointments to the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

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

20. Consider Amendment of the AltaMed Health Services, AMVI/Prospect Medical Group, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Monarch HealthCare, Noble Community Medical Associates and United Care Medical Group OneCare Shared Risk Health Network Contracts to Extend These Agreements for the Period January 1, 2018 through December 31, 2018

21. Consider Authorizing Amendment of the AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Orange County Advantage Medical Group, Prospect Health Plan and United Care Medical Group Cal MediConnect (OneCare Connect) Health Network Contracts

22. Consider Authorizing Expenditures in Support of CalOptima's Participation in the Family Voices of California's (FVCA) 2018 Annual Health Summit, in Preparation for the Upcoming Transition of the California Children's Services (CCS) Benefit to CalOptima

23. Consider Chief Executive Officer Performance Review, Compensation, and Amendment to Employment Contract *(to follow Closed Session)*

ADVISORY COMMITTEE UPDATES

24. Provider Advisory Committee Update

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

26. Member Advisory Committee Update

INFORMATION ITEMS

27. September and August 2017 Financial Summaries

28. Compliance Report

29. Federal and State Legislative Advocates Report

30. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

CS 1 Pursuant to Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer)

CS 2 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)

ADJOURNMENT

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

CalOptima
A Public Agency
Better. Together.

MEMORANDUM

DATE:	November 2, 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

Executive Team

CalOptima recently welcomed Greg Hamblin and Lori Shaw as Chief Financial Officer and Executive Director, Human Resources, respectively. Both were hired after national recruitments conducted over several months. Most recently, Mr. Hamblin was vice president of finance for Molina Healthcare Inc. Prior to that, he was CFO for Molina Healthcare of California, where he gained experience in lines of business like CalOptima's, including Medi-Cal plans, Dual Eligible Special Needs Plans (OneCare) and Medicare-Medicaid Plans (OneCare Connect). Ms. Shaw comes to us with nearly 20 years of HR leadership in a variety of health care organizations, including hospitals, clinics and health plans. Most recently, she was HR director for Alliance Healthcare Services in Irvine, and she also worked for Optum, the parent company for Monarch HealthCare. She has experience with training, coaching, employee engagement and organization culture. I look forward to their significant contributions to CalOptima and our mission.

Quality Recognition

CalOptima and our provider partners have much to celebrate! Our Better. Together. effort to deliver quality care for members was recognized twice in the past two months. First, in September, CalOptima was again rated California's top Medi-Cal plan, according to the NCQA's Medicaid Health Insurance Plan Ratings 2017–2018. It is the fourth year in a row that NCQA has named CalOptima best overall in the state. Second, at the Department of Health Care Services (DHCS) Quality Conference in October, CalOptima was honored with the Outstanding Performance Award for a Large Scale Medi-Cal Plan. The DHCS award is based on 2016 HEDIS results. These latest awards are objective measures that CalOptima is fulfilling our mission. Thanks to your Board for your ongoing support and guidance!

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

Progress continues in our effort to expand PACE into South Orange County, and staff is working on three initiatives in parallel. First, on October 16, CalOptima submitted a Notice of Intent to Apply for Service Area Expansion (SAE) to DHCS. This is the initial step for an SAE filing in fourth quarter of 2017. Once we submit the application, it can take six to nine months for review and approval by both DHCS and the Centers for Medicare & Medicaid Services (CMS). Approval of an expanded service area is contingent upon strategies being in place to provide the PACE model of care countywide. The Board-approved strategies that will make expansion possible are the use of Alternative Care Setting (ACS) sites and community-based physicians,

which represent our second and third ongoing initiatives. Regarding ACS, CalOptima released a Request for Proposal (RFP) for ACS sites, and we anticipate that several Community-Based Adult Services centers will respond. Finally, regarding community-based physicians, CalOptima submitted a waiver in September to DHCS and CMS. Staff anticipate implementing the community-based physician strategy no sooner than the second quarter of 2018. Separately, in August, the state released a PACE draft policy letter and solicited comments. The draft letter: 1) Prohibits a PACE organization from delegating PACE operations to a separate entity, 2) Allows the use of ACS sites, and 3) Creates a process with multiple approvals for outside PACE operators to open in county organized health system (COHS) counties without oversight by the COHS plan. CalOptima submitted comments consistent with protecting the COHS model while allowing appropriate delegation of selected PACE services, but it is our understanding that the three principles in the draft are likely to remain when the final policy letter is released. In the meantime, I will continue updating your Board on PACE expansion activities, and staff will return to a future Board meeting to request authorization to contract with ACS sites and community-based physicians.

Behavioral Health (BH) Transition
Staff are making significant progress in preparation for the January 1, 2018, transition of the BH benefit from Magellan Healthcare to CalOptima. The development of the provider network is well underway. In September, we mailed contracts to 550 mental health services providers, conducting outreach to the 140 providers who collectively deliver 90 percent of the services. In October, CalOptima mailed contracts to 70 Applied Behavior Analysis (ABA) vendors. To remain transparent and collaborative, CalOptima held a meeting with ABA vendors on October 10, 2017, in part to discuss the rates, which are set for 2018 based on a fixed and limited ABA budget from the state. The next meeting with ABA vendors is scheduled for October 25, 2017.

California Children's Services (CCS)
One of DHCS's highest priorities for 2018 is the transition of critical components of the CCS program from counties to COHS plans, including CalOptima. This will be a major initiative for CalOptima in 2018, as we have the largest CCS population among the COHS plans included in the transition. The transition from the Orange County Health Care Agency to CalOptima becomes effective January 1, 2019. In the coming months, I will share information with your Board regarding our transition plan with the County and our engagement with CCS families and providers. Our goal across the transition is for these children to have continued access to the same PCPs, specialists, hospitals, durable medical equipment suppliers, and other providers essential to their care.

Funding Distributions
CalOptima made two significant funding distributions to health networks and hospitals in recent weeks. In September, health networks with shared risk group contracts received shared risk pool distributions totaling approximately $160 million for FY 2015. On behalf of hospitals, CalOptima received from the state a $271 million Quality Assurance Fee (QAF) payment covering FY 2015–16. As you know, the DHCS QAF program provides supplemental payments to hospitals through managed care plans. Following the Hospital Association of Southern

California distribution schedule, CalOptima released these funds to Orange County hospitals in late October.

Intergovernmental Transfers
Using funds from IGT 4, CalOptima's first comprehensive Member Health Needs Assessment is well underway. To date, staff has coordinated 28 member focus groups throughout Orange County. The focus groups have been conducted in all seven threshold languages (plus two additional languages), targeting a broad spectrum of member populations, including parents of children with autism, homeless members, older adults, teens, working adults, members with disabilities and other. In addition, CalOptima consultants have conducted 24 key stakeholder interviews with community leaders, service providers and members of your Board. The final assessment will also include data gathered from 5,542 completed member surveys, collected either by mail, online or telephone. Staff plans to share an executive summary with your Board next month. Separately, CalOptima received payment from DHCS for IGT 6, and CalOptima's share of these funds totals $15.2 million. We expect to receive $12.1 million from IGT 7 in early spring, bringing the anticipated cumulative IGT 6 and 7 funding total to $27.3 million. Staff has developed an IGT 6 and 7 Expenditure Plan process, and the first step was executed on October 19, with the release of a solicitation for Letters of Interest from organizations interested in working on projects in three Board-approved areas: Opioid and Other Substance Overuse, Homeless Health, and Children's Mental Health. Due by November 13, the letters will be used to guide grant funding allocation amounts. Grant funding applications will be released in early 2018.

Key Meetings
- *Health Network CEO Meeting*: On September 13, CalOptima held our quarterly meeting with leadership of the health networks. The meeting covered various topics, including CalOptima administration of the Medi-Cal BH benefit starting on January 1, 2018; the Whole Person Care program's use of recuperative care; the state medical loss ratio (MLR) audit of CalOptima sometime in the future; CalOptima's MLR audits of health networks; CalOptima's risk-pool distributions to health networks with shared risk group agreements; and possible reductions to rates for Medi-Cal Expansion members starting July 1, 2018.
- *Joint Advisory Committee Meeting*: On September 14, CalOptima's Member and Provider Advisory Committees came together for a joint meeting. The agenda featured presentations that highlighted Orange County's impressive work in serving people who are homeless or who have substance use disorders. Orange County Director of Care Coordination Susan Price spoke about the growth in the homeless population and current interventions, while Sandra Fair, administrative manager of Behavioral Health Services at the Orange County Health Care Agency, covered the County's five-year pilot project to strengthen Drug Medi-Cal.
- *Local Health Plans of California (LHPC)*: On October 9, I attended the LHPC Board meeting in Huntington Beach. Department of Managed Health Care Director Shelley Rouillard provided an update about the regulator's activities, including in the priority areas of provider directories, timely access to care and clinical quality improvement. Another key element of the meeting was the development of a document outlining the association's principles regarding universal coverage. Considering the passage of a single-payer bill in the California State Senate (before it was held in the Assembly) and the attention on Sen. Bernie

Sanders' bill in Washington, D.C., my fellow LHPC Board members and I think the best course of action is to set forth key principles that will be used to evaluate proposals in future state or federal legislative efforts. As a COHS, CalOptima has an interest in ensuring access to care. However, we believe that any reform efforts should build upon the success of Medi-Cal managed care plans in expanding coverage thus far. The current versions of the single-payer bills are based upon the fee-for-service delivery model.

- *California Association of Health Plans (CAHP)*: On October 10, as part of the CAHP Board meeting and separate dinner in the evening, I attended the CAHP Annual Conference in Huntington Beach. Among other topics, CAHP leaders highlighted the association's aggressive advocacy effort on prescription drug price transparency, which resulted in the passage of SB 17. The governor signed the bill, now requiring drug companies to give payers notice of major price increases and time to plan for the increases. SB 17 was sponsored by Sen. Ed Hernandez, who also spoke at the conference.
- *Annual Healthy Smiles Gala*: On October 21, a few CalOptima staff including myself attended the Annual Healthy Smiles Gala at the Bowers museum to receive the Community Partner of the Year award, on behalf of CalOptima. I spoke at the event and described how "Better. Together." CalOptima and Healthy Smiles serve many of the same children from low-income families in Orange County.

Back to Agenda

MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

September 7, 2017

A Regular Meeting of the CalOptima Board of Directors was held on September 7, 2017, at CalOptima, 505 City Parkway West, Orange, California, and the following teleconference location: 44600 Indian Wells Lane, Indian Wells, California. Chair Paul Yost, M.D., called the meeting to order at 2:04 p.m. Vice Chair Penrose led the Pledge of Allegiance.

ROLL CALL

Members Present: Paul Yost, M.D., Chair; Lee Penrose, Vice Chair; Supervisor Lisa Bartlett, Ria Berger, Supervisor Andrew Do, Dr. Nikan Khatibi, Alexander Nguyen, M.D., Richard Sanchez (non-voting), Scott Schoeffel (via teleconference)

Members Absent: Ron DiLuigi

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

Chair Yost made the following announcements: As there is a teleconference location for this meeting, all votes will be taken by roll call; and Agenda Item 16, Consider Chief Executive Officer Performance Review and Compensation, will be considered after closed session.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader reported that the Department of Health Care Services (DHCS) released a draft policy letter on August 30, 2017, that included a revised review process and timeline affecting applications for Program of All-Inclusive Care for the Elderly (PACE) expansion and new PACE organizations. Staff is in the process of analyzing the draft policy letter and plans to submit a response within the given two-week public comment period. Additionally, based on direction from the Board at the PACE Study Session in May, staff is moving forward with the PACE Service Area Expansion application process for expanding CalOptima's PACE services to south Orange County using the Alternative Care Setting (ACS) model.

PUBLIC COMMENTS

Khang Joseph Nguyen, Vietnamese Provider Association; Martina Barnhart, Proof Positive ABA Therapies, a Division of Autism Learning Partners; Andy Patterson, Autism Business Association; and Rob Haupt, Autism Spectrum Therapies – Oral re: Agenda Item 3, Consider Further Actions Related to the Provision of Behavioral Health Services for CalOptima Medi-Cal Members.

CONSENT CALENDAR

2. Minutes

a. Approve Minutes of the August 3, 2017 Regular Meeting of the CalOptima Board of Directors

b. Receive and File Minutes of the June 8, 2017 Meeting of the CalOptima Board of Directors' Provider Advisory Committee, and the June 22, 2017 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) Member Advisory Committee

Action: On motion of Director Berger, seconded and carried, the Board of Directors approved the Consent Calendar as presented. (Motion carried. Roll call vote: 8 votes in favor [Bartlett, Berger, Do, Khatibi, Nguyen, Penrose, Schoeffel, and Yost]; Director DiLuigi absent)

REPORTS

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

Director 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 on this item due to potential conflicts of interest based on campaign contributions under the Levine Act. Supervisor Do did not participate in Recommended Actions 1b through 3 due to potential conflicts of interest based on campaign contributions under the Levine Act.

Chair Yost reported that at the August 3, 2017 Board meeting, an ad hoc, composed of Vice Chair Penrose, Supervisor Do, and Director Khatibi, was established to further evaluate options related to the provision of behavioral health services for CalOptima Medi-Cal members going forward, including exploring the possibility of further extending the Magellan contract for behavioral health services for CalOptima Medi-Cal members.

On behalf of the ad hoc, Supervisor Do reported that behavioral health services that CalOptima provides are essential to many of our most vulnerable members and their families. The ad hoc focused on ensuring that members continue to receive the services they need, and that any disruption to member care is kept to an absolute minimum. The ad hoc examined a variety of scenarios including having further discussions with Magellan, as well as considering re-contracting with the prior vendor, considering other RFP responders, and conducting a new RFP process. After considering the options, and the timing and economics of each, the ad hoc supports the staff recommendation of bringing the administration of behavioral health benefit for CalOptima Medi-Cal members in-house.

Vice Chair Penrose commented that as the ad hoc worked through the analysis, a separate issue surfaced regarding the way the funds for the behavioral health benefit received from the state are divided up by CalOptima. One of the issues identified was the payment to Health Networks for Screening, Brief Interventions, and Referral to Treatment (SBIRT) for unhealthy alcohol and drug use. To address this issue and to ensure that behavioral health dollars are allocated to where the services are being provided, the ad hoc suggested that staff conduct further modeling and return to the Board with recommendations on more appropriate allocation/reallocation of SBIRT funds.

Back to Agenda

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the Chief Executive Officer to: 1a) Integrate Medi-Cal covered Behavioral Health, which includes Mental Health (MH) and Applied Behavior Analysis (ABA) services, within CalOptima internal operations effective January 1, 2018. (Motion carried. Roll call vote: 6 votes in favor [Berger, Do, Khatibi, Nguyen, Penrose and Yost]; Supervisor Bartlett recused; Directors DiLuigi and Schoeffel absent)***

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors authorized the Chief Executive Officer to: 1b) Establish a standard CalOptima provider fee schedule for MH and ABA services; 1c) Enter into contracts, with the assistance of legal counsel, with MH and ABA providers; 1d) 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; 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. (Motion carried. Roll call vote: 5 votes in favor [Berger, Khatibi, Nguyen, Penrose and Yost]; Supervisors Bartlett and Do recused; Directors DiLuigi and Schoeffel absent)***

<u>4. Consider Adoption of Resolution Approving Updated Human Resources Policies</u>

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors adopted Resolution No. 17-0907, Approving CalOptima's Updated Human Resources Policies as presented. (Motion carried. Roll call vote: 7 votes in favor [Berger, Do, Khatibi, Nguyen, Penrose, Schoeffel and Yost]; Supervisor Bartlett voting no; Director DiLuigi absent)***

<u>5. Consider Authorizing Expenditures for CalOptima Staff Wellness Programs from Funding Received from CIGNA HealthCare for Calendar Year 2017</u>

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized expenditures for CalOptima staff wellness programs from funding received from CIGNA HealthCare Wellness/Health Improvement Fund for calendar year 2017 as presented. (Motion carried. Roll call vote: 8 votes in favor [Bartlett, Berger, Do, Khatibi, Nguyen, Penrose, Schoeffel and Yost]; Director DiLuigi absent)***

<u>6. Consider Authorizing Employee and Retiree Group Health Insurance for Calendar Year 2018</u>
Director Schoeffel did not vote on this item due to potential conflicts of interest.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors: 1) Authorized the Chief Executive Officer (CEO), with the assistance of Legal***

Back to Agenda

Counsel, to enter into contracts and/or amendments to provide group health insurance policies, including medical, dental, vision, for CalOptima employees and retirees, and basic employee life insurance and accidental death and dismemberment, short-term and long-term disability, employee assistance program, and flexible spending accounts, for CalOptima employees, effective January 1, 2018, for a total amount for calendar year (CY) 2018 not to exceed $17,480,553; 2) Authorized an increase to employer contributions (based on the percent of premium the employer pays for each plan), to absorb a portion of the increase to premium rates, increasing costs to CalOptima for CY 2018 of an amount not to exceed $1,368,980; and 3) Authorized a Spousal Surcharge of $50 per pay period (for 24 pay periods) for those employees/retirees whose spouses or Registered Domestic Partners (1) have access to other medical plans through their own employers or other sources, but choose to be enrolled under the CalOptima plan, or (2) are enrolled in their own medical plan, and elect to also enroll under the CalOptima plan. The employees/retirees will be required to submit an attestation substantiating enrollment of their spouse/Registered Domestic Partner. The anticipated savings for CalOptima is $193,200 for CY 2018. (Motion carried. Roll call vote: 7 votes in favor [Bartlett, Berger, Do, Khatibi, Nguyen, Penrose, and Yost]; Director Schoeffel recused; DiLuigi absent)

7. Consider Actions Related to Reimbursement for Newborn Coverage

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors authorized payment of capitation to Health Networks for eligible newborn members who are assigned a Client Index Number (CIN), even though CalOptima does not receive payment from the Department of Health Care Services for all of these members. (Motion carried. Roll call vote: 7 votes in favor [Bartlett, Berger, Do, Nguyen, Penrose, Schoeffel and Yost]; Director Khatibi abstaining; Director DiLuigi absent)***

8. Consider Authorizing Amendment of Existing Contract with Verscend Technologies to Include Scope of Services Related to Review of Institutional and Professional Claims for All Lines of Business Covering the Period January 1, 2017 through February 28, 2018

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 Supervisor Bartlett, seconded and carried, the Board of Directors: 1) Authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the existing Verscend Technologies contract to include a new scope of work for review of institutional and professional claims for the period January 1, 2017 through February 28, 2018; and 2) Approved unbudgeted expenditures of up to $788,500 from existing reserves for the Verscend Technologies contract amendment. (Motion carried. Roll call vote: 7 votes in favor [Bartlett, Berger, Do, Khatibi, Nguyen, Penrose, and Yost]; Directors DiLuigi and Schoeffel absent)***

Back to Agenda

9. Consider Actions Related to OneCare Connect Enrollment and Deemed Eligibility; Consider Amendments to Related Contracts and Policies

Director Schoeffel did not participate in this item due to potential conflicts of interest and left the room during the discussion and vote. Supervisor 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 Khatibi, seconded and carried, the Board of Directors: 1) Ratified a two-month deeming period effective September 1, 2017 for OneCare Connect (OCC) members who no longer meet Cal MediConnect (CMC) eligibility requirements due to loss of Medi-Cal eligibility with CalOptima as determined by the Department of Health Care Services; 2) Authorized the Chief Executive Officer, with the assistance of legal counsel, to amend CalOptima's contract with Liberty Dental to allow two-month deemed eligibility for OCC members receiving Denti-Cal services provided by Liberty Dental; and 3) Directed the Chief Executive Officer to amend OneCare Connect Policy CMC.4004, Member Disenrollment, to implement said deeming period and operational updates. (Motion carried. Roll call vote: 6 votes in favor [Bartlett, Berger, Khatibi, Nguyen, Penrose, and Yost]; Supervisor Do recused; Directors DiLuigi and Schoeffel absent)***

10. Consider Authorizing a Grant to the Orange County Health Care Agency in Conjunction with the County's Whole Person Care Pilot of Intergovernmental Transfer (IGT) Funds Previously Allocated to Reimburse Hospitals for Qualifying Recuperative Care for CalOptima Members

Director Khatibi 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 Supervisor Bartlett, seconded and carried, the Board of Directors: 1) Approved updated expenditure plan for remaining Intergovernmental Transfers (IGT) 2 and 3 recuperative care program funds, in an amount not to exceed $619,300, less any Recuperative Care funds paid from this pool to hospitals subsequent to July 31, 2017; 2) Authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into a grant agreement with the Orange County Health Authority to utilize remaining IGT 2 and 3 Recuperative Care IGT project funds for recuperative care under the County's Whole Person Care (WPC) Pilot for qualifying homeless CalOptima members; and 3) Authorized expanded use of the above-referenced CalOptima IGT Recuperative Care funds to include CalOptima Medi-Cal members referred to the County's Recuperative Care Services program from a broader range of settings, including but not limited to, nursing homes and clinics and from public health nurses, in addition to those referred from the CalOptima contracted hospital setting, subject to amendment of the Department of Health Care Services (DHCS)/County of Orange WPC Pilot Contract ("DHCS/County Contract"), or other written approval from DHCS, reflecting this broader range of settings. (Motion carried. Roll call vote: 7 votes in favor [Bartlett, Berger, Do, Nguyen, Penrose, Schoeffel, and Yost]; Directors DiLuigi and Khatibi absent)***

Back to Agenda

11. Authorize and Direct Execution of a New Three-way Agreement Between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) for the Cal MediConnect Program

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute the new three-way Agreement, which replaces the prior agreement in place, to extend the Agreement for an additional two (2) years to December 31, 2019, and incorporate language adopting requirements outlined in the Medicaid and CHIP Managed Care Final Rule. (Motion carried. Roll call vote: 8 votes in favor [Bartlett, Berger, Do, Khatibi, Nguyen, Penrose, Schoeffel, and Yost]; Director DiLuigi absent)***

12. Specific to the CalOptima PACE Program, Consider Authorizing an Amendment to the Physician Services Contract with the Regents of the University of California on Behalf of University of California, Irvine, Including Rates, Compensation Methodology, and an Incentive Program, Among Other Changes, and Contracts with Additional Providers for PACE Primary Care Services
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.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors: 1) Authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into an amendment of the Program of All-Inclusive Care for the Elderly (PACE) contract between CalOptima and the Regents of the University of California on behalf of the University of California Irvine, School of Medicine, Geriatric Program (UCI) for physician and non-physician medical practitioner (NPMP) services to amend the scope of work, compensation terms, and to add an incentive program, upon regulatory approval; 2) Established maximum hourly rates for PACE Physician and Non-physician Providers; 3) Authorized the implementation of an incentive program for UCI PACE PCP services, in accordance with the attached CalOptima PACE PCP Incentive Program Grid, subject to any necessary regulatory agency approval; and 4) Authorized contracting with additional providers as necessary to provide appropriate Primary Care coverage for the ongoing operation of PACE. (Motion carried. Roll call vote: 6 votes in favor [Bartlett, Berger, Do, Khatibi, Penrose, and Yost]; Directors DiLuigi, Nguyen and Schoeffel absent)***

13. Consider Authorizing Request for Waiver Allowing Community Based Physicians to Serve as the Primary Care Provider for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE)
Chair Yost reported that the second recommended action, "Authorize Chief Executive Officer, with the assistance of legal counsel, to enter into contracts with CBPs to provide such services, subject to the requested waiver first being granted." is continued to a future Board meeting.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized the Chief Executive Officer to file a waiver request for CalOptima's PACE for Section 903 of the Benefits Improvement and Protection Act of 2000,***

Back to Agenda

to the Department of Health Care Services and the Centers for Medicare & Medicaid Services in order to allow Community Based Physicians to serve as the primary care provider, in collaboration with the PACE interdisciplinary team. (Motion carried. Roll call vote: 8 votes in favor [Bartlett, Berger, Do, Khatibi, Nguyen, Penrose, Schoeffel, and Yost]; Director DiLuigi absent)

14. Consider Extension of Deadline for Intergovernmental Transfer (IGT) Project with University of California, Irvine (UCI) Health's Observation Stay Pilot Program

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.

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors extended the deadline for CalOptima and UCI Health to reach an agreement on project terms under IGT 4 for the UCI Health Observation Stay Pilot Program to December 31, 2017. (Motion carried. Roll call vote: 6 votes in favor [Bartlett, Berger, Do, Khatibi, Penrose, and Yost]; Directors DiLuigi, Nguyen and Schoeffel absent)***

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

Action: ***On motion of Chair Yost, seconded and carried, the Board of Directors: 1) Authorized the expenditures for CalOptima's participation in the following events: up to $6,000 and staff participation at the Vietnamese Cultural Center's 2017 Mid-Autumn Festival on Sunday, October 1, 2017 at Mile Square Park in Fountain Valley; up to $3,000 and staff participation at the Vietnamese Physician Association of Southern California Foundation's Free Health Fair on Sunday, October 15, 2017 at the Westminster Rose Center in Westminster; up to $2,500 and staff participation at the 8th Annual Alzheimer's Orange County Latino Conference on Saturday, November 4, 2017 at Templo Calvario Church in Santa Ana; 2) Made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and 3) Authorized the Chief Executive Officer to execute agreements as necessary for the events and expenditures. (Motion carried. Roll call vote: 8 votes in favor [Bartlett, Berger, Do, Khatibi, Nguyen, Penrose, Schoeffel, and Yost]; Director DiLuigi absent)***

ADVISORY COMMITTEE UPDATES

17. Member Advisory Committee (MAC) Update

MAC Chair Sally Molnar reported that a joint meeting of the MAC and Provider Advisory Committee is scheduled on Thursday, September 14, 2017, with the focus on homelessness issues.

18. Provider Advisory Committee (PAC) Update

Teri Miranti, PAC Chair, provided an overview of the topics to be discussed at the joint MAC/PAC meeting on September 14, 2017, including the County's homeless initiatives, Drug Medi-Cal and Substance Use Disorder, and the Orange County Strategic Plan for Aging.

Back to Agenda

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

OCC MAC Chair Gio Corzo presented an update on the July 27, 2017 OCC MAC meeting activities, including receiving presentations on access to geropsychiatric beds in Orange County, an overview on post-acute care and skilled nursing facilities (SNF), and the SNF admission process.

INFORMATION ITEMS

The following Information Items were accepted as presented:

20. July 2017 Financial Summary
21. Compliance Report
22. Federal and State Legislative Advocates Reports
23. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Director Khatibi commented on his recent meeting with CalOptima Deputy Chief Medical Officer Richard Bock, M.D., regarding the opioid epidemic, and noted an approximate 8% reduction since last year in the number of opioid prescriptions written per member per month, and outreach and education to physicians and pharmacies in the community regarding prescribing habits. Director Khatibi further commented on the need to ensure that these members are utilizing behavioral health services. Supervisor Bartlett also commented on the opioid crisis and the connection between opioids, mental health, and homelessness, and extended her appreciation for CalOptima's participation with IGT funds for the County's Whole Person Care Pilot program for qualifying homeless CalOptima members.

Board members thanked staff for their work on transitioning the administration of behavioral health services for CalOptima Medi-Cal members into CalOptima operations beginning January 1, 2018 to ensure continuity of care and access to services.

Chair Yost commented that CalOptima's contract for state advocacy services with Edelstein Gilbert Robson & Smith is in its final year, and a Request for Proposal (RFP) process will commence this month to contract with a vendor for an anticipated term beginning January 2018. Chair Yost formed an ad hoc committee to interview RFP finalists and present recommendations to the full Board, and appointed Supervisors Bartlett and Do, and Directors Berger and Khatibi to serve on this ad hoc committee.

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 4:43 p.m. pursuant to:

CS 1 Government Code Section 54957, PUBLIC EMPLOYEE PERFORMANCE EVALUATION (Chief Executive Officer)

CS 2 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)

The Board reconvened to open session at 6:05 p.m. with no reportable actions taken.

Back to Agenda

16. Consider Chief Executive Officer Performance Review and Compensation
This item was continued to a future Board meeting.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 6:06 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: November 2, 2017

Back to Agenda

MINUTES

Regular Meeting
of the
CalOptima Board of Directors'
Finance and Audit Committee

CalOptima
505 City Parkway West
Orange, California

May 18, 2017

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

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

Members Absent: All members present

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

MANAGEMENT REPORTS

Chief Financial Officer (CFO) Report
Nancy Huang, Interim Chief Financial Officer, provided a brief update on the Department of Health Care Services' (DHCS) Medical Loss Ratio (MLR) reconciliation. The DHCS continues to develop the draft MLR methodology for Medi-Cal Expansion members. It is anticipated that the MLR reconciliation will be conducted in two phases: Phase 1, January 2014 to June 2015; and Phase 2, July 2015 to June 2016. Staff will keep the Committee informed of the progress.

PUBLIC COMMENT
1. Marlene Turner, AltaMed Health Services; Kenneth McFarland, Fountain Valley Regional Hospital; Bill Barcellona, CAPG; and Teri Miranti, Monarch HealthCare – Oral re: Agenda Item 3, Consider Board of Directors' Approval of the CalOptima Fiscal Year 2017-18 Operating Budget; and
2. Bill Barcellona, CAPG; and Teri Miranti, Monarch HealthCare – Oral re: Agenda Item 9, CalOptima Care Network Performance: Financial and Quality Analysis.

Back to Agenda

INVESTMENT ADVISORY COMMITTEE UPDATE

1. Treasurer's Report

Ms. Huang presented an overview of the Treasurer's Report for the period January 1, 2017 through March 31, 2017. Based on a review by the Board of Directors' Investment Advisory Committee, all investments were compliant with Government Code section 53600 *et seq.*, and with CalOptima's Annual Investment Policy.

CONSENT CALENDAR

2. Approve the Minutes of the February 16, 2017 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee; Receive and File Minutes of the January 23, 2017 Meeting of the CalOptima Board of Directors' Investment Advisory Committee

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

REPORTS

3. Consider Recommending Board of Directors' Approval of the CalOptima Fiscal Year 2017-18 Operating Budget

Chief Executive Officer Michael Schrader commented on the proposed FY 2017-18 Operating and Capital Budgets, 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. CalOptima has received its Medi-Cal rates from the state, which included reductions in Medi-Cal Classic and MCE rates totaling $117 million. While the state is lowering CalOptima's rates for Classic and MCE members, management's 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. Management's proposed operating budget includes recommended reductions in the capitation rates that CalOptima pays to health networks for hospital services, which would also impact the size of health network shared risk pools. Additionally, CalOptima proposes eliminating $17 million in capital projects, cutting 93 open, vacant 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, staff has met with the Provider and Member Advisory Committees, the Hospital Association of Southern California, and with the health networks regarding the proposed reductions.

Ms. Huang reported that the proposed FY 2017-18 Operating Budget assumes an average monthly enrollment of approximately 803,000 members, revenue at approximately $3.1 billion, medical costs of approximately $3 billion, operating income of ($4.7) million, and a total change in net assets of ($1.7) million. A detailed review of the proposed FY 2017-18 Operating Budget by line of business was presented to the Committee for discussion.

After considerable discussion of the matter, the Committee directed staff to revise the budget to remove the compensation study, and to examine further opportunities to reduce administrative

Back to Agenda

expenses beyond staff's proposal that includes eliminating 93 open, vacant positions. The Committee also suggested that staff meet with risk sharing health networks to hear their recommendations on addressing the rate reductions received from the state, and to work with the health networks throughout the year to increase Risk Adjustment Factor (RAF) scores.

Action: ***On motion of Director DiLuigi, seconded and carried, the Committee recommended that the Board of Directors: 1) Approve the CalOptima Fiscal Year (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; and 3) Approve continued Medi-Cal medical expenditures at payment rates in effect on June 30, 2017, 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. (Motion carried 3-0-0)***

4. Consider Recommending Board of Directors' Approval of the CalOptima Fiscal Year 2017-18 Capital Budget

Ms. Huang presented the action to recommend that the CalOptima Board of Directors approve the CalOptima FY 2017-18 Capital Budget composed of the following: information systems hardware, software and professional fees, $8.4 million; 505 Building improvements, $1.4 million; and PACE, $52,000. As proposed, the FY 2017-18 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 DiLuigi, seconded and carried, the Committee recommended Board of Directors' approval of the CalOptima FY 2017-18 Capital Budget as presented. (Motion carried 3-0-0)***

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

Action: ***On motion of Director DiLuigi, seconded and carried, the Committee recommended that the Board of Directors reappoint Rodney Johnson to the CalOptima Board of Directors' Investment Advisory Committee for a two-year term beginning June 7, 2017. (Motion carried 3-0-0)***

6. Consider Recommending Board of Directors' Approval of Compensation Review Consultant, and Authorization of Agreement for Employee Compensation Program Review, Revisal, Update, and Design

This item was continued to a future Board of Directors' Finance and Audit Committee meeting.

Back to Agenda

7. Consider Recommending Board of Directors' Approval of the Revised Reinsurance Program for Catastrophic Claims and Update CalOptima Policy Accordingly

Ms. Huang presented the action to consider recommending Board of Directors' approval of the revised reinsurance program for catastrophic claims, and update CalOptima policy accordingly. The reinsurance program was designed to assist eligible Medi-Cal health networks and hospitals cover catastrophic cases. Under the program, capitated HMOs, physician groups and hospitals are reimbursed for submitted claims exceeding the thresholds, and shared risk pools are adjusted for claims exceeding the thresholds. CalOptima has provided this enhanced supplemental benefit since 1996, and the program has not been updated since 2012. It was noted that reinsurance is not provided by the majority of other public plans in the state.

Ms. Huang reported that, pursuant to CalOptima Policy FF.1007, 2016-17 Health Network Reinsurance Coverage, CalOptima will pay for 90% of covered expenses for losses in excess of the annual deductible. An increase to the coinsurance level from 10% to 20% for Policy Year 2017-18 was recommended. In addition, it was recommended that the attachment points be revised to $17,000 for physician groups and $150,000 for hospitals.

Action: ***On motion of Director DiLuigi, seconded and carried, the Committee recommended that the Board of Directors: 1) Approve the proposed revision of the CalOptima reinsurance program for capitated health networks, excluding health maintenance organizations that are at-risk for catastrophic claims of $17,000 for physician groups and $150,000 for hospitals and a coinsurance level of 20% effective July 1, 2017; and 2) Direct staff to update CalOptima Policy No. FF. 1007: Health Network Reinsurance Coverage, consistent with the proposed changes for Policy Year 2017-18. (Motion carried 2-0-0; Director Schoeffel absent)***

INFORMATION ITEMS

8. 2017 Audit Planning

John Blakey and Aparna Venkateswaran of Moss-Adams LLP, presented a review of the scope of services for the annual consolidated financial statement audit for the year ending June 30, 2017, and provided a brief overview of the recent changes in accounting standards. Interim fieldwork is scheduled to begin on May 23, 2017, and final fieldwork will begin on July 24, 2017. The draft audited financial statements will be presented to the Finance and Audit Committee for review at the September meeting.

9. CalOptima Care Network (CCN) Network Performance: Financial and Quality Analysis

Richard Helmer, M.D., Chief Medical Officer, presented a review of the financial and quality performance of the CalOptima Care Network. Financial performance included revenue, utilization/Risk Adjustment Factor (RAF), and Medical Loss Ratio (MLR). Performance on quality measures included clinical measures and Consumer Assessment of Healthcare Providers & Systems (CAHPS) satisfaction measures.

Back to Agenda

Based on this analysis, it was noted that CCN financial performance, as measured by the MLR, is comparable with delegated health networks. CCN performed better than average on Medi-Cal clinical quality, and performed better than the average health network model on satisfaction in the areas of Adult and Child CAHPS, and highest in primary care provider satisfaction for both Adult and Child.

10. Update on CalOptima Business Insurance – Policy Year 2018
Kelly Klipfel, Financial Compliance Director, provided a review of business insurance coverage for policy year 2018. Coverage for 505 City Parkway West, the Data Center, and the PACE Center includes the following: Managed Care and Excess E&O, PACE Medical Malpractice, D&O/Excess D&O, Umbrella and Excess Liability, Network & Privacy, Pollution, Earthquake, and Workers Comp. A savings of $208,000 over policy year 2017 was reported.

The following Information Items were accepted as presented:
11. March 2017 Financial Summary
12. CalOptima Computer Systems Security Update
13. Cost Containment Improvements/Initiatives
14. Update on 505 City Parkway West Development Rights
15. Quarterly Reports to the Finance and Audit Committee
    a. Shared Risk Pool Performance
    b. Reinsurance Report
    c. Health Network Financial Report
    d. Purchasing Report

COMMITTEE MEMBER COMMENTS
Committee members thanked staff for their work on the FY 2017-18 Operating and Capital Budgets.

ADJOURNMENT
Hearing no further business, Chair Penrose adjourned the meeting at 5:22 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: September 21, 2017

Back to Agenda

MINUTES

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

CALOPTIMA
505 CITY PARKWAY WEST
ORANGE, CALIFORNIA

May 22, 2017

CALL TO ORDER
Chair Paul Yost called the meeting to order at 4:00 p.m. Director Berger led the pledge of Allegiance.

Members Present: Paul Yost, M.D., Chair; Ria Berger; Dr. Nikan Khatibi (at 4:18 p.m.); Alexander Nguyen M.D.

Members Absent: All members present

Others Present: Michael Schrader, Chief Executive Officer; Richard Helmer, M.D., Chief Medical Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Caryn Ireland, Executive Director Quality Analytics; Suzanne Turf, Clerk of the Board

PUBLIC COMMENTS
There were no requests for public comment.

CONSENT CALENDAR

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

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

REPORTS

2. Consider Recommending Board of Directors' Approval of the 2017 CalOptima Utilization Management (UM) Program and 2017 UM Work Plan
Richard Bock, M.D., Deputy Chief Medical Officer, presented the action to recommend Board of Directors' approval of the 2017 CalOptima UM Program and 2017 UM Work Plan. The 2017 UM Program is based on the Board approved 2016 UM Program. The following revisions were reviewed with the Committee: program descriptions and committee references are aligned with the Quality

Management Program; updated committee structure organization chart reflecting new structure and operational unit support; and a detailed description of metrics for measuring UM effectiveness.

The 2017 UM Work Plan projects and initiatives include: over/under utilization tracking and trending; enriched clinical decision making resources; medical management systems enhancements; improved coordination of services between CalOptima and County Mental Health Plan; oversight and internal auditing consistent with the Centers for Medicare & Medicaid Services (CMS), the Department of Health Care Services (DHCS) and the National Committee for Quality Assurance (NCQA); improved member notices; and continued development of Long-Term Support Services (LTSS) metrics.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee recommended Board of Directors' approval of the 2017 CalOptima UM Program and 2017 UM Work Plan as presented. (Motion carried 3-0-0; Director Khatibi absent)***

3. Receive and File 2016 Utilization Management Program Evaluation

Dr. Bock presented the recommended action to receive and file the 2016 Utilization Management Program Evaluation. Accomplishments during 2016 include the development of audit tools to monitor and improve UM processing quality and timeliness, Notice of Action Team instituted to improve quality and timeliness, established Hospitalist Program serving four highest volume facilities, and assembled a Health Network Denial Task Force to share best practices and challenges faced when drafting denial letters. The 2016 accomplishments in the areas of UM delegated provider oversight, and prior authorization and pharmacy operational performance were reviewed with the Committee.

Action: ***On motion of Director Berger, seconded and carried, the Committee received and filed the 2016 Utilization Management Program Evaluation as presented. (Motion carried 3-0-0; Director Khatibi absent)***

4. Receive and File 2016 Quality Improvement Program Evaluation

Caryn Ireland, Executive Director, Quality Analytics, presented the recommended action to receive and file the 2016 Quality Improvement (QI) Program Evaluation. A review of the accomplishments during 2016 in the areas of behavioral health integration, case management, LTSS, cultural and linguistics, and grievance and appeals were reviewed with the Committee. Accomplishments around safety included the implementation of pharmacy management programs with regard to monitoring underutilization of asthma, diabetes, cardiovascular and osteoporosis medications, and monitoring the overutilization of opioid medications. Continued enhancement of disease management programs, participation in performance improvement projects, and continued actions to improve Consumer Assessment of Healthcare Providers & Systems (CAHPS) results were also noted.

Action: ***On motion of Director Nguyen, seconded and carried, the Committee received and filed the 2016 Quality Improvement Program Evaluation as presented. (Motion carried 4-0-0)***

5. Consider Recommending Board of Directors' Approval of the 2017 Delegation Grid, Appendix B to 2017 Quality Improvement Program Description and Work Plan

Ms. Ireland presented the action to recommend Board of Directors' approval of the 2017 Delegation Grid, Appendix B to the 2017 Quality Improvement Program Description and Work Plan, which was

Back to Agenda

approved by the Board of Directors on March 2, 2017. The 2017 Delegation Grid outlines and updates CalOptima's delegation agreement with health networks to meet accreditation and regulatory requirements, and includes elements delegated to Magellan Healthcare.

Action: ***On motion of Director Khatibi, seconded and carried, the Committee recommended Board of Directors approval of the 2017 Delegation Grid, Appendix B to 2017 Quality Improvement Program Description and Work Plan as presented. (Motion carried 4-0-0)***

INFORMATION ITEMS

6. CalOptima Care Network (CCN) Performance: Quality and Financial Analysis
Richard Helmer M.D., Chief Medical Officer, presented an overview of CCN performance including the background of CalOptima Direct and CCN, and membership growth in CCN for both the Medi-Cal and One Care Connect (OCC) programs. A review of performance on quality measures, and CCN financial performance were also reviewed with the Committee. Future considerations include the need to address OCC's high readmission rate, completion of incentive programs for CCN primary care providers, implementing a proposed Long Term Connect program to meet the unique needs of CalOptima's institutionalized members, and establishing appropriate funding for CCN Medi-Cal membership.

7. Behavioral Health Integration Update
Donald Sharps, M.D., Medical Director, provided an update on Behavioral Health Integration with Magellan Behavioral Healthcare, including a review of call center staffing, the results of a recent customer service audit, and the implementation of utilization management and quality assurance protocols in response to audit findings. It was noted that increased collaboration with the County Mental Health Plan includes a Memorandum of Understanding (MOU) with the Orange County Health Care Agency (OCHCA) to ensure the appropriate level of care. An addendum to the MOU is in development to ensure coordination of Substance Use Disorder (SUD) screening and the provision of services between CalOptima and the OCHCA, and supports integrated services with behavioral health and physical health.

8. 2016 Group Needs Assessment Final Results
Pshyra Jones, Health Education and Disease Management Director, provided a brief overview of the final results of the 2016 Group Needs Assessment (GNA). The DHCS requires health plans to conduct GNAs every five years to identify the needs of members, available health education, cultural and linguistic program resources, and gaps in services. The areas of focus included people who provide health care, medical interpreters, member health perception and health plan benefits, forms and health plan materials, and social determinants of health. CalOptima completed the assessment in October 2016 with over 3,000 responses. The top three health concerns identified were: not enough clinics and doctor's nearby, appointment time at doctor's office and clinics, and safe places to walk or play. Staff is sharing the survey results with the member health needs assessment initiative, work groups within CalOptima, and the Provider Advisory Committee.

9. PACE Member Advisory Committee Update
Mallory Vega, PACE Member Advisory Committee (PMAC) Community Representative, reported on the activities at the March 6, 2017 PMAC meeting. A committee composed of PACE staff and

participants are currently working on a newsletter that will be published quarterly beginning in June 2017. PACE participants suggested an 'Employee of the Month' feature, and additional religious and spiritual services at the PACE Center.

10. Quarterly Reports to the Quality Assurance Committee

a. Quality Improvement Report
Caryn Ireland provided a brief update on the first quarter progress on the HEDIS initiatives and the various incentive programs including: the roll-out of three public service announcements in Spanish, Vietnamese, and Farsi; and proposed changes in the member and provider incentive for breast cancer and cervical cancer screenings.

b. Member Trend Report
This Information Item was accepted as presented.

COMMITTEE MEMBER COMMENTS
Committee members thanked staff for the presentations provided and for all of their work.

ADJOURNMENT
Hearing no further business, Chair Yost adjourned the meeting at 6:12 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: September 20, 2017

Back to Agenda

MINUTES

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

July 13, 2017

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on July 13, 2017, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER
Vice Chair Patty Mouton called the meeting to order at 2:34 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Patty Mouton, Vice Chair; Suzanne Butler, Sandy Finestone, Connie Gonzalez, Donna Grubaugh, Jaime Munoz, Carlos Robles, Velma Shivers, Sister Mary Therese Sweeny, Christine Tolbert, Lisa Workman

Members Absent: Sally Molnar, Chair; Ilia Rolon, Christina Sepulveda, Mallory Vega

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Candice Gomez, Executive Director, Program Implementation; Donald Sharps, MD, Medical Director; Phil Tsunoda, Executive Director, Public Affairs; Sesha Mudunuri, Executive Director, Operations; Michelle Laughlin, Executive Director, Network Operations; Caryn Ireland, Executive Director, Quality Analytics; Belinda Abeyta, Director, Customer Service; Becki Melli, Customer Service; Pamela Reichardt, Executive Assistant

MINUTES

Approve the Minutes of the May 11, 2017, Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee

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

PUBLIC COMMENT
Nathan Young – Oral re: Agenda Item VI.C. Behavioral Health Integration Update – Depression Screening, and access to behavioral health care.

CHIEF EXECUTIVE OFFICER AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer Update
Michael Schrader, Chief Executive Officer, reported that on June 28, 2017, Magellan Healthcare gave notice to CalOptima that they were terminating the Medi-Cal behavioral health contract, effective July 1, 2017. CalOptima immediately took steps to ensure that all members continued to

Back to Agenda

have access to behavioral health services. In addition, CalOptima is working on contingency plans to continue providing behavioral health services, including bringing mental health services in-house.

Mr. Schrader reported that CalOptima continues to stay abreast of federal health care reform efforts, especially changes to Medicaid Expansion. CalOptima will keep MAC members informed of new developments.

Vice Chair Mouton reordered the agenda to hear Agenda Item VI.C, Behavioral Health Integration Update – Depression Screening

Behavioral Health Integration Update – Depression Screening

Donald Sharps, M.D., Medical Director, Behavioral Health, reported that the U.S. Preventive Services Task Force recommends screening of adolescents for major depressive disorders. CalOptima has implemented a two-year physician incentive program to increase the rate of depression screenings among 12-year old CalOptima members. Funded by Intergovernmental Transfer (IGT) funding, 641 pediatricians were provided instructions on administering the screening tool and submitting claims for incentive payments. Dr. Sharps reported that 16,730 members turn 12 years old in 2017.

Chief Medical Officer Update

Dr. Sharps reiterated that CalOptima took immediate action to ensure members had access to behavioral health services following Magellan's contract termination. In addition, CalOptima continued to provide customer service, utilization management and claims management. Following considerable discussion about Magellan, CalOptima assured MAC members that we are working diligently to prevent disruption of services to members.

Mimi Chung, Supervisor, Quality Analytics, announced that CalOptima launched three member incentives in June 2017, including breast cancer screening, cervical cancer screening and post-partum screening. CalOptima anticipates that these incentives will positively impact the Healthcare Effectiveness Data and Information Set (HEDIS) rates for 2018. In addition, CalOptima launched provider incentive initiatives, including a cervical cancer provider office incentive and a post-partum provider office incentive.

Chief Operating Officer Update

Ladan Khamseh, Chief Operating Officer, reported that at a future meeting, the Board of Directors would consider a recommendation to approve a two-month deeming period for One Care Connect members that lose Medi-Cal eligibility. Currently, the deeming period is one month.

Ms. Khamseh reported that CalOptima implemented the Non-Medical Transportation (NMT) Medi-Cal benefit on July 1, 2017, mandated by the Department of Health Care Services (DHCS), which includes roundtrip transportation to locations offering Medi-Cal services covered by CalOptima. CalOptima leveraged existing processes to launch the new benefit, which includes NMT services via taxi, bus and private passenger car with gas mileage reimbursement. Ms. Khamseh reported that the Board of Directors would consider a request to ratify a contract amendment to expand NMT

with American Logistics, the current vendor for taxi services for OneCare, OneCare Connect and some Medi-Cal services.

Federal and State Legislative Update

Phil Tsunoda, Executive Director, Public Policy and Government Affairs, announced that Governor Brown signed the California Budget Act of 2017, which continues the Cal MediConnect program, One Care Connect in Orange County through December 31, 2019. He also reported that the additional revenue that the Proposition 56 Tobacco Tax initiative is expected to generate would be split between increased payment rates for Medi-Cal providers and funding for general obligations.

INFORMATION ITEMS

MAC Member Updates

Vice Chair Mouton announced that the next meeting is a Joint MAC/PAC meeting on Thursday, September 14, 2017 from 8:00 to 10:00 a.m. Members Patty Mouton and Christine Tolbert met with representatives of the Provider Advisory Committee (PAC) to determine an agenda for the meeting. The focus of the meeting will be on homelessness, including recuperative care, substance abuse and addiction, and improving the quality of life for these members.

Vice Chair Mouton asked if there were volunteers to present at future MAC meetings. Member Connie Gonzalez tentatively agreed to present in November with Member Sr. Mary Therese Sweeney scheduled as a back-up presenter for November.

Member Christine Tolbert requested an agenda item for future meetings that includes comments, concerns and issues from MAC members. CalOptima staff responded that there is an area at the end of the agenda for specific topics from MAC members. The Chair can reorder the agenda to include this item at the top of the meeting. In addition, MAC members may reach out to the Chair to ask for an item to be included on a future agenda.

MAC Member Presentation on ResCare Workforce Services

MAC 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.

Community Engagement

Claudia Hernandez, Manager of Strategic Development, provided an overview on CalOptima's approach to community engagement. CalOptima's community engagement efforts seek to create and maintain a positive influence and impact in the community by strengthening our community partnerships, which includes approximately 350 community organizations. In addition, CalOptima attends approximately 130 community meetings and collaborative events and provides more than $45,000 in community sponsorships annually.

ADJOURNMENT

Back to Agenda

Vice Chair Mouton announced that the next meeting is the Joint MAC/PAC meeting on Thursday, September 14, 2017.

Hearing no further business, Chair Mouton adjourned the meeting at 4:34 p.m.

/s/ Pamela Reichardt
Pamela Reichardt
Executive Assistant

Approved: September 14, 2017

CalOptima Board Action Agenda Referral

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

Consent Calendar

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

Contact

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

Recommended Actions

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

Background

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

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

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

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

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

Discussion

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

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

Back to Agenda

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

Distribution of Incentive Dollars

Performance allocations are distributed based upon final calculation and validation of each measurement rate. To qualify for payment for each of the clinical measures, the provider must meet the minimum denominator and distribution, as noted.
The Medi-Cal CCN provider payments for clinical measures will be based on the provider's measurement rate for each clinical performance measure and member months. As CalOptima did not obtain individual provider satisfaction data, staff recommends that CAHPS payments will be distributed based on the provider's percent of total CCN Medi-Cal membership.

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

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

Attachments

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

Back to Agenda

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

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

Back to Agenda

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Pay for Value Program CCN Provider Payment Methodology

Board of Directors' Quality Assurance Committee Meeting

September 20, 2017

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

Deputy Chief Medical Officer

Back to Agenda

Medi-Cal Health Network Payment Methodology

Population Included

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

SPD Members Weighted 4x Non-SPD Members

Payment Calculation

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

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

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

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

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

Back to Agenda

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

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

Based upon December, 2016 Prospective Rates

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Back to Agenda

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

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

Based upon December, 2016 Prospective Rates

Back to Agenda

Medi-Cal Health Network Payments CAHPS Adult

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

Based upon measurement years 2015 and 2014 results

Back to Agenda

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Medi-Cal Health Network Payments CAHPS Child

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

Based upon measurement years 2015 and 2014 results

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Back to Agenda

Medi-Cal CCN Providers

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

Back to Agenda

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Medi-Cal CCN Health Network Payment

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

Back to Agenda

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Medi-Cal CCN Provider Payment Methodology

Population Included

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

Payment Calculation

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

Clinical Provider Payment

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

CAHPS Provider Payment

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

Total CCN Provider Payment

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

Back to Agenda

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Medi-Cal P4V Clinical Measures

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

Back to Agenda

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Medi-Cal CCN Provider Payment Methodology Clinical Calculation

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

Back to Agenda

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Medi-Cal CCN Provider Payment Adult Clinical Calculation Example

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

Back to Agenda

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Medi-Cal CCN Provider Payment
Adult Clinical Calculation Example

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

Provider A

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

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

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

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Back to Agenda

Medi-Cal CCN Provider Payment Child Clinical Calculation Example

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

Back to Agenda

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Medi-Cal CCN Provider Payment Child Clinical Calculation Example

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

Provider A

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

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

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

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Back to Agenda

Medi-Cal CCN Provider Clinical Payment

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

Back to Agenda

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Medi-Cal P4V CAHPS Measures

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

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Back to Agenda

Medi-Cal CCN Provider Payment CAHPS Calculation Example

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

Provider A

MM / Total MM = MM Percent

460,000 / 738,744 = 62.27%

MM Percent * CCN CAHPS Funds = CAHPS Payment

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

Back to Agenda

Medi-Cal CCN Provider Total Payment

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

Back to Agenda

OneCare Connect Health Network Payment Methodology

Population Included
Total Number of Member Months (MM)

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

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Back to Agenda

OneCare Connect CCN Health Network Payment

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

Back to Agenda

OneCare Connect Provider Payment Methodology

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

Back to Agenda

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OneCare Connect P4V Measures

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

Back to Agenda

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OneCare Connect CCN
Provider Calculation and Payment Example

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

Provider A

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

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

Back to Agenda

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CalOptima Board Action Agenda Referral

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

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

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

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

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

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

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

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

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

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

<table>
<tr><th colspan="2">Population Included:</th></tr>
<tr><td>Total # of Adults in Health Network</td><td>Total # of Children in Health Network</td></tr>
<tr><td colspan="2">Apply Acuity Score (SPD Weight 4X, TANF Weight 1X)</td></tr>
<tr><th colspan="2">Payment</th></tr>
<tr><td colspan="2">50% based on Performance score and 50% based on Improvement score
Improvement score will be weighted by CalOptima's overall improvement</td></tr>
<tr><td>Clinical Measures = 60% of the Total</td><td>CAHPS Measures = 40% of the Total</td></tr>
<tr><th colspan="2"><u>Proposed</u> Scoring for Measure Performance:</th></tr>
<tr><td colspan="2">• A relative point system by measure, based on:
• NCQA National HEDIS Percentiles (clinical measures)
• NCQA National CAHPS Percentiles (satisfaction measures)
• Final score is the sum of points for each measure
• Improvement score based on improvement from previous year (receiving 1 point for increasing each percentile level and negative 1 point for decreasing)</td></tr>
</table>

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

<u>Negative one (-1) point for decreasing
1 percentile level</u>
(e.g. -1 point for 75th percentile to 50th percentile;
-2 points for 50th percentile to 10th percentile, etc.)</td></tr>
</table>

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

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

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

Distribution of Incentive Dollars

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

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

Attachments

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

/s/ Michael Schrader | *09/29/2016*

Authorized Signature | **Date**

Back to Agenda

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Pay-for-Value 2016

Board of Directors Meeting
October 6, 2016

Richard Helmer, M.D., Chief Medical Officer

Back to Agenda

Pay for *Value* - 2016

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

Back to Agenda

Medi-Cal P4V Clinical Measures

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

Back to Agenda

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MediCal P4V CAHPS Measures

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

Back to Agenda

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Introduced Display Measures

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

Back to Agenda

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Payment Methodology

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

Back to Agenda

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Recommended Scoring - Amended

P4V Scoring - NEW

Performance Points – HEDIS & CAHPS

1 point: >= 50th percentile
2 points: >= 75th percentile
3 points: >= 90th percentile
No points <50th percentile

Improvement points – HEDIS & CAHPS

1 point for increasing 1 percentile level
(e.g. 1 point for 25th percentile to 50th percentile;
2 points for 50th percentile to 90th percentile, etc.)

Negative one (-1) point for decreasing
1 percentile level
(e.g. -1 point for 75th percentile to 50th percentile;
-2 points for 50th percentile to 10th percentile, etc.)

Back to Agenda

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

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

Back to Agenda

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OneCare Connect P4V Clinical Measures

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

Back to Agenda

Where Do We Go From Here?

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

- Next Steps

Back to Agenda

CalOptima Board Action Agenda Referral

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

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

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

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

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

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

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

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

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

Medi-Cal Changes:

- All health networks will have performance measures for both adult and child care. This addresses the unique needs of children in all networks.
- Introduction of an "acuity" calculation to address the unique health needs in the populations.
- Addition of access to care measures:
  - Adults Access to Preventative/Ambulatory Care Services
  - Children's Access to Primary Care Physicians
- Retirement of the "provider satisfaction with the health network and UM process" measure.
- The weighting of each domain in the Medi-Cal Pay for Performance program has been adjusted accordingly. Increased weighting has been allocated to member experience. This aligns with CalOptima's increased focus on improving member experience.

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

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

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

Windstone:
- Reinstate pay for value measures for Windstone Behavioral Health.

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

Back to Agenda

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

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

Fiscal Impact

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

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

Rationale for Recommendation

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

Concurrence

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

Attachments

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

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

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

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

<table>
<tr><th>Pediatric Measures</th><th>2016 Measurement Year

HEDIS 2017 Specifications
Anticipated Payment Date: Q4 2017</th><th>Measurement Assessment Methodology</th></tr>
<tr><td>Clinical Domain
HEDIS

Weight: 60.00%

SPD Weight 4.0

TANF Weight 1.0</td><td>Respiratory
• Medication Management for People with Asthma
• Appropriate Testing for Children with Pharyngitis (CWP)
• Appropriate Treatment for Children with Upper Respiratory Infection (URI)

Prevention
• Childhood Immunization Status Hepatitis Combo 10 (CIS)
• Well-Care Visits in the 3-6 Years of Life (W34)
• Adolescent Well-Care Visits (AWC)

Access to Care
• Children’s Access to Primary Care Physicians</td><td>A relative point system by measure based on:
• NCQA National HEDIS Percentiles
• Percent improvement</td></tr>
<tr><td>Patient Experience Domain-
CAHPS

Weight: 40%</td><td>Child Satisfaction Survey (Child CAHPS)

1. Getting Appointment with a Specialist
2. Timely Care and Service
3. Rating of PCP
4. Rating of All Healthcare</td><td>A relative point system by measure based on:
• NCQA National CAHPS Percentiles
• Percent improvement</td></tr>
</table>

Windstone Behavioral Health

Calculations for these measures will be the responsibility of CalOptima.

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

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

Participation in Quality Improvement Initiatives

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

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

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

MEASUREMENT DETAILS:

I. Clinical Domain (HEDIS measures)

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

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

Criteria
The following criteria were considered in selecting these indicators:

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

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

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

II. Customer Satisfaction

Member Satisfaction

Background

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

Survey Methodology

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

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

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

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2016 Pay For Value Programs

Board of Directors Meeting

April 7, 2016

Richard Bock, M.D.

Deputy Chief Medical Officer

Back to Agenda

Pay for Performance - Current

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

Back to Agenda

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Pay for *Value* - 2016

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

Back to Agenda

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Medi-Cal P4V Clinical Measures

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

Back to Agenda

MediCal P4V CAHPS Measures

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

Back to Agenda

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Introducing Display Measures

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

Back to Agenda

Payment Methodology

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

Back to Agenda

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

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

Back to Agenda

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OneCare Connect P4V Clinical Measures

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

Back to Agenda

OneCare Connect P4V: Windstone Behavioral Health

2016 Measurement Year Measures – Windstone
1. Follow-up After Hospitalization for Mental Illness: • Follow-up Visit after 7 days • Follow-up Visit after 30 days
2. Reduction in Emergency Department use for Seriously Mentally Ill and Substance Use Disorders (per CMS-defined standards)

Back to Agenda

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CalOptima Board Action Agenda Referral

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

Consent Calendar

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

Contact

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

Recommended Action

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

Background

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

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

Discussion

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

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

Medi-Cal Changes:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Back to Agenda

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

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

Back to Agenda

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

Back to Agenda

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

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

Back to Agenda

Participation in Quality Improvement Initiatives

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

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

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

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

MEASUREMENT DETAILS:

1. Clinical Domain (HEDIS measures)

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

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

Criteria
The following criteria were considered in selecting these indicators:

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

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

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

Back to Agenda

II. Customer Satisfaction

Member Satisfaction

Background

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

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

Survey Methodology

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

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

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

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar

4. Consider Approval of Revised Medi-Cal Quality Improvement and Accreditation Activities during CalOptima Fiscal Year (FY) 2017-18 for Member and Provider Incentives

Contact

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

Recommended Action

Approve proposed revisions to Member and Provider incentive program start and end dates, subject to Regulatory Approval, as applicable.

Background

In CalOptima's 2013-2016 Strategic Plan, one of the strategic priorities was related to Quality Programs and Services. As a part of this strategic priority, CalOptima staff has worked diligently to provide members with access to quality health care services and ensure optimal health outcomes for all our members. At the November 16, 2016 meeting of the Quality Assurance Committee, approval of the plan for Medi-Cal Quality Improvement and Accreditation Activities during CalOptima Fiscal Year (FY) 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million was recommended, and Board approval was obtained on December, 1, 2016.

At the February 15, 2017 meeting of the Quality Assurance Committee, approval of the implementation plan for the proposed quality initiatives was recommended, and Board approval was obtained on March 2, 2017.

As of August 31, 2017, the majority of the proposed initiatives have been implemented; however there is one provider initiative that has had a delayed implementation due to challenges with provider engagement. In addition, the member incentives have had a slow uptake. Consequently, additional time is recommended to allow additional members to quality for the incentive.

Discussion

The requested changes are all requests to extend the program or advise of a delayed start to a provider incentive.

Specifically:

- During the implementation of the two cervical cancer provider incentive programs, staff experienced challenges with engaging providers and appointment availability, resulting a request for the following extensions:
    - Cervical Cancer: Provider Extended Hours initiative implemented October 1 – December 15, 2017;
    - Cervical Cancer: Provider Office Staff incentive extended to December 31, 2017.
- Staff recommends that member incentives be extended due to slow member uptake, to support an

Back to Agenda

extension of the previously approved member incentives. This extension was also requested by the external providers who serve on the Quality Improvement Committee (QIC), upon review of the progress of the initiatives at the August 8, 2017 meeting. QIC discussed the importance of encouraging members to get needed services and requested these incentives to be extended as follows:

- Breast Cancer Screening incentive extended until December 31, 2017;
- Postpartum Care member incentive program extended until November 5, 2017. (incentive extension date aligns with HEDIS Postpartum Care measurement period)

There is no additional fiscal impact to the requests to extend or alter the initiative program length or start date. Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives.

Regulatory approval was received from DHCS on February 23, 2017 for Postpartum Member Incentive, February 22, 2017 for Breast Cancer Screening Member Incentive and May 23, 2017 for Cervical Cancer Screening Member Incentive.

Fiscal Impact

The recommended action to revise the FY 2017-18 member and provider incentive program is budget neutral to CalOptima. Maximum expenditures covered by this initiative and previously approved are $10,000.00 for providers and $260,687.00 for members.

Rationale for Recommendation

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

Concurrence

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

Attachments

1. Board Action dated March 2, 2017, Consider Authorizing Staff to Develop and Implement Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17 for Member and Provider Incentives
    a. Attachment - Board Action dated December 1, 2016, Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million

/s/ Michael Schrader — *10/23/2017*

Authorized Signature — **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar

6. Consider Authorizing Staff to Develop and Implement Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year (FY) 2016-17 for Member and Provider Incentives

Contact

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

Recommended Action

Authorize staff to develop and implement Member and Provider incentive programs in the amounts listed on Attachment 1, subject to applicable regulatory approval and guidelines.

Background

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

At the December 1, 2016, meeting, the CalOptima Board of Directors approved the Medi-Cal quality improvement and accreditation activities for Fiscal Year 2016-17. Specifically, the Board:

- Directed Staff to develop member and provider incentive programs in the amounts listed in Attachment 1, subject to applicable regulatory approval and guidelines, and final approval by the Board prior to implementation; and
- Authorized unbudgeted expenditures not to exceed $1.1 million to implement a budget augmentation for current quality initiatives (i.e., Surveys & NCQA fees, Consulting services, Quality Initiatives in flight, Required Training) and new requests for quality initiatives.

Discussion

Attachment 1 provides the requested additional detail on the HEDIS measures and proposed member and provider incentives. During the development of these incentive programs, staff has been able to more precisely identify the scope and cost per incentive. Some incentives are designed as pilot programs, in order to evaluate their effectiveness prior to launching to a larger number of members or providers. As such, Attachment 2 provides further detail on the proposed revisions to the expenditures for Medi-Cal Quality Improvement and Accreditation activities from the December 1, 2016, Board action.

Member incentives will follow the guidelines in CalOptima Policy AA.1208 – Non-Monetary Member Incentives.

Fiscal Impact
There is no additional fiscal impact for the recommended action.

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

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

Attachments
1. PowerPoint Presentation: Proposed Member and Provider Incentive Plan
2. Revision to Expenditures for Medi-Cal Quality Improvement and Accreditation Activities
3. Board Action dated December 1, 2016, Consider Approval of Medi-Cal Quality Improvement and Accreditation Activities During CalOptima Fiscal Year 2016-17, Including Contracts and Contract Amendments with Consultant(s), Member and Provider Incentives, and Expenditures of Unbudgeted Funds of up to $1.1 Million

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

Back to Agenda

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Proposed Member and Provider Incentive Plan

Board of Directors Meeting

March 2, 2017

Caryn Ireland

Executive Director, Quality and Analytics

Back to Agenda

Introduction

- All proposed incentives are pilot projects; results of each incentive will be brought back to the Board when analyzed
- No additional funds are requested
- Staff has refined the originally proposed costs to reflect expenditures during FY16-17 vs. through year end
- Staff has incorporated DHCS guidance on best practices for member incentives
  - Member incentives will be in the form of gift cards
- Offices/clinics identified for the Provider incentives will be based on the following criteria:
  - High Volume Providers, in good standing with CalOptima

Back to Agenda

Postpartum: Member Incentive

	Description
Objectives	To increase the number of members who had a delivery to obtain their postpartum visit within the prescribed timeframe. CalOptima's goal is to increase the HEDIS postpartum visit rate to above the 25th percentile.
Target Population	Medi-Cal members with a delivery between March 1 – June 30, 2017 (postpartum visit may occur after July 1st)
Requirements	• Voluntary participation in the postpartum incentive program. • Member must complete a postpartum visit with a provider within prescribed timeframe after delivery. • Member must complete and return required form provided by CalOptima to verify postpartum visit to obtain member incentive.
Incentive Type/Amount:	• $25 gift card per participating member •Additional entrance into a monthly opportunity drawing [50 members will be given a $100 gift card every month through opportunity drawing].
Duration:	• March 1- June 30, 2017
Total Cost:	**$90, 682** Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017

Back to Agenda

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Postpartum: Provider Office Staff Incentive

	Description
Objectives	Provide “just in time” training on Medical Records documentation of postpartum visits in order to improve our postpartum chart review results. Incomplete medical record documentation contributes to our declining postpartum score. Staff have analyzed postpartum medical record documentation that contributed to lack of compliance. Goal is to raise rates on Postpartum Care.
Target Population	Three PCPs, Clinics or OB/GYN offices with the highest number of members who had a delivery between January-June, 2017
Requirements	•Clinic staff must participate in a review 2016 medical record results with CalOptima staff for training on documentation which may lead to low rates. (March) •Clinic staff will implement changes within their office processes to ensure complete documentation; •Clinic staff will review sample of medical records with CalOptima team for training (April, May, June) •Requires Office Manager & Clinical Staff participation in all sessions
Incentive Type/Amount:	• $1000 per provider office or clinic for participation in the program • $1000 per provider office for demonstrated improvement
Duration:	4 months (Mar-June 30, 2017)
Total Cost:	**$10,000 (includes payments to providers and chart review resources)**

Back to Agenda

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Cervical Cancer Screening: Member Incentive

	Description
Objectives	To improve cervical cancer screening HEDIS rates
Target Population	Medi-Cal members between the ages of 21-64 years old.
Requirements	• Voluntary participation in the cervical cancer screening incentive program. • Member must complete a cervical cancer screening between February 15 – August 31, 2017. • Member must complete and return required form provided by CalOptima to verify cervical cancer screening to obtain member incentive.
Incentive Type/Amount:	• $15 gift card/member for completing cervical cancer screening. • Additional entrance into a monthly opportunity drawing [75 members will be given a $100 gift card every month through opportunity drawing].
Duration:	6 months (February 15 - August 31, 2017)
Total Cost:	**$87,505 by June 30, 2017** • 4,167 members to complete cervical cancer screening by June 30, 2017 • 4,167 members x 15 = $62,505, plus $25,000 in opportunity drawing = $87,505. •Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017

Back to Agenda

Cervical Cancer: Provider Office Staff Incentive

	Description
Objectives	1) To improve cervical cancer screening rates (HEDIS CCS) at targeted office sites by incentivizing staff to assist CalOptima members to get a pap test in greater volume than their current monthly average. CalOptima staff to calculate monthly average of completed pap tests for each targeted office. This may include helping to schedule appts for members, helping with transportation services, providing follow-up reminder calls, etc. 2) To understand and learn about any barriers at the provider level in an effort to provide resources and support.
Target Population	1) Target 5 High volume Medi-Cal provider offices, and 5 High volume Medi-Cal clinics, focus on office staff to help member get and keep appointments for pap tests. 2) Additional offices may be added to the campaign
Requirements	• Voluntary participation in the Provider Office Staff incentive program. • Conduct member outreach efforts (outbound calling, scheduling, record-keeping, maintaining communication with CalOptima). • Monthly communication/update with CalOptima.
Incentive Type/Amount:	• Two (2) meals will be provided at Provider Offices; Once at program launch and a second time at program completion. • $10/member above the monthly cervical cancer screening average for the office
Example for $10 incentive: Dr. John Smith	Avg. # Cervical Cancer Screenings for CalOptima Members: 25 Completed # of Cervical Cancer Screenings in February, 2017: 55 Increase over average screening rate: 30 (validated via claim/encounter submission) Total Incentive Earned for February, 2017: $300 (10 X $30=$300) Incentive may be earned for each month of the program , but amount will vary depending upon the number of members screened above the monthly average .
Duration:	6 months (February 15 – August 31, 2017)
Total Cost:	**$ Up to 72,500;** Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017

Back to Agenda

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Cervical Cancer: Extended Hours Initiative

	Description
Objectives	To promote women's health (breast and cervical cancer screenings) and improve screening rates at targeted provider offices.
Target Population	Target 1-2 high volume PCP offices. * Additional offices may be added to the campaign
Requirements	• Voluntary participation in the Provider Office Extended Hours Initiative. • Extend office hours for CalOptima members at least two (2) times per month for 3 months. Extended hours could be evening or weekends; targeting 8 additional hours per month per provider office. • Conduct member outreach efforts (outbound calling, scheduling appointments, record-keeping, maintaining communication with CalOptima). • Conduct well-women exams to include pap test, exclusively for CalOptima members during extended hours.
Incentive Type/Amount:	• Each office may receive up to $200/hour (up to a maximum of 16 hours over 3 months) to cover the cost of extending office hours, staffing resources and others. • Cost may vary between offices due to staffing resources and extended hours.
Duration:	3 months (March 1 – June 30, 2017)
Total Cost:	**$10,000**

Back to Agenda

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Breast Cancer Screening: Member Incentive

	Description
Objectives	To improve breast cancer screening HEDIS rates
Target Population	Medi-Cal members between the ages of 50 -74 years old.
Requirements	• Voluntary participation in the breast cancer screening incentive program. • Member must complete a breast cancer screening between February 1 – August 31, 2017. • Member must complete and return required form provided by CalOptima to verify breast cancer screening to obtain member incentive.
Incentive Type/Amount:	• $10 gift card/member for completing breast cancer screening. • Additional entrance into a monthly opportunity drawing [50 members will be given a $100 gift card every month through opportunity drawing].
Duration:	• 6 months (February 15 – August 31, 2017)
Total Cost:	**$82, 500 by June 30, 2017** • 5,750 members to complete breast cancer screening by August 31, 2017 • 5,750 x 10 = $57,000; plus $25,000 in opportunity drawing = $82,500 •Dollars will be calculated and accrued for any incentive paid in the 2nd half of the year, 2017

Back to Agenda

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Attachment 2: Revision to Expenditures for Medi-Cal Quality Improvement and Accreditation Activities

	12/1/16 Board Action		Recommended Action	
Item	**Detail**	**Total Amount (Not to Exceed)**	**Detail**	**Total Amount (Not to Exceed)**
Member Programs	• Prenatal/postpartum incentive (Increase volume of outreach): $10,887 • Breast cancer screening (Downward trend; Reminder mailing & incentive): $99,900 • Cervical cancer screening (Below MPL; Reminder mailing & incentive): $149,900	$260,687	• Prenatal/postpartum incentive: $90,682 • Breast cancer screening: $82,500 • Cervical cancer screening: $87,505	$260,687
Provider Programs	• Physician office extended hours pilot project - MPL measures: $10,000 • Prenatal/postpartum provider office incentive: $5,000 • PCP office staff incentives for well women visits/screenings: $75,000 • Physician office extended hours initiative mailing: $2,500	$92,500	• Postpartum provider office staff incentive: $10,000 • Cervical cancer provider office staff incentive: $72,500 • Cervical cancer extended hours initiative: $10,000	$92,500

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar

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

Contact

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

Recommended Actions

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

Background

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

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

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

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

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

Discussion

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

Expenditures requested are classified as:

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

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

Fiscal Impact

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

Rationale for Recommendation

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

Concurrence

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

Attachments

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

/s/ Michael Schrader   *11/22/2016*

Authorized Signature   **Date**

Back to Agenda

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

A. Budget Augmentation for Current Quality Initiatives

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

Back to Agenda

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

B. New Request for Quality Initiatives

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

Back to Agenda

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Quality Analytics Budget

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

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

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

Back to Agenda

FY 2016-2017 Budget

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

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

Back to Agenda

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Budget Augmentation for Current Quality Initiatives: $457,740

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

Back to Agenda

Budget Augmentation for Current Quality Initiatives (cont.)

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

- Miscellaneous — $7,775

Back to Agenda

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Funding for Additional Program: $605,839

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

Back to Agenda

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

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar
5. Consider Approval of Proposed Fiscal Year (FY) 2019 (Measurement Year 2018) Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect

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

Recommended Action
Approve Fiscal Year 2019 (Measurement Year (MY) 2018) "Pay for Value (P4V) Programs for Medi-Cal and OneCare Connect (OCC)," which defines measures and allocations for performance and improvement, as described in Attachment 1, subject to regulatory approval, as applicable.

Background
CalOptima has implemented a comprehensive Health Network P4V Performance Measurement Program intended to recognize outstanding performance and support on-going improvement in the provision of quality health care. Annually, the CalOptima staff conducts a review of the current measures and their performance over time. A part of this analysis includes evaluating both the overall performance of the measure and the level of improvement left to achieve. In addition, staff analyzes the difficulty of improving a measure due to the size of the eligible population (such as Anti-Depressant Medication Management – AMM) or difficulty in data gathering (such as Controlling Blood Pressure). Additionally, staff evaluates any changes to the measures that are important to CalOptima's NCQA Accreditation status or overall Health Plan Rating.

The purpose of CalOptima's MY 2018 P4V program for the Health Networks, including CalOptima Community Network (CCN), is consistent with the P4V programs of the prior two years, which remains:

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

Discussion
For the MY 2018 programs, staff recommends maintaining the tenets from the prior year, with some modifications. As proposed, for the Medi-Cal line of business, both Adult and Child measures remain in the measurement set and weighting by acuity (Seniors and Persons with Disabilities (SPD) vs. non-SPD) will carry forward in the proposed 2018 P4V program.

In order to sustain improvements and leverage resources that the Health Networks have allocated towards improvement in P4V measures, staff recommends the following modifications to the MY 2017 plan for MY 2018:

Measurement Year 2018 Medi-Cal P4V Measures Changes:

Recommend replacing existing P4V measure:

- Medication Management for People with Asthma (MMA) - Total 75% compliance
    - With:
        - MMA 5-11 years (child)
        - MMA 19-50 years (adult)

Recommend retiring:

- Comprehensive Diabetes Care (CDC) - HbA1c testing
- CAHPS
    - Getting Appointment with a Specialist
    - Timely Care and Service Composite
    - Rating of all Healthcare

Recommend adding three new Clinical measures:

- Well Child visits in the first 15 months of Life (W15) - six well child visits
- Comprehensive Diabetes Care (CDC) - HbA1c <8 (adequate control)
- Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)

Recommend adding three new Member Experience measures: (CAHPS Surveys - Medi-Cal Adult and Child)

- Getting Needed Care
- Getting Care Quickly
- How well Doctors Communicate

Measurement Year 2018 OneCare Connect P4V Measures Changes:

Recommend retiring two existing measures

- Antidepressant Medication Management (AMM) – Continuation and Acute Phase Treatment
    - small denominator measure
- Controlling Blood Pressure (CBP)
    - requires chart review, which makes it resource intensive to get a statistically significant sample size of chart review data across all health networks

Recommend adding two new measures:

- Breast Cancer Screening (BCS)
    - Model of Care and STAR measure
- Comprehensive Diabetes Care (CDC) - HbA1c >9 poor control
    - STAR measure

Back to Agenda

Display measures are not eligible for P4V payments. The intent of including them in the data set is to raise awareness of the measure and provide time for the Health Networks to evaluate, educate, monitor and implement actions to improve the rates. The CalOptima P4V team will also monitor the performance of these display measures throughout the year and offer recommendations to potentially include them as payment measures for MY 2019. As proposed, the display measures for Medi-Cal will remain the same for MY 2018; however, staff is recommending adding one new Display Measure for the OneCare Connect program:

- Colorectal Cancer Screening (COL)
  - Model of Care and STAR measure

Distribution of Incentive Dollars

The following P4V program requirements will remain for MY 2018:

- All health networks will continue to have performance measures for both adult and child care.

- Performance and improvement allocations are distributed upon final calculation and validation of each measurement rate. Payment for Medi-Cal will be paid in proportion to acuity level, as determined by aid category. Weighting of performance and improvement may be adjusted based on overall CalOptima performance.

- To qualify for payment for each of the Clinical and CAHPS measures, the Health Network must have a minimum denominator size of 30 eligible members for Medi-Cal line of business and 5 eligible members for each specified quality measure for the OneCare Connect line of business.

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

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

- Payment of any reward under the P4V program will occur after CalOptima receives official notice of HEDIS and CAHPS scores for 2018, which is anticipated to be on or around 4th quarter, 2019. The time of payment is subject to change at CalOptima's discretion.

- Distribution methodology to CCN providers for measurement years 2016 and 2017 payout will remain the same as approved by Board of Directors.

Fiscal Impact

The fiscal impact of the Medi-Cal P4V program will not exceed $2.00 per member per month (PMPM) and the OneCare Connect P4V program will not exceed $20.00 PMPM for the Measurement Year of January 1, 2018 through December 31, 2018. Since the distribution of incentive dollars for the MY

2018 P4V programs for Medi-Cal and OneCare Connect will be made in FY 2019-20, Management will include expenses related to the MY 2018 P4V program in a future operating budget.

Rationale for Recommendation

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

Concurrence

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

Attachments

1. 2018 Medi-Cal and OCC P4V Program Measurement Set
2. PowerPoint Presentation - 2018 Medi-Cal and OneCare Connect Pay for Value Programs
3. Board Action dated March 2, 2017, Consider Approval of the Fiscal Year 2018 (Measurement Year 2017) Pay for Value Programs for Medi-Cal and OneCare Connect

/s/ Michael Schrader — *10/23/2017*

Authorized Signature — **Date**

Back to Agenda

Attachment 1: FY 201~~8~~9 (MY 201~~7~~8) Medi-Cal and OCC
Pay for Value Program Measurement Set

Adult Measures	~~2017~~ 2018 Measurement Year / HEDIS ~~2018~~ 2019 Specifications Anticipated Payment Date: Q3 ~~2018~~2019	Measurement Assessment Methodology
Clinical Domain - HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	Prevention: • Breast Cancer Screening (BCS) • Cervical Cancer Screening (CCS) Diabetes: • HbA1c ~~Testing~~<8 (adequate control) • Retinal Eye Exams Access to Care: • Adults Access to Preventive/Ambulatory Care (AAP) Respiratory: • Medication Management for People with Asthma (MMA) – 19-50 years 75% compliance • Avoidance of Antibiotic Treatment in Adults with Bronchitis (AAB)	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percent~~ile~~ Improvement

Back to Agenda

Adult Measures	**2018 Measurement Year / HEDIS 2019 Specifications** **Anticipated Payment Date: Q3 2019**	**Measurement Assessment Methodology**
Patient Experience Domain - CAHPS Weight: 40%	Adult Satisfaction Survey (Adult CAHPS): 1. Getting appointment with a SpecialistNeeded Care 2. Timely Care and ServiceGetting Care Quickly 3. Rating of PCP 4. Rating of all HealthcareHow Well Doctors Communicate	A relative point system by measure based on: • NCQA National HEDISCalifornia CAHPS percentiles • Percentile Improvement
Display Measure	Initial Health Assessment	A relative point system by measure, based on: • DHCS percentiles • Percent Improvement

Back to Agenda

Pediatric Measures	~~2017~~ 2018 Measurement Year / HEDIS ~~2018~~ 2019 Specifications Anticipated Payment Date: Q3 ~~2018~~2019	Measurement Assessment Methodology
Clinical Domain - HEDIS Weight: 60.00% SPD Weight 4.0 TANF Weight 1.0	Respiratory: • Medication Management for People with Asthma (MMA) – 5-11 years 75% Compliance • Appropriate Testing for Children with Pharyngitis (CWP) • Appropriate Treatment for Children with Upper Respiratory Infection (URI) Prevention: • Childhood Immunization Status Combo 10 (CIS) • Well-Care Visits in the 3-6 Years of Life (W34) • Adolescent Well-Care Visits (AWC) • Well Child Visits in the First 15 months of Life – six well child visits (W15) Access to Care: • Children's Access to Primary Care Physician (CAP)	A relative point system by measure based on: • NCQA National HEDIS percentiles • Percent~~ile~~ Improvement

Back to Agenda

Pediatric Measures	**2018 Measurement Year / HEDIS 2019 Specifications** **Anticipated Payment Date: Q3 2019**	**Measurement Assessment Methodology**
Patient Experience Domain - CAHPS Weight: 40%	Child Satisfaction Survey (Child CAHPS) • Getting ~~Appointment with a Specialist~~Needed Care • ~~Timely Care and Service~~Getting Care Quickly • Rating of PCP • ~~Rating of all Healthcare~~How Well Doctors Communicate	A relative point system by measure based on: • NCQA ~~National HEDIS~~ California CAHPS percentiles • Percent~~ile~~ Improvement

Back to Agenda

OneCare Connect Measures	~~2017~~ 2018 Measurement Year / HEDIS ~~2018~~ 2019 Specifications Anticipated Payment Date: Q3 ~~2018~~2019	Measurement Assessment Methodology
Clinical Domain - HEDIS Weight: 60.00% Each measure weighted equally	Measures: • Breast Cancer Screening (BCS) • Comprehensive Diabetes Care (CDC) – HbA1c poor control (>9) • Plan All Cause Readmissions • Part D Medication Adherence for Diabetes • • ~~Antidepressant Medication Management Outcome Measures~~ • ~~Blood Pressure Control~~ • ~~Part D Medication Adherence for Diabetes~~	A relative point system by measure based on: • ~~NCQA National HEDIS~~CMS STAR thresholds ~~percentiles~~ • Percent Improvement **For the Part D Medication Adherence Measure**: A relative point system by measure based on: • CMS Star Rating Percentiles • Percent~~ile~~ Improvement

Back to Agenda

Patient Experience Domain – CAHPS Weight: 40%	Adult Satisfaction Survey (Adult CAHPS): • Annual Flu Vaccine • Getting Appointments and Care Quickly • Getting Needed Care • Rating of Healthcare Quality	A relative point system by measure, based on: • NCQA National HEDIS percentiles • Percent Improvement
Display Measures	Colorectal Cancer Screening	CMS Technical Specifications and Benchmarks for STAR measures

Back to Agenda

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Measurement Year 2018 Pay for Value Program

Board of Directors' Quality Assurance Committee Meeting

September 20, 2017

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

Deputy Chief Medical Officer

Back to Agenda

Introduction

- Annually, staff conduct a review of CalOptima's performance on key quality performance metrics such as:
  - NCQA Accreditation
  - Pay4Value
  - Health Plan Ratings
  - Model of Care
  - CMS STARS
- This analysis includes evaluating the overall performance of the measure, improvement over time and the level of improvement left to achieve.

P4V Measure Set Considerations

- The P4V measure sets include a diverse set of measures including:
  - Preventive screenings for children and adults
  - Chronic Care Measures
  - Outcomes based Measures
  - Member Experience
  - Utilization/Readmissions
- Measures must be actionable by PCPs;
  - Monthly, staff provide industry benchmarks and data-driven feedback to Health Networks, including CCN physicians, on their performance on P4V measures.
- Reporting Administrative Data Only - obtaining chart review data can be challenging (cost- and labor-intensive)

Back to Agenda

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Measures recommended for removal

Medi-Cal:

- Diabetes Care: HbA1c testing
- Medication Management for People with Asthma: Total 75% Compliance
  - ➢ Separated the measure by sub measure – Adult & Child

OneCare Connect:

- Antidepressant Medication Management Acute Phase
- Antidepressant Medication Management Continuation Phase
- Controlling Blood Pressure

Back to Agenda

Medi-Cal P4V Clinical Measures - Adult

2018 Measurement Year Measures	
Adult	**Quality Strategy**
Adult Access to Preventive Care Services	Area of HEDIS auditor focus due to declining rates; at 5th percentile Nationally
Breast Cancer Screening	Accreditation and Health Plan Rating
Cervical Cancer Screening	Accreditation, DHCS, and Health Plan Rating
NEW: Diabetes Care: HbA1c <8.0% (adequate control)	Accreditation and Health Plan Rating
Diabetes Care: Retinal Eye Exams	Accreditation, DHCS, and Health Plan Rating
NEW : Medication Management for People with Asthma: Age 19 – 50 years 75% Compliance	Accreditation, Health Plan Rating
NEW: Avoidance of Antibiotic Treatment in Adults with Bronchitis	Accreditation

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Back to Agenda

Medi-Cal P4V Clinical Measures - Child

2018 Measurement Year Measures	
Child	**Quality Strategy**
Adolescent Well-Care Visits	Health Plan Rating
Appropriate Testing for Children with Pharyngitis	Accreditation and Health Plan Rating
Appropriate Treatment for Children with URI	Accreditation and Health Plan Rating
Childhood Immunizations: Combo 10	Accreditation and Health Plan Rating
Children's Access to Primary Care Providers	Area of HEDIS Auditor focus; below 50th percentile Nationally
NEW : Medication Management for People with Asthma: Age 5 – 11 years 75% Compliant	Accreditation, DHCS, and Health Plan Rating
Well-Child Visits 3–6 Years	DHCS and Health Plan Rating
NEW: Well Child Visits in the first 15 Months of Life	Health Plan Rating and HN performance dropped 7.66% from last year

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Back to Agenda

Medi-Cal P4V CAHPS Measures

2018 Measurement Year Measures	
Adult and Child Measures	
NEW: Getting Needed Care	Accreditation and Health Plan Rating
NEW: Getting Care Quickly	Accreditation and Health Plan Rating
Rating of PCP	Accreditation and Health Plan Rating
NEW: How well Doctors Communicate	Accreditation

Back to Agenda

Medi-Cal P4V Display Measures

2018 Measurement Year Display Measures
Initial Health Assessment

Back to Agenda

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Medi-Cal Health Network Payment Methodology - NO CHANGES

Population Included

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

SPD Members Weighted 4x Non-SPD Members

Payment Calculation

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

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

- **Clinical Funds =** Performance Funds ($0.60 PMPM) + Improvement Funds ($0.60)
- **Performance Payments =** Performance Funds
- **Improvement Payments =** Improvement Funds **x** CalOptima Overall Improvement Pct.

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

- **CAHPS Funds =** Performance Funds ($0.40 PMPM) + Improvement Funds ($0.40)
- **Performance Payments =** Performance Funds
- **Improvement Payments =** Improvement Funds **x** CalOptima Overall Improvement Pct.

Back to Agenda

OneCare Connect P4V Measures

2018 Measurement Year Measures	
NEW: Breast Cancer Screening	Model of Care and STAR measure
NEW: Diabetes Care – HbA1c poor control (>9%)	STAR measure
Medication Adherence for Diabetes Medications (Part D measure)	Model of Care, STAR, and Quality Withhold
Plan All-Cause Readmissions	STAR and Quality Withhold measure

Back to Agenda

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OneCare Connect P4V CAHPS Measures

2018 Measurement Year Measures	
Annual Flu Vaccine	STAR
Getting Appointments and Care Quickly	Model of Care and STAR
Getting Needed Care	Model of Care and STAR
Rating of Healthcare Quality	Model of Care and STAR

Back to Agenda

OneCare Connect P4V Display Measure - NEW

2018 Measurement Year Display Measure	
Colorectal Cancer Screening	Model of Care and STAR

Back to Agenda

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OneCare Connect Health Network Payment Methodology

Population Included

Total Number of Member Months (MM)

Payment Calculation

- **Allocated Funds =** Total MM for all Health Networks x the Allocated PMPM.
- Allocated PMPM for 2018 is **$20**.

Clinical Funds = 60% of Allocated Funds ($12.00 PMPM)

- **Clinical Funds =** Performance Funds ($6 PMPM) + Improvement Funds ($6)
- **Performance Payments =** Performance Funds
- **Improvement Payments =** Improvement Funds **x** CalOptima Overall Improvement Pct.

CAHPS Funds = 40% of Allocated Funds ($8.00 PMPM)

- **CAHPS Funds =** Performance Funds ($4 PMPM) + Improvement Funds ($4)
- **Performance Payments =** Performance Funds
- **Improvement Payments =** Improvement Funds **x** CalOptima Overall Improvement Pct.

Back to Agenda

CalOptima Board Action Agenda Referral

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

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

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

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

Background
CalOptima has implemented a comprehensive Health Network Performance Measurement System consisting of recognizing outstanding performance and supporting on-going improvement that will strengthen CalOptima’s mission of providing quality health care.
The purpose of the Health Network performance measurement system, which includes both delegates and the CalOptima Community Network as previously approved by the Board on March 1, 2014, is three-fold:
1. To recognize and reward Health Networks and their physicians for demonstrating quality performance;
2. To provide comparative information for members, providers, and the public on CalOptima’s performance; and
3. To provide industry benchmarks and data-driven feedback to Health Networks on their quality improvement efforts.

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

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

Medi-Cal Changes:

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

.

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

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

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

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

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

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

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

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

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

Time of Payment

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

Rationale for Recommendation

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

Concurrence

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

Attachments

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

/s/ Michael Schrader — *2/23/2017*

Authorized Signature — **Date**

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

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

Back to Agenda

<table>
<tr><th>Pediatric Measures</th><th>2017 Measurement Year / HEDIS 2018 Specifications

Anticipated Payment Date: Q3 2018</th><th>Measurement Assessment Methodology</th></tr>
<tr><td>Clinical Domain - HEDIS

Weight: 60.00%

SPD Weight 4.0

TANF Weight 1.0</td><td><u>Respiratory:</u>
Medication Management for People with Asthma (MMA)
Appropriate Testing for Children with Pharyngitis (CWP)
Appropriate Treatment for Children with Upper Respiratory Infection (URI)
<u>Prevention:</u>
Childhood Immunization Status Combo 10 (CIS)
Well-Care Visits in the 3-6 Years of Life (W34)
Adolescent Well-Care Visits (AWC)
<u>Access to Care:</u>
Children's Access to Primary Care Physician</td><td>A relative point system by measure based on:
NCQA National HEDIS percentiles
Percentile Improvement</td></tr>
<tr><td>Patient Experience Domain - CAHPS

Weight: 40%</td><td><u>Child Satisfaction Survey (Child CAHPS</u>)
Getting Appointment with a Specialist
Timely Care and Service
Rating of PCP
Rating of all Healthcare</td><td>A relative point system by measure based on:
NCQA California CAHPS percentiles
Percentile Improvement</td></tr>
</table>

Back to Agenda

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

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

Back to Agenda

Participation in Quality Improvement Initiatives

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

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

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

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

MEASUREMENT DETAILS:

1. Clinical Domain (HEDIS measures)

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

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

Criteria
The following criteria were considered in selecting these indicators:

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

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

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

Back to Agenda

II. Customer Satisfaction

Member Satisfaction

Background

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

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

Survey Methodology

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

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

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

Back to Agenda

CalOptima Board Action Agenda Referral

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

Consent Calendar

6. Consider Authorization of Additional Expenditures Related to the OneCare and OneCare Connect Sales Incentive Program

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Action

Authorize expenditures of up to $334,960 from existing reserves for one-time expenses related to the OneCare and OneCare Connect sales incentive program in Fiscal Year (FY) 2018.

Background

Shortly after the launch of CalOptima's OneCare Program in 2005, CalOptima hired a sales team to assist with the enrollment of potential members into the program. By 2014, OneCare had the highest enrollment of any Dual-Eligible Special Needs Plan (D-SNP) in Orange County. In 2015, CalOptima launched the OneCare Connect program and utilized the existing sales team to support enrollment into this new program as well. The rationale for this program has been:

- To encourage sales staff to be more effective and efficient in assisting potential OneCare/ OneCare Connect members with the benefits of enrollment into the program as appropriate;
- To promote the OneCare / OneCare Connect programs and showcase the programs' benefits in order to compete with other D-SNP or Medicare Advantage plans that are available in Orange County;
- To increase potential revenue for CalOptima from both the state and federal level, as revenue for OneCare / OneCare Connect is tied to overall enrollment.

Staff has made an extensive evaluation of the program to determine the best approach to address compensation for the sales staff. This evaluation resulted in incorporation of appropriate language into CalOptima Policy GA. 8042: Supplemental Compensation addressing incentive compensation for the sales staff. The recommended updates to policy GA. 8042 were approved by the Board at its September 7, 2017 meeting, with additional direction to staff to return with a follow-up action to include the fiscal impact of the sales incentive program.

Discussion

In the last fiscal year, the sales incentive program was covered by the savings achieved from CalOptima's vacancy factor. During the FY 2018 budgeting process, the vast majority of open positions were removed from the Operating Budget in order to reduce CalOptima's overall budgeted administrative costs, which eliminated the possibility of funding the sales incentive program with savings from CalOptima's vacancy factor. As a result, staff is returning to the Board with a recommendation that unbudgeted funds be used to cover the costs of the sales incentive program.

Management believes these expenditures are justified as each additional enrollment in the OneCare and OneCare Connect programs positively impacts the revenue received.

Fiscal Impact
At the September 7, 2017 meeting, the Board approved revisions to CalOptima Policy GA.8042: Supplemental Compensation to include changes to the OneCare and OneCare Connect sales incentive program. Funding for OneCare and OneCare Connect sales incentive program is an unbudgeted item. Based on FY 2016-17 actual expenses, an allocation of up to $334,960 from existing reserves will be used to fund this recommended action through June 30, 2018.

Rationale for Recommendation
Staff recommends approval of the proposed recommendation to maintain CalOptima's sales incentive program and to support increased enrollment for the OneCare and OneCare Connect programs in FY 2018.

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

Attachment
CalOptima Policy GA.8042: Supplemental Compensation

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

CalOptima
A Public Agency
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Policy #: GA.8042
Title: **Supplemental Compensation**
Department: Human Resources
Section: Not Applicable

CEO Approval: Michael Schrader _________

Effective Date: 01/01/11
Last Review Date: 09/07/17
Last Revised Date: 09/07/17

Board Approved Policy

I. PURPOSE

This policy establishes general guidelines concerning the use of supplemental compensation above regular base pay to compensate for business needs and to identify items to be reported to CalPERS as "Special Compensation."

II. POLICY

A. CalOptima considers the following as Special Compensation pursuant to Title 2, Section 571 of the California Code of Regulations (CCR):

1. Bilingual pay/Bilingual Premium;

2. Night Shift premium/Shift Differential;

3. Active Certified Case Manager (CCM) Pay/Educational Incentive; and

4. Executive Incentive Program/Bonus Pay.

B. Overtime Pay: As a public agency, CalOptima follows Federal wage and hour laws. Overtime pay for non-exempt employees will be provided for all hours worked in excess of forty (40) in any one (1) workweek at the rate of 1.5 times the employee's base hourly rate of pay. Exempt employees are not covered by the overtime provisions and do not receive overtime pay.

C. Bilingual Pay: CalOptima provides supplemental bilingual pay for qualified exempt and non-exempt employees who are fluent in at least one (1) of CalOptima's Threshold Languages. This is considered Bilingual Premium pursuant to 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Bilingual Pay is based on the following schedule:

Proficiency	Rate Per Pay Period
Bilingual language usage is required in the job description and used more than fifty percent (50%) of the time in the performance of the employee's job duties.	$60.00
Bilingual language usage is preferred in the job description and used less than fifty percent (50%) of the time in the performance of the employee's job duties.	$40.00

D. Translation Pay: In certain circumstances when, for business reasons and for the benefit of CalOptima Members, there is a need to translate documents and other written material into

languages other than English, the Exempt Employee providing such service will be paid supplemental pay. Non-Exempt Employees are not eligible for translation pay.

1. A CalOptima Exempt Employee, who does not work in the Cultural & Linguistic Services Department (C&L) and who is not required as part of his or her regular job responsibilities to translate, but is qualified to translate based on successfully passing the CalOptima Bilingual Screening Process, may be eligible for Translation Pay for performing translation work. Eligible employees, who are interested in performing translation work during non-work hours, may elect to provide translation services during his or her own personal time based on the rates indicated below. The C&L Department shall assign the work to qualified Exempt Employees on an occasional, as-needed basis.

2. There are two (2) key activities in providing translation services:

   a. Translation of materials from English into the desired language, or from another language into English; and

   b. Review and revision of the translation to ensure quality and consistency in usage of terms.

3. Translating is more difficult and time-consuming than reviewing and editing of the already translated materials, and as a result, translation of materials will be reimbursed at a higher rate. CalOptima will reimburse for services at the following rates:

   a. Translation – Thirty-five dollars ($35.00) per page; and

   b. Review and revision of translated materials – Twenty-five dollars ($25.00) per page.

4. The use of this supplemental pay is limited to situations where the use of professional translation services is either not available or unfeasible due to business constraints.

E. Night Shift: CalOptima provides supplemental pay for work performed as part of a Night Shift. Assignments for Night Shift are subject to business needs and are at the discretion of CalOptima management. This is considered a Shift Differential pursuant to 2, CCR, Section 571(a) and is to be reported to CalPERS as Special Compensation. The rate for Night Shift is based on the following schedule:

Definition	Eligibility	Rates (per hour)
Night Shift – Seven (7) consecutive hours or more, including at least four (4) hours of work between 4 p.m. and 8 a.m.	Non-exempt employees	Second shift employees (start time 3 p.m.) will receive $1.50 per hour. Third shift employees (start time 11 p.m.) will receive $2.00 per hour.

F. Call Back and On Call: CalOptima provides supplemental pay for work performed as part of a Call Back and On Call requirement. Assignments for Call Back and On Call are subject to business needs and are at the discretion of CalOptima management. The rates for Call Back and On Call Pay are based on the following schedule:

Definition	Eligibility	Rates (per hour)
Call Back – Must physically return to work within one (1) hour when requested by a Supervisor. A Supervisor may assign the employee other work until the guaranteed four (4) hour time elapses.	Non-exempt employees	1.5 times of base hourly rate with a minimum of four (4) hours of pay.
On Call – Must remain accessible after normally scheduled work hours and be available to fix problems or report to work, if necessary. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Non-exempt employees	$3.00/hour for being on-call. If a call is taken, employee is paid 1.5 times the regularly hourly rate with a thirty (30) minute minimum call.
On Call Medical Case Managers (RN or LVN) and Clinical Pharmacists - Must remain accessible to accept or respond to calls within a reasonable time designated by Employee's supervisor. In no event shall Employee's supervisor require a response time less than thirty (30) minutes. Employee will be informed of the need for their availability to work either from home or at the work site. Employees on call are waiting to be engaged and are free to use their On Call time as they deem appropriate.	Exempt employees excluding those in supervisory positions	25% of base hourly rate multiplied by the number of hours on call.

G. Active Certified Case Manager (CCM) Pay: CalOptima may recognize supplemental pay of one hundred dollars ($100) per pay period to an RN who holds an active CCM certification when such certification is required or preferred in the job description and used regularly in performance of the employee's job duties. This is considered as an Educational Incentive pursuant to 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation.

H. Executive Incentive Program: The Chief Executive Officer (CEO) may recognize Executive Staff, including interim appointments, using incentive compensation as described in this policy. For Executive Staff who achieve superior performance, the incentive compensation is considered Bonus Pay pursuant to 2 CCR Section 571(a) and is to be reported to CalPERS as Special Compensation for Classic Members.

I. Sales Incentive Program: The OneCare Community Partner and Senior (Sr.) Community Partner staff in the OneCare Sales & Marketing Department shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect programs.

1. The licensed Community Partner and Sr. Community Partner staff will receive a monthly Sales Incentive based on the number of eligible members enrolled into the OneCare and OneCare Connect program on the following monthly incentive range:

Enrollments	Incentive per eligible member enrolled
1 – 25	$0.00

Back to Agenda

Enrollments	Incentive per eligible member enrolled
26 – 30	$50.00
31 – 45	$100.00
46 – 50	$125.00
51+	$150.00

2. The Sales Incentive for the Manager Member Outreach & Education shall be based on the number of eligible members enrolled into the OneCare and OneCare Connect programs by the Community Partner and Sr. Community Partner in the OneCare Sales & Marketing Department. The Manager, Member Outreach & Education will receive twenty dollars ($20.00) per member enrolled, if and only if, the Community Partner or Sr. Community Partner reporting to the Manager, Member Outreach & Education, enrolls thirty-one (31) or more members per month. If a Community Partner or Sr. Community Partner fails to enroll at least thirty-one (31) members per month, the Manager, Member Outreach & Education, would not be eligible for the Sales Incentive for that Community Partner or Sr. Community Partner.

J. Employee Incentive Program: At the discretion of the CEO, specific employees may be recognized through incentive compensation, when doing so is consistent with CalOptima's business needs and mission, vision, and values.

K. Retention Incentive: In order to preserve organizational talent and to maintain business continuity when the loss of key personnel may cause risk or damage to operational efficiency, regulatory compliance and/or strategic imperatives, CalOptima may, at the discretion of the CEO, and on an exception basis, award a retention incentive.

L. Recruitment Incentive: At the discretion of the CEO, a recruitment incentive of up to fifteen percent (15%) of the median base pay for the applicable position may be offered to entice an individual to join CalOptima. Recruitment incentives offered for Executive Director and Chief positions require Board of Directors approval.

M. Incentive programs may be modified or withdrawn, at any time. Award of incentive compensation is entirely at the discretion of the CEO and/or Board of Directors, as applicable. It is not intended to be a binding contract between Executive Staff or employees and CalOptima.

N. Employer-Paid Member Contribution (EPMC): CalOptima contributes seven percent (7%) of Compensation Earnable, on behalf of eligible employees who hold Management Staff positions as identified in the CalOptima salary schedule, and who qualify based on all of the following:

1. Hired, promoted, or transferred into a Management Staff position, including interim appointments; and

2. Included in one (1) of the following categories:

   a. A CalPERS Classic Member; or

   b. A member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.

O. Annual Performance Lump Sum Bonus: Employees paid at the pay range maximum are not eligible for future base pay increases. As a result, in lieu of future base pay increases, these employees may

be eligible for a merit bonus pay delivered as a lump sum bonus in accordance with Section III.J of this policy, provided that their performance meets the goals and objectives set forth by their managers.

P. Automobile Allowance: CalOptima may, at the discretion of the CEO, provide employees in Executive Staff positions, including interim appointments, with a monthly automobile allowance in an amount not to exceed five hundred dollars ($500) for the use of their personal vehicle for CalOptima business.

Q. Supplemental Retirement Benefit: Consistent with applicable Board actions, the CEO is authorized to determine CalOptima's contribution rate for employees to the supplemental retirement benefit (SRB) plan administered by the Public Agency Retirement System (PARS) within the limits of the budget and subject to contribution limits established by applicable laws. With the exception employees in Executive Staff positions, the contribution rate shall be uniform for all employees. For employees in Executive Staff positions who earn more than the applicable compensation limits, the CEO is authorized to provide additional supplemental contributions to PARS, subject to the limitations of applicable laws. These SRB contribution rates to the PARS retirement plan shall continue from year to year, unless otherwise adjusted or discontinued.

III. PROCEDURE

A. Overtime Pay: Overtime must be approved in advance by an employee's manager. Adjustments for overtime pay cannot be calculated until the completion of an employee's workweek. This may result in one (1) pay period's delay in the employee receiving the additional compensation.

B. Bilingual Pay: An employee or potential employee shall undergo a written and verbal bilingual evaluation when bilingual proficiency is a part of the employee's or potential employee's job description and used in the performance of the employee's job duties. If the employee or potential employee passes the evaluations, the bilingual pay shall be established.

C. Translation Pay: If an eligible Exempt Employee elects to provide translation services, and such services are not part of the employee's regular job duties, the employee shall submit their interest to the C&L Department. If selected, the translation pay, identified above, will be provided depending on the variables noted above, taking into account whether professional translation services are either not available or unfeasible due to business constraints.

D. Night Shift:

1. Night shift differential is automatically calculated for those employees regularly working a night shift, defined as seven (7) consecutive hours or more, including at least four (4) hours of work between 4 p.m. and 8 a.m.

2. Employees who, at their own request and for their own convenience, adjust their work schedule, such as requesting make up time or alternative hours, and as a result, would be eligible for night shift pay, shall be deemed as having waived their right to same. When appropriate, a new Action Form should be submitted, removing the employee from the night shift.

E. Call Back and On Call Pay:

1. If an employee is on call or gets called back to work, the employee is responsible for adding this time to their schedule through CalOptima's time keeping system, which is then approved by their Supervisor.

F. Active Certified Case Manager (CCM) Pay:

1. To receive CCM supplemental pay, an employee is responsible for providing a copy of the employee's case management certification issued by the Case Management Society of America to the Human Resources Department.

G. Incentive Compensation

1. The Board of Directors approves CalOptima's strategic plan for each fiscal year, and the CEO is expected to meet the goals set forth in the strategic plan. The CEO in turn sets goals for the Executive Staff.

2. The CEO may establish an incentive compensation program for Executive Staff based on the Executive Incentive Program attached within budgeted parameters in accomplishing specific results according to the department and individual goals set forth by the CEO and the level of achievement. Executive Staff will receive a performance evaluation based on the Performance Review of Executives Template attached, which measures their performance against the established goals. Based on the level of performance, the Executive Staff member may be eligible for a lump sum bonus payment. The Executive Staff member must still be employed by CalOptima and in good standing at the time the bonus is distributed in order to be eligible to receive the bonus payment. For eligible Executive Staff members who achieve superior performance, CalOptima will report the bonus payment to CalPERS as Special Compensation. The CEO is authorized to make minor revisions to the Executive Incentive Program and Performance Review of Executives Template from time to time, as appropriate.

3. As circumstances warrant and at the discretion of the CEO, employees not at the Executive Staff level, whose accomplishments have provided extraordinary results, may be considered for incentive compensation.

H. Sales Incentive Program

1. The One Care Community Partner and Sr. Community Partner staff, in the OneCare Sales & Marketing Department, shall have an active Resident Insurance Producer license to enroll eligible members into the OneCare and OneCare Connect Programs.

2. The Community Partner and Sr. Community Partner staff shall be eligible to receive Sales Incentive pay as described in Section II.I.1 of this policy for successfully enrolling new members into the OneCare and OneCare Connect Programs. Sales Incentive pay for the Manager, Member Outreach & Education, shall be based on the number of members enrolled into the OneCare and OneCare Connect Programs by the Community Partner and Sr. Community Partner as described in Section II.I.2 of this policy.

   a. CalOptima shall follow the Medicare Marketing Guidelines (MMGs) charge-back guidelines of ninety (90) calendar day rapid disenrollment and recouping the Sales Incentive with the exceptions as specified under the guidelines and applicable CalOptima policies.

3. CalOptima shall pay the Sales Incentive to the eligible employee on a monthly basis approximately one and a half (1 ½) months after the month in which the eligible employee earned the Sales Incentive.

   a. In the event a OneCare or OneCare Connect member disenrolls from their respective program within ninety (90) calendar days for reasons other than the exceptions specified under the guidelines and applicable CalOptima policies, the Sales Incentive previously earned will be deducted from a future Sales Incentive.

4. The Chief Operating Officer, Executive Director of Network Operations and Director Network Management who oversee the OneCare Sales & Marketing Department shall approve the Sales Incentive payout.

5. Enrollment goals for the Community Partner and Community Partner Sr. staff will be pro-rated for the month if the employee misses one (1) or more full weeks due to vacations, sick days, or a Leave of Absence.

6. The Director, Network Management, Executive Director of Network Operations and the Chief Operations Officer will review the Sales Incentive structure on an annual basis.

I. Retention Incentive: As circumstances warrant, the CEO may award an employee a retention incentive to prevent or delay departures that may adversely impact business operations. The employee offered a retention incentive must be in good standing and accept and sign a retention agreement which contains the condition(s) to be met in order to receive payment. Payment of the incentive will be made when the terms of the agreement have been fully met and at the conclusion of the retention period. The CEO has the authority to offer retention incentives for up to twelve (12) employees per calendar year in an amount not to exceed ten percent (10%) of the employee's current base annual salary. Retention incentives that exceed ten percent (10%) of the employee's current base annual salary require Board of Directors approval.

J. Recruitment Incentive: As circumstances warrant, the CEO may offer a recruitment incentive based on the Compensation Administration Guidelines managed by the Human Resources Department to entice an individual to join CalOptima. Board of Directors approval is required for recruitment incentives offered for Executive Director and Chief positions. In order to receive the recruitment incentive, the individual offered the incentive is required to accept and sign an offer letter which contains a "claw-back" provision obligating the recipient of a recruitment incentive to return the full amount of the recruitment incentive if the recipient voluntarily terminates employment with CalOptima within twenty-four (24) months of the date of hire.

K. Annual Performance Lump Sum Bonus: Once an employee has reached the pay range maximum, the employee may be eligible for merit bonus pay delivered as a lump sum bonus, provided that his or her annual performance evaluation meets the established goals and objectives set forth by their managers. Merit bonus pay will not exceed the maximum percentage of the merit increase matrix and reflects the employee's superior performance measured against established objectives. Annual performance lump sum bonuses are paid out in two (2) incremental amounts – the first half when merit salary increases are normally distributed and the second half six (6) months later. The employee must still be employed by CalOptima in order to be eligible to receive the lump sum bonus payments.

L. Automobile Allowance: As circumstances warrant, the CEO may offer to employees in Executive Staff positions an automobile allowance in lieu of the IRS standard mileage reimbursement rate that

Back to Agenda

would otherwise apply in the use of their personal vehicle in the performance of their duties. Such automobile allowance will be identified on the Executive Staff's W-2 forms as taxable income. In addition, as a condition of receiving such allowance, the Executive Staff member must comply with the following requirements:

1. He or she must maintain adequate levels of personal vehicle insurance coverage;

2. He or she shall purchase his or her own fuel for the vehicle; and

3. He or she shall ensure that the vehicle is properly maintained.

IV. ATTACHMENTS

A. Executive Incentive Program
B. Performance Review of Executives Template

V. REFERENCES

A. CalOptima Employee Handbook
B. Compensation Administration Guidelines
C. Government Code, §20636 and 20636.1
D. Title 2, California Code of Regulations (CCR), §571

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 09/07/17: Regular Meeting of the CalOptima Board of Directors
B. 12/03/15: Regular Meeting of the CalOptima Board of Directors
C. 05/01/14: Regular Meeting of the CalOptima Board of Directors
D. 01/05/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	01/01/2011	GA.8042	Pay Differentials	Administrative
Revised	01/05/2012	GA.8042	Pay Differentials	Administrative
Revised	05/20/2014	GA.8042	Supplemental Compensation	Administrative
Revised	12/03/2015	GA.8042	Supplemental Compensation	Administrative
Revised	09/07/2017	GA.8042	Supplemental Compensation	Administrative

IX. GLOSSARY

Term	Definition
Bilingual Certified Employee	An employee who has passed CalOptima's Bilingual Screening Process either upon hire or any time during their employment.
Bilingual Screening Process:	Prospective staff translators are identified by Cultural and Linguistic (C&L) Services Department based on qualifications obtained through CalOptima's bilingual screening process. The screening is either conducted as part of their initial hiring process or later during their employment. All staff translators must possess a strong ability to read, write and understand the target language. Once identified as potential staff translators, they are required to take a proficiency test created by C&L Services Department. They are evaluated on their vocabulary, grammar, orthography, flow, accuracy, cultural sensitivity, as well as consistency in usage of translated terms. The selection is based on their overall score.
Bonus Pay	Compensation to employees for superior performance such as "annual performance bonus" and "merit pay." If provided only during a member's final compensation period, it shall be excluded from final compensation as "final settlement" pay. A program or system must be in place to plan and identify performance goals and objectives to count as Special Compensation for CalPERS purposes.
CalPERS	California Public Employees Retirement System
CalPERS Classic Member	A member enrolled in CalPERS prior to January 1, 2013.
Classic Director	A Management Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Classic Executive	An Executive Staff who is either a CalPERS Classic Member or a member prior to 01/01/2013 of another California public retirement system that is eligible for reciprocity with CalPERS.
Compensation Earnable	The pay rate and special compensation as defined in Government Code sections 20636 and 20636.1.
Executive Staff	Staff holding Executive level positions as specifically designated by the Board of Directors.
Exempt Employee	Employees who are exempt from the overtime provisions of the federal Fair Labor Standards Act (FLSA) and state regulations governing wages and salaries. Exempt status is determined by the duties and responsibilities of the position and is defined by Human Resources for each position.
Leave of Absence (LOA)	A term used to describe a scheduled period of time off longer than five (5) days that an employee is to be away from his or her primary job, while maintaining the status of employee.
Management Staff	Staff holding positions at or above Director level.
Sales Incentive	An amount of money paid, in addition to base pay, to an employee for successfully enrolling a member into the OneCare or/ OneCare Connect Program.
Special Compensation	Payment of additional compensation earned separate from an employee's base pay that meets the criteria listed in Title 2, California Code of Regulations (CCR) section 571(a).

Back to Agenda

Term	Definition
Threshold Language	For purposes of this policy, a threshold language as defined by the Centers for Medicare & Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.

CalOptima Board Action Agenda Referral

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

Consent Calendar
7. Consider Appointment of CalOptima Treasurer

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

Recommended Action
Appoint Greg Hamblin, CalOptima Chief Financial Officer, as CalOptima's Treasurer.

Background
At its September 10, 1996 meeting, the CalOptima Board of Directors authorized the creation of the CalOptima Investment Advisory Committee (IAC), and stipulated that CalOptima's Chief Financial Officer (CFO) would automatically serve on the IAC by virtue of his or her position.

At its June 2, 1998, meeting, the Board approved the substitution of the title "Treasurer," in place of "CFO" as the CalOptima staff person appointed to the IAC.

Discussion
In accordance with CalOptima's Annual Investment Policy, the Treasurer is responsible for oversight of the management of CalOptima's investment program. Section V. of the Annual Investment Policy provides that "The Treasurer shall be responsible for all actions undertaken and shall establish a system of controls to regulate the activities of subordinate officials and Board approved investment managers."

The proposed action is to appoint new CalOptima CFO, Greg Hamblin, to serve as Treasurer, effective upon Board approval.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
Appointing CalOptima's CFO as the CalOptima Treasurer will ensure stability and continuity in the oversight of CalOptima's treasury functions, and activities of investment managers, consistent with the requirements of CalOptima's Annual Investment Policy.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

Back to Agenda

CalOptima Foundation Board Action Agenda Referral

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

Consent Calendar
8. Consider Appointment of CalOptima Foundation Chief Financial Officer

Contact
Michael Schrader, Executive Director, (714) 246-8400

Recommended Action
Appoint Greg Hamblin, CalOptima Chief Financial Officer (CFO), as the CalOptima Foundation CFO.

Background/Discussion
At its August 5, 2010 meeting, the CalOptima Foundation (Foundation) Board of Directors appointed officers, established Bylaws and a Conflict of Interest Code, and authorized staff to take all steps necessary to make the CalOptima Foundation operational, including, but not limited to, the filing of applications for exemption from federal and California state income tax, and the establishment of bank accounts, as may be reasonably necessary to commence activities of the Foundation.

Consistent with the CalOptima Foundation Bylaws, the proposed recommendation to appoint CalOptima CFO Greg Hamblin, as CalOptima Foundation CFO, will be effective upon Foundation Board approval. As the CalOptima Foundation CFO, Mr. Hamblin will be responsible for performing duties pursuant to Foundation Bylaws Article 10. Section 5. Officers: Chief Financial Officer. These duties include, but are not limited to: maintaining adequate and correct accounts of the corporation, depositing all moneys and other valuables with the corporation's depositories, disbursing funds as order by the Board of Directors, and providing an account of all such transactions and of the financial condition of the corporation.

Fiscal Impact
There is no fiscal impact.

Rationale for Recommendation
The recommendation to appoint CalOptima CFO to serve as the CalOptima Foundation CFO is consistent with the Foundation Bylaws and will ensure continuity in accountability for the oversight of Foundation financial matters.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

9. Consider Accepting and Receiving and Filing Fiscal Year 2017 CalOptima Audited Financial Statements

Contact

Greg Hamblin, Chief Financial Officer, (714) 246-8400
Nancy Huang, Controller, (714) 246-8400

Recommended Action

Accept and receive and file the Fiscal Year (FY) 2017 CalOptima consolidated audited financial statements as submitted by independent auditors Moss-Adams, LLP.

Background

CalOptima has contracted with financial auditors Moss-Adams, LLP since May 21, 2015, to complete CalOptima's annual financial audit. At the May 18, 2017, meeting of the CalOptima Finance and Audit Committee, Moss-Adams presented the 2017 Audit Plan. The plan includes performing mandatory annual consolidated financial statement audit, and drafting of the consolidated financial statements for the year ending June 30, 2017.

Discussion

Moss-Adams conducted the interim audit from May 23, 2017, through May 26, 2017, and the on-site year-end audit from July 24, 2017, through August 11, 2017. The significant audit areas that Moss-Adams reviewed included:

- Capitation revenue and receivables;
- Cash and cash equivalents;
- Investments; and
- Medical claims liability, capitation payable and obligations payable to State of California.

Results from CalOptima's FY 2017 Audit were positive. The auditor made no changes in CalOptima's approach to applying critical accounting policies, and did not report encountering any significant difficulties during the audit. Additionally, there were no material misstatements identified by the auditor. As such, Management recommends that the Board accept the CalOptima FY 2017 audited financial statements as presented.

Fiscal Impact

There is no fiscal impact related to this recommended action.

Concurrence

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

Back to Agenda

Attachments

1. FY 2017 CalOptima Audited Financial Statements
2. Presentation by Moss-Adams, LLP

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

Back to Agenda

REPORT OF INDEPENDENT AUDITORS AND CONSOLIDATED FINANCIAL STATEMENTS WITH SUPPLEMENTARY INFORMATION

FOR

ORANGE COUNTY HEALTH AUTHORITY, A PUBLIC AGENCY/DBA ORANGE PREVENTION AND TREATMENT INTEGRATED MEDICAL ASSISTANCE/DBA CALOPTIMA

June 30, 2017 and 2016

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Back to Agenda

Table of Contents

	PAGE
Management's Discussion and Analysis	1–15
Report of Independent Auditors	16–17
Financial Statements	
Consolidated Statements of Net Position	18–19
Consolidated Statements of Revenues, Expenses and Changes in Net Position	20
Consolidated Statements of Cash Flows	21
Notes to Consolidated Financial Statements	22–55
Supplementary Information	
Schedule of Changes in Net Pension Liability and Related Ratios	56
Schedule of Plan Contributions	57
Schedule of Funding Progress – Postemployment Health Care Plan	58

The intent of management's discussion and analysis of CalOptima's consolidated financial performance is to provide readers with an overview of the agency's financial activities for the fiscal years ended June 30, 2017 and 2016. Readers should review this summation in conjunction with CalOptima's consolidated financial statements and accompanying notes to the consolidated financial statements to enhance their understanding of CalOptima's financial performance.

Key Operating Indicators

The table below compares key operating indicators for CalOptima for the fiscal years ended June 30, 2017, 2016 and 2015:

Key Operating Indicators	2017	2016	2015
Members (at end of fiscal period):			
Medi-Cal program	772,228	776,713	739,567
OneCare	1,121	1,174	12,951
OneCare Connect	15,505	29,416	-
PACE	212	168	95
Average member months			
Medi-Cal program	777,057	765,938	698,718
OneCare	1,237	6,879	13,595
OneCare Connect	16,834	9,626	-
PACE	190	135	71
Operating revenues (in millions)	$ 3,549	$ 3,148	$ 2,916
Operating expenses (in millions)			
Medical expenses	3,400	3,022	2,600
Administrative expenses	111	107	88
Operating income (in millions)	$ 38	$ 19	$ 228
Operating revenues PMPM (per member per month)	$ 372	$ 337	$ 365
Operating expenses PMPM			
Medical expenses PMPM	356	323	328
Administative expenses PMPM	12	11	10
Opeating income (loss) PMPM	$ 4	$ 3	$ 27
Medical loss ratio	96%	96%	90%
Administrative expenses ratio	3%	3%	3%
Premium tax revenue and expenses not included above			
Operating revenues (in millions)	$ 138	$ 114	$ 125
Administrative expenses (in millions)	138	114	125

Overview of the Consolidated Financial Statements

This annual report consists of consolidated financial statements and notes to those statements, which reflect CalOptima's financial position as of June 30, 2017 and 2016 and results of its operations for the fiscal years ended June 30, 2017 and 2016. The consolidated financial statements of CalOptima, including the consolidated statements of net position, statements of revenues, expenses and changes in net position, and statements of cash flows, represent the consolidated accounts and transactions of the five (5) programs – Medi-Cal, OneCare, OneCare Connect, Program of All-inclusive Care for the Elderly (PACE), and CalOptima Foundation.

- The consolidated statements of net position include all of CalOptima's assets, deferred outflows of resources, liabilities, and deferred inflows of resources, using the accrual basis of accounting, as well as an indication about which assets and deferred outflows of resources are utilized to fund obligations to providers and which are restricted as a matter of Board of Directors' policy.
- The consolidated statements of revenues, expenses and changes in net position present the results of operating activities during the fiscal year and the resulting increase or decrease in net position.
- The consolidated statements of cash flows report the net cash provided by or used in operating activities, as well as other sources and uses of cash from investing and capital and related financing activities.

The following discussion and analysis addresses CalOptima's overall program activities. CalOptima's Medi-Cal program accounted for 88.6 percent, 89.4 percent, and 93.8 percent of its annual revenues during fiscal years 2017, 2016, and 2015, respectively. CalOptima's OneCare accounted for 0.5 percent, 3.3 percent, and 6.0 percent of its annual revenues during fiscal years 2017, 2016, and 2015, respectively. CalOptima's OneCare Connect program accounted for 10.5 percent and 7.0 percent of its annual revenues during fiscal year 2017 and 2016. All other programs consolidated accounted for 0.4 percent, 0.3 percent, and 0.2 percent of CalOptima's annual revenues during fiscal years 2017, 2016, and 2015, respectively.

CalOptima Foundation (the Foundation) was formed as a not-for-profit benefit corporation in 2010 and is dedicated to the betterment of public health care services in Orange County. The activities of the Foundation are included in the consolidated financial statements of CalOptima.

2017 and 2016 Financial Highlights

As of June 30, 2017 and 2016, total assets and deferred outflows of resources were approximately $2,743.0 million and $2,307.8 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $716.3 million and $662.5 million, respectively.

Net position increased by approximately $53.9 million, or 8.1 percent, during fiscal year 2017 and increased by approximately $32.5 million, or 5.2 percent, during fiscal year 2016.

Table 1a: Condensed Consolidated Statements of Net Position as of June 30,

(Dollars in Thousands)

Financial Position	2017	2016	Change From 2016 Amount	Change From 2016 Percentage
Assets				
Current assets	$ 2,141,667	$ 1,771,671	$ 369,996	20.9%
Board-designated assets and restricted cash	535,438	476,146	59,292	12.5%
Capital assets, net	54,301	54,996	(695)	-1.3%
Total assets	$ 2,731,406	$ 2,302,813	$ 428,593	18.6%
Deferred outflows of resources	$ 11,577	$ 5,003	$ 6,574	131.4%
Total assets and deferred outflows of resources	$ 2,742,983	$ 2,307,816	$ 435,167	18.9%
Liabilities				
Current liabilities	$ 1,981,295	$ 1,609,330	$ 371,965	23.1%
Other liabilities	44,017	33,864	10,153	30.0%
Total liabilities	$ 2,025,312	$ 1,643,194	$ 382,118	23.3%
Deferred inflows of resources	$ 1,340	$ 2,155	$ (815)	-
Net posiition				
Net investment in capital assets	$ 54,104	$ 54,995	$ (891)	-1.6%
Restricted	98,445	89,284	9,161	10.3%
Unrestricted	563,782	518,188	45,594	8.8%
Total net position	$ 716,331	$ 662,467	$ 53,864	8.1%
Total liabilities, deferred inflows of resources and net position	$ 2,742,983	$ 2,307,816	$ 435,167	18.9%

Current assets increased $370.0 million from $1,771.7 million in 2016 to $2,141.7 million in 2017. The increase in current assets is due to increases in cash, short-term investments and premium receivables. Current liabilities increased $ 372.0 million from $1,609.3 million in 2016 to $1,981.2 million in 2017. The increase is mainly due to additional payables to the health networks of approximately $173.0 million related to shared risk payout estimates and an increase of $549.4 million in the Due to DHCS liability account, which is the result from the change in categorization of excess payments related to Medi-Cal expansion rate changes from unearned revenue. Both are offset by a decrease of $387.9 million in the unearned revenue for the above mentioned category change. The net increase of the excess Medi-Cal expansion payments is $161.5 million from fiscal year 2016.

2017 and 2016 Financial Highlights (continued)

Board-designated assets and restricted cash increased by $59.3 million and $15.7 million in fiscal years 2017 and 2016, respectively. The Board of Directors' policy is to augment Board-designated assets to provide a desired level of funds between 1.4 months and 2 months of premium revenue to meet future contingencies. CalOptima's reserve level of tier one and two investment portfolios as of June 30, 2017 is at 1.9 times of monthly average premium revenue. CalOptima is also required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975.

2016 and 2015 Financial Highlights

As of June 30, 2016 and 2015, total assets and deferred outflows of resources were approximately $2,307.8 million and $1,869.5 million, respectively, and exceeded liabilities and deferred inflows of resources by approximately $662.5 million and $629.9 million, respectively.

Net position increased by approximately $32.5 million, or 5.2 percent, during fiscal year 2016 and increased by approximately $231.0 million, or 57.9 percent, during fiscal year 2015.

Table 1b: Condensed Consolidated Statements of Net Position as of June 30,
(Dollars in Thousands)

Financial Position	2016	2015	Change From 2015 Amount	Change From 2015 Percentage
Assets				
Current assets	$ 1,771,671	$ 1,350,744	$ 420,927	31.2%
Board-designated assets and restricted cash	476,146	460,449	15,697	3.4%
Capital assets, net	54,996	53,349	1,647	3.1%
Total assets	$ 2,302,813	$ 1,864,542	$ 438,271	23.5%
Deferred outflows of resources - pension contributions	$ 5,003	$ 4,951	$ 52	1.1%
Total assets and deferred outflows of resources	$ 2,307,816	$ 1,869,493	$ 438,323	23.4%
Liabilities				
Current liabilities	$ 1,609,330	$ 1,206,097	$ 403,233	33.4%
Other liabilities	33,864	27,861	6,003	21.5%
Total liabilities	$ 1,643,194	$ 1,233,958	$ 409,236	33.2%
Deferred inflows of resources - excess earnings	$ 2,155	$ 5,581	$ (3,426)	-
Net posiition				
Net investment in capital assets	$ 54,995	$ 53,349	$ 1,646	3.1%
Restricted	89,284	86,144	3,140	3.6%
Unrestricted	518,188	490,461	27,727	5.7%
Total net position	$ 662,467	$ 629,954	$ 32,513	5.2%
Total liabilities, deferred inflows of resources and net position	$ 2,307,816	$ 1,869,493	$ 438,323	23.4%

2016 and 2015 Financial Highlights (continued)

Current assets increased $420.9 million from $1,350.7 million in 2015 to $1,771.7 million in 2016. The increase in current assets is primarily due to the delay of the Department of Healthcare Services' (DHCS) recovery of Medi-Cal Expansion capitation rate overpayments in fiscal 2016 that resulted in increased cash and investments. The excess payments are primarily due to capitation payments received that do not reflect the current Medi-Cal expansions rates issued by DHCS. Current liabilities increased $ 403.2 million from $1,206.1 million in 2015 to $1,608.9 million in 2016. Current liabilities increased in the Due to DHCS liability category from the above Medi-Cal Expansion overpayments. Moreover, additional payables to the health networks of approximately $163.1 million were recorded for shared risk payout estimate in 2016. Deferred outflows of resources – pension contributions and deferred inflows of resources – excess earnings were recognized in the 2015 consolidated statement of net position related to the implementation of GASB 68. Refer to Note 6 for additional information.

Board-designated assets and restricted cash increased by $15.7 million and $305.4 million in fiscal years 2016 and 2015, respectively. The Board of Directors' policy is to augment Board-designated assets to provide a desired level of funds between 1.4 months and 2 months of premium revenue to meet future contingencies. CalOptima's reserve level of tier one and two investment portfolios as of June 30, 2017 is at 1.8 times of monthly average premium revenue. CalOptima is also required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975.

2017 and 2016 Results of Operations

CalOptima's fiscal year 2017 operations and nonoperating revenues resulted in a $53.9 million increase in net position, $21.4 million higher compared to a $32.5 million increase in fiscal year 2016. The following table reflects the changes in revenues and expenses for 2017 compared to 2016:

Table 2a: Consolidated Revenues, Expenses and Changes in Net Position for Fiscal Years Ended June 30
(Dollars in Thousands)

Results of Operations	2017	2016	Change From 2016 Amount	Change From 2016 Percentage
Capitation revenues	$ 3,549,462	$ 3,148,260	$ 401,202	12.7%
Other income	27	305	(278)	-91.1%
Total operating revenues	3,549,489	3,148,565	400,924	12.7%
Medical expenses	3,399,612	3,022,418	377,194	12.5%
Administative expenses	113,736	107,182	6,554	6.1%
Total operating expenses	3,513,348	3,129,600	383,748	12.3%
Operating income	36,141	18,965	17,176	90.6%
Nonoperating revenues and expenses	17,724	13,548	4,176	30.8%
Increase in net position	53,865	32,513	21,352	65.7%
Net position, beginning of year	662,467	629,954	32,513	5.2%
Net position, end of year	$ 716,332	$ 662,467	$ 53,865	8.1%

Back to Agenda

2017 and 2016 Operating Revenues

The increase in consolidated operating revenues of $ 401.2 million in fiscal year 2017 is attributable to additional revenue from rate increases, continued growth in Medi-Cal Expansion and update in the revenue recognition methodology for Care Coordinated Initiative (CCI) and Long-term care (LTC) services. An update to the revenue recognition methodology for CCI resulted in additional revenue of $64.7 million for fiscal year 2016 reflected in fiscal year 2017. Similarly, $56.3 million of additional revenue for Long-term Care (LTC) services for fiscal year 2016 was reflected in fiscal year 2017.

2017 and 2016 Medical Expenses

Overall medical expenses increased by 12.5 percent in fiscal year 2017, totaling $3,399.6 million, compared to $ 3,022.4 million in fiscal year 2016. CalOptima's medical loss ratio, or medical expenses as a percentage of operating revenues, was 95.8 percent in fiscal year 2017 compared to 96.0 percent in fiscal year 2016.

Medi-Cal Provider capitation, comprising capitation payments to CalOptima's contracted health networks, increased by 5.3 percent from fiscal year 2016 to fiscal year 2017 due to the transition of one shared risk group network and a Managed Behavior Health Organization (MBHO) to an HMO model during the year. Capitated member enrollment accounted for approximately 78.6 percent of CalOptima's enrollment, averaging members 610,893 during fiscal year 2017, and 80.0 percent of CalOptima's enrollment, averaging 612,704 members during fiscal year 2016. Included in the capitated environment are 298,552 or 48.9 percent and 342,498 or 44.7 percent members in a Shared Risk Network for fiscal years 2017 and 2016, respectively. Shared Risk Networks receive capitation for professional services and are claim-based for hospital services.

Medi-Cal capitation expenses totaled $985.2 million in fiscal year 2017, compared to $935.4 million in fiscal year 2016, which reflects the increased enrollment in capitated networks.

Medi-Cal Claim expense to providers and facilities, including LTC facilities increased by 16.2 percent from fiscal year 2016 to fiscal year 2017. This increase is attributable to an overall increase in cost per member, enrollment and a change in methodology to account for In-Home Supportive Services (IHSS) benefits.

In addition to the above Medi-Cal revenues and claims expenses in fiscal year 2017, Quality Assurance Fee (QAF) payments received and passed through to hospitals increased from $ 42.1 million to $307.8 million from fiscal year 2016 to fiscal year 2017. These receipts and payments are not included in the consolidated statements of revenues, expenses and changes in net position.

Pharmacy costs increased by 8.6 percent in fiscal year 2017, compared to fiscal year 2016. Results from fiscal year 2017 reflect higher enrollment and increase Pharmacy drug prices.

Back to Agenda

2017 and 2016 Administrative Expenses

Total administrative expenses were $111.2 million in 2017 compared to $107.2 million in 2016. Overall administrative expenses increased by 3.8 percent or $4.1 million, due to increases in salaries and benefits, along with typical inflation factors. During fiscal years 2017 and 2016, respectively, CalOptima's administrative expenses were 3.1 percent and 3.4 percent of total operating revenues.

2016 and 2015 Results of Operations

CalOptima's fiscal year 2016 operations and nonoperating revenues resulted in a $32.5 million increase in net position, $198.5 million lower compared to a $231.0 million increase in fiscal year 2015. The following table reflects the changes in revenues and expenses for 2016 compared to 2015:

Table 2b: Consolidated Revenues, Expenses and Changes in Net Position for Fiscal Years Ended June 30
(Dollars in Thousands)

Results of Operations	2016	2015	Change From 2015 Amount	Change From 2015 Percentage
Capitation revenues	$ 3,148,260	$ 2,910,655	$ 237,605	8.2%
Other income	305	5,233	(4,928)	-94.2%
Total operating revenues	3,148,565	2,915,888	232,677	8.0%
Medical expenses	3,022,418	2,599,868	422,550	16.3%
Administative expenses	107,182	88,382	18,800	21.3%
Total opeating expenses	3,129,600	2,688,250	441,350	16.4%
Operating income	18,965	227,638	(208,673)	-91.7%
Nonoperating revenues and expenses	13,548	3,389	10,159	299.8%
Increase in net position	32,513	231,027	(198,514)	-85.9%
Net position, beginning of year	629,954	398,927	231,027	57.9%
Net position, end of year	$ 662,467	$ 629,954	$ 32,513	5.2%

2016 and 2015 Operating Revenues

The increase in consolidated operating revenues of $ 232.7 million in fiscal year 2016 is attributable to additional revenue from the new IHSS benefit and continued growth in Medi-Cal Expansion program, offset by rate reductions from State of California Department of Health Care Services (DHCS) for the Medi-Cal Expansion population, as well as a decrease of $187.1 million of contingency payable to the State for meeting the 85 percent medical loss ratio as compared to fiscal year 2015. Hepatitis C drug revenue totaled $40.8 million and $18.4 million in fiscal year 2016 and 2015, respectively.

2016 and 2015 Medical Expenses

Overall medical expenses increased by 16.3 percent in fiscal year 2016, totaling $3,022 million, compared to $ 2,600 million in fiscal year 2015. CalOptima's medical loss ratio, or medical expenses as a percentage of operating revenues, was 96.0 percent in fiscal year 2016, compared to 89.2 percent in fiscal year 2015.

Medi-Cal Provider capitation, comprising capitation payments to CalOptima's contracted health networks, increased by 9.2 percent from fiscal year 2015 to fiscal year 2016 due to an overall increase in enrollment and Medi-Cal expansion rates. Capitated member enrollment accounted for approximately 80.0 percent of CalOptima's enrollment, averaging members 612,704 during fiscal year 2016, and 79.3 percent of CalOptima's enrollment, averaging 554,271 members during fiscal year 2015. Included in the capitated environment are 342,498 or 44.7 percent and 306,847, or 43.9 percent members in a Shared Risk Network for fiscal years 2016 and 2015, respectively. Shared Risk Networks receive capitation for professional services and are claim-based for hospital services.

Medi-Cal capitation expense totaled $935.4 million in fiscal year 2016, compared to $856.4 million in fiscal year 2015, which reflects the increased enrollment in capitated networks.

Medi-Cal Claim expense to providers and facilities, including LTC facilities increased by 10.7 percent from fiscal year 2015 to fiscal year 2016. This increase is mainly attributable to new IHSS benefits starting July 1, 2015.

In addition to the above Medi-Cal revenues and claims expense in fiscal year 2016, Quality Assurance Fee (QAF) payments received and passed through to hospitals decreased from $ 102.6 million to $42.1 million from fiscal year 2015 to fiscal year 2016. These receipts and payments are not included in the consolidated statements of revenues, expenses and changes in net position.

Pharmacy costs increased by 30.3 percent in fiscal year 2016, compared to fiscal year 2015. Results from fiscal year 2016 reflect higher enrollment and new Hepatitis C drug costs.

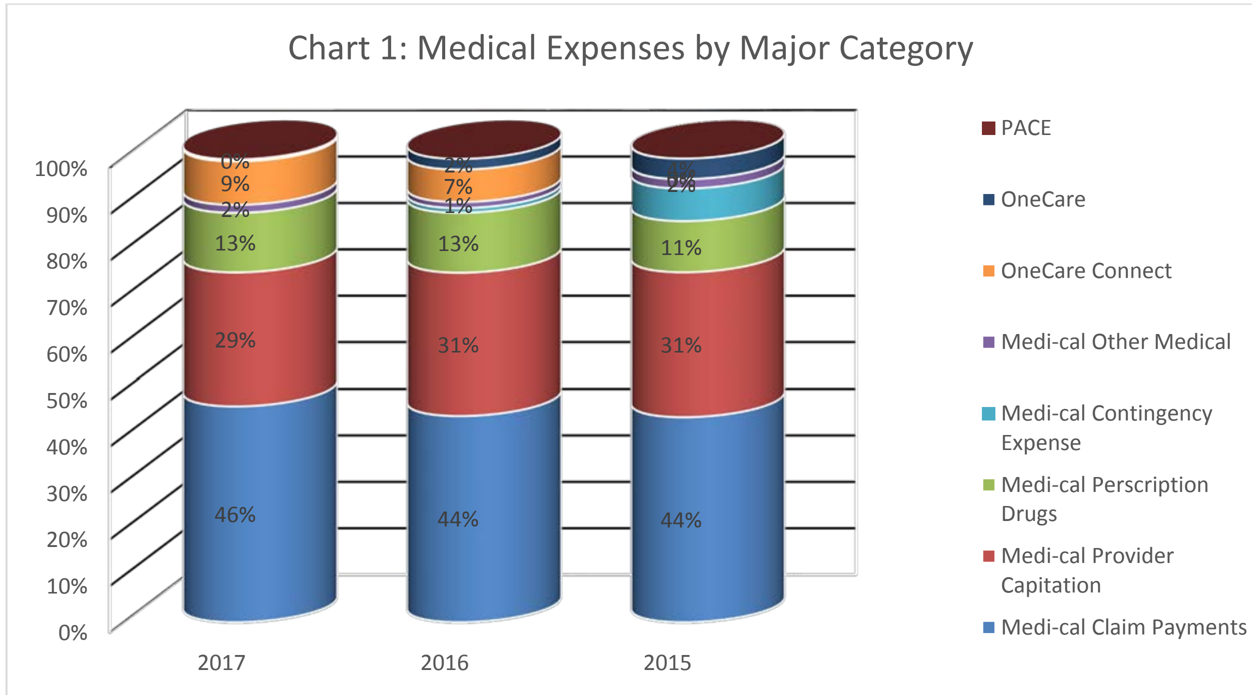
2016 and 2015 Administrative Expenses

Total administrative expenses were $107.2 million in 2016. Overall administrative expenses increased by 21.2 percent, due to additional expenses related to higher enrollment and new program implementation costs for the OneCare Connect program. During fiscal years 2016 and 2015, respectively, administrative expenses were 3.4 percent and 2.8 percent of operating revenues.

Back to Agenda

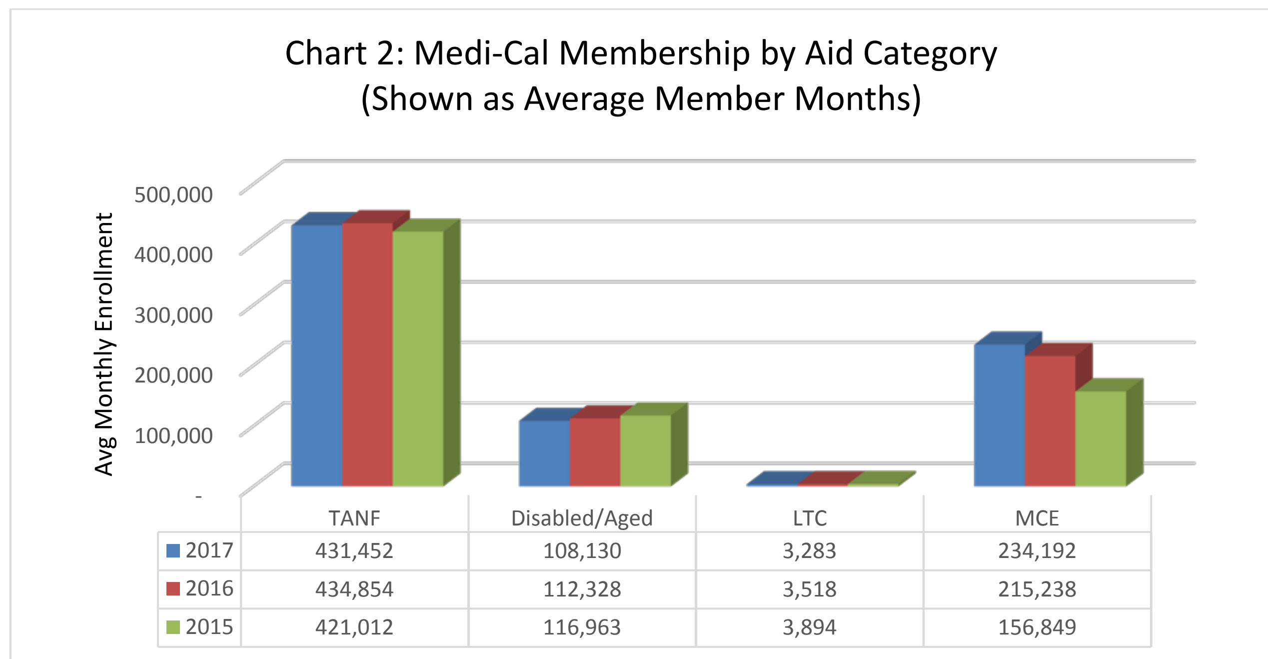
2017, 2016 and 2015 Medical Expenses by Major Category

Below is a comparison chart of medical expenses by major category and their respective percentages of the overall medical expenditures by fiscal year.



2017, 2016 and 2015 Enrollment

During fiscal year 2017, CalOptima served an average of 777,057 Medi-Cal members per month compared to an average of 765,938 members per month in 2016, and 698,718 members per month in 2015. The chart below displays a comparative view of average monthly membership by Medi-Cal aid category during 2017, 2016, and 2015:



	TANF	Disabled/Aged	LTC	MCE
2017	431,452	108,130	3,283	234,192
2016	434,854	112,328	3,518	215,238
2015	421,012	116,963	3,894	156,849

Significant aid categories are defined as follows:

Temporary Assistance to Needy Families (TANF) includes families, children and poverty-level members who qualify for the TANF federal welfare program, which provides cash aid and job-search assistance to poor families. TANF also includes members who migrated from CalOptima, Health Net and Kaiser Healthy Family programs.

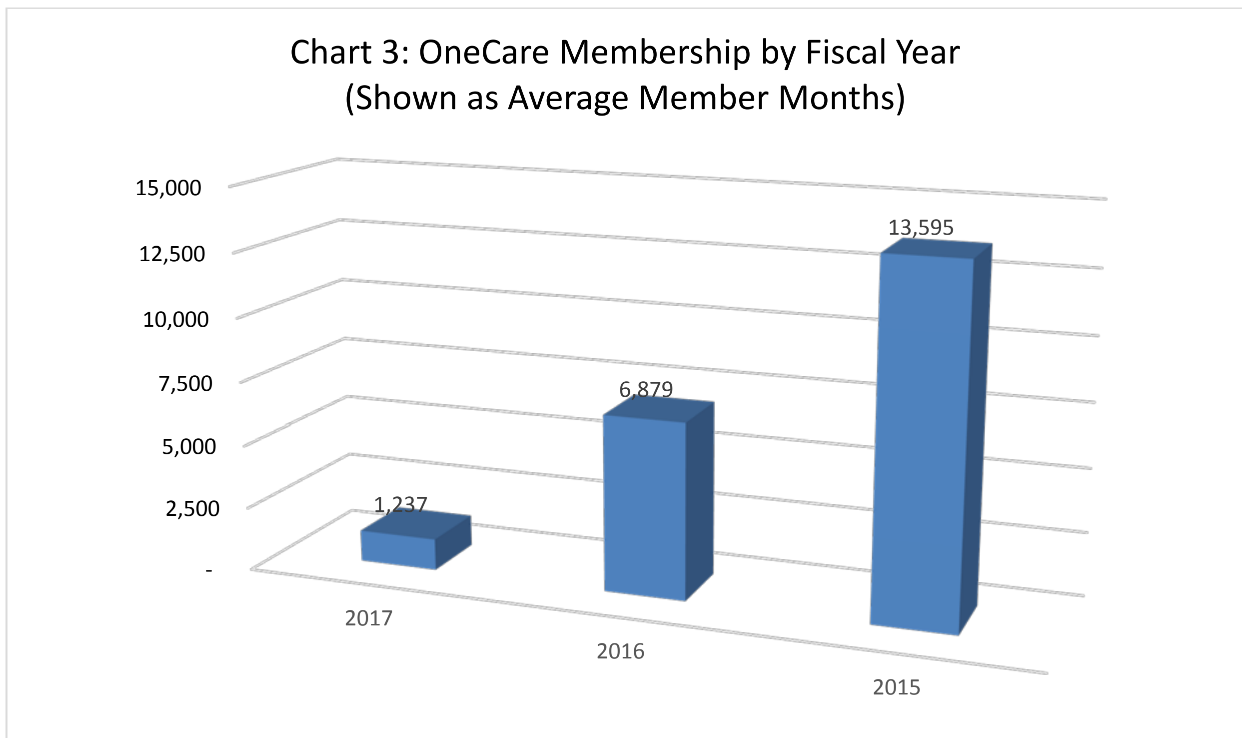
Disabled and Aged includes individuals who have met the criteria for disability set by the Social Security Administration, and individuals of 65 years of age and older who receive supplemental security income (SSI) checks, or are medically needy, or have an income of 100 percent or less of the federal poverty level.

LTC includes frail elderly, nonelderly adults with disabilities and children with developmental disabilities and other disabling conditions requiring long-term care services.

Medi-Cal Expansion program (MCX and MSI) includes adults without children, ages 19-64, qualified based upon income, as required by the Patient Protection and Affordable Care Act (ACA).

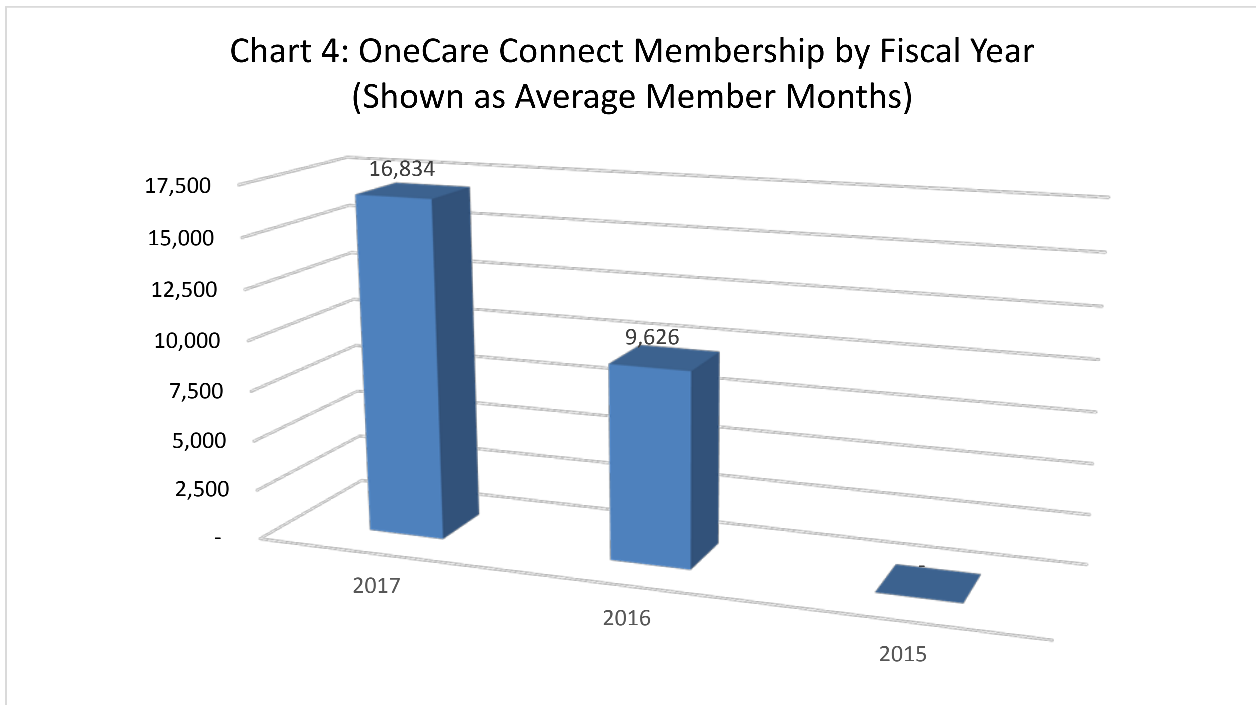
2017, 2016 and 2015 Enrollment (continued)

OneCare was introduced in fiscal year 2006 to service the unique Medicare Advantage Special Needs Plan. It provides a full range of health care services to average member months of 1,237, 6,879, and 13,595 for the years ended June 30, 2017, 2016, and 2015, respectively. Members are eligible for both the Medicare and Medi-Cal programs. The membership decrease in 2017 was primarily due to more than 10,000 OneCare members transitioning to CalOptima's OneCare Connect. The chart below displays the average member months for the past three years.



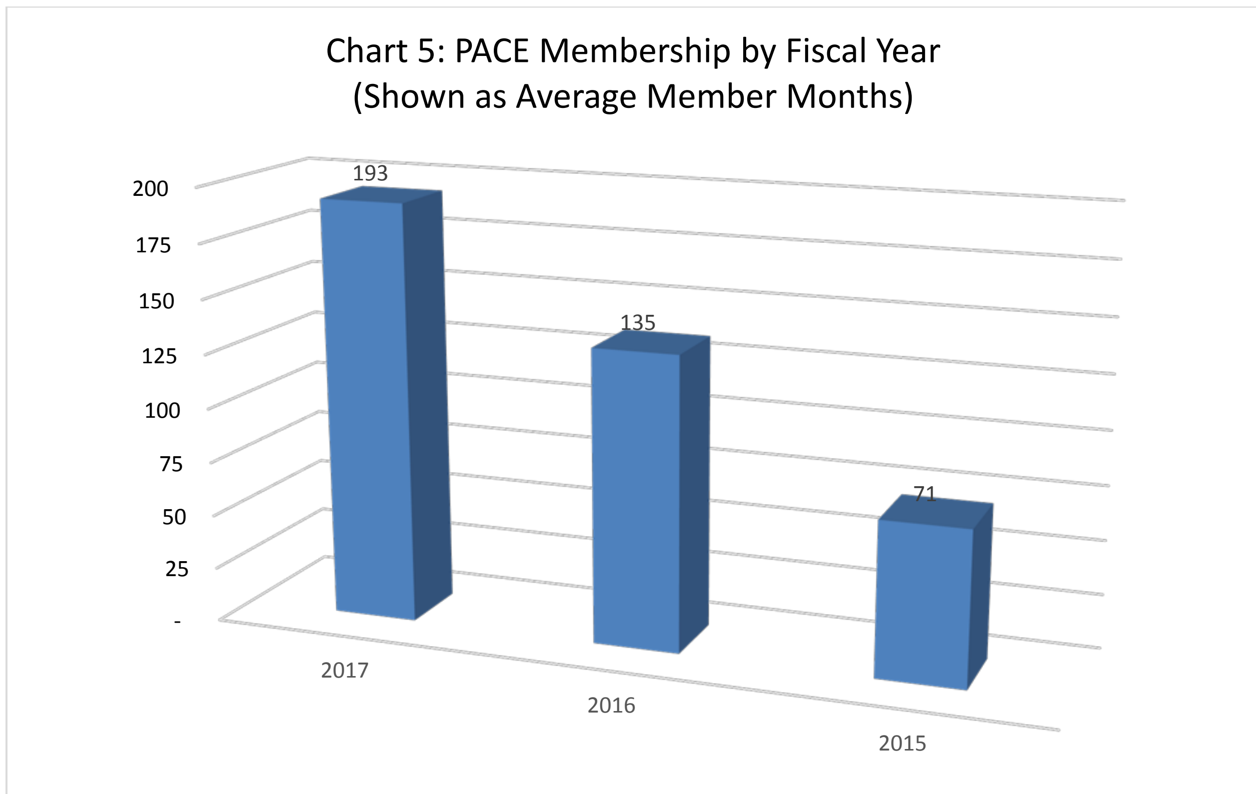
2017, 2016 and 2015 Enrollment (continued)

CalOptima launched OneCare Connect (OCC) program to serve dual eligible members in Orange County on July 1, 2015. This new program combines members' Medicare and Medi-Cal coverage and adds other benefits and supports. Average member months were 16,834 in fiscal year 2017. The chart below displays the average member months for the past three years.



2017, 2016 and 2015 Enrollment (continued)

PACE (Program of All-Inclusive Care for the Elderly) started operation in October 2013. It is a community-based Medicare and Medi-Cal program that provides coordinated and integrated health care services to frail elders to help them continue living independently in the community. It provides a full range of health care services to average member months of 193, 135, and 71 for the years ended June 30, 2017, 2016, and 2015, respectively. The chart below displays the average member months for the past three years.



Economic Factors and the State's Fiscal Year 2017 Budget

On June 27, 2017, Governor Jerry Brown signed the Fiscal Year (FY) 2017-18 budget. The budget is consistent with his overall focus for a balanced state budget while addressing his key priorities: pay down debts and liabilities, make infrastructure improvements, invest in education, fund the earned income tax credit and provide Medi-Cal coverage for millions of Californians.

General Fund spending in the budget package is $125.1 billion, an increase of $3.7 billion or 3% from the revised FY 2016-17 budget. The budget includes $19.5 billion in General Fund spending for the Medi-Cal program, representing a $577 million or 3% increase compared to last fiscal year. Major Medi-Cal policies adopted in the budget include: an allocation of $1.3 billion in Proposition 56 tobacco tax revenue to Medi-Cal to fund increases to provider payments and anticipated program growth, the restoration of full adult dental benefits effective January 1, 2018, the removal of the In-Home Supportive Services as a Medi-Cal managed care benefit and the continuation of the Cal Medi-Connect Program for two additional years.

The budget projects $125.9 billion in General Fund revenues and transfers in FY 2017-18, an increase of $7.3 million or 6% compared to last fiscal year. The three largest General Fund taxes (i.e., personal income tax, sales and use tax, corporation tax) are projected to increase by 5%. The state is projected to end FY 2017-18 with $9.9 billion in total reserves.

Patient protection and affordable care act

In March 2010, the President signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Healthcare Reform Legislation), which considerably transforms the U.S. health-care system and increases regulations within the U.S. health insurance industry. This legislation is intended to expand the availability of health insurance coverage to millions of Americans. The Healthcare Reform Legislation contains provisions that take effect from 2010 through 2018, with most measures effective in 2015. Under the Healthcare Reform Legislation, Medi-Cal coverage expanded as of January 2015 for low-income families, children, pregnant women, seniors, and persons with disabilities. For the years ended June 30, 2017 and 2016, CalOptima served an average of 231,000 and 199,000 Medi-Cal Expansion members per month, with increased revenues by approximately $88,812,000 and $100,431,000, respectively.

DHCS medical review (February 2014) – DHCS conducted a Focused Medical Review of CalOptima's Medi-Cal program in February 2014. The corrective actions from the DHCS report were received in March 2014 and were consistent with the corrective actions that were identified by CMS.

DHCS listed its findings and recommendations in seven areas: Utilizations Management, Prior Authorization Procedures, Referral Tracking System, Delegation of Utilization Management, Pharmaceutical Services, Grievances and Appeals, and Antifraud and Abuse Program.

During the year ended June 30, 2016, CalOptima had passed the audit from CMS and the medical review from DHCS. CMS sanction had been lifted during the year ended June 30, 2016.

Requests for Information

This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of CalOptima's operations. If the reader has questions or would like additional information about CalOptima Foundation, please direct the requests to CalOptima, 505 City Parkway West, Orange, CA 92868 or call 714.347.3237.

MOSSADAMS

Report of Independent Auditors

The Board of Directors
Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Report on Financial Statements

We have audited the accompanying consolidated financial statements of Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") (a discrete component unit of the County of Orange, California), as of and for the years ended June 30, 2017 and 2016, and the related notes to the consolidated financial statements, which collectively comprise CalOptima's basic consolidated financial statements, as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these consolidated financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the consolidated financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the consolidated financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the consolidated financial statements.

We believe that the audit evidence obtained is sufficient and appropriate to provide a basis for our audit opinion.

Back to Agenda

Opinion

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of CalOptima as of June 30, 2017 and 2016, and the results of its operations and its cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the management's discussion and analysis, schedules of changes in net pension liability and related ratios, schedule of plan contributions, and schedule of funding progress for the postemployment health-care plan, as listed in the table of contents, be presented to supplement the basic consolidated financial statements. Such information, although not a part of the basic consolidated financial statements, is required by the Governmental Accounting Standards Board, which considers it to be an essential part of financial reporting for placing the basic consolidated financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods or preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic consolidated financial statements, and other knowledge we obtained during our audit of the basic consolidated financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated October 5, 2017 on our consideration of the CalOptima's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering CalOptima's internal control over financial reporting and compliance.

Moss Adams LLP

Irvine, California
October 5, 2017

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Consolidated Statements of Net Position

	JUNE 30, 2017	JUNE 30, 2016
Current Assets		
Cash and cash equivalents	$ 510,062,983	$ 258,888,726
Investments	1,082,425,753	1,019,222,143
Premiums receivable from the State of California	522,793,705	470,263,571
Prepaid expenses and other	26,384,678	23,296,446
Total current assets	2,141,667,119	1,771,670,886
Board-Designated Assets and Restricted Cash		
Cash and cash equivalents	17,709,682	10,144,102
Investments	517,428,691	465,701,798
Restricted deposit	300,000	300,000
	535,438,373	476,145,900
Capital Assets, net	54,301,035	54,995,566
Total assets	2,731,406,527	2,302,812,352
Deferred Outflows of Resources	11,577,140	5,003,017
Total assets and deferred outflows of resources	$ 2,742,983,667	$ 2,307,815,369

See accompanying notes.

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Consolidated Statements of Net Position (Continued)

	JUNE 30, 2017	JUNE 30, 2016
Current Liabilities		
Medical claims liability and capitation payable		
Medical claims liability	$ 1,074,345,956	$ 800,095,760
Provider capitation and withholds	580,839,710	401,826,300
Accrued insurance costs	5,681,300	4,884,800
Payable to State of California and the Centers for Medicare and Medicaid Services (CMS)	198,204,767	181,769,823
Unearned revenue	102,298,450	198,309,455
	1,961,370,183	1,586,886,138
Accounts payable and other	9,823,907	10,606,638
Accrued payroll and employee benefits and other	10,101,233	11,837,190
Total current liabilities	1,981,295,323	1,609,329,966
Postemployment health-care plan	28,586,000	27,327,000
Net pension liability	15,430,763	6,536,809
Total Liabilities	2,025,312,086	1,643,193,775
Deferred Inflows of Resources	1,340,010	2,154,540
Net position		
Net investment in capital assets, net of related debt	54,103,912	54,995,566
Restricted - required tangible net equity and restricted deposit	98,445,479	89,283,747
Unrestricted	563,782,180	518,187,741
Total net position	716,331,571 -	662,467,054
Total liabilities, deferred inflows of resources and net position	$ 2,742,983,667	$ 2,307,815,369

See accompanying notes.

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Consolidated Statements of Revenues, Expenses and Change in Net Position

	YEARS ENDED JUNE 30,	
	2017	2016
REVENUES:		
Premium revenues	$ 3,549,461,873	$ 3,148,260,022
Other income	27,164	304,591
Total operating revenues	3,549,489,037	3,148,564,613
OPERATING EXPENSES:		
Medical expenses		
Provider capitation	984,439,058	935,360,536
Claims expense to providers and facilities	1,567,941,100	1,349,950,877
Prescription drugs	425,136,805	391,480,137
OneCare	16,424,252	86,724,744
OneCare Connect	355,096,108	205,122,734
Other medical	50,575,067	53,779,018
Total medical expenses	3,399,612,390	3,022,418,046
Administrative expenses		
Salaries, wages and employee benefits	71,882,654	64,666,948
Professional fees	1,241,416	4,368,357
Purchased services	11,278,918	10,032,627
Supplies, occupancy, insurance and other	22,788,692	24,972,237
Depreciation	6,544,639	3,142,262
Total administrative expenses	113,736,319	107,182,431
Total operating expenses	3,513,348,709	3,129,600,477
OPERATING INCOME	36,140,328	18,964,136
NON-OPERATING REVENUES (EXPENSES):		
Investment income	15,766,423	13,880,954
Rental income, net of related expenses	1,957,766	(332,490)
Total non-operating revenues and expenses	17,724,189	13,548,464
Increase in net position	53,864,517	32,512,600
Net position, beginning of year	662,467,054	629,954,454
Net position, end of year	$ 716,331,571	$ 662,467,054

See accompanying notes.

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Consolidated Statements of Cash Flows

	2017	2016
CASH FLOWS FROM OPERATING ACTIVITIES		
Capitation payments received and other	$ 3,417,382,842	$ 3,407,332,160
Payment to providers and facilities	(2,945,552,284)	(2,792,070,397)
Payments to vendors	(39,179,989)	(41,899,573)
Payments to employees	(70,854,310)	(59,538,135)
Net cash provided by operating activities	361,796,259	513,824,055
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchases of capital assets	(5,850,108)	(4,788,437)
Net cash used in capital and related financing activities	(5,850,108)	(4,788,437)
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment income received	11,823,120	10,003,777
Purchases of securities	(644,508,177)	(435,645,219)
Sales of securities	527,913,163	150,063,575
Net cash used in investing activi ies	(104,771,894)	(275,577,867)
Net increase in cash and cash equivalents	251,174,257	233,457,751
CASH AND CASH EQUIVALENTS, beginning of year	258,888,726	25,430,975
CASH AND CASH EQUIVALENTS, end of year	$ 510,062,983	$ 258,888,726
RECONCILIATION OF OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Operating income	$ 36,140,328	$ 18,964,136
ADJUSTMENT TO RECONCILE OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Depreciation	6,544,639	3,142,262
Changes in assets and liabilities		
Capita ion receivable from the State of California	(52,530,134)	88,846,559
Prepaid expenses and other assets	(3,088,232)	(2,885,883)
Medical claims liability	274,250,196	159,174,641
Payable to the State of California and CMS	16,434,944	164,064,697
Unearned revenue	(96,011,005)	(9,636,709)
Capita ion and withholds	179,013,410	111,193,389
Accounts payable and other	(782,731)	359,531
Accrued payroll and employee benefits and other	(1,735,957)	2,605,109
Accrued insurance costs	796,500	(24,527,381)
Postemployment health-care plan	1,259,000	524,508
Net pension obligation	1,505,301	1,999,196
Net cash provided by operating activities	$ 361,796,259	$ 513,824,055
SUPPLEMENTAL SCHEDULE OF NON-CASH OPERATING AND INVESTING ACTIVITIES		
Change in unrealized appreciation on investments	$ (1,252,325)	$ 3,007,940

See accompanying notes.

Back to Agenda

Note 1 – Organization

Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") is a county-organized health system ("COHS") serving primarily Medi-Cal beneficiaries in Orange County, California. Pursuant to the California Welfare and Institutions Code, CalOptima was formed by the Orange County Board of Supervisors as a public/private partnership through the adoption of Ordinance NO. 3896 in August 1992. The agency began operations in October 1995.

As a COHS, CalOptima maintains an exclusive contract with the State of California Department of Health Care Services ("DHCS") to arrange for the provision of health-care services to Orange County's approximately 772,000 and 777,000 Medi-Cal beneficiaries for the years ended June 30, 2017 and 2016, respectively. CalOptima also offers OneCare, a Medicare Advantage Special Needs Plan, via a contract with the Centers for Medicare, and Medicaid Services ("CMS"). In January 2016, CalOptima began transferring subscribers from OneCare to the OneCare Connect Cal MediConnect Plan. OneCare serves approximately 1,100 and 1,000 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2017 and 2016, respectively. In January 2016, CalOptima began offering OneCare Connect Cal MediConnect Plan ("OCC"), a Medicare-Medicaid Plan, via a contract with CMS. OCC serves approximately 16,000 and 29,000 members eligible for both Medicare and Medi-Cal for the years ended June 30, 2017 and 2016, respectively. CalOptima also contracts with the California Department of Aging to provide case management of social and health-care services to approximately 200 Medi-Cal eligible seniors under California's Multipurpose Senior Services program. The Program of All-inclusive Care for the Elderly ("PACE") provides services to 55 years of age or older members who reside in the PACE service area and meet California nursing facility level of care requirements. The program receives Medicare and Medi-Cal funding.

CalOptima in turn subcontracts the delivery of health-care services through health maintenance organizations and provider-sponsored organizations, known as Physician/Hospital Consortia, and Shared Risk Groups. Additionally, CalOptima has direct contracts with hospitals and providers for its fee-for service network.

CalOptima is licensed by the State of California as a Health Care Service Plan pursuant to the Knox-Keene Health Care Services Act of 1975 (the "Act"), as amended. As such, CalOptima is subject to the regulatory requirements of the Department of Managed Health Care under Section 1300, Title 28 of the California Administrative Code, including minimum requirements of Tangible Net Equity, which CalOptima exceeded as of June 30, 2017 and 2016.

CalOptima Foundation (the "Foundation") was formed as a not-for-profit benefit corporation in 2010 and is dedicated to the betterment of public health-care services in Orange County.

Note 2 – Summary of Significant Accounting Policies

Basis of presentation – CalOptima is a county-organized health system governed by an 11-member Board of Directors appointed by the Orange County Board of Supervisors. The CalOptima Board of Directors also serves as the Board of Directors of the Foundation. Effective for the fiscal year ended June 30, 2014, CalOptima began reporting as a discrete component unit of the County of Orange, California. The County made this determination based on the County Board of Supervisors having the right to elect 100 percent of the CalOptima Board of Directors.

Principle of consolidation – The consolidated financial statements include the accounts of CalOptima and the Foundation (collectively referred to herein as the "Organization").

Basis of accounting – CalOptima uses enterprise fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. The accompanying consolidated financial statements have been prepared in accordance with the standards of the Governmental Accounting Standards Board ("GASB").

Use of estimates – The preparation of the consolidated financial statements in accordance with accounting principles generally accepted in the United States of America requires management to make estimates and assumptions that affect the amounts reported in the consolidated financial statements and accompanying notes. Actual results could differ from those estimates.

Cash and cash equivalents – The Organization considers all highly liquid investments with original maturities of three months or less to be cash and cash equivalents.

Investments – Investments are stated at fair value in accordance with GASB Codification Section 150. The fair value of investments is estimated based on quoted market prices, when available. For debt securities not actively traded, fair values are estimated using values obtained from external pricing services or are estimated by discounting the expected future cash flows, using current market rates applicable to the coupon rate, credit and maturity of the investments.

All investments with an original maturity of one year or less when purchased are recorded as current investments, unless designated or restricted.

Board-designated assets and restricted cash – CalOptima's Board of Directors designated the establishment of certain reserve funds for contingencies. According to CalOptima's policy, the desired level for these funds is between 1.4 months and 2 months of premium revenues. CalOptima is required to maintain a $300,000 restricted deposit as a part of the Knox-Keene Health Care Service Plan Act of 1975 (see Note 9).

Note 2 – Summary of Significant Accounting Policies (continued)

Capital assets – Capital assets are stated at cost at the date of acquisition. The costs of normal maintenance, repairs and minor replacements are charged to expense when incurred.

Depreciation is calculated using the straight-line method over the estimated useful lives of the assets. Long-lived assets are periodically reviewed for impairment. The following estimated useful lives are used:

	Years
Furniture	5 years
Vehicles	5 years
Computers and software	3 years
Leasehold improvements	15 years or life of lease, whichever is less
Building	40 years
Building components	10 to 30 years
Land improvements	8 to 25 years
Tenant improvements	7 years or life of lease, whichever is less

Fair value of financial instruments – The consolidated financial statements include financial instruments for which the fair market value may differ from amounts reflected on a historical basis. Financial instruments of the Organization consist of cash deposits, investments, premium receivable, accounts payable, and certain accrued liabilities. The Organization's other financial instruments generally approximate fair market value based on the relatively short period of time between origination of the instruments and their expected realization.

Medical claims liability and expenses – CalOptima establishes a claims liability based on estimates of the ultimate cost of claims in process and a provision for incurred but not yet reported ("IBNR") claims, which is actuarially determined based on historical claim payment experience and other statistics. Such estimates are continually monitored and analyzed with any adjustments made as necessary in the period the adjustment is determined. CalOptima retains an outside actuary to perform an annual review of the actuarial projections. Amounts for claims payment incurred related to prior years vary from previously estimated liabilities as the claims ultimately are settled.

Note 2 – Summary of Significant Accounting Policies (continued)

Provider capitation and withholds – CalOptima has provider services agreements with several health networks in Orange County, whereby the health networks provide care directly to covered members or through subcontracts with other health-care providers. Payment for the services provided by the health networks is on a fully capitated basis. The capitation amount is based on contractually agreed-upon terms with each health network. CalOptima withholds amounts from providers at an agreed upon percentage of capitation payments made to ensure the financial solvency of each contract. CalOptima also records a liability related to quality incentive payments and risk-share provisions. The quality incentive liability is estimated based on member months and rates agreed upon by the Board of Directors. For the risk-share provision liability, management allocates surplus or deficits, multiplied by a contractual rate, with the shared-risk groups. Estimated amounts due to health networks pertaining to risk-share provisions are approximately $532,665,000 and $359,800,000 as of June 30, 2017 and 2016, respectively. During the years ended June 30, 2017 and 2016, CalOptima incurred approximately $1,096,426,000 and $973,118,000, respectively, of capitation expense relating to health-care services provided by health networks. The Capitation expense is included in the provider capitation and OneCare line items in the consolidated statements of revenues, expenses and changes in net position. Estimated amounts due to health networks as of June 30, 2017 and 2016, related to the capitation withhold arrangements, quality incentive payments, and risk-share provisions are approximately $580,840,000 and $401,826,000, respectively.

Premium deficiency reserves – CalOptima performs periodic analyses of its expected future health care costs and maintenance costs to determine whether such costs will exceed anticipated future revenues under its contracts. Should expected costs exceed anticipated revenues, a premium deficiency reserve is accrued. Investment income is not included in the calculation to estimate premium deficiency reserves. CalOptima's management determined that no premium deficiency reserves were necessary as of June 30, 2017 and 2016.

Accrued compensated absences – CalOptima's policy permits employees who are regularly scheduled to work more than 20 hours per week to accrue 18 days of paid time off (PTO) (23 days for exempt employees) based on their years of continuous service, with an additional week of accrual after three years of service and another after 10 years of service. Unused PTO may be carried over into subsequent years, not to exceed two and a half times the annual accrual. If an employee reaches his/her PTO maximum accrual, a portion of the accrued PTO equal to half of the employees' annual PTO accruals will be automatically paid out to the employees. Accumulated PTO will be paid to the employees upon separation from service with CalOptima. All compensated absences are accrued and recorded in accordance with GASB Codification Section C60, and are included in accrued payroll and employee benefits.

Note 2 – Summary of Significant Accounting Policies (continued)

Net position – Net position is reported in three categories, defined as follows:

- **Net investment in capital assets** – This component of net position consists of capital assets, including restricted capital assets, net of accumulated depreciation, and is reduced by the outstanding balances of any bonds, notes or other borrowings that are attributable (if any) to the acquisition, construction or improvement of those assets.

- **Restricted** – This component of net position consists of external constraints placed on net asset use by creditors (such as through debt covenants), grantors, contributors, or the law or regulations of other governments. It also pertains to constraints imposed by law or constitutional provisions or enabling legislation (see also Note 9).

- **Unrestricted** – This component of net position consists of net position that does not meet the definition of "restricted" or "net investment in capital assets, net of related debt."

Operating revenues and expenses – CalOptima's consolidated statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with arranging for the provision of health-care services. Operating expenses are all expenses incurred to arrange for the provision of health-care services as well as the costs of administration. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in operating expenses. Non-exchange revenues and expenses are reported as nonoperating revenues and expenses.

Revenue recognition and receivable from the State of California and CMS – Premium revenue is recognized in the period the members are eligible to receive healthcare services. Premium revenue is generally received from the State of California (the "State") each month following the month of coverage based on estimated enrollment and capitation rates as provided for in the State contract. As such, premium revenue includes an estimate for amounts receivable from or refundable to the State for these retrospective adjustments. These estimates are continually monitored and analyzed, with any adjustments recognized in the period when determined. OneCare premium revenue is generally received from CMS each month for the month of coverage. Premiums received in advance are recorded in unearned revenue on the consolidated statements of net position. CalOptima recognized an increase to premium revenue in the amount of approximately $164,025,000 and a decrease of approximately $1,000,000 related to retroactive capitation rate adjustments during the years ended June 30, 2017 and 2016, respectively.

Note 2 – Summary of Significant Accounting Policies (continued)

Effective with the enrollment of the Medi-Cal Expansion Population per the Affordable Care Act ("ACA") CalOptima is subject to DHCS requirements to meet the minimum 85% medical loss ratio (MLR) for this population. Specifically, CalOptima will be required to expend at least 85% of the Medi-Cal premium revenue received for this population on allowable medical expenses as defined by DHCS. In the event CalOptima expends less than the 85% requirement, CalOptima will be required to return to DHCS the difference between the minimum threshold and the actual allowed medical expenses. During 2017, CalOptima expended more than 85% of the Medi-Cal premium revenue, therefore no reserve was recorded for the period ending June 30, 2017. Approximately $15,493,000 for the year ended June 30, 2016, was recorded as a reduction to the premium revenues in the consolidated statements of revenues, expenses, and changes in net position to meet the 85% requirement. As of June 30, 2017 and 2016, approximately $164,875,000 was accrued. This liability is presented in the Payable to State of California line item in the accompanying consolidated statements of net position.

Premium revenue and related net receivables as a percent of the totals were as follows:

	Years Ended June 30,			
	2017		2016	
Revenue	Revenue	%	Revenue	%
Medi-Cal	$ 3,143,998,722	88.6%	$ 2,829,513,864	89.9%
OneCare	18,615,729	0.5%	104,201,695	3.3%
OneCare Connect	371,630,947	10.5%	220,185,400	7.0%
PACE	15,216,475	0.4%	9,852,063	0.3%
MLR Reduction	-	0.0%	(15,493,000)	-0.5%
	$ 3,549,461,873	100.0%	$ 3,148,260,022	100.0%

	As of June 30,			
	2017		2016	
Receivables	Receivables	%	Receivables	%
Medi-Cal	$ 506,599,613	96.9%	$ 447,869,626	95.2%
OneCare	28,106	0.0%	-	0.0%
OneCare Connect	12,630,469	2.4%	21,241,317	4.5%
PACE	3,535,517	0.7%	1,152,628	0.3%
	$ 522,793,705	100.0%	$ 470,263,571	100.0%

Administrative services contract – CalOptima previously contracted with a specialty managed mental health-care organization to arrange, coordinate and manage mental health outpatient services for its Mental Health Program. Revenue was recognized based on contractual terms, which could not exceed a prescribed budgeted administrative rate. The contract ended June 30, 2016. Revenue of approximately $4,984,000 is included in other income during the year ended June 30, 2016.

Back to Agenda

Note 2 – Summary of Significant Accounting Policies (continued)

Intergovernmental transfer – CalOptima entered into an agreement with DHCS and the University of California, Irvine ("UCI") to receive an intergovernmental transfer ("IGT") through a capitation rate increase of approximately $71,309,000 and $30,457,000 during the years ended June 30, 2017 and 2016, respectively. Under the agreement, approximately $56,891,000 and $23,500,000 of the funds that were received from the IGT were passed through to UCI during the years ended June 30, 2017 and 2016, respectively. Under GASB, the amounts that will be passed through to UCI are not reported in the consolidated statements of revenues, expenses, and changes in net position or the consolidated statements of net position. CalOptima accounts for the IGT transfer for CalOptima purposes as an exchange transaction requiring funds to be expended prior to revenue recognition. The funds were not yet expended for the required purpose during the years ended June 30, 2017 or 2015 as the revenue recognition criteria had not been met. CalOptima retains a portion of the IGT, which must be used to enhance provider reimbursement rates and strengthen the delivery system. A retainer in the amount of approximately $14,418,000 and $6,996,000 as of June 30, 2017 and 2016, respectively, is included in unearned revenues in the consolidated statements of net position.

Medicare Part D – CalOptima covers prescription drug benefits in accordance with Medicare Part D under multiple contracts with CMS. The payments CalOptima receives monthly from CMS and members, which are determined from its annual bid, represent amounts for providing prescription drug insurance coverage. CalOptima recognizes premiums for providing this insurance coverage ratably over the term of its annual contract. CalOptima's CMS payment is subject to risk sharing through the Medicare Part D risk corridor provisions. In addition, receipts for reinsurance and low-income cost subsidies, as well as receipts for certain discounts on brand name prescription drugs in the coverage gap represent payments for prescription drug costs for which CalOptima is not at risk.

The risk corridor provisions compare costs targeted in CalOptima's bids to actual prescription drug costs, limited to actual costs that would have been incurred under the standard coverage as defined by CMS. Variances exceeding certain thresholds may result in CMS making additional payments to CalOptima or require CalOptima to refund to CMS a portion of the premiums CalOptima received. CalOptima estimates and recognizes an adjustment to premiums revenue related to these risk corridor provisions based upon pharmacy claims experience to date as if the annual contract were to terminate at the end of the reporting period. Accordingly, this estimate provides no consideration to future pharmacy claims experience. CalOptima records a receivable or payable at the contract level and classifies the amount as current or long-term in the accompanying consolidated statements of net position based on the timing of expected settlement.

Grant revenue recognition – The Foundation recognized approximately $80,800 and $653,300 in grant revenues during the years ended June 30, 2017 and 2016, respectively. Grant revenue is recognized when all eligibility requirements are met, and is included in other income in the consolidated statements of revenues, expenses, and changes in net position.

Note 2 – Summary of Significant Accounting Policies (continued)

Income taxes – CalOptima operates under the purview of the Internal Revenue Code, Section 501(a), and corresponding California Revenue and Taxation Code provisions. As such, CalOptima is not subject to federal or state taxes on related income. The Foundation is operated as a tax-exempt organization under Section 501(c)(3) of the federal Internal Revenue Code and applicable sections of the California statutes. Accordingly, no provision for income tax has been recorded in the accompanying consolidated financial statements.

Premium taxes – California passed Senate Bill 78 *Public health: Medi-Cal managed care plan taxes* (SB 78) pursuant of Section 1 Article V of the Revenue and Taxation Code. Effective July 1, 2013, SB 78 levies a tax on all sellers of Medi-Cal managed care plans for the privilege of selling Medi-Cal health care services at retail at a rate of 3.94 percent of gross receipts. CalOptima recognized sales tax expense of $113,654,000 in the consolidated statements of revenue, expenses, and change in net position for the year ended June 30, 2016. Effective July 1, 2016, sales tax under SB 78 is no longer imposed.

Effective July 1, 2016, Senate Bill X2-2 (SB X2-2) *Managed Care Organization Tax* authorized Department of Health Care Services (DHCS) to implement a Managed Care Organization provider tax subject to approval by the federal Centers for Medicare and Medicaid Services. This approved tax structure is based on enrollment (total member months) between specified tiers that are assessed different tax rates. Using the approved structure, each MCO's total tax liability for year ended June 30, 2017 was calculated. CalOptima recognized premium tax expense of $137,975,000 in the consolidated statements of revenue, expenses, and change in net position for the year ended June 30, 2017.

Pensions – For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions, and pension expense, information about the fiduciary net position of CalOptima's California Public Employees' Retirement System Plan (the "CalPERS Plan") and additions to/deductions from the Plan's fiduciary net position have been determined on the same basis as they are reported by CalPERS. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Reclassifications – Certain accounts in the prior-year financial statements have been reclassified for comparative purposes to conform with the presentation in the current-year financial statements.

Recent accounting pronouncements – In February 2015, GASB issued Statement No. 72, *Fair Value Measurement and Application,* ("GASB No. 72") which is effective for periods beginning after June 15, 2015. GASB No. 72 addresses accounting and financial reporting issues related to fair value measurements. GASB No. 72 provides guidance for determining a fair value measurement for financial reporting purposes as well as guidance for applying fair value to certain investments and disclosures related to all fair value measurements. The Organization has adopted GASB No. 72 effective July 1, 2015.

Note 2 – Summary of Significant Accounting Policies (continued)

In June 2015, the GASB issued Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions* ("GASB No. 75"). The primary objective of this Statement is to improve accounting and financial reporting by state and local governments for postemployment benefits other than pensions (other postemployment benefits or OPEB). It also improves information provided by state and local governmental employers about financial support for OPEB that is provided by other entities. This Statement results from a comprehensive review of the effectiveness of existing standards of accounting and financial reporting for all postemployment benefits (pensions and OPEB) with regard to providing decision-useful information, supporting assessments of accountability and interperiod equity, and creating additional transparency. The Organization is evaluating the impact of adopting this standard on the consolidated financial statements.

In June 2015, GASB also issued Statement No. 76, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments* ("GASB No. 76"), which is effective for periods beginning after June 15, 2015. The objective of GASB No. 76 is to identify the hierarchy of generally accepted accounting principles ("GAAP") in the context of the current governmental financial reporting environment. The Statement reduces GAAP hierarchy to two categories of authoritative GAAP and addresses the use of authoritative and non-authoritative literature in the event that the accounting treatment for a transaction or other event is not specific within a source of authoritative GAAP. The Organization has adopted GASB No. 76 effective July 1, 2015.

In December 2015, the GASB issued Statement No. 79, *Certain External Investment Pools and Pool Participants* ("GASB No. 79"). This Statement addresses accounting and financial reporting for certain external investment pools and pool participants. Specifically, it establishes criteria for an external investment pool to qualify for making the election to measure all of its investments at amortized cost for financial reporting purposes. An external investment pool qualifies for that reporting if it meets all of the applicable criteria established in this Statement. The specific criteria address (1) how the external investment pool transacts with participants; (2) requirements for portfolio maturity, quality, diversification, and liquidity; and (3) calculation and requirements of a shadow price. Significant noncompliance prevents the external investment pool from measuring all of its investments at amortized cost for financial reporting purposes. Professional judgment is required to determine if instances of noncompliance with the criteria established by this Statement during the reporting period, individually or in the aggregate, were significant. The Organization has adopted GASB No. 79 effective July 1, 2015.

Note 3 – Cash and Investments

The Organization categorizes its fair value investments within the fair value hierarchy established by GAAP. The hierarchy for fair value measurements is based upon the transparency of inputs to the valuation of an asset or liability as of the measurement date.

Level 1 Quoted prices in active markets for identical assets or liabilities

Level 2 Inputs other than quoted prices included within Level 1 that are observable for an asset or liability, either directly or indirectly

Level 3 Significant unobservable inputs

The following is a description of the valuation methodologies used for instruments at fair value on a recurring basis and recognized in the accompanying consolidated statements of net position, as well as the general classification of such instruments pursuant to the valuation hierarchy.

Marketable securities – Where quoted market prices are available in an active market, securities are classified within Level 1 of the valuation hierarchy. If quoted market prices are not available, then fair values are estimated by using pricing models, quoted prices of securities with similar characteristics, or discounted cash flows. These securities are classified within Level 2 of the valuation hierarchy. In certain cases where Level 1 or Level 2 inputs are not available, securities are classified within Level 3 of the hierarchy.

Note 3 – Cash and Investments (continued)

The following table presents the fair value measurements of assets recognized in the accompanying consolidated statements of net position measured at fair value on a recurring basis and the level within the fair value hierarchy in which the fair value measurements fall:

	Investment Assets at Fair Value as of June 30, 2017			
	Level 1	Level 2	Level 3	Total
U.S. treasury notes	$ 540,798,261	$ -	$ -	$ 540,798,261
Government	-	109,063,165	-	109,063,165
U.S. agencies	-	119,391,299	-	119,391,299
Asset-backed securities	-	97,004,215	-	97,004,215
Corporate bonds	-	451,582,267	-	451,582,267
Mortgage-backed securities	-	84,380,043	-	84,380,043
Municipal bonds	-	88,409,606	-	88,409,606
Certificates of deposit	-	55,580,933	-	55,580,933
Commercial paper	-	47,777,235	-	47,777,235
	$ 540,798,261	$ 1,053,188,763	$ -	$ 1,593,987,024

	Investment Assets at Fair Value as of June 30, 2016			
	Level 1	Level 2	Level 3	Total
U.S. treasury notes	$ 615,829,030	$ -	$ -	$ 615,829,030
Money market funds	-	34,971,635	-	34,971,635
Government	-	72,625,568	-	72,625,568
U.S. agencies	-	202,911,440	-	202,911,440
Asset-backed securities	-	115,567,448	-	115,567,448
Corporate bonds	-	332,854,276	-	332,854,276
Mortgage-backed securities	-	39,116,801	-	39,116,801
Municipal bonds	-	67,822,241	-	67,822,241
Tax exempt	-	70,000	-	70,000
	$ 615,829,030	$ 865,939,409	$ -	$ 1,481,768,439

Note 3 – Cash and Investments (continued)

Cash and investments are reported in the June 30 consolidated statements of net position as follows:

	June 30,	
	2017	2016
Current assets:		
Cash and cash equivalents	$ 510,062,983	$ 258,888,726
Investments	1,082,425,753	1,019,222,143
Board-designated assets and restricted cash:		
Cash and cash equivalents	17,709,682	10,144,102
Investments	517,428,691	465,701,798
Restricted deposit	300,000	300,000
	$ 2,127,927,109	$ 1,754,256,769

Custodial credit risk-deposits – Custodial credit risk is the risk that in the event of a bank failure the Organization may not be able to recover its deposits or collateral securities that are in the possession of an outside party. The California Government Code requires that a financial institution secure deposits made by public agencies by pledging securities in an undivided collateral pool held by a depository regulated under the state law. At June 30, 2017 and 2016, no deposits were exposed to custodial credit risk, as the Organization has pledged collateral to cover the amounts.

Investments – CalOptima invests in obligations of the U.S. Treasury, other U.S. government agencies and instrumentalities, state obligations, corporate securities, money market funds, and mortgage or asset-backed securities.

Note 3 – Cash and Investments (continued)

Interest rate risk – In accordance with its Annual Investment Policy ("investment policy"), CalOptima manages its exposure to decline in fair value from increasing interest rates by matching maturity dates to the extent possible with CalOptima's expected cash flow draws. Its investment policy limits maturities to five years, while also staggering maturities. CalOptima maintains a low-duration strategy, targeting a portfolio duration of three years or less, with the intent of reducing interest rate risk. Portfolios with low duration are less volatile because they are less sensitive to interest rate changes. As of June 30, 2017 and 2016, CalOptima's investments, including cash equivalents, had the following modified duration:

	June 30, 2017			
		Investment Maturities (In Years)		
Investment Type	Fair Value	Less Than 1	1-5	More Than 5
U.S. agencies	$ 119,391,299	$ 48,257,233	$ 71,134,066	$ -
Asset-backed securities	97,004,215	-	97,004,215	-
Corporate bonds	451,582,267	206,123,298	245,458,969	-
Government	109,063,165	86,287,057	22,776,108	-
Money market funds	-	-	-	-
Mortgage-backed securities	84,380,043	18,022,438	66,357,605	-
Municipal bonds	88,409,606	19,158,923	69,250,683	-
Tax exempt	-	-	-	-
U.S. treasury notes	540,798,261	239,393,915	301,404,346	-
Certificates of deposit	55,580,933	36,574,619	19,006,314	-
Commercial paper	47,777,235	47,777,235	-	-
Cash equivalents	427,030,649	427,030,649	-	-
Cash	38,188,358	38,188,358	-	-
		$ 1,166,813,725	$ 892,392,306	$ -
Accrued interest receivable	5,901,069			
	$ 2,065,107,100			

	June 30, 2016			
		Investment Maturities (In Years)		
Investment Type	Fair Value	Less Than 1	1-5	More Than 5
U.S. agencies	$ 202,911,440	$ 129,250,132	$ 73,661,308	$ -
Asset-backed securities	115,567,448	33,757,195	81,810,253	-
Corporate bonds	332,854,276	172,443,370	160,410,906	-
Government	80,201,578	63,092,333	17,109,245	-
Money market funds	49,203,358	49,203,358	-	-
Mortgage-backed securities	39,116,801	4,571,699	34,545,102	-
Municipal bonds	67,822,241	31,268,171	36,554,070	-
Tax exempt	70,000	70,000	-	-
U.S. treasury notes	594,021,297	427,506,736	166,514,561	-
Cash equivalents	206,178,840	162,945,771	43,233,069	-
Cash	2,434,995	2,434,995	-	-
		$ 1,076,543,760	$ 613,838,514	$ -
Accrued interest receivable	3,544,687			
	$ 1,693,926,961			

Note 3 – Cash and Investments (continued)

Investment with fair values highly sensitive to interest rate fluctuations – When interest rates fall, debt is refinanced and paid off early. The reduced stream of future interest payments diminishes the fair value of the investment. The mortgage-backed and asset-backed securities in the CalOptima portfolio are of high credit quality, with relatively short average lives that represent limited prepayment and interest rate exposure risk. CalOptima's investments include the following investments that are highly sensitive to interest rate and prepayment fluctuations to a greater degree than already indicated in the information provided above:

	June 30,	
	2017	2016
Asset-backed securities	$ 97,004,215	$ 115,567,448
Mortgage-backed securities	84,380,043	39,116,803
	$ 181,384,258	$ 154,684,251

Note 3 – Cash and Investments (continued)

Credit risk – CalOptima's investment policy conforms to the California Government Code as well as to customary standards of prudent investment management. Credit risk is mitigated by investing in only permitted investments. The investment policy sets minimum acceptable credit ratings for investments from the three nationally recognized rating services: Standard and Poor's Corporation ("S&P"), Moody's Investor Service ("Moody's") and Fitch Ratings ("Fitch"). For an issuer of short-term debt, the rating must be no less than A-1 ("S&P"), P-1 ("Moody's") or F-1 ("Fitch"), while an issuer of long-term debt shall be rated no less than an "A."

As of June 30, 2017, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt From Disclosure	Rating as of Year-End: AAA	Aa & Aa+	Aa-	A+	A/A-1	A-
U.S. Treasury notes	$ 556,751,675	N/A	$ 556,751,675	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	165,604,426	N/A	165,604,426	-	-	-	-	-	-
Corporate bonds	383,257,883	A-	-	13,708,720	31,590,024	30,992,688	104,003,338	135,217,263	67,745,850
FRN securities	144,908,196	A-	-	45,470,984	13,985,742	6,212,772	25,873,521	37,150,063	16,215,114
Asset-backed securities	125,246,607	AAA	-	97,063,263	15,854,777	9,441,408	-	2,887,159	-
Mortgage-backed securities	84,491,487	AAA	-	83,412,108	1,079,379	-	-	-	-
Municpal bonds	63,298,591	A	-	2,566,925	27,034,118	33,210,423	-	-	487,125
Supranational	79,184,258	AAA	-	79,184,258	-	-	-	-	-
Certificates of deposit	40,642,387	A1/P1	-	40,642,387	-	-	-	-	-
Commercial paper	92,223,209	A1/P1	-	92,223,209	-	-	-	-	-
Money market mutual funds	329,498,381	AAA	-	329,498,381	-	-	-	-	-
Total	$ 2,065,107,100		$ 722,356,101	$ 783,770,235	$ 89,544,040	$ 79,857,291	$ 129,876,859	$ 175,254,485	$ 84,448,089

As of June 30, 2016, following are the credit ratings of investments and cash equivalents:

Investment Type	Fair Value	Minimum Legal Rating	Exempt From Disclosure	Rating as of Year-End: AAA	Aa & Aa+	Aa-	A+	A/A-1	A-
U.S. Treasury notes	$ 616,851,820	N/A	$ 616,851,820	$ -	$ -	$ -	$ -	$ -	$ -
U.S. Agency notes	309,299,967	N/A	309,299,967	-	-	-	-	-	-
Corporate bonds	291,879,044	A-	-	6,770,725	20,108,792	33,512,510	81,895,966	100,120,087	49,470,964
FRN securities	109,240,846	A-	-	29,305,294	10,348,080	7,764,295	22,470,192	23,481,111	15,871,874
Asset-backed securities	124,658,150	AAA	-	87,932,577	15,578,743	15,523,429	1,836,149	3,787,252	-
Mortgage-backed securities	73,327,090	A	-	73,327,090	-	-	-	-	-
Municpal bonds	36,798,228	AAA	-	4,763,191	17,750,954	12,009,958	2,274,125	-	-
Supranational	27,322,075	AAA	-	27,322,075	-	-	-	-	-
Commercial paper	19,930,039	A1/P1	-	19,930,039	-	-	-	-	-
Money market mutual funds	84,619,702	AAA	-	84,619,702	-	-	-	-	-
Total	$ 1,693,926,961		$ 926,151,787	$ 333,970,693	$ 63,786,569	$ 68,810,192	$ 108,476,432	$ 127,388,450	$ 65,342,838

Note 3 – Cash and Investments (continued)

Concentration of credit risk – Concentration of credit risk is the risk of loss attributed to the magnitude of CalOptima's investment in a single issuer. CalOptima's investment policy limits to no more than 5 percent of the total fair value of investments in the securities of any one issuer, except for obligations of the U.S. government, U.S. government agencies or government-sponsored enterprises; and no more than 10 percent may be invested in one money market mutual fund unless approved by the governing board. The investment policy also places a limit of 35 percent of the amount of investment holdings with any one government-sponsored issuer and 5 percent of all other issuers. At June 30, 2017 and 2016, all holdings complied with the foregoing limitations. The following holdings exceeded 5 percent of the portfolio at June 30, 2017 and 2016:

		Percentage of Portfolio June 30,	
Investment Type	Issuer	2017	2016
U.S agency notes	Federal Home Loan Bank	2.05	5.28
U.S. Treasury notes	United States Treasury	26.09	35.14

Note 4 – Capital Assets

Capital assets activity during the year ended June 30, 2017 consisted of the following:

	June 30, 2016	Additions	Retirements	Transfers	June 30, 2017
Capital assets not being depreciated:					
Land	$ 5,876,002	$ -	$ -	$ -	$ 5,876,002
Construc ion in progress	6,256,236	5,850,106	-	(11,403,807)	702,535
	12,132,238	5,850,106	-	(11,403,807)	6,578,537
Capital assets being depreciated:					
Furniture and equipment	10,259,595	-	(3,905,109)	8,491,231	14,845,717
Computers and software	18,470,898	-	-	-	18,470,898
Land improvement	45,665	-	-	-	45,665
Leasehold improvements	5,043,363	-	(1,112)	137,894	5,180,145
Building	40,847,315	-	-	2,774,682	43,621,997
	74,666,836	-	(3,906,221)	11,403,807	82,164,422
Less accumulated depreciation for:					
Furniture and equipment	3,156,343	1,029,162	-	-	4,185,505
Computers and software	19,668,092	3,036,775	(3,905,109)	-	18,799,758
Land improvement	2,240,662	2,283	-	-	2,242,945
Leasehold improvements	2,138,972	590,196	(1,112)	-	2,728,056
Building	4,599,439	1,886,221	-	-	6,485,660
	31,803,508	6,544,637	(3,906,221)	-	34,441,924
Total depreciable assets, net	42,863,328	(6,544,637)	-	11,403,807	47,722,498
Capital assets, net	$ 54,995,566	$ (694,531)	$ -	$ -	$ 54,301,035

Note 4 – Capital Assets (continued)

Capital asset activity during the year ended June 30, 2016 consisted of the following:

	June 30, 2015	Additions	Retirements	Transfers	June 30, 2016
Capital assets not being depreciated:					
Land	$ 5,876,002	$ -	$ -	$ -	$ 5,876,002
Construction in progress	3,011,170	3,263,116	-	(18,050)	6,256,236
	8,887,172	3,263,116	-	(18,050)	12,132,238
Capital assets being depreciated:					
Furniture and equipment	6,633,398	3,842,809	(216,612)	-	10,259,595
Computers and software	18,470,898	-	-	-	18,470,898
Land improvement	45,665	-	-	-	45,665
Leasehold improvements	5,043,363	-	-	-	5,043,363
Building	40,747,980	81,285	-	18,050	40,847,315
	70,941,304	3,924,094	(216,612)	18,050	74,666,836
Less accumulated depreciation for:					
Furniture and equipment	2,185,730	970,613	-	-	3,156,343
Computers and software	17,611,500	2,273,204	(216,612)	-	19,668,092
Land improvement	1,126,651	1,114,011	-	-	2,240,662
Leasehold improvements	1,560,341	578,631	-	-	2,138,972
Building	3,994,863	604,576	-	-	4,599,439
	26,479,085	5,541,035	(216,612)	-	31,803,508
Total depreciable assets, net	44,462,219	(1,616,941)	-	18,050	42,863,328
Capital assets, net	$ 53,349,391	$ 1,646,175	$ -	$ -	$ 54,995,566

Note 5 – Medical Claims Liability

Medical claims liability consists of the following:

	June 30, 2017	June 30, 2016
Claims payable or pending approval	$ 26,870,842	$ 18,004,864
Provisions for IBNR claims	261,801,881	279,577,548
Due to DHCS	785,673,233	502,513,348
	$ 1,074,345,956	$ 800,095,760

The cost of health-care services is recognized in the period in which care is provided and includes an estimate of the cost of services that has been incurred but not yet reported. CalOptima estimates accrued claims payable based on historical claims payments and other relevant information. Unpaid claims adjustment expenses are an estimate of the cost to process the IBNR claims and are included in medical claims liability. Estimates are continually monitored and analyzed, and as settlements are made or estimates adjusted, differences are reflected in current operations.

Note 5 – Medical Claims Liability (continued)

Such estimates are subject to the impact of changes in the regulatory environment and economic conditions. Given the inherent variability of such estimates, the actual liability could differ significantly from the amounts provided.

The following is a reconciliation of the accrued claims liability:

	For the years ended June 30,	
	2017	2016
Beginning balance	$ 800,095,760	$ 640,921,119
Incurred:		
Current	2,049,335,092	1,860,940,751
Prior	(5,602,159)	(16,801,929)
	2,043,732,933	1,844,138,822
Paid		
Current	1,568,167,854	1,453,165,737
Prior	201,314,883	231,798,444
	1,769,482,737	1,684,964,181
Ending balance	$ 1,074,345,956	$ 800,095,760

Amounts incurred related to prior years vary from previously estimated liabilities as the claims are ultimately adjudicated and paid. Liabilities at any year-end are continually reviewed and re-estimated as information regarding actual claim payments becomes known. This information is compared to the originally established prior reporting period liability. Negative amounts reported for incurred, related to prior years, result from claims being adjudicated and paid for amounts less than originally estimated. The year ended June 30, 2017 results included a decrease of prior year incurred of approximately $5,602,000. The year ended June 30, 2016 results included a decrease of prior year incurred of approximately $16,802,000. Original estimates are increased or decreased as additional information becomes known regarding individual claims.

The amounts accrued in Due to DHCS represent excess payments from DHCS that are primarily due to capitation payments received that do not reflect the current Medi-Cal expansion rates issued by DHCS. DHCS has not recouped these overpayments as of June 30, 2017.

Note 6 – Defined Benefit Pension Plan

Plan description – CalOptima's defined benefit pension plan, Miscellaneous Plan of the Orange County Health Authority (the "CalPERS Plan"), provides retirement and disability benefits, annual cost-of-living adjustments, and death benefits to plan members and beneficiaries. The CalPERS Plan is part of the public agency portion of the California Public Employees Retirement Systems ("CalPERS"), an agent multiple-employer plan administered by CalPERS, which acts as a common investment and administrative agent for participating public employers within the state of California. A menu of benefit provisions as well as other requirements is established by state statues within the Public Employees' Retirement Law. CalOptima selects optional benefit provisions from the benefit menu by contract with CalPERS and adopts those benefits through the Board of Directors' approval. CalPERS issues a publicly available financial report that includes financial statements and required supplementary information for CalPERS. Copies of the report can be obtained from CalPERS Executive Office, 400 P Street, Sacramento, CA 95814.

Benefits provided – CalPERS provides service retirement and disability benefits, annual cost of living adjustments and death benefits to plan members, who must be public employees and beneficiaries. Benefits are based on years of credited service, equal to one full year of full time employment. Members with five years of total service are eligible to retire at age 50 with statutorily reduced benefits. All members are eligible for non-duty disability benefits after 10 years of service. The death benefit is one of the following: The Basic Death Benefit, the 1957 Survivor Benefit, or the Optional Settlement 2W Death Benefit. The cost of living adjustments for the plan are applied as specified by the Public Employees' Retirement Law.

The CalPERS Plan's provisions and benefits in effect at June 30, 2017 are summarized as follows:

Hire Date	Prior to January 1, 2013	On or after January 1, 2013
Benefit formula	2.0% at 60	2.0% at 62
Benefit vesting schedule	5 years of service	5 years of service
Benefit payments	monthly for life	monthly for life
Retirement age	50 plus	52 plus
Monthly benefits as a % of eligible compensation	2.0% to 2.7%	1.0% to 2.5%
Required employee contribution rates	7.0%	7.3%
Required employer contribution rates	8.4%	8.4%

The following is a summary of plan participants:

	June 30, 2017	June 30, 2016
Active employees	1097	1100
Retirees and beneficiaries:		
Receiving benefits	59	102
Deferred Retirement benefits:		
Terminated employees	45	1
Surviving spouses	3	5
Beneficiaries	3	0

Back to Agenda

Note 6 – Defined Benefit Pension Plan (continued)

Contributions – Section 20814(c) of the California Public Employees' Retirement Law ("PERL") requires that the employer contribution rates for all public employers are determined on an annual basis by the actuary and shall be effective on the July 1 following notice of a change in the rate. The total plan contributions are determined through CalPERS' annual actuarial valuation process. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability. The employer is required to contribute the difference between the actuarially determined rate and the contribution rate of employees. The average active employee contribution rate is 6.82 percent of annual pay for both the years ended June 30, 2017 and 2016. The employer's contribution rate is 8.65 percent and 8.41 percent of annual payroll for the years ended June 30, 2017 and 2016, respectively.

CalOptima's net pension liability for the CalPERS Plan is measured as the total pension liability, less the pension plan's fiduciary net position. For the measurement period ended June 30, 2016 (the measurement date), the total pension liability was determined by rolling forward the June 30, 2015 total pension liability. Total pension liabilities were based on the following actuarial methods and assumptions as of June 30, 2016 and June 30, 2015, respectively:

Valuation Date	June 30, 2015
Measurement Date	June 30, 2016
Actuarial Cost Method	Entry Age Normal
Actuarial Assumptions:	
Discount Rate	7.65%
Inflation	2.75%
Salary Increases	Varies by Entry Age and Service
Investment Rate of Return	7.5% Net of Pension Plan Investment and Administrative Expenses; includes Inflation
Mortality Rate Table	Derived using CalPERS' Membership data for all funds
Post Retirement Benefit Increase	Contract COLA up to 2.75% until Purchasing Power Protection Allowance Floor on Purchasing Power applies, 2.75% thereafter

The underlying mortality table was developed based on CalPERS' specific data. The table includes 20 years of mortality improvements using Society of Actuaries Scale BB. All other actuarial assumptions used in the June 30, 2015 valuation were based on the results of an actuarial experience study for the period 1997 to 2011, including updates to salary increase mortality and retirement rates. The Experience Study report can be obtained at CalPERS' website.

Note 6 – Defined Benefit Pension Plan (continued)

Changes in the Net Pension Liability are as follows:

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2016	$ 96,499,544	$ 89,962,735	$ 6,536,809
Changes during the year:			
Service Cost	10,272,406	-	10,272,406
Interest on the total pension liability	7,702,198	-	7,702,198
Changes of benefit terms	-	-	-
Differences between expected and actual experience	102,384	-	102,384
Changes of assumptions	-	-	-
Contributions from the employer	-	3,787,544	(3,787,544)
Contributions from employees	-	4,951,820	(4,951,820)
Net investment income	-	498,498	(498,498)
Benefit payments, including refunds of employee contributions	(2,111,578)	(2,111,578)	-
Administrative expenses	-	(54,828)	54,828
Net changes during the year	15,965,410	7,071,456	8,893,954
Balance at June 30, 2017	$ 112,464,954	$ 97,034,191	$ 15,430,763

	Increase (Decreases)		
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
Balance at June 30, 2015	$ 83,711,464	$ 82,651,970	$ 1,059,494
Changes during the year:			
Service Cost	8,363,183	-	8,363,183
Interest on the total pension liability	6,620,025	-	6,620,025
Changes of benefit terms	-	-	-
Differences between expected and actual experience	1,444,808	-	1,444,808
Changes of assumptions	(1,963,270)	-	(1,963,270)
Contributions from the employer	-	3,033,171	(3,033,171)
Contributions from employees	-	4,142,126	(4,142,126)
Net investment income	-	1,913,380	(1,913,380)
Benefit payments, including refunds of employee contributions	(1,676,666)	(1,676,666)	-
Administrative expenses	-	(101,246)	101,246
Net changes during the year	12,788,080	7,310,765	5,477,315
Balance at June 30, 2016	$ 96,499,544	$ 89,962,735	$ 6,536,809

Note 6 – Defined Benefit Pension Plan (continued)

Discount rate and long term rate of return – The discount rate used to measure the total pension liability was 7.65 percent for the CalPERS Plan. To determine whether the municipal bond rate should be used in the calculation of a discount rate for each plan, CalPERS stress tested plans that would most likely result in a discount rate that would be different from the actuarially assumed discount rate. Based on the testing, none of the tested plans run out of assets. Therefore, the current 7.65 percent discount rate is adequate and the use of the municipal bond rate calculation is not necessary. The long term expected discount rate of 7.50 percent will be applied to all plans in the Public Employees Retirement Fund (PERF). The stress test results are presented in a detailed report called "GASB Crossover Testing Report" that can be obtained from the CalPERS website.

GASB No. 68 requires that the long-term discount rate should be determined without reduction for pension plan administrative expense. The 7.50 percent investment return assumption used is net of administrative expenses. Administrative expenses are assumed to be 15 basis points. An investment return excluding administrative expenses would have been 7.65 percent, which is the rate used for the year ended June 30, 2017.

The long-term expected rate of return on pension plan investments was determined using a building-block method in which best-estimate ranges of expected future real rates of return (expected returns, net of pension plan investment expense and inflation) are developed for each major asset class.

In determining the long-term expected rate of return, CalPERS took into account both short-term and long-term market return expectations as well as the expected pension fund cash flows. Such cash flows were developed assuming that both members and employers will make the required contributions as scheduled in all future years. Using historical returns of all the funds' asset classes, expected compound returns were calculated over the short-term (first 10 years) and the long-term (11-60 years) using a building-block approach. Using the expected nominal returns for both short-term and long-term, the present value of benefits was calculated for each fund. The expected rate of return was set by calculating the single equivalent expected return that arrived at the same present value of benefits for cash flows as the one calculated using both short-term and long-term returns. The expected rate of return was then set equivalent to the single equivalent rate calculated above and rounded down to the nearest one quarter of one percent.

Back to Agenda

Note 6 – Defined Benefit Pension Plan (continued)

The table below reflects long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These geometric rates of return are net of administrative expenses.

New Strategic Asset Class	Real Return Allocation	Real Return Years 1-10 (a)	Years 11+ (b)
Global Equity	51.0%	5.25%	5.71%
Global Fixed Income	20.0%	0.99%	2.43%
Inflation Sensitive	6.0%	0.45%	3.36%
Private Equity	10.0%	6.83%	6.95%
Real Estate	10.0%	4.50%	5.13%
Infrastructure and Forestland	2.0%	4.50%	5.09%
Liquidity	1.0%	-0.55%	-1.05%

(a) An expected inflation of 2.5% was used for this period
(b) An expected inflation of 3.0% was used for this period

The following presents the net pension liability of the CalPERS Plan calculated using the discount rate, as well as what the net pension liability would be if it were calculated using a discount rate that is 1-percentage point lower or 1-percentage point higher than the current rate:

	June 30, 2017		
	Discount Rate -1% 6.65%	Current Discount Rate 7.65%	Discount Rate +1% 8.65%
Net Pension Liability	$ 34,792,255	$ 15,430,763	$ (159,810)

	June 30, 2016		
	Discount Rate -1% 6.65%	Current Discount Rate 7.65%	Discount Rate +1% 8.65%
Net Pension Liability	$ 23,232,749	$ 6,536,809	$ (6,906,026)

Note 6 – Defined Benefit Pension Plan (continued)

Pension expense and deferred outflows/inflows of resources related to pensions – CalOptima recognized pension expense of approximately $6,870,000 and $9,219,000 for the years ended June 30, 2017 and 2016, respectively. At June 30, 2017, CalOptima recognized deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Outflows of Resources	Deferred Inflows of Resources
June 30, 2017		
Contributions from employers subsequent to the measurement date	$ 5,234,198	-
Net differences between projected and actual earnings on plan investments	5,270,171	-
Changes in assumptions	-	$ 1,340,010
Differences between expected and actual experiences	1,072,771	-
	$ 11,577,140	$ 1,340,010

	Deferred Outflows of Resources	Deferred Inflows of Resources
June 30, 2016		
Contributions from employers subsequent to the measurement date	$ 3,787,544	-
Net differences between projected and actual earnings on plan investments	-	$ 502,900
Changes in assumptions	-	1,651,640
Differences between expected and actual experiences	1,215,473	-
	$ 5,003,017	$ 2,154,540

Back to Agenda

Note 6 – Defined Benefit Pension Plan (continued)

The deferred outflows of resources related to employer contributions subsequent to the measurement date will be recognized as a reduction of the net pension liability during the year ended June 30, 2017. The net differences reported as deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Years ending June 30,	Deferred Inflows of Resources
2018	$ 783,586
2019	783,586
2020	2,178,726
2021	1,258,097
2022	(8,941)
Thereafter	7,878
	$ 5,002,932

Note 7 – Employee Benefit Plans

Deferred compensation plan – CalOptima sponsors a deferred compensation plan created in accordance with Internal Revenue Code Section 457 (the "457 Plan") under which employees are permitted to defer a portion of their annual salary until future years. CalOptima may make discretionary contributions to the 457 Plan as determined by the Board of Directors. For the years ended June 30, 2017 and 2016, no discretionary employer contributions were made.

Defined contribution plan – Effective January 1, 1999, CalOptima established a supplemental retirement plan for its employees called the CalOptima Public Agency Retirement System Defined Contribution Supplemental Retirement Plan ("PARS Plan"). All regular and limited-term employees are eligible to participate in the PARS Plan. The current PARS Plan design does not require employee contributions. CalOptima makes discretionary employer contributions to the PARS Plan as authorized by the CalOptima Board of Directors. Vesting occurs over 16 quarters of service. For the years ended June 30, 2017 and 2016, CalOptima contributed approximately $2,718,000 and $2,467,000, respectively.

Note 8 – Postemployment Health-Care Plan

Plan description – CalOptima sponsors and administers a single-employer, defined benefit postemployment health-care plan (the "Plan") to provide medical and dental insurance benefits to eligible retired employees and their beneficiaries. Benefit provisions are established and may be amended by the CalOptima Board of Directors.

Note 8 – Postemployment Health-Care Plan (continued)

Effective January 1, 2004 CalOptima terminated postemployment health-care benefits for employees hired on or after January 1, 2004. For employees hired prior to January 1, 2004, the employee's eligibility for retiree health benefits remains similar to the eligibility requirements for the defined benefit pension plan.

During the year ended June 30, 2006, CalOptima modified the benefit offered to eligible participants, requiring participants to enroll in Medicare and specifying that CalOptima would be responsible only for the cost of Medicare supplemental coverage, subject to a cost sharing between the participant and CalOptima.

Funding policy – The contribution requirements of Plan members and CalOptima are established and may be amended by the CalOptima Board of Directors. Plan members receiving benefits contribute at the same rate as current active employees. CalOptima's contribution is based on projected pay-as-you-go financing requirements, with no additional amount to prefund benefits. CalOptima contributed $572,000, including $545,000 in premium payments for retirees and $27,000 for implied subsidies for the year ended June 30, 2017. CalOptima contributed $537,000, including $510,000 in premium payments for retirees and $27,000 for implied subsidies for the year ended June 30, 2016. The most recent actuarial report for the Plan was June 30, 2017. As of that point the actuarial accrued liability and unfunded actuarial accrued liability for benefits were approximately $28,580,000 and a funded ratio of 0.0 percent with a covered payroll of $7,606,000.

Note 8 – Postemployment Health-Care Plan (continued)

Annual other postemployment benefit cost and net obligation – CalOptima's annual other postemployment benefit (OPEB) cost (expense) is calculated based on the annual required contribution (ARC) of the employer, an amount actuarially determined in accordance with the parameter of GASB Codification Section P50. The ARC represents a level of funding that, if paid on an ongoing basis, is projected to cover normal costs each year and amortize any unfunded actuarial liabilities (or funding excess) over a 20-year closed amortization period. The following table shows the components of CalOptima's annual OPEB costs for the years, the amount actually contributed to the Plan, and changes in CalOptima's net OPEB obligation (dollars in thousands):

	Years Ended June 30,	
	2017	2016
ARC:		
Normal cost	$ 845	$ 872
Actuarial accrued liability (AAL) amortization	2,936	2,694
Total, end of year	$ 3,781	$ 3,566
Annual OPEB costs (ACC):		
ARC	$ 3,782	$ 3,566
Interst on net OPEB obligation (NOO)	1,082	1,032
Amortization of NOO	(3,025)	(2,791)
Total	$ 1,839	$ 1,807
Beginning NOO	$ 27,327	$ 26,057
AOC	1,839	1,807
Contributions	(586)	(537)
Ending NOO	$ 28,580	$ 27,327

CalOptima reported approximately $28,580,000 and $27,327,000 at June 30, 2017 and 2016, respectively, in postemployment health-care plan liabilities on the consolidated statements of net position.

CalOptima's annual OPEB cost, the percentage of annual OPEB cost contributed to the Plan, and the net postemployment health-care plan obligation at June 30, 2017 were as follows:

Years Ended June 30	Annual OPEB Cost	Percentage of Annual OPEB Cost Contributed	Net OPEB Obligation
2015	$ 2,529,000	29.5	26,802,000
2016	1,807,000	29.7	27,327,000
2017	1,831,000	31.2	28,580,000

Note 8 – Postemployment Health-Care Plan (continued)

Projections of benefits for consolidated financial reporting purposes are based on the substantive plan (the plan as understood by the employer and plan members) and include the types of benefits provided at the time of each valuation and the historical pattern of sharing of benefit costs between employer and plan members to that point. The actuarial methods and assumptions used include techniques that are designed to reduce the effects of short-term volatility in actuarial accrued liabilities and the actuarial value of assets, consistent with the long-term perspective calculations.

Actuarial valuations involve estimates of the value of reported amounts and assumptions about the probability of events in the future and are subject to continual revision as actual results are compared to past expectations and new estimates are made about the future. In the January 1, 2015 actuarial valuation, the entry age normal actuarial cost method was used. The actuarial assumptions included a 4.0 percent investment rate of return (net of administrative expenses) and annual health-care cost trend rates for medical of approximately 7.5% (respective of the plan type and the population selected) initially, decreasing to 5.0 percent over six years; dental of 3.0 percent for all years; and vision of 3.0 percent for all years. Salary scale and demographic assumptions for withdrawal, mortality, disability and retirement rates were based on the CalPERS 1997-2002 experience study (2.0 percent at 60).

The required schedule of funding progress immediately following the notes to the consolidated financial statements presents multiyear trend information about the actuarial accrued liability for benefits.

Note 9 – Restricted Net Position

On June 28, 2000, CalOptima became a fully licensed health-care service plan under the Act, as required by statues governing the Healthy Families program. Under the Act, CalOptima is required to maintain and meet a minimum level of tangible net equity as of June 30, 2017 and 2016 of $98,455,479 and $89,283,747, respectively. As of June 30, 2017, the Organization is in compliance with its TNE requirement.

The Act further required the CalOptima maintain a restricted deposit in the amount of $300,000. Both CalOptima and the Foundation meet the requirement as of June 30, 2017 and 2016.

Note 10 – Lease Commitments

CalOptima leases office space and equipment under noncancelable, long-term operating leases, with minimum annual payments as follows:

Years ending June 30,	Minimum Lease Payments
2018	$ 500,906
2019	515,933
2020	531,411
2021	547,353
2022	277,721
	$ 2,373,324

Rental expense under operating leases was approximately $472,000 and $471,000 for the years ended June 30, 2017 and 2016, respectively.

Note 11 – Contingencies

Litigation – CalOptima is party to various legal actions and is subject to various claims arising in the ordinary course of business. Management believes that the disposition of these matters will not have a material adverse effect on CalOptima's financial position or results of operations.

Regulatory matters – The health-care industry is subject to numerous laws and regulations of federal, state and local governments. Violations of these laws and regulations could result in expulsion from government health-care programs together with the imposition of significant fines and penalties. Management believes that CalOptima is in compliance with fraud and abuse, as well as other applicable government laws and regulations. Compliance with such laws and regulations can be subject to future government review and interpretation as well as regulatory actions unknown or unasserted at this time.

Note 12 – Consolidating Information

The consolidating assets, deferred outflows of resources, liabilities, deferred inflows of resources and net position at June 30, 2017 are as follows:

ASSETS	CalOptima	CalOptima Foundation	Eliminations	Consolidated
Current Assets				
Cash and cash equivalents	$ 507,169,844	$ 2,893,139	$ -	$ 510,062,983
Investments	1,082,425,753	-	-	1,082,425,753
Capitation receivable from the State of California, net	522,793,705	-	-	522,793,705
Prepaid expenses and other	26,384,678	-	-	26,384,678
Due From Affiliates	25,000	-	(25,000)	-
Total current assets	2,138,798,980	2,893,139	(25,000)	2,141,667,119
Board-Designated Assets and Restricted Cash				
Cash and cash equivalents	17,709,682	-	-	17,709,682
Investments	517,428,691	-	-	517,428,691
Restricted deposit	300,000	-	-	300,000
	535,438,373	-	-	535,438,373
Capital Assets, net	54,301,035			54,301,035
Total assets	2,728,538,388	2,893,139	(25,000)	2,731,406,527
Deferred Outflows of Resources	11,577,140	-	-	11,577,140
Total assets and deferred outflows of resources	$ 2 740 115 528	$ 2 893 139	$ (25 000)	$ 2 742 983 667
LIABILITIES AND NET POSITION				
Current Liabilities				
Medical claims liability and capitation payable				
Medical claims liability	$ 1,074,345,956	$ -	$ -	$ 1,074,345,956
Capitation and withholds	580,839,710	-	-	580,839,710
Accrued insurance costs	5,681,300	-	-	5,681,300
Payable to State of California and the Centers for Medicare & Medicaid Services (CMS)	198,204,767	-	-	198,204,767
Unearned revenue	102,298,450	-	-	102,298,450
	1,961,370,183	-	-	1,961,370,183
Accounts payable and other	9,823,907	-	-	9,823,907
Accrued payroll and employee benefits and other	10,101,233	-	-	10,101,233
Due to affiliates	-	25,000	(25,000)	-
Total current liabilities	1,981,295,323	25,000	(25,000)	1,981,295,323
Postemployment health-care plan	28,586,000	-	-	28,586,000
Net pension liability	15,430,763			15,430,763
Total Liabilities	2,025,312,086	25,000	(25,000)	2,025,312,086
Deferred Inflows of Resources	1,340,010	-	-	1,340,010
Net position				
Net investment in capital assets, net of related debt	54,103,912	-	-	54,103,912
Restricted - required tangible net equity and restricted deposit	98,445,479	-	-	98,445,479
Unrestricted	560,914,041	2,868,139	-	563,782,180
Total net position	713,463,432	2,868,139	-	716,331,571
Total liabilities, deferred inflows of resources and net position	$ 2,740,115,528	$ 2,893,139	$ (25,000)	$ 2,742,983,667

Note 12 – Consolidating Information (continued)

The consolidating assets, deferred outflows of resources, liabilities, deferred inflows of resources and net position at June 30, 2016 are as follows:

ASSETS	CalOptima	CalOptima Foundation	Eliminations	Consolidated
Current Assets				
Cash and cash equivalents	$ 255,993,881	$ 2,894,845	$ -	$ 258,888,726
Investments	1,019,222,143	-	-	1,019,222,143
Capitation receivable from the State of California, net	470,263,571	-	-	470,263,571
Prepaid expenses and other	23,261,087	35,359	-	23,296,446
Due From Affiliates	61	-	(61)	-
Total current assets	1,768,740,743	2,930,204	(61)	1,771,670,886
Board-Designated Assets and Restricted Cash				
Cash and cash equivalents	10,144,102	-	-	10,144,102
Investments	465,701,798	-	-	465,701,798
Restricted deposit	300,000	-	-	300,000
	476,145,900	-	-	476,145,900
Capital Assets, net	54,995,566			54,995,566
Total assets	2,299,882,209	2,930,204	(61)	2,302,812,352
Deferred Outflows of Resources	5 003 017	-	-	5 003 017
Total assets and deferred outflows of resources	$ 2,304,885,226	$ 2,930,204	$ (61)	$ 2,307,815,369
LIABILITIES AND NET POSITION				
Current Liabilities				
Medical claims liability and capitation payable				
Medical claims liability	$ 800,095,760	$ -	$ -	$ 800,095,760
Capitation and withholds	401,826,300	-	-	401,826,300
Accrued insurance costs	4,884,800	-	-	4,884,800
Payable to State of California and the Centers for Medicare & Medicaid Services (CMS)	181,769,823	-	-	181,769,823
Unearned revenue	198 309 455	-	-	198 309 455
	1,586,886,138	-	-	1,586,886,138
Accounts payable and other	10,571,340	35,298	-	10,606,638
Accrued payroll and employee benefits and other	11,837,190	-	-	11,837,190
Due to affiliates	-	61	(61)	-
Total current liabilities	1,609,294,668	35,359	(61)	1,609,329,966
Postemployment health-care plan	27,327,000	-	-	27,327,000
Net pension liability	6,536,809	35,359	(61)	6,572,107
Total Liabilities	1,643,158,477	35,359	(61)	1,643,229,073
Deferred Inflows of Resources	2,154,540	-	-	2,154,540
Net position				
Net investment in capital assets, net of related debt	54,995,566	-	-	54,995,566
Restricted - required tangible net equity and restricted deposit	89,283,747	-	-	89,283,747
Unrestricted	515,292,896	2,894,845	-	518,187,741
Total net position	659,572,209	2,894,845	-	662,467,054
Total liabilities, deferred inflows of resources and net position	$ 2,304,885,226	$ 2,930,204	$ (61)	$ 2,307,850,667

Note 12 – Consolidating Information (continued)

The consolidating statements of revenues, expenses, and changes in net position for the year ended June 30, 2017 are as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
Operating revenues				
Capitation revenues	$ 3,549,461,873	$ -	$ -	$ 3,549,461,873
Other income	-	80,829	(53,665)	27,164
Total operating revenues	3,549,461,873	80,829	(53,665)	3,549,489,037
Operating expenses				
Medical expenses				
Provider capitation	984,439,058	-	-	984,439,058
Claim payments to providers and facilities	1,567,941,100	-	-	1,567,941,100
Prescription drugs	425,136,805	-	-	425,136,805
OneCare	16,424,252	-	-	16,424,252
OneCare Connect	355,096,108	-	-	355,096,108
Other medical	50,575,067	-	-	50,575,067
Total medical expenses	3,399,612,390	-	-	3,399,612,390
Administrative expenses				
Salaries, wages and employee benefits	71,882,654	53,435	(53,435)	71,882,654
Professional fees	1,241,416	-	-	1,241,416
Purchased services	11,278,918	-	-	11,278,918
Supplies, occupancy, insurance and other	22,734,822	54,100	(230)	22,788,692
Depreciation	6,544,639	-	-	6,544,639
Total administrative expenses	113,682,449	107,535	(53,665)	113,736,319
Total operating expenses	3,513,294,839	107,535	(53,665)	3,513,348,709
Operating income (loss)	36,167,034	(26,706)	-	36,140,328
Non-operating revenues and expenses				
Investment income and other	15,766,423	-	-	15,766,423
Rental income, net of related expenses	1,957,766	-	-	1,957,766
Total non-operating revenues and expenses	17,724,189	-	-	17,724,189
Increase in net position	53,891,223	(26,706)	-	53,864,517
Net position, beginning of year	659,572,209	2,894,845	-	662,467,054
Net position, end of year	$ 713,463,432	$ 2,868,139	$ -	$ 716,331,571

Note 12 – Consolidating Information (continued)

The consolidating statements of revenues, expenses, and changes in net position for the year ended June 30, 2016 are as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
Operating revenues				
Capitation revenues	$ 3,148,260,022	$ -	$ -	$ 3,148,260,022
Other income	-	653,323	(348,732)	304,591
Total operating revenues	3,148,260,022	653,323	(348,732)	3,148,564,613
Operating expenses				
Medical expenses				
Provider capitation	935,360,536	-	-	935,360,536
Claim payments to providers and facilities	1,349,950,877	-	-	1,349,950,877
Prescription drugs	391,480,137	-	-	391,480,137
OneCare	86,724,744	-	-	86,724,744
OneCare Connect	205,122,734	-	-	205,122,734
Other medical	53,779,018	-	-	53,779,018
Total medical expenses	3,022,418,046	-	-	3,022,418,046
Administrative expenses				
Salaries, wages and employee benefits	64,645,790	363,086	(341,928)	64,666,948
Professional fees	4,368,357	-	-	4,368,357
Purchased services	10,032,627	-	-	10,032,627
Supplies, occupancy, insurance and other	24,677,045	301,996	(6,804)	24,972,237
Depreciation	3,142,262	-	-	3,142,262
Total administrative expenses	106,866,081	665,082	(348,732)	107,182,431
Total operating expenses	3,129,284,127	665,082	(348,732)	3,129,600,477
Operating income	18,975,895	(11,759)	-	18,964,136
Non-operating revenues and expenses				
Investment income and other	13,880,954	-	-	13,880,954
Rental income, net of related expenses	(332,490)	-	-	(332,490)
Total non-operating revenues and expenses	13,548,464	-	-	13,548,464
Increase in net position	32,524,359	(11,759)	-	32,512,600
Net position, beginning of year	627,047,850	2,906,604	-	629,954,454
Net position, end of year	$ 659,572,209	$ 2,894,845	$ -	$ 662,467,054

Note 12 – Consolidating Information (continued)

The consolidating statement of cash flows for the year ended June 30, 2017 is as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
CASH FLOWS FROM OPERATING ACTIVIT ES				
Capitation payments received and other	$ 3,417,320,319	$ 62,523	$ -	$ 3,417,382,842
Payment to providers and facilities	(2,945,552,284)		-	(2,945,552,284)
Payments to vendors	(39,115,530)	(64,459)	-	(39,179,989)
Payments to employees	(70,854,540)	230	-	(70,854,310)
Net cash provided by operating activities	361,797,965	(1,706)	-	361,796,259
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVIT ES				
Purchases of capital assets	(5,850,108)	-	-	(5,850,108)
Net cash used in capital and related financing activities	(5,850,108)	-	-	(5,850,108)
CASH FLOWS FROM INVESTING ACTIVIT ES				
Investment income received	11,823,120	-	-	11,823,120
Purchases of securities	(644,508,177)	-	-	(644,508,177)
Sales of securities	527,913,163	-	-	527,913,163
Net cash provided by (used in) investing activities	(104,771,894)	-	-	(104,771,894)
Net increase (decrease) in cash and cash equivalents	251,175,963	(1,706)	-	251,174,257
CASH AND CASH EQUIVALENTS, beginning of year	255,993,881	2,894,845	-	258,888,726
CASH AND CASH EQUIVALENTS, end of year	$ 507,169,844	$ 2,893,139	$ -	$ 510,062,983

The consolidating statement of cash flows for the year ended June 30, 2016 is as follows:

	CalOptima	CalOptima Foundation	Eliminations	Consolidated
CASH FLOWS FROM OPERAT NG ACTIVITIES				
Capitation payments received and other	$ 3,406,665,573	$ 666,587	$ -	$ 3,407,332,160
Payment to providers and facilities	(2,792,070,397)	-	-	(2,792,070,397)
Payments to vendors	(41,577,997)	(321,576)	-	(41,899,573)
Payments to employees	(59,175,049)	(363,086)	-	(59,538,135)
Net cash provided by operating activities	513,842,130	(18,075)	-	513,824,055
CASH FLOWS FROM CAPITAL AND RELATED F NANCING ACTIVITIES				
Purchases of capital assets	(4,788,437)	-	-	(4,788,437)
Net cash used in capital and related financing activities	(4,788,437)	-	-	(4,788,437)
CASH FLOWS FROM NVEST NG ACTIVITIES				
Investment income received	10,003,777	-	-	10,003,777
Purchases of securities	(435,645,219)	-	-	(435,645,219)
Sales of securities	150,063,575	-	-	150,063,575
Net cash provided by (used in) investing activities	(275,577,867)	-	-	(275,577,867)
Net increase (decrease) in cash and cash equivalents	233,475,826	(18,075)	-	233,457,751
CASH AND CASH EQUIVALENTS, beginning of year	22,518,055	2,912,920	-	25,430,975
CASH AND CASH EQUIVALENTS, end of year	$ 255 993 881	$ 2 894 845	$ -	$ 258 888 726

Back to Agenda

Supplementary Information

Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Schedule of Changes in Net Pension Liability and Related Ratios

	JUNE 30, 2017	JUNE 30, 2016	JUNE 30, 2015
Total Pension Liability			
Service Cost	$ 10,272,406	$ 8,363,183	$ 6,464,105
Interest	7,702,198	6,620,025	5,661,111
Changes in Benefit Terms	-	-	-
Differences Between Expected and Actual Experience	102,384	1,444,808	-
Changes in Assumptions	-	(1,963,270)	-
Benefit Payments, Including Refunds of Employee Contr butions	(2,111,578)	(1,676,666)	(1,326,364)
Net Change in Total Pension Liability	15,965,410	12,788,080	10,798,852
Total Pension Liability - Beginning	96,499,544	83,711,464	72,912,613
Total Pension Liability - Ending	$ 112,464,954	$ 96,499,544	$ 83,711,465
Plan Fiduciary Net Position			
Contributions - Employer	$ 3,787,544	$ 3,033,171	$ 3,119,804
Contributions - Employee	4,951,820	4,142,126	3,385,296
Net Investment Income	498,498	1,913,380	12,062,654
Benefit Payments, Including Refunds of Employee Contrbutions	(2,111,578)	(1,676,666)	(1,326,364)
Other Changes in Fiduciary Net Position	(54,828)	(101,246)	-
Net Change in Fiduciary Net Position	7,071,456	7,310,765	17,241,390
Plan Fiduciary Net Position - Beginning	89,962,735	82,651,970	65,410,580
Plan Fiduciary Net Position - Ending	$ 97,034,191	$ 89,962,735	$ 82,651,970
Plan Net Pension Liability - Ending	$ 15,430,763	$ 6,536,809	$ 1,059,495
Plan Fiduciary Net Position as Percentage of the Total Liability	86.28%	93.23%	98.73%
Covered-Employee Payroll	$ 68,583,296	$ 55,676,606	$ 40,940,556
Plan Net Pension Liability as a Percentage of Covered Employee Payroll	22.50%	11.74%	2.59%

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Schedule of Plan Contributions

	YEARS ENDED JUNE 30,		
	2017	2016	2015
Actuarially Determined Contributions	$ 3,787,544	$ 3,033,171	$ 3,119,804
Contributions in Relation To the Actuarially Determined Contribution	(3,787,544)	(3,033,171)	(3,119,804)
Contribution Deficiency (Excess)	$ -	$ -	$ -
Covered-Employee Payroll	$ 68,583,296	$ 55,676,606	40,940,556
Contributions as a Percentage of Covered-Employee Payroll	5.52%	5.45%	7.62%

See accompanying report of independent auditors.

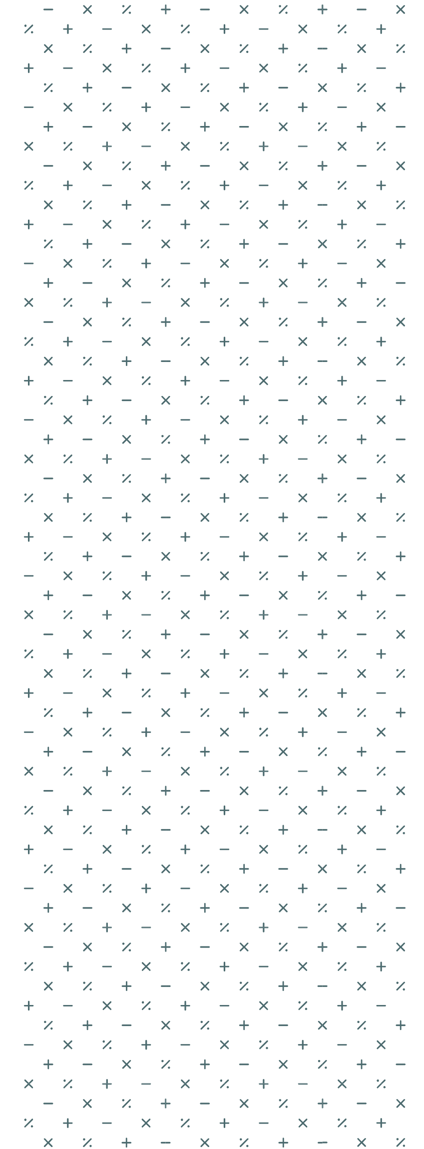
Back to Agenda

Orange County Health Authority, a Public Agency/ dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima

Schedule of Funding Progress – Postemployment Health Care Plan

June 30, 2017
(in Thousands)
(unaudited)

Actuarial Valuation Date	Actuarial Value of Assets	Actuarial Accrued Liability (AAL)-- Entry Age	Unfunded AAL (UAAL)	Funded Ratio	Covered Payroll	UAAL as a Percentage of Covered Payroll
6/30/2009	$ -	$ 17,618	$ 17,618	$ 0.0%	$ 9,476	$ 185.9%
6/30/2012	-	19,184	19,184	0.0%	8,547	224.5%
6/30/2013	-	24,799	24,799	0.0%	7,606	326.0%
6/30/2014	-	26,057	26,057	0.0%	7,379	353.1%
6/30/2015	-	27,335	27,335	0.0%	7,148	382.4%
6/30/2016	-	28,580	28,580	0.0%	6,936	412.1%



2017 Audit Results: CalOptima

Back to Agenda

FINANCE AND AUDIT COMMITTEE

CalOptima

Dear Finance and Audit Committee (FAC) Members:

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the consolidated financial statements of CalOptima ("the Organization") for the year ended June 30, 2017.

The accompanying report, which is intended solely for the use of the FAC and management, presents important information regarding the CalOptima's consolidated financial statements and our audit that we believe will be of interest to you. It is not intended and should not be used by anyone other than these specified parties.

We receive the full support and assistance of the Organization's personnel. We are pleased to serve and be associated with CalOptima as its independent public accountants and look forward to our continued relationship.

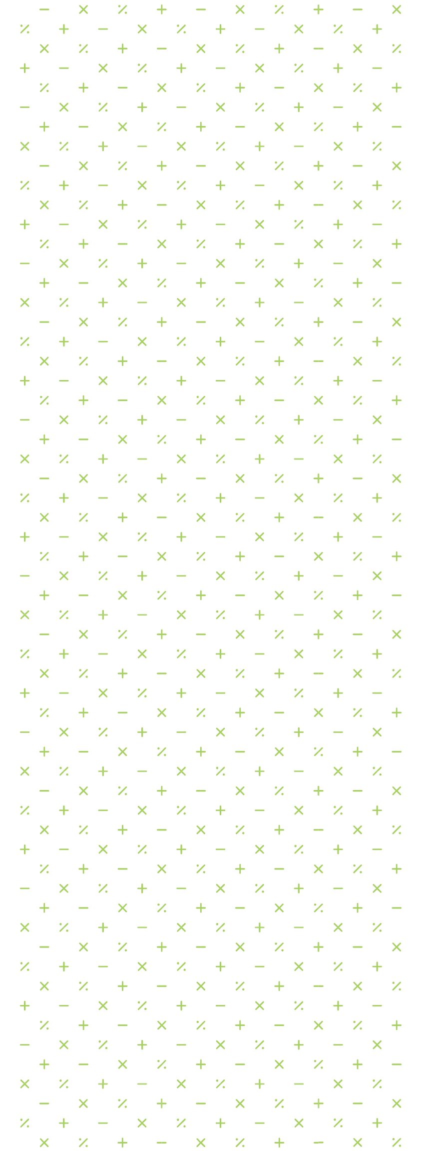
We look forward to discussing our report or any other matters of interest with you during this meeting.

Back to Agenda

Agenda

- Auditor Opinions and Reports
- Communication with FAC
- Areas of audit emphasis

Back to Agenda



Auditor Opinion & Report

Better Together: Moss Adams & CalOptima

Back to Agenda

Scope of Services

We have performed the following services for CalOptima:

- Annual consolidated financial statement audit for the year ended June 30, 2017

We have also performed the following non-attest services:

- Assisted in the drafting of the consolidated financial statements of CalOptima
- Preparation of the Form 990 for the Foundation

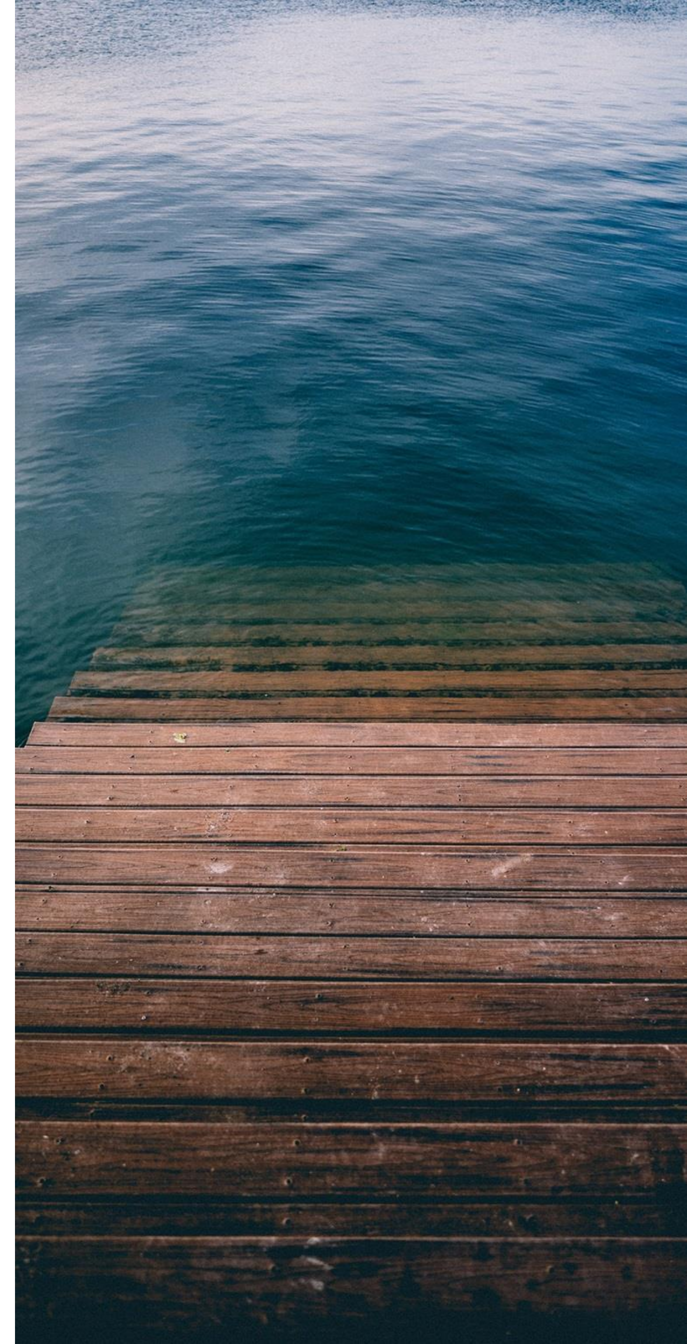
Back to Agenda

Auditor Report on the Financial Statements

Unmodified Opinion

- Consolidated financial statements are presented fairly and in accordance with US GAAP

Back to Agenda



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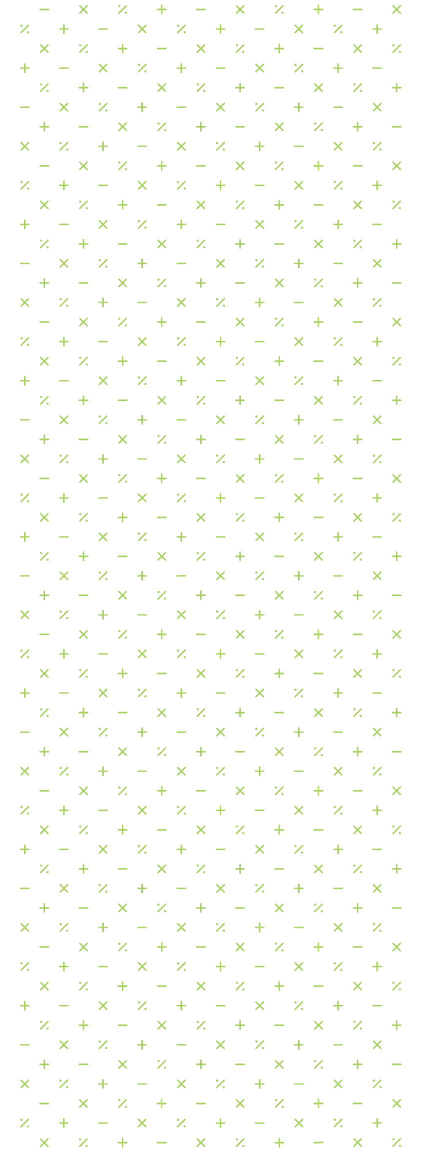
Communication with FAC

Back to Agenda



Our Responsibility

Our responsibility under US Generally Accepted Auditing Standards and Government Auditing Standards.

1	2	3	4
To express our opinion on whether the consolidated financial statements prepared by management with your oversight are fairly presented, in all material respects, and in accordance with U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.	To perform an audit in accordance with generally accepted auditing standards issued by the AICPA, and Government Auditing Standards issued by the Comptroller General of the United States, and design the audit to obtain reasonable, rather than absolute, assurance about whether the consolidated financial statements are free of material misstatement.	To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.	To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Back to Agenda

Planned Scope & Timing of the Audit

It is the auditor's responsibility to determine the overall audit strategy and the audit plan, including the nature, timing and extent of procedures necessary to obtain sufficient and appropriate audit evidence and to communicate with those charged with governance and overview of the planned scope and timing of the audit.

OUR COMMENTS

- The planned scope and timing of the audit was communicated to CalOptima's FAC at the audit entrance meeting and was included in the engagement letter for the year ended June 30, 2017

Back to Agenda

Significant Accounting Policies & Unusual Transactions

The auditor should determine that the FAC is informed about the initial selection of and changes in significant accounting policies or their application. The auditor should also determine that the FAC is informed about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

OUR COMMENTS

- Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by CalOptima are described in the footnotes to the consolidated financial statements. Throughout the course of an audit, we review changes, if any, to significant accounting policies or their application, and the initial selection and implementation of new policies. There were no changes to significant accounting policies for the year ended June 30, 2017.
- We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

Back to Agenda

Management Judgements & Accounting Estimates

The FAC should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basics for the auditor's conclusions regarding the reasonableness of those estimates.

OUR COMMENTS

- Management's judgements and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We apply audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the consolidated financial statements.
- Significant management estimates impacted the consolidated financial statements including the following: **fair value of investments; fixed asset lives; actuarially determined accruals for incurred but not reported (IBNR) medical claims liabilities, Non-IBNR liabilities; and pension, and other post-employment liabilities.**
- We deem them to be reasonable

Back to Agenda

Management Judgements & Accounting Estimates

Our views about the quantitative aspects of the entity's significant accounting policies, accounting estimates, and financial statement disclosures.

OUR COMMENTS

- The disclosures in the consolidated financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users. We call your attention to the following notes:
    - Note 2 – Summary of Significant accounting policies
    - Note 3 – Cash and Investments
    - Note 5 – Medical Claims Liability
    - Note 6 – Defined Benefit Pension Plan

Back to Agenda

Significant Audit Adjustments & Unadjusted Differences Considered by Management to Be Immaterial

The FAC should be informed of all significant audit adjustments arising from the audit. Consideration should be given to whether an adjustment is indicative of a significant deficiency or a material weakness in CalOptima's internal control over financial reporting, or in its process for reporting interim financial information, that could cause future consolidated financial statements to be materially misstated.

The FAC should also be informed of uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented that were determined by management to be immaterial, both individually and in the aggregate, to the consolidated financial statements as a whole.

OUR COMMENTS

- There were no corrected or uncorrected audit adjustments.

Back to Agenda

Deficiencies in Internal Control

Any material weaknesses and significant deficiencies in the design or operation of internal control that came to the auditor's attention during the audit must be reported to the FAC.

OUR COMMENTS

- Material weakness
  - None noted
- Significant deficiencies
  - Nothing to communicate

Back to Agenda

Potential Effect on the Consolidated Financial Statements of Any Significant Risks & Exposures

The FAC should be adequately informed of the potential effect on financial statements of significant risks and exposures and uncertainties that are disclosed in the financial statements.

OUR COMMENTS

- CalOptima is subject to potential legal proceedings and claims that arise in the ordinary course of business, which are disclosed in the notes to the financial statements.

Back to Agenda

Difficulties Encountered in Performing the Audit

The FAC should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to CalOptima's consolidated financial statements, or the auditor's report.

OUR COMMENTS

- No significant difficulties were encountered during our audit.
- We are pleased to report that there were no disagreements with management.

Back to Agenda

Material Uncertainties Related to Events & Conditions/ Fraud & Noncompliance with Laws and Regulations

Any doubt regarding the entity's ability to continue, as a going concern, should be communicated to the FAC.

Fraud involving senior management and fraud (whether caused by senior management or other employees) that causes a material misstatement of the consolidated financial statements should be communicated. We are also required to communicate any noncompliance with laws and regulations involving senior management that come to our attention, unless clearly inconsequential.

OUR COMMENTS

- No such matters came to our attention
- We have not become aware of any instances of fraud or noncompliance with laws and regulations.

Back to Agenda

Other Material Written Communications

The FAC should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to CalOptima's consolidated financial statements, or the auditor's report.

OUR COMMENTS

- We have requested certain representations from management that will be included in the representation letter, which we will receive prior to issuance.
- Other than the engagement letter, management representation letter, and communication to those charged with governance, there have been no other significant communications.

Back to Agenda

Management’s Consultation with Other Accountants

In some cases, management may decide to consult about auditing and accounting matters. If management has consulted with other accountants about an auditing and accounting matter that involves application of an accounting principle to CalOptima’s consolidated financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts.

OUR COMMENTS

- We are not aware of any significant accounting or auditing matters for which management consulted other accountants.

Back to Agenda

Areas of Audit Emphasis

- Capitation Revenue and Receivables
- Cash and Investments
- Medical Claims Liability
- Payable to State of California

Back to Agenda

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Back to Agenda

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THANK YOU

The material appearing in this presentation is for informational purposes only and should not be construed as advice of any kind, including, without limitation, legal, accounting, or investment advice. This information is not intended to create, and receipt does not constitute, a legal relationship, including, but nor limited to, an accountant-client relationship. Although this information may have been prepared by professionals, it should not be used as a substitute for professional services. If legal, accounting, investment, or other professional advice is required, the services of a professional should be sought.

Assurance, tax, and consulting offered through Moss Adams LLP. Wealth management offered through Moss Adams Wealth Advisors LLC. Investment banking offered through Moss Adams Capital LLC.

Back to Agenda

CalOptima Foundation Board Action Agenda Referral

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

Report Item
10. Consider Accepting and Receiving and Filing CalOptima Foundation Fiscal Year 2017 Audited Financial Statements

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

Recommended Action
Accept and receive and file the CalOptima Foundation Fiscal Year (FY) 2017 audited financial statements as submitted by independent auditors Moss-Adams, LLP.

Background/Discussion
Moss-Adams has been contracted to audit the financial statements of the CalOptima Foundation since May 21, 2015, and has prepared a FY 2017 Audit Plan. The plan included performing the mandatory annual consolidated financial statement audit, and the drafting of the consolidated financial statements for the year ending June 30, 2017.

Moss-Adams performed the interim audit from May 23, 2017 through May 26, 2017, and the year-end on-site audit from July 24, 2017, through August 11, 2017.

Results from the CalOptima Foundation's FY 2017 Audit were positive. The auditor made no changes in the Foundation's approach to applying the critical accounting policies, and did not report encountering any significant difficulties during the audit. Additionally, there were no material misstatements identified by the auditor. As such, Management recommends that the Foundation Board to accept the CalOptima Foundation FY 2017 audited financial statements as presented.

Fiscal Impact
There is no fiscal impact related to this recommended action.

Concurrence
Gary Crockett, Chief Counsel
CalOptima Foundation Audit Committee

Attachments
1. FY 2017 CalOptima Foundation Audited Financial Statements
2. Presentation by Moss-Adams, LLP

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

Back to Agenda

REPORT OF INDEPENDENT AUDITORS AND FINANCIAL STATEMENTS

FOR

CALOPTIMA FOUNDATION

June 30, 2017 and 2016

MOSSADAMS.COM

Back to Agenda

Table of Contents

	PAGE
Management's Discussion and Analysis	1–3
Report of Independent Auditors	4–5
Financial Statements	
Statements of Net Position	6
Statements of Revenues, Expenses and Changes in Net Position	7
Statements of Cash Flows	8
Notes to Financial Statements	9–10

Back to Agenda

Introduction

CalOptima Foundation (the "Foundation") is a not-for-profit organization and foundation established by Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") in June 2010. It was formed for the benefit of CalOptima members and others in the Orange County community. One of the primary objectives for the Foundation is to take advantage of health related programs and funding opportunities that are not available to governmental entities. Other planned activities are focused on addressing unmet community needs and increasing provider capacity.

The following discussion and analysis of the Foundation's financial statements presents an overview of the financial position and activities as of June 30, 2017 and 2016. This discussion has been prepared by management and should be read in conjunction with the accompanying financial statements and related notes.

Using the Financial Statements

The Foundation's annual report contains three financial statements: the statement of net position, the statement of revenues, expenses and changes in net position, and the statement of cash flows. The report was prepared using the accrual basis of accounting. These statements provide information on the Foundation as a whole and present the Foundation's financial position and results of operations. In the opinion of management, the financial statements represent accurately the financial situation of the Foundation as of June 30, 2017 and 2016. The various components of the financial statements document financial position of the Foundation and its ability to meet its financial obligations as they come due.

Financial Highlights

The Foundation was formed in June 2010. The total assets and liabilities as of June 30, 2017 and 2016 were $2,893,139 and $2,930,204, respectively.

As approved by the CalOptima Board of Directors, management team are working with contracted vendor to conduct a Member Health Needs Assessment. The results of this assessment will be utilized by CalOptima's Board of Directors and executive staff to guide future grant making and program development opportunities in CalOptima Foundation for improving the overall health of CalOptima members.

CalOptima Regional Extension Center (COREC), which is part of the CalOptima Foundation, achieved 100 percent of the Health Information Technology for Economic and Clinical Health (HITECH) grant goal during 2017 for assisting local doctors with the use of electronic health record systems. The completion date for the HITECH grant, as extended, was September 26, 2016.

Back to Agenda

Statements of Net Position

The statements of net position are point-in-time financial statements. The purpose of these statements is to present a fiscal snapshot of the Foundation to the readers of the financial statements at June 30, 2017 and 2016. The statements of net position include year-end information concerning current and noncurrent assets, current and noncurrent liabilities, and net position (assets less liabilities). Current assets and liabilities include other assets and obligations that can reasonably expect to be sold, collected, consumed or paid within 12 months of the date of the statement. The statements also present the available assets that can be used to satisfy those liabilities.

The following table summarizes the Foundation's assets, liabilities and net position as of June 30, 2017 and June 30, 2016:

	2017	2016
Current assets	$ 2,893,139	$ 2,930,204
Total assets	$ 2,893,139	$ 2,930,204
Current liabilities	$ 25,000	$ 35,359
Net position	2,868,139	2,894,845
Total liabilities and net position	$ 2,893,139	$ 2,930,204

Statements of Revenues, Expenses and Changes in Net Position

Changes in net position as presented on the statements of net position are based on the activity presented in the statements of revenues, expenses and changes in net position. The purpose of the statements is to present the revenue earned by the Foundation, both operating and nonoperating, and the expenses incurred by the Foundation, both operating and nonoperating, and any other revenues, expenses, gains and losses earned or incurred by the Foundation.

The following table summarizes the Foundation's revenues, expenses and changes in net position for the years ended June 30:

	2017	2016	2015
Revenues:			
Operating revenues			
Grant revenue	$ 27,164	$ 304,593	$ 249,283
Contributions	53,665	348,730	235,478
Total revenues	80,829	653,323	484,761
Operating expenses	107,535	665,082	578,182
Change in net position	(26,706)	(11,759)	(93,421)
Net position:			
Beginning	2,894,845	2,906,604	3,000,025
Ending	$ 2,868,139	$ 2,894,845	$ 2,906,604

Back to Agenda

Statements of Revenues, Expenses and Changes in Net Position (continued)

Operating revenues – For the years ended June 30, 2017, 2016 and 2015, operating revenues totaled $80,829, $653,323, and $484,761, respectively. The revenues are from HITECH grant activities and contributions from CalOptima. CalOptima provided $53,665, $348,730, and $235,478, respectively, of staff services that are recognized as non-exchange transactions for the years ended June 30, 2017, 2016, and 2015.

Operating expenses – For the years ended June 30, 2017, 2016 and 2015, operating expenses totaled $107,536, $665,082, and $578,182, respectively. The expenses from the HITECH grant activities include staff services, miscellaneous supplies, and travel.

Economic Factors That May Affect the Future

In 2010, the Foundation was awarded the HITECH grant with projected total revenues in excess of $6.6 million over four years. As of June 30, 2017, the Foundation has received $6.6 million of the HITECH grant, with finalization of remaining funding completed early in fiscal 2017.

Requests for Information

This financial report has been prepared in the spirit of full disclosure to provide the reader with an overview of CalOptima Foundation's operations. If the reader has questions or would like additional information about CalOptima Foundation, please direct the request to CalOptima Foundation, 505 City Parkway West, Orange, CA 92868 or call 714.347.3237.

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Report of Independent Auditors

The Board of Directors
CalOptima Foundation

Report on Financial Statements

We have audited the accompanying financial statements of CalOptima Foundation (the "Foundation"), a component unit of the Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima, as of and for the years ended June 30, 2017 and 2016, and the related notes to the financial statements, which collectively comprise the Foundation's basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States of America; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Foundation as of June 30, 2017 and 2016, and the respective changes in financial position and, where applicable, cash flows thereof for the years then ended, in accordance with accounting principles generally accepted in the United States of America.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 1 to 3 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, which considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquires, the basic financial statements and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Moss Adams LLP

Irvine, California
October 5, 2017

Back to Agenda

	JUNE 30, 2017	JUNE 30, 2016
ASSETS		
CURRENT ASSETS		
Cash	$ 2,893,139	$ 2,894,845
Grants receivables	-	35,359
Total assets	$ 2,893,139	$ 2,930,204
LIABILITIES AND NET POSITION		
CURRENT LIABILITIES		
Accounts payable	$ -	$ 35,298
Payable to CalOptima	25,000	61
Total liabilities	25,000	35,359
UNRESTRICTED NET POSITION	2,868,139	2,894,845
Total liabilities and net position	$ 2,893,139	$ 2,930,204

See accompanying notes.

Back to Agenda

CalOptima Foundation
Statements of Revenues, Expenses and Changes in Net Position

	YEARS ENDED JUNE 30, 2017	YEARS ENDED JUNE 30, 2016
Operating Revenues		
Grant revenue	$ 27,164	$ 304,593
Total operating revenues	27,164	304,593
Operating Expenses		
Salaries, wages, and employee benefits	53,435	363,086
Supplies and other	54,100	301,996
Total operating expenses	107,535	665,082
Operating loss	(80,371)	(360,489)
Nonoperating Revenues		
Contributions	53,665	348,730
Total nonoperating revenues	53,665	348,730
Change in net position	(26,706)	(11,759)
Net Position		
Beginning	2,894,845	2,906,604
Ending	$ 2,868,139	$ 2,894,845

See accompanying notes.

Back to Agenda

	YEARS ENDED JUNE 30, 2017	2016
CASH FLOWS FROM OPERATING ACTIVITIES		
Grant payments and contributions received	$ 62,523	$ 317,857
Payments to vendors	(64,459)	(321,576)
Payments to employees	230	(14,356)
Net cash used in operating activities	(1,706)	(18,075)
Net change in cash	(1,706)	(18,075)
Cash		
Beginning	2,894,845	2,912,920
Ending	$ 2,893,139	$ 2,894,845
RECONCILIATION OF OPERATING LOSS TO NET CASH USED IN OPERATING ACTIVITIES		
Operating loss	$ (80,371)	$ (360,489)
Contributions	53,665	348,730
Adjustments to reconcile operating loss to net cash used in operating activities:		
Changes in assets and liabilities		
Grant receivables	35,359	13,264
Accounts payable	(35,298)	(14,606)
Payable to CalOptima	24,939	(4,974)
Net cash used in operating activities	$ (1,706)	$ (18,075)

See accompanying notes.

Back to Agenda

Note 1 – Nature of Operations, Reporting Entity and Significant Accounting Policies

Nature of operations – CalOptima Foundation (the Foundation) is a nonprofit organization formed in June 2010 in the state of California. The operations of the Foundation include, but are not limited to, applying for and administering grants dedicated to the betterment of public health-care services. The Foundation is organized and operated exclusively to benefit Orange County Health Authority, a Public Agency/dba Orange Prevention and Treatment Integrated Medical Assistance/dba CalOptima ("CalOptima") program needs.

Reporting entity – The Foundation has no component units, but is a component unit of CalOptima because the Foundation's governing body is the same as the governing body of CalOptima. The financial statements present only the Foundation, and do not purport to, and do not present, the financial position of CalOptima as of June 30, 2017 and 2016, or the changes in its financial position, or its cash flows for the years then ended, in conformity with accounting principles generally accepted in the United States of America.

Basis of accounting – The financial statements of the Foundation have been prepared using the economic resource management focus and the accrual basis of accounting. Revenues are recognized when earned, and expenses and liabilities are recognized when incurred.

The Foundation considers grant revenues earned as operating revenue. Expenses associated with managing the grant and the Foundation are considered operating expenses. All revenues and expenses not meeting this definition are reported as nonoperating revenues and expenses.

Net position – Net position represents the difference between assets and liabilities. Net position is reported as restricted if there are limitations imposed on their use. When an expense is incurred for purposes for which both restricted and unrestricted net positions are available, the Foundation first applies restricted resources. The Foundation had no restricted net position at June 30, 2017 or 2016.

Revenue recognition – Grant revenue and contributions are recorded as earned over the period covered in accordance with the grant provisions.

Income tax status – The Internal Revenue Service has recognized the Foundation as exempt from federal and state income tax on related income under Section 501(c)(3) of the Internal Revenue Code. The Foundation is not classified as a private foundation. The Foundation has reviewed its tax positions for all open tax years and has concluded that no liabilities exist as of June 30, 2017 and 2016. The Foundation files tax returns with the U.S. federal and the State of California jurisdictions.

Note 2 – Cash and Custodial Credit Risk

As of June 30, 2017 and 2016, all cash deposits held with financial institutions were insured by the Federal Deposit Insurance Corporation and through securities pledged by the financial institutions held in an individual collateral pool by a depository regulated under California state law.

Back to Agenda

Note 3 – Related-Party Transactions

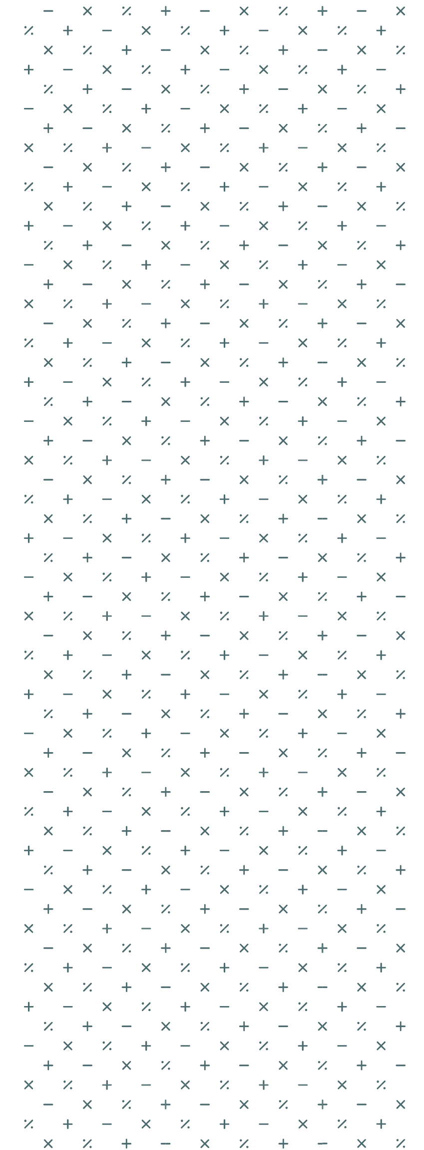
CalOptima provides certain services for the benefit of the Foundation at no charge. The cost of the services provided by CalOptima is reported as in-kind income and expenses by the Foundation. These services include, but are not limited to: staff compensation, travel, equipment and supplies. Total contributions from CalOptima were $53,655 and $348,730, for the years ended June 30, 2017 and 2016, respectively. As of June 30, 2017 and 2016, the Foundation has recorded a payable to CalOptima of $25,000 and $61, respectively.

Note 4 – Grant Revenue

The Foundation was awarded a four-year HITECH grant on September 26, 2010, plus a one-year post-award amendment effective until September 26, 2015. During the year ended June 30, 2016, the Foundation received an additional one-year post-award amendment, which extended the award to September 26, 2016. This grant is for the Foundation to assist Orange County health-care providers with adopting and implementing electronic health records. The Foundation is responsible for enrolling 1,000 providers as well as project management of multiple phases of demonstrating meaningful use. Grant income is recognized when qualifying expenditures have been incurred and upon achievement of other criteria. Recipients of the HITECH grant are required to meet a 10 percent match in proportion to the expenditures of the federal share of the total project costs. CalOptima provides this match through in-kind contributions. The funds from the HITECH grant were fully expended during the year ended June 30, 2017.

Back to Agenda

2017 Audit Results: CalOptima Foundation



Back to Agenda

CalOptima Foundation

Dear Foundation Audit Committee (FAC) Members:

Thank you for your continued engagement of Moss Adams LLP. We are pleased to have the opportunity to meet with you to discuss the results of our audit of the financial statements of CalOptima Foundation ("the Foundation") for the year ended June 30, 2017.

The accompanying report, which is intended solely for the use of the FAC and management, presents important information regarding the Foundation's financial statements and our audit that we believe will be of interest to you. It is not intended and should not be used by anyone other than these specified parties.

We receive the full support and assistance of the Foundation's personnel. We are pleased to serve and be associated with the Foundation as its independent public accountants and look forward to our continued relationship.

We look forward to discussing our report or any other matters of interest with you during this meeting.

Back to Agenda

Agenda

- Auditor Opinions and Reports
- Communication with FAC
- Areas of audit emphasis

Back to Agenda

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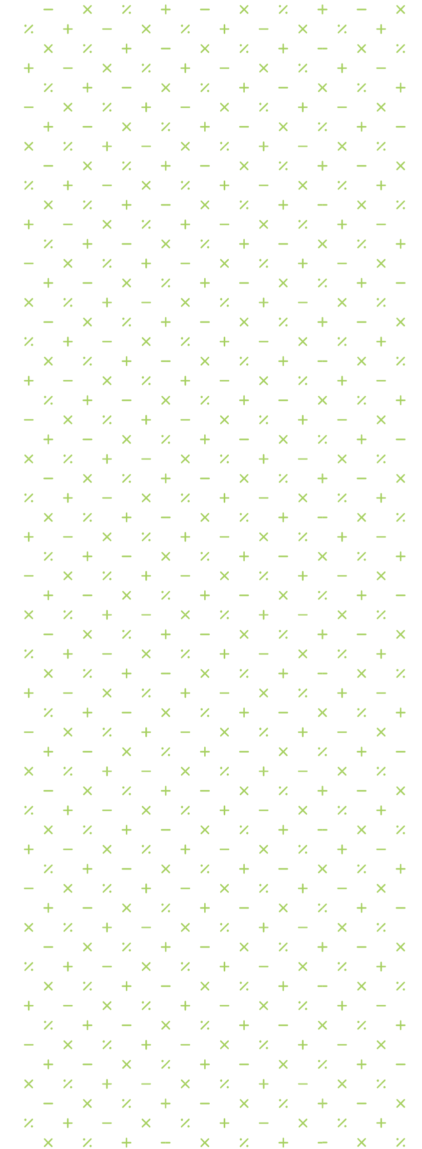
Auditor Opinion & Report



Back to Agenda

Scope of Services

We have performed the following services for CalOptima Foundation:

- Annual financial statement audit for the year ended June 30, 2017

We have also performed the following non-attest services:

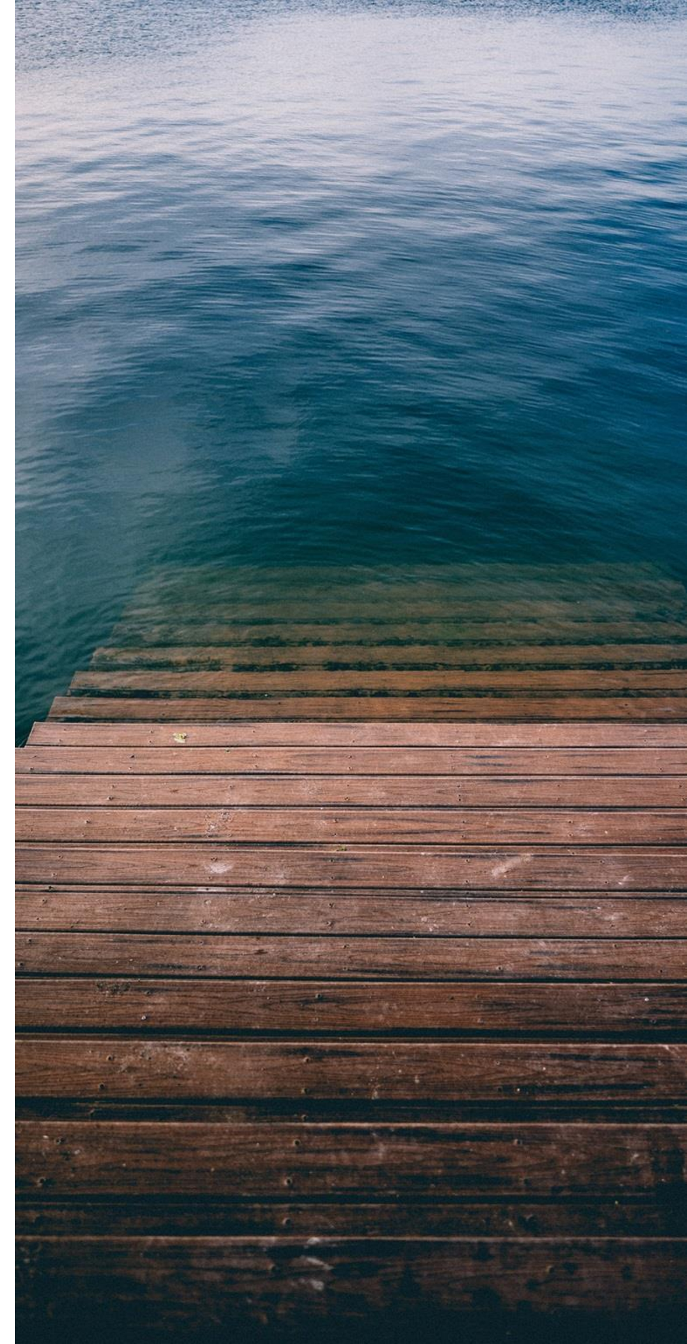
- Assisted in the drafting of the financial statements of the Foundation
- Preparation of the Form 990 for the Foundation

Back to Agenda

Auditor Report on the Financial Statements

Unmodified Opinion

- Financial statements are presented fairly and in accordance with US GAAP



Back to Agenda

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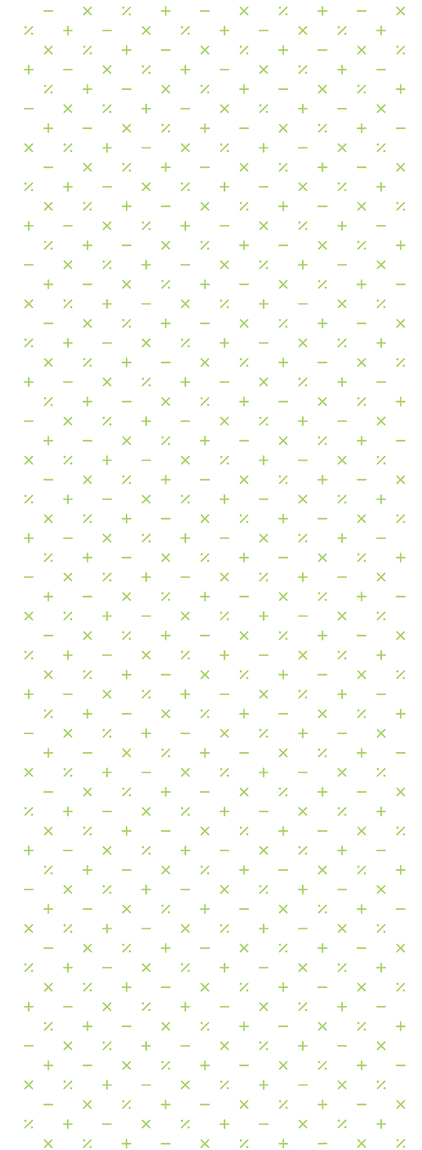
Communication with FAC



Back to Agenda

Our Responsibility

Our responsibility under US Generally Accepted Auditing Standards.

1

To express our opinion on whether the financial statements prepared by management with your oversight are fairly presented, in all material respects, and in accordance with U.S. GAAP. However, our audit does not relieve you or management of your responsibilities.

2

To perform an audit in accordance with generally accepted auditing standards issued by the AICPA and design the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free of material misstatement.

3

To consider internal control over financial reporting as a basis for designing audit procedures but not for the purpose of expressing an opinion on its effectiveness or to provide assurance concerning such internal control.

4

To communicate findings that, in our judgment, are relevant to your responsibilities in overseeing the financial reporting process. However, we are not required to design procedures for the purpose of identifying other matters to communicate to you.

Back to Agenda

Planned Scope & Timing of the Audit

It is the auditor's responsibility to determine the overall audit strategy and the audit plan, including the nature, timing and extent of procedures necessary to obtain sufficient and appropriate audit evidence and to communicate with those charged with governance and overview of the planned scope and timing of the audit.

OUR COMMENTS

- The planned scope and timing of the audit was communicated to the Foundation's FAC at the audit entrance meeting and was included in the engagement letter for the year ended June 30, 2017

Back to Agenda

Significant Accounting Policies & Unusual Transactions

The auditor should determine that the FAC is informed about the initial selection of and changes in significant accounting policies or their application. The auditor should also determine that the FAC is informed about the methods used to account for significant unusual transactions and the effect of significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

OUR COMMENTS

- Management has the responsibility for selection and use of appropriate accounting policies. The significant accounting policies used by the Foundation are described in the footnotes to the financial statements. Throughout the course of an audit, we review changes, if any, to significant accounting policies or their application, and the initial selection and implementation of new policies. There were no changes to significant accounting policies for the year ended June 30, 2017.
- We believe management has selected and applied significant accounting policies appropriately and consistent with those of the prior year.

Back to Agenda

Management Judgements & Accounting Estimates

The FAC should be informed about the process used by management in formulating particularly sensitive accounting estimates and about the basics for the auditor's conclusions regarding the reasonableness of those estimates.

OUR COMMENTS

- Management's judgements and accounting estimates are based on knowledge and experience about past and current events and assumptions about future events. We apply audit procedures to management's estimates to ascertain whether the estimates are reasonable under the circumstances and do not materially misstate the financial statements.
- Significant management estimates impacted the financial statements including the following: **grant revenue**
- We deem them to be reasonable

Back to Agenda

Management Judgements & Accounting Estimates

Our views about the quantitative aspects of the entity's significant accounting policies, accounting estimates, and financial statement disclosures.

OUR COMMENTS

- The disclosures in the financial statements are clear and consistent. Certain financial statement disclosures are particularly sensitive because of their significance to financial statements users. We call your attention to the following notes:
- Note 1 – Nature of operations, Reporting Entity and Significant Accounting Policies

Back to Agenda

Significant Audit Adjustments & Unadjusted Differences Considered by Management to Be Immaterial

The FAC should be informed of all significant audit adjustments arising from the audit. Consideration should be given to whether an adjustment is indicative of a significant deficiency or a material weakness in the Foundation's internal control over financial reporting, or in its process for reporting interim financial information, that could cause future financial statements to be materially misstated.

The FAC should also be informed of uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented that were determined by management to be immaterial, both individually and in the aggregate, to the financial statements as a whole.

OUR COMMENTS

- There were no corrected or uncorrected audit adjustments.

Back to Agenda

Deficiencies in Internal Control

Any material weaknesses and significant deficiencies in the design or operation of internal control that came to the auditor's attention during the audit must be reported to the FAC.

OUR COMMENTS

- Material weakness
  - None noted
- Significant deficiencies
  - Nothing to communicate

Back to Agenda

Potential Effect on the Financial Statements of Any Significant Risks & Exposures

The FAC should be adequately informed of the potential effect on financial statements of significant risks and exposures and uncertainties that are disclosed in the financial statements.

OUR COMMENTS

- The Foundation is subject to potential legal proceedings and claims that arise in the ordinary course of business, which are disclosed in the notes to the financial statements.

Back to Agenda

Difficulties Encountered in Performing the Audit

The FAC should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the Foundation's financial statements, or the auditor's report.

OUR COMMENTS

- No significant difficulties were encountered during our audit.
- We are pleased to report that there were no disagreements with management.

Back to Agenda

Material Uncertainties Related to Events & Conditions/ Fraud & Noncompliance with Laws and Regulations

Any doubt regarding the entity's ability to continue, as a going concern, should be communicated to the FAC.

Fraud involving senior management and fraud (whether caused by senior management or other employees) that causes a material misstatement of the financial statements should be communicated. We are also required to communicate any noncompliance with laws and regulations involving senior management that come to our attention, unless clearly inconsequential.

OUR COMMENTS

- No such matters came to our attention
- We have not become aware of any instances of fraud or noncompliance with laws and regulations.

Back to Agenda

Other Material Written Communications

The FAC should be informed of any significant difficulties encountered in dealing with management related to the performance of the audit, including disagreements with management, whether or not satisfactorily resolved, about matters that individually or in the aggregate could be significant to the Foundation's financial statements, or the auditor's report.

OUR COMMENTS

- We have requested certain representations from management that will be included in the representation letter, which we will receive prior to issuance.
- Other than the engagement letter, management representation letter, and communication to those charged with governance, there have been no other significant communications.

Back to Agenda

Management's Consultation with Other Accountants

In some cases, management may decide to consult about auditing and accounting matters. If management has consulted with other accountants about an auditing and accounting matter that involves application of an accounting principle to the Foundation's financial statements or a determination of the type of auditor's opinion that may be expressed on those statements, our professional standards require the consulting accountant to check with us to determine that the consultant has all the relevant facts.

OUR COMMENTS

- We are not aware of any significant accounting or auditing matters for which management consulted other accountants.

Back to Agenda

Areas of Audit Emphasis

- Grant revenue
- Cash

Back to Agenda

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In today's fast-paced world, we know how precious your time is. We also know that knowledge is key. These resources offer what you need to know, when you need to know it, and is presented in the format that fits your life.

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Back to Agenda

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THANK YOU

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Back to Agenda

CalOptima Board Action Agenda Referral

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

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

Contact
Ladan Khamseh, Chief Operations Officer, (714) 246-8400
Lori Shaw, Executive Director Human Resources, (714) 246-8400

Recommended Action
1. Adopt Resolution Approving CalOptima's Updated Human Resources Policies GA.8031 Internship Program and GA.8058 Salary Schedule.

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

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

The following table lists 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.8031 Internship Program	• Minor language and formatting changes • Included greater specificity for purpose of the program, eligibility requirements and procedures for both paid and unpaid internships • Added language that specifies how school agreements for interns will be handled • Added language on when to consider interns for benefits	- Annual review with minor updates and formatting changes - HR/Legal recommendations - Paid Sick Leave, ACA - GA.8030 Background Check policy

		• Added Medi-Cal Suspended & Ineligible (S&I) list as part of background check	
2.	GA.8058 Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment A – Salary Schedule has been revised in order to reflect recent changes, including the addition of a position. A summary of the changes to the Salary Schedule is included for reference.	- 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. 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)

Fiscal Impact

The recommended action to add a new position, Supervisor Behavioral Health, is funded through Board actions taken at the September 7, 2017 meeting authorizing the provision of behavioral health services for CalOptima Medi-Cal members.

Rationale for Recommendation

The proposed new Supervisor Behavioral Health (BH) position is responsible for the daily operation of Member Liaison Specialists (MLS) activities to ensure members receive appropriate BH care management needs, which includes, but is not limited to, securing BH appointment for members, following up with members before and after appointments, providing member information and referring to community resources, conducting utilization review, and assisting members in navigating the mental health system of care. The position is accountable for establishing and achieving quality and productivity standards for the teams, and for ensuring compliance with department policies and procedures. In addition, the incumbent will provide clinical support for the CalOptima BH phone line triage team, and work under the direction of the Manager, BH and in partnership with the Director and/or other department leadership to support department goals. The proposed position is to be a resource for CalOptima providers, health networks and community partners.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Resolution No. 17-1102, Approve Updated Human Resources Policies

Back to Agenda

2. Revised CalOptima Policies:
   a. GA.8031 Internship Program (redlined and clean copies)
   b. GA.8058 Salary Schedule (redlined and clean copies) with revised Attachment A
3. Summary of Changes to Salary Schedule

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

Back to Agenda

RESOLUTION NO. 17-1102

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.8031 Internship Program; and GA.8058 Salary Schedule.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Policy #:	GA.8031
Title:	**Internship Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader ______
	~~2/1~~
Effective Date:	02/01/14
Last Review Date:	11/02/17
Last Revised Date:	11/02/17

I. PURPOSE

~~To establish~~This policy establishes an Internship Program ~~structure compliant with federal and state laws, and to~~ to provide an opportunity for vocational, college, university, and/or graduate students to apply traditional academic classroom learning to actual work experience~~.~~

~~II. DEFINITIONS~~

~~A. Internship Program: A program offered by CalOptima to college and graduate students to apply traditional academic classroom learning to actual work experience.~~

~~B. Sponsoring Department: A department~~ within ~~CalOptima requesting~~Orange County's only public agency health plan, and to support our community by providing a ~~college or graduate student intern and overseeing~~cost effective means to create an experienced and skilled workforce for the ~~management and work of the interns pursuant to this Policy.~~ future.

~~III.~~II. POLICY

A. CalOptima may offer paid or unpaid internship positions, at the discretion of each Sponsoring Department, and in accordance with U.S. Department of Labor (DOL) Fair Labor Standards Act (FLSA) guidelines, to provide students in vocational, college, university, or graduate level courses with practical experience.

B. CalOptima shall comply with all applicable laws and regulations with respect to CalOptima's administration of the Internship Program, including, but not limited to, licensing or certification requirements.

~~B.~~C. Interns are not intended to displace employees, and interns should not be used as a means to fill vacant positions.

D. ~~Each Sponsoring~~This policy excludes residency/fellowships in connection with pharmacy and medical programs.

~~C.~~E. The Human Resources Department, with the assistance of the ~~Human Resources~~Sponsoring Department, shall be responsible for administering the Internship Program within the respective Sponsoring Department, and ensuring that the following Internship Program guidelines are followed.

1. Unpaid ~~Internships~~Internship Requirements

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a. According to the ~~U.S. Department of Labor (~~DOL~~),~~, in order to qualify as ~~trainees/interns~~a trainee/intern exempt from the minimum wage requirements, the following six (6) criteria must be met:

i. The internship, even though it includes actual operation of the facilities of the employer, is similar to training which would be given in an educational environment;

ii. The internship experience is for the benefit of the intern;

iii. The intern does not displace regular employees, but works under close supervision of existing staff;

iv. The employer that provides the training derives no immediate advantage from the activities of the intern, and on occasion its operations may actually be impeded;

v. The intern is not necessarily entitled to a job at the conclusion of the internship; and

vi. The employer and intern understand that the intern is not entitled to wages for the time spent in the internship.

b. Unpaid Intern Relationship~~:~~

i. Unpaid interns must be enrolled in a college or university two- or four-year degree program, ~~two-year degree program, or~~an accredited vocational institution, or a graduate program, and will receive school credit for the internship.

ii. The Human Resources Department, with the assistance of the Sponsoring ~~Departments~~Department, shall be responsible for ensuring the Internship Program for unpaid interns meets the DOL's six (6) criteria~~.~~ as described in Section II.E.1.a. of this policy.

2

iii. Unpaid interns shall not be deemed employees of CalOptima, but rather, are volunteers as defined pursuant to Title 29, Code of Federal Regulations (CFR~~) Title 29,~~), Section 553.101.

iv. As a result, unpaid interns are not covered under CalOptima's workers' compensation policy.

~~2.~~v. However, unpaid interns are considered members of CalOptima's "workforce" as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) regulations at ~~CFR~~ Title 45, CFR, Section 160.103, and shall therefore be required to comply with all HIPAA requirements.

vi. ~~Paid Internships:~~ School agreements will be coordinated by the Budget and Vendor Management Department with approval of the agreement template and any deviations therefrom by the Legal Affairs Department, and final approval by the Chief Executive

DRAFT

1 Officer. School agreements should be presented to the Board of Directors for approval
2 in situations where the school requires adherence to their agreement(s), as written, and
3 staff identifies potential risks. Approved and signed school agreements will be reviewed
4 annually by the Sponsoring Department, HR, and the Budget and Vendor Management
5 Departments.
6
7 2. Paid Internship Requirements/Relationship
8
9 a. At the discretion of each Sponsoring Department, the Sponsoring Department may provide
10 paid internship positions to qualified candidates meeting the education, qualifications, and
11 experience required by the Sponsoring Department.
12
13 b. Paid interns must be enrolled in a college or university two (2)- or four (4)-year degree
14 program, an accredited vocational institution or a graduate program, and may receive school
15 credit for the internship.
16
17 c. In the case of a paid intern's school requiring a signed agreement with CalOptima, the following
18 will be required: School agreements will be coordinated by the Budget and Vendor
19 Management Department with approval of the agreement template and any deviations therefrom
20 by the Legal Affairs Department, and final approval by the Chief Executive Officer. School
21 agreements should be presented to the Board of Directors for approval in situations where the
22 school requires adherence to their agreement(s), as written, and staff identifies potential risks.
23 Approved and signed school agreements will be reviewed annually by the Sponsoring
24 Department, HR, and the Budget and Vendor Management Departments.
25
26 d. A Sponsoring Department's ability to use paid student interns will be based on the Sponsoring
27 Department's internal budget constraints.
28
29 e. Paid student interns will be hired into approved open intern positions under the Intern job title,
30 which is an As--Needed classification.
31
32 f. Paid interns shall be paid at least minimum wage, and will be considered employees of
33 CalOptima for the purposes of Workers' Compensation insurance and members of CalOptima's
34 "workforce" as that term is defined by HIPAA regulations at CFR Title 45, CFR, Section
35 160.103.
36
37 g. Paid interns who work thirty (30) or more days within one (1) year from the start of their date of
38 employment shall receive twenty-four (24) hours or three (3) days, whichever is greater, of paid
39 sick leave beginning at the commencement of employment or engagement, subject to the
40 restrictions for use pursuant to CalOptima Policy GA.8018: Paid Time Off (PTO).
41
42 3.h. Paid interns will not be entitled to any other benefits for time spent performing work as part of
43 the internship, or any time thereafter.. However, if a paid intern is averaging thirty (30) or more
44 hours per week, his or her assignment will conclude on or before the ninetieth (90) calendar day
45 of employment, unless the Sponsoring Department has arranged in advance to change the status
46 of the intern to either full-time or part-time and offer benefits to comply with the Affordable
47 Care Act (ACA).

DRAFT

1
2 3. CalOptima Employee as a Volunteer:
3
4 a. Additional issues must be considered when the proposed intern is a CalOptima employee
5 who is volunteering his or her services at CalOptima.
6
7 b. Such persons may not volunteer to perform the same type of services in which the
8 individual is employed to perform for CalOptima (e.g., non-exempt Media
9 RelationsGovernment Affairs Department staff volunteering on the weekend to speak about
10 CalOptima at a community event).
11
12 4.c. If the proposed intern or volunteer is a CalOptima employee, the Human Resources and/or
13 Legal Affairs Department must be consulted for an exception.
14
15 D.F. Intern Qualifications (Unpaid Intern)
16
17 1. Interns will be required to:
18
19 a. Pass a background investigation, including a review of the Office of Inspector General
20 (OIG) List of Excluded Individuals/Entities (LEIE) the General Services Administration's
21 (GSA) System for Award Management (SAM) OIG/SAM and the Medi-Cal Suspended &
22 Ineligible ("S&I") Website.
23
24 a. Meet Pass a background investigation and reference check;
25
26 b. the school requirements for his or her internship program. Submit an application, resume,,
27 and cover letter; to CalOptima.
28 b.
29
30 c. Provide proof of concurrent enrollment in an academic internship course and/or credit in
31 college or, university, graduate courses; or an accredited vocational institution.
32
33 d. Submit a signed acknowledgment confirming the intern understands:
34
35 i. The expectations;
36
37 ii. That the intern is not entitled to a job at the conclusion of the internship;
38
39 iii. That either:
40
41 1) The intern is an unpaid intern and is not entitled to wages or benefits for time
42 spent performing work as part of the internship; or
43
44 2)iii. The intern is a paid intern and is entitled only to specified wages as presented in
45 the offer letter, but is not otherwise entitled to any other benefits;
46

DRAFT

iv. That the internship is a voluntary, at-will relationship, which can be terminated at any time;

v. The intern releases CalOptima of all liability, promises not to sue, and assumes all risks associated with participating in the internship program; and

vi. The intern agrees to comply with all CalOptima Policies and Procedures and understands that CalOptima may prohibit an intern from continuing in the program, regardless of whether the individual has completed personal objectives or school requirements.

e. Complete HIPAA and compliance training programs; and

e. Comply, along with all tuberculosis (TB) or health screening requirements for the position, where applicable CalOptima Policies and Procedures as determined by the Human Resources Department and/or the Sponsoring Department. .

f. Sign CalOptima's confidentiality agreement.

G. Intern Qualifications (Paid Intern)

1. Interns will be required to:

a. Pass a background investigation, including a review of the OIG LEIE, the GSA OIG/SAM, and the Medi-Cal S&I Website.

b. Submit an application through CalOptima's applicant tracking system.

c. Meet the school requirements for his or her internship program if applicable.

d. Provide proof of concurrent enrollment in college, university, graduate courses or an accredited vocational institution.

e. Submit a signed acknowledgment confirming the intern understands:

i. The expectations;

ii. That the intern is not entitled to a job at the conclusion of the internship;

iii. The intern is a paid intern and is entitled only to specified wages as presented in the offer letter, but is not otherwise entitled to any other benefits unless the intern works thirty (30) or more days within one (1) year from the start of his or her date of employment, then he or she will be provided with up to twenty-four (24) hours or three (3) days, whichever is greater, of paid sick leave, as specified in CalOptima Policy GA.8018: Paid Time Off (PTO);

DRAFT

1 iv. In the event the paid intern works over forty (40) hours in any one (1) work week, he or
2 she is entitled to overtime pay at the rate of 1 ½ times the non-exempt intern's regular
3 rate of pay. Overtime must be approved in advance by management.
4
5 v. Paid interns will not be entitled to any other benefits for time spent performing work as
6 part of the internship. However, if a paid intern is averaging thirty (30) or more hours
7 per week, his or her assignment will conclude on or before the ninetieth (90) calendar
8 day of employment, unless the Sponsoring Department has arranged in advance to
9 change the status of the intern to either full-time or part-time and offer benefits to
10 comply with the Affordable Care Act (ACA).
11
12 vi. That the internship is a voluntary, at-will relationship, which can be terminated at any
13 time;
14
15 vii. The intern releases CalOptima of all liability, promises not to sue, and assumes all risks
16 associated with participating in the internship program; and
17
18 viii. The intern agrees to comply with all CalOptima Policies and Procedures and
19 understands that CalOptima may prohibit an intern from continuing in the program,
20 regardless of whether the individual has completed personal objectives or school
21 requirements.
22
23 f. Complete HIPAA and compliance training programs, along with tuberculosis (TB) or health
24 screening requirements for the position, where applicable; and
25
26 g. Sign CalOptima's confidentiality agreement.
27
28 E.H. Internship Program Oversight
29
30 1. The Human Resources Department shall be the designated point of contact to address questions,
31 verify intern qualifications, maintain consistency, and coordinate and administer the Internship
32 Program, including coordination of signed agreements required by the universities or colleges
33 and CalOptima.
34
35 2. Each Sponsoring Department shall be responsible for coordinating with the Human Resources
36 Department and designating a Sponsoring Department contact to serve as the supervisor to the
37 intern.
38
39 3. The designated intern supervisor should be someone who: possesses expertise in the area in
40 which the intern will work; is interested in working with vocational, college, university or
41 graduate students; has the time to invest in the internship; and will oversee and assign the
42 student intern's work.
43
44 4.a. Interns should work a minimum of five (5) hours and a maximum of forty (40) hours per
45 week, and the internship should have a clear start date and clear end date, no longer than a
46 one (1) year duration or one thousand (1,000) hours in a Fiscal Year (whichever comes
47 first), that is identified before the internship begins.. If a paid intern is averaging thirty (30)

DRAFT

1 or more hours per week, his or her assignment will conclude on or before the ninetieth (90)
2 calendar day of employment, unless the Sponsoring Department has arranged in advance to
3 change the status of the intern to either full-time or part-time and offer benefits to comply
4 with the Affordable Care Act (ACA).
5
6 4. Weekly meetings between the intern and the intern supervisor should be held to discuss what
7 has been learned the prior week and what is expected the next week. The intern's supervisor
8 shall document such meetings. The intern's supervisor or department manager shall sign the
9 department intern evaluations.
10
11 5. At the conclusion of the internship, the designated intern supervisor shall submit an interna
12 Department Intern Evaluation Form, or equivalent school provided form and provide a copy to
13 the intern. The intern shall complete a CalOptima Student Evaluation of Internship Form and
14 both forms shall be submitted to -the Human Resources Department.
15
16 6. In the event the intern's college or university requires a form or forms to be completed and
17 executed by CalOptima, any indemnification, hold harmless or insurance language must be
18 reviewed and approved by the Finance and Legal Affairs Departments prior to execution.
19 Budget and Vendor Management Departments prior to the start of the internship program. Any
20 deviations from CalOptima's approved contract templates may also require a review by the
21 Legal Affairs Department, and final approval will be required by the Chief Executive Officer.
22
23
24 **IV.III. PROCEDURE**
25
26 A. Application: Candidates for internship positions shall be required to apply online through
27 CalOptima's applicant tracking system, attaching their resume and cover letter identifying the type
28 of work the candidate is interested in performing, i.e., finance, governmental affairs, health care
29 administration, human resources, etc. Additional requirements and/or submittals may be specified
30 by the Human Resources Department and/or the Sponsoring Department.
31
32 B. Requirements: In order to qualify for an internship, the candidate must meet the following criteria:
33
34 1. Receive credit for the internship and be enrolled in either: (i) a four-year degree program, (ii) a
35 two-year degree program, or (iii) a graduate program;
36
37 2. Submit a letter of recommendation from an instructor at the educational institute he/she is
38 currently enrolled in;
39
40 3. Have a current cumulative Grade Point Average of at least 2.5;
41
42 4. Demonstrate strong verbal and written communication skills, and where applicable, technical
43 skills;

DRAFT

Responsible Party	Action
Intern	1. The intern is responsible for reviewing the internship description and ensuring that he or she meets the qualifications and minimum requirements for the internship before submitting an application. 2. Apply for an intern position either through CalOptima's applicant tracking system online if for a paid internship, or by submitting a paper application for an unpaid internship to HR-. 3. Submit a verification of enrollment from the college, university, accredited vocational institution or graduate program to establish good academic standing and eligibility. 4. Participate in an interview, background check and health screening, if required. 5. If accepted, submit a signed Offer Letter, Internship Agreement and complete other documents, or tests, as required.

DRAFT

Responsible Party	Action
Sponsoring Department	1. Identify and request the number of intern positions per year, and request positions through the annual budget process if paid interns are anticipated. ▪ For paid interns, receive approval and position control numbers from Finance. ▪ For unpaid interns, obtain approval from Executive Director or Chief for each intern or per contractual agreement if an ongoing program. ▪ Coordinate with Facilities for space considerations. 2. Determine length of assignment and scheduled hours. If intern will be averaging thirty (30) or more hours per week, discuss status considerations with HR and the Finance Department for ACA benefit implications and Paid Sick Leave Act requirements. 3. Submit request for intern position to Human Resources, including number of interns requested, details of the position requirements, and period of time. 4. Review internship applications and notify Human Resources to schedule an interview if applicant is qualified. 5. Interview internship applicants. 6. Once a qualified internal applicant has been identified and the Sponsoring Department is interested in selecting that applicant to fill an internship position, coordinate with Human Resources to provide Offer Letter and complete the internship on-boarding process, including but not limited to, background checks, execution of the Internship Agreement, execution of school affiliation agreements, etc. 7. Designate a contact to serve as the supervisor of each intern. 8. Ensure that all required evaluation forms or other forms necessary to ensure the intern receives credit are completed and submitted in a timely manner to the school. Ensure the intern's activities are within the scope of practice applicable to their license or certification and that they perform within this scope if applicable. 9. 10. Ensure the intern meets any and all qualifications as defined by the school. 11. Notify and collaborate with Human Resources if the intern is not adhering to the programs or agency's policies or procedures. 12. Annually review affiliation agreements required by colleges, universities, accredited vocational schools and graduate programs, and update, as appropriate, with the assistance of the Finance and Budget and Vendor Management Departments.

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Responsible Party	Action
Human Resources	1. Administer and coordinate all internships. 2. Receive requests for an intern/s from the Sponsoring Department and verify all necessary approvals, including budgeted positions, have been obtained. 3. Receive and review internship applications from potential interns. 4. Provide Desktop procedure for Internship Program to Sponsoring Department. 5. Coordinate internship interviews and on-boarding process, including but not limited to, background, reference, and review of OIG LEIE, the GSA OIG/SAM, Medi-Cal S&I Website exclusion checks, preparation of offer letters, coordinating health screening, where applicable, and coordinating the intern's start date with the Sponsoring Department. 6. Review the affiliation agreements required by colleges, universities, accredited vocational schools and graduate programs to ensure consistency with CalOptima's operations and requirements. Coordinate the internal review, revision, negotiation, approval and execution of required documents with the Finance and Budget and Vendor Management Departments. Agreements may only be executed on behalf of CalOptima in accordance with the Board approved signature policies. 7. Coordinate on-boarding activities, off-boarding activities, and all training requirements. 8. Maintain all internship records. 9. Monitor and support the internship program activities and outcomes. 10. Annually review affiliation agreements required by colleges, universities, accredited vocational schools and graduate programs, and update, as appropriate, with the assistance of the Finance and Budget and Vendor Management Departments.

1
2 5. Meet Sponsoring Department specified qualifications;
3
4 6. Pass background investigation and reference check; and
5
6 7.b. Submit a signed acknowledgment confirming the intern understands:
7
8 i. The expectations;
9
10 ii.i. That the intern is not entitled to a job at the conclusion of the internship;
11
12 iii. That either:
13
14 1) the intern is an unpaid intern and is not entitled to wages or benefits for time spent
15 performing work as part of the internship; or
16

DRAFT

~~2) the intern is a paid intern and is entitled only to specified wages as presented in the offer letter, but is not otherwise entitled to any other benefits;~~

~~iv. That the internship is a voluntary, at-will relationship, which can be terminated at any time;~~

~~v. The intern releases CalOptima of all liability, promises not to sue, and assumes all risks associated with participating in the internship program; and~~

~~vi. The intern agrees to comply with all CalOptima Policies and Procedures.~~

~~C. Intern Selection Process: The selection of interns should be based on the applicant's demonstrated ability, skills, values, interests, and willingness to learn. CalOptima shall not discriminate based on race, color, ancestry, national origin, religion, sex, marital status, age, medical condition, pregnancy, disability, gender, gender identity, gender expression, genetic information, sexual orientation, or any other prohibited basis in the selection and supervision of interns.~~

~~D. Orientation and Training: Prior to beginning an internship assignment, all student interns shall be required to complete orientation and training, which should include:~~

~~1. HIPAA and compliance training;~~

~~2. CalOptima Policies GA.5005a: Use of Technology Resources and GA.5005b: Email and Internet Use Policy;~~

~~3. A tour of the Sponsoring Department (including emergency evacuation procedures) and introduction to the intern's supervisor and staff who will be working with the intern;~~

~~4. A clear list of expectations, duties, responsibilities and goals; and~~

~~5. A list of resources available to the intern.~~

~~E. Intern Assignments: The primary beneficiary of the internship program should be the intern. To that end, designated intern supervisors should strive to develop a program within their Sponsoring Department which incorporates the following:~~

~~1. Successful learning experience;~~

~~2. Development of transferable skills;~~

~~3. Learning objectives;~~

~~4. Manageable projects; and~~

~~5. Equal time between supervised work and learning (training, shadowing, and networking with other employees).~~

~~F. Intern Responsibilities~~

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1. Interns should:

a. Adhere to CalOptima's Policies, Procedures, and rules governing professional behavior;

b. Be punctual, and work the agreed upon hours at times agreed to by the intern and his or her supervisor;

c. Notify his or her supervisor if they are unable to attend as planned;

d. Behave and dress appropriately to the particular workspace;

e. Respect the confidentiality of the workplace, its members and its employees.

f. Take initiative and volunteer for different tasks or other work; and

g. Discuss any problems with his or her supervisor and, if necessary, with the point of contact in the Human Resources Department.

G. Designated Intern Supervisor Responsibilities

1. Designated intern Supervisors from the Sponsoring Departments are responsible for overseeing and assigning the student intern's work, monitoring the intern's time, and submitting an intern evaluation form.

H. Human Resources Department Responsibilities

1. The Human Resources Department is responsible for being the point of contact for interns, maintaining the Internship Program records, exclusions lists monitoring (Office of Inspector General and System for Award Management), Social Security Number verification and criminal background investigations, ensuring that interns complete required orientation and training, and monitoring the Internship Program.

I. Evaluation

1. Regularly scheduled evaluations help avoid common problems, including miscommunication, misunderstanding of job roles, and lack of specific goals and objectives. Criteria to consider when evaluating in intern should include:

a. Progress towards or accomplishment of learning objectives;

b. Skill development or job knowledge gained over the course of the internship;

c. Overall contribution to CalOptima's mission;

d. Dependability, punctuality, and attendance;

DRAFT

1 e. Relations with others, and overall attitude; and
2
3 f. Potential in the field.
4
5 J. Completion
6
7 1. At the conclusion of the internship, the Supervisor shall:
8
9 a.i.Submit an Intern Observation Form and provide a copy to the intern. The intern shall
10 complete a Student Evaluation of Internship Form and both forms are to be submitted to
11 the Human Resources Department.
12
13 b. Complete all required college/university evaluation or documentation in order for
14 the intern to receive credit;
15
16 c. If requested, write a letter of recommendation (with a copy provided to the Human
17 Resources Department); and
18
19
20 **V.IV. ATTACHMENTS**
21
22 A. Internship Application
23
24 **VI.V. REFERENCES**
25
26 A. California Business and Professions Code §§ 4114, 4116, and 4119.6
27 B. CalOptima Policy GA.5005a: Use8018: Paid Time Off (PTO)
28 C. CalOptima's Student Evaluation of Internship Form
29 D. Department Intern Evaluation Form
30 E. Internship Program Guidelines
31 F. Internship Offer Letter
32 G. Internship Agreement
33 H. Title 29, Code of Federal Regulations (CFR) § 553.101
34 I. Title 45, Code of Federal Regulations (CFR) § 160.103
35 A. U.S. Department of Technology Resources Policy Labor (DOL) Fair Labor Standards Act (FLSA)
36 GuidelinesTitle 29, Code of Federal Regulations (CFR) § 553.101
37 CalOptima Policy GA.5005b: Email and Internet Use Policy
38
39 Title 45, Code of Federal Regulations (CFR) § 160.103California Business and Professions Code §§
40 4114, 4116, and 4119.
41 Internship Program Guidelines
42 Internship Offer Letter
43 Internship Agreement
44 Department Intern Evaluation ForCalOptima's Student Evaluation of Internship Form
45
46 **VI. REGULATORY AGENCY APPROVALS OR**

DRAFT

1
2 None to Date
3
4 **VII. BOARD ACTIONACTIONS**
5
6 A. 11/02/17: Regular Meeting of the CalOptima Board of Directors
7 A.B. 5/105/01/14: Regular Meeting of the CalOptima Board Meetingof Directors
8
9 **VIII. REVIEW/REVISION HISTORY**
10
11 Not Applicable
12
13 **IX. KEYWORDS**
14
15 Internship
16 Intern
17 Sponsoring Department
18
19
20
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Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/2014	GA.8031	Internship Program	Administrative
Revised	11/02/2017	GA.8031	Internship Program	Administrative

29

DRAFT

1
2 **IX. GLOSSARY**
3

Term	Definition
Internship Program	A program offered by CalOptima to vocational, college, university and/or graduate students to apply traditional academic classroom learning to actual work experience.
Sponsoring Department	A department within CalOptima requesting a vocational, college, university or graduate student intern and overseeing the management and work of the interns pursuant to this policy.

4

DRAFT

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Policy #:	GA.8031
Title:	**Internship Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader __________
Effective Date:	02/01/14
Last Review Date:	11/02/17
Last Revised Date:	11/02/17

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I. PURPOSE

This policy establishes an Internship Program to provide an opportunity for vocational, college, university, and/or graduate students to apply traditional academic classroom learning to actual work experience within Orange County's only public agency health plan, and to support our community by providing a cost effective means to create an experienced and skilled workforce for the future.

II. POLICY

A. CalOptima may offer paid or unpaid internship positions, at the discretion of each Sponsoring Department, and in accordance with U.S. Department of Labor (DOL) Fair Labor Standards Act (FLSA) guidelines, to provide students in vocational, college, university, or graduate level courses with practical experience.

B. CalOptima shall comply with all applicable laws and regulations with respect to CalOptima's administration of the Internship Program, including, but not limited to, licensing or certification requirements.

C. Interns are not intended to displace employees, and interns should not be used as a means to fill vacant positions.

D. This policy excludes residency/fellowships in connection with pharmacy and medical programs.

E. The Human Resources Department, with the assistance of the Sponsoring Department, shall be responsible for administering the Internship Program within the respective Sponsoring Department, and ensuring that the following Internship Program guidelines are followed.

1. Unpaid Internship Requirements

    a. According to the DOL, in order to qualify as a trainee/intern exempt from the minimum wage requirements, the following six (6) criteria must be met:

        i. The internship, even though it includes actual operation of the facilities of the employer, is similar to training which would be given in an educational environment;

        ii. The internship experience is for the benefit of the intern;

        iii. The intern does not displace regular employees, but works under close supervision of existing staff;

iv. The employer that provides the training derives no immediate advantage from the activities of the intern, and on occasion its operations may actually be impeded;

v. The intern is not necessarily entitled to a job at the conclusion of the internship; and

vi. The employer and intern understand that the intern is not entitled to wages for the time spent in the internship.

b. Unpaid Intern Relationship

i. Unpaid interns must be enrolled in a college or university two- or four-year degree program, an accredited vocational institution, or a graduate program, and will receive school credit for the internship.

ii. The Human Resources Department, with the assistance of the Sponsoring Department, shall be responsible for ensuring the Internship Program for unpaid interns meets the DOL's six (6) criteria as described in Section II.E.1.a. of this policy.

2

iii. Unpaid interns shall not be deemed employees of CalOptima, but rather, are volunteers as defined pursuant to Title 29, Code of Federal Regulations (CFR), Section 553.101.

iv. As a result, unpaid interns are not covered under CalOptima's workers' compensation policy.

v. However, unpaid interns are considered members of CalOptima's "workforce" as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA) regulations at Title 45, CFR, Section 160.103, and shall therefore be required to comply with all HIPAA requirements.

vi. School agreements will be coordinated by the Budget and Vendor Management Department with approval of the agreement template and any deviations therefrom by the Legal Affairs Department, and final approval by the Chief Executive Officer. School agreements should be presented to the Board of Directors for approval in situations where the school requires adherence to their agreement(s), as written, and staff identifies potential risks. Approved and signed school agreements will be reviewed annually by the Sponsoring Department, HR, and the Budget and Vendor Management Departments.

2. Paid Internship Requirements/Relationship

a. At the discretion of each Sponsoring Department, the Sponsoring Department may provide paid internship positions to qualified candidates meeting the education, qualifications, and experience required by the Sponsoring Department.

b. Paid interns must be enrolled in a college or university two (2)- or four (4)-year degree program, an accredited vocational institution or a graduate program, and may receive school credit for the internship.

DRAFT

c. In the case of a paid intern's school requiring a signed agreement with CalOptima, the following will be required: School agreements will be coordinated by the Budget and Vendor Management Department with approval of the agreement template and any deviations therefrom by the Legal Affairs Department, and final approval by the Chief Executive Officer. School agreements should be presented to the Board of Directors for approval in situations where the school requires adherence to their agreement(s), as written, and staff identifies potential risks. Approved and signed school agreements will be reviewed annually by the Sponsoring Department, HR, and the Budget and Vendor Management Departments.

d. A Sponsoring Department's ability to use paid student interns will be based on the Sponsoring Department's internal budget constraints.

e. Paid interns will be hired into approved open intern positions under the Intern job title, which is an As-Needed classification.

f. Paid interns shall be paid at least minimum wage, and will be considered employees of CalOptima for the purposes of Workers' Compensation insurance and members of CalOptima's "workforce" as that term is defined by HIPAA regulations at Title 45, CFR, Section 160.103.

g. Paid interns who work thirty (30) or more days within one (1) year from the start of their date of employment shall receive twenty-four (24) hours or three (3) days, whichever is greater, of paid sick leave beginning at the commencement of employment or engagement, subject to the restrictions for use pursuant to CalOptima Policy GA.8018: Paid Time Off (PTO).

h. Paid interns will not be entitled to any other benefits for time spent performing work as part of the internship. However, if a paid intern is averaging thirty (30) or more hours per week, his or her assignment will conclude on or before the ninetieth (90) calendar day of employment, unless the Sponsoring Department has arranged in advance to change the status of the intern to either full-time or part-time and offer benefits to comply with the Affordable Care Act (ACA).

3. CalOptima Employee as a Volunteer

   a. Additional issues must be considered when the proposed intern is a CalOptima employee who is volunteering his or her services at CalOptima.

   b. Such persons may not volunteer to perform the same type of services in which the individual is employed to perform for CalOptima (e.g., non-exempt Government Affairs Department staff volunteering on the weekend to speak about CalOptima at a community event).

   c. If the proposed intern or volunteer is a CalOptima employee, the Human Resources and/or Legal Affairs Department must be consulted for an exception.

F. Intern Qualifications (Unpaid Intern)

1. Interns will be required to:

   a. Pass a background investigation, including a review of the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE) the General Services Administration's

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(GSA) System for Award Management (SAM) OIG/SAM and the Medi-Cal Suspended & Ineligible ("S&I") Website.

b. Meet the school requirements for his or her internship program. Submit an application, resume, and cover letter to CalOptima.

c. Provide proof of concurrent enrollment in an academic internship course and/or credit in college, university, graduate courses or an accredited vocational institution.

d. Submit a signed acknowledgment confirming the intern understands:

i. The expectations;

ii. That the intern is not entitled to a job at the conclusion of the internship;

iii. The intern is an unpaid intern and is not entitled to wages or benefits for time spent performing work as part of the internship;

iv. That the internship is a voluntary, at-will relationship, which can be terminated at any time;

v. The intern releases CalOptima of all liability, promises not to sue, and assumes all risks associated with participating in the internship program; and

vi. The intern agrees to comply with all CalOptima Policies and Procedures and understands that CalOptima may prohibit an intern from continuing in the program, regardless of whether the individual has completed personal objectives or school requirements.

e. Complete HIPAA and compliance training programs, along with tuberculosis (TB) or health screening requirements for the position, where applicable.

f. Sign CalOptima's confidentiality agreement.

G. Intern Qualifications (Paid Intern)

1. Interns will be required to:

a. Pass a background investigation, including a review of the OIG LEIE, the GSA OIG/SAM, and the Medi-Cal S&I Website.

b. Submit an application through CalOptima's applicant tracking system.

c. Meet the school requirements for his or her internship program if applicable.

d. Provide proof of concurrent enrollment in college, university, graduate courses or an accredited vocational institution.

e. Submit a signed acknowledgment confirming the intern understands:

DRAFT

i. The expectations;

ii. That the intern is not entitled to a job at the conclusion of the internship;

iii. The intern is a paid intern and is entitled only to specified wages as presented in the offer letter, but is not otherwise entitled to any other benefits unless the intern works thirty (30) or more days within one (1) year from the start of his or her date of employment, then he or she will be provided with up to twenty-four (24) hours or three (3) days, whichever is greater, of paid sick leave, as specified in CalOptima Policy GA.8018: Paid Time Off (PTO);

iv. In the event the paid intern works over forty (40) hours in any one (1) work week, he or she is entitled to overtime pay at the rate of 1 ½ times the non-exempt intern's regular rate of pay. Overtime must be approved in advance by management.

v. Paid interns will not be entitled to any other benefits for time spent performing work as part of the internship. However, if a paid intern is averaging thirty (30) or more hours per week, his or her assignment will conclude on or before the ninetieth (90) calendar day of employment, unless the Sponsoring Department has arranged in advance to change the status of the intern to either full-time or part-time and offer benefits to comply with the Affordable Care Act (ACA).

vi. That the internship is a voluntary, at-will relationship, which can be terminated at any time;

vii. The intern releases CalOptima of all liability, promises not to sue, and assumes all risks associated with participating in the internship program; and

viii. The intern agrees to comply with all CalOptima Policies and Procedures and understands that CalOptima may prohibit an intern from continuing in the program, regardless of whether the individual has completed personal objectives or school requirements.

f. Complete HIPAA and compliance training programs, along with tuberculosis (TB) or health screening requirements for the position, where applicable; and

g. Sign CalOptima's confidentiality agreement.

H. Internship Program Oversight

1. The Human Resources Department shall be the designated point of contact to address questions, verify intern qualifications, maintain consistency, and coordinate and administer the Internship Program, including coordination of signed agreements required by the universities or colleges and CalOptima.

2. Each Sponsoring Department shall be responsible for coordinating with the Human Resources Department and designating a Sponsoring Department contact to serve as the supervisor to the intern.

DRAFT

3. The designated intern supervisor should be someone who: possesses expertise in the area in which the intern will work; is interested in working with vocational, college, university or graduate students; has the time to invest in the internship; and will oversee and assign the student intern's work.

   a. Interns should work a minimum of five (5) hours and a maximum of forty (40) hours per week, and the internship should have a clear start date and clear end date. If a paid intern is averaging thirty (30) or more hours per week, his or her assignment will conclude on or before the ninetieth (90) calendar day of employment, unless the Sponsoring Department has arranged in advance to change the status of the intern to either full-time or part-time and offer benefits to comply with the Affordable Care Act (ACA).

4. Weekly meetings between the intern and the intern supervisor should be held to discuss what has been learned the prior week and what is expected the next week. The intern's supervisor shall document such meetings. The intern's supervisor or department manager shall sign the department intern evaluations.

5. At the conclusion of the internship, the designated intern supervisor shall submit a Department Intern Evaluation Form, or equivalent school provided form and provide a copy to the intern. The intern shall complete a CalOptima Student Evaluation of Internship Form and both forms shall be submitted to the Human Resources Department.

6. In the event the intern's college or university requires a form or forms to be completed and executed by CalOptima, any indemnification, hold harmless or insurance language must be reviewed and approved by the Finance and Budget and Vendor Management Departments prior to the start of the internship program. Any deviations from CalOptima's approved contract templates may also require a review by the Legal Affairs Department, and final approval will be required by the Chief Executive Officer.

III. PROCEDURE

Responsible Party	Action
Intern	1. The intern is responsible for reviewing the internship description and ensuring that he or she meets the qualifications and minimum requirements for the internship before submitting an application. 2. Apply for an intern position either through CalOptima's applicant tracking system online if for a paid internship, or by submitting a paper application for an unpaid internship to HR. 3. Submit a verification of enrollment from the college, university, accredited vocational institution or graduate program to establish good academic standing and eligibility. 4. Participate in an interview, background check and health screening, if required. 5. If accepted, submit a signed Offer Letter, Internship Agreement and complete other documents, or tests, as required.

DRAFT

Responsible Party	Action
Sponsoring Department	1. Identify and request the number of intern positions per year, and request positions through the annual budget process if paid interns are anticipated. ▪ For paid interns, receive approval and position control numbers from Finance. ▪ For unpaid interns, obtain approval from Executive Director or Chief for each intern or per contractual agreement if an ongoing program. ▪ Coordinate with Facilities for space considerations. 2. Determine length of assignment and scheduled hours. If intern will be averaging thirty (30) or more hours per week, discuss status considerations with HR and the Finance Department for ACA benefit implications and Paid Sick Leave Act requirements. 3. Submit request for intern position to Human Resources, including number of interns requested, details of the position requirements, and period of time. 4. Review internship applications and notify Human Resources to schedule an interview if applicant is qualified. 5. Interview internship applicants. 6. Once a qualified internal applicant has been identified and the Sponsoring Department is interested in selecting that applicant to fill an internship position, coordinate with Human Resources to provide Offer Letter and complete the internship on-boarding process, including but not limited to, background checks, execution of the Internship Agreement, execution of school affiliation agreements, etc. 7. Designate a contact to serve as the supervisor of each intern. 8. Ensure that all required evaluation forms or other forms necessary to ensure the intern receives credit are completed and submitted in a timely manner to the school. 9. Ensure the intern's activities are within the scope of practice applicable to their license or certification and that they perform within this scope if applicable. 10. Ensure the intern meets any and all qualifications as defined by the school. 11. Notify and collaborate with Human Resources if the intern is not adhering to the programs or agency's policies or procedures. 12. Annually review affiliation agreements required by colleges, universities, accredited vocational schools and graduate programs, and update, as appropriate, with the assistance of the Finance and Budget and Vendor Management Departments.

DRAFT

Responsible Party	Action
Human Resources	1. Administer and coordinate all internships. 2. Receive requests for an intern/s from the Sponsoring Department and verify all necessary approvals, including budgeted positions, have been obtained. 3. Receive and review internship applications from potential interns. 4. Provide Desktop procedure for Internship Program to Sponsoring Department. 5. Coordinate internship interviews and on-boarding process, including but not limited to, background, reference, and review of OIG LEIE, the GSA OIG/SAM, Medi-Cal S&I Website exclusion checks, preparation of offer letters, coordinating health screening, where applicable, and coordinating the intern's start date with the Sponsoring Department. 6. Review the affiliation agreements required by colleges, universities, accredited vocational schools and graduate programs to ensure consistency with CalOptima's operations and requirements. Coordinate the internal review, revision, negotiation, approval and execution of required documents with the Finance and Budget and Vendor Management Departments. Agreements may only be executed on behalf of CalOptima in accordance with the Board approved signature policies. 7. Coordinate on-boarding activities, off-boarding activities, and all training requirements. 8. Maintain all internship records. 9. Monitor and support the internship program activities and outcomes. 10. Annually review affiliation agreements required by colleges, universities, accredited vocational schools and graduate programs, and update, as appropriate, with the assistance of the Finance and Budget and Vendor Management Departments.

IV. ATTACHMENTS

A. Internship Application

V. REFERENCES

A. California Business and Professions Code §§ 4114, 4116, and 4119.6
B. CalOptima Policy GA.8018: Paid Time Off (PTO)
C. CalOptima's Student Evaluation of Internship Form
D. Department Intern Evaluation Form
E. Internship Program Guidelines
F. Internship Offer Letter
G. Internship Agreement
H. Title 29, Code of Federal Regulations (CFR) § 553.101
I. Title 45, Code of Federal Regulations (CFR) § 160.103
U.S. Department of Labor (DOL) Fair Labor Standards Act (FLSA) Guidelines

VI. REGULATORY AGENCY APPROVALS

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1
2 None to Date
3
4 **VII. BOARD ACTIONS**
5
6 A. 11/02/17: Regular Meeting of the CalOptima Board of Directors
7 B. 05/01/14: Regular Meeting of the CalOptima Board of Directors
8
9 **VIII. REVIEW/REVISION HISTORY**
10

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	02/01/2014	GA.8031	Internship Program	Administrative
Revised	11/02/2017	GA.8031	Internship Program	Administrative

12

DRAFT

1
2 **IX. GLOSSARY**
3

Term	Definition
Internship Program	A program offered by CalOptima to vocational, college, university and/or graduate students to apply traditional academic classroom learning to actual work experience.
Sponsoring Department	A department within CalOptima requesting a vocational, college, university or graduate student intern and overseeing the management and work of the interns pursuant to this policy.

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Student Internship Application

PERSONAL INFORMATION:			
Name:		**Date:**	**SSN:**
Address:			
City:	**State:**	**Zip Code:**	**DOB:**
Email:		**Telephone:**	
~~**Are you legally eligible to work in the US?**~~ ~~☐ Yes ☐No~~		**Alternative Phone:**	

ACADEMIC INFORMATION:		
Name ~~of Current~~ Vocational,~~-~~ College, ~~/~~University, or ~~/~~Grad School:	**Major:**	
School Address:	**Academic Advisor ~~Supervisor~~ Name:**	
Academic ~~Supervisor~~ Advisor Email:	**Academic Advisor ~~Supervisor~~ Telephone:**	
Academic Course (If Receiving Credit For Internship): _____	**Number Of Credits Receiving For Internship (If Applicable):** _____	
Vocational, College, University or Grad School Credit: ~~**College/University/Graduate School Credit:**~~ ☐ Yes ☐No	**Dates Attended:** TO	**Cumulative GPA:**

DEPARTMENT APPLYING FOR:	
Department:	**Beginning and End Dates to Perform Internship:** TO
Days Available to Work: ☐ Mon. ☐ Tues. ☐ Wed. ☐ Th. ☐Fri.	**Proposed # of Hours Per Week (Min 5, Max ~~25~~40)**

Describe your current qualifications for the internship position including education, skills, abilities, work habits and work experience:

Back to Agenda

Briefly state your main objectives for participating in this internship:

THREE PROFESSIONAL REFERENCES (3):		
Name, Title and Address:	**Relationship:**	**~~Telephone~~ Phone and Email:**
Name, Title and Address:	**Relationship:**	**~~Telephone~~ Phone and Email:**
Name, Title and Address:	**Relationship:**	**~~Telephone~~ Phone and Email:**

Instructions:

1. Complete the entire application and sign.
2. Provide proof of concurrent enrollment in a college, university, graduate or vocational course (e.g., transcript, schedule).
3. Attach your cover letter and resume.
4. Return form and all documents to:
   CalOptima
   c/o Human Resources
   505 City Parkway West
   Orange, CA 92868

~~1. ____ Complete the entire form~~
~~2. ____ Have your Academic Advisor sign the form entitled "Verification of Academic Credit"~~
~~3. ____ Attach your resume, cover letter, and letter of recommendation~~
~~4. ____ Sign and Date Intern Agreement~~
~~5. ____ Return to Human Resources~~

By signing below, I, the Applicant, acknowledge that all information contained above is accurate. I understand that in order to be eligible I have to:

- Submit all information and documentation required by CalOptima.
- Pass a background investigation and reference check.
- Provide proof of concurrent enrollment in a college, university, graduate or vocational course.
- If accepted, review the Offer Letter and return a fully executed copy of the Offer Letter and Internship Agreement.

~~☐ Submit all information and documentation required by CalOptima.~~

☐ ~~Pass a background investigation and reference check.~~

☐ ~~Provide proof of concurrent enrollment in an academic internship course and/or credit in college or graduate course.~~

☐ ~~If accepted, review the Offer Letter and return a fully executed copy of the Offer Letter and Internship Agreement.~~

Please be advised, in the event your school requires CalOptima to execute any agreement or forms, processing time to review and obtain approval may delay the start of the internship. CalOptima reserves the right to revoke the offer if CalOptima and your school cannot come to an agreement or if CalOptima's needs change.

Applicant Name (*Print*): _ ________________ **Applicant Signature**: ______________________________

Date: ________________

CalOptima HR Only

Received By: ________________________________ Date: ________________

Application is Complete: Yes ☐ No ☐

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Student Internship Application

PERSONAL INFORMATION:			
Name:		Date:	SSN:
Address:			
City:	State:	Zip Code:	DOB:
Email:		Telephone:	
		Alternative Phone:	

ACADEMIC INFORMATION:		
Name Vocational, College, University, or Grad School:	Major:	
School Address:	Academic Advisor Name:	
Academic Advisor Email:	Academic Advisor Telephone:	
Academic Course (If Receiving Credit For Internship):	Number Of Credits Receiving For Internship (If Applicable):	
Vocational, College, University or Grad School Credit: ☐ Yes ☐No	Dates Attended: TO	Cumulative GPA:

DEPARTMENT APPLYING FOR:	
Department:	Beginning and End Dates to Perform Internship: TO
Days Available to Work: ☐ Mon. ☐ Tues. ☐ Wed. ☐ Th. ☐Fri.	Proposed # of Hours Per Week (Min 5, Max 40)

Describe your current qualifications for the internship position including education, skills, abilities, work habits and work experience:

Back to Agenda

Briefly state your main objectives for participating in this internship:

THREE PROFESSIONAL REFERENCES (3):		
Name, Title and Address:	**Relationship:**	**Phone and Email:**
Name, Title and Address:	**Relationship:**	**Phoneand Email:**
Name, Title and Address:	**Relationship:**	**Phone and Email:**

Instructions:

1. Complete the entire application and sign.
2. Provide proof of concurrent enrollment in a college, university, graduate or vocational course (e.g., transcript, schedule).
3. Attach your cover letter and resume.
4. Return form and all documents to:
   CalOptima
   c/o Human Resources
   505 City Parkway West
   Orange, CA 92868

By signing below, I, the Applicant, acknowledge that all information contained above is accurate. I understand that in order to be eligible I have to:

- Submit all information and documentation required by CalOptima.
- Pass a background investigation and reference check.
- Provide proof of concurrent enrollment in a college, university, graduate or vocational course.
- If accepted, review the Offer Letter and return a fully executed copy of the Offer Letter and Internship Agreement.

Please be advised, in the event your school requires CalOptima to execute any agreement or forms, processing time to review and obtain approval may delay the start of the internship. CalOptima reserves the right to revoke the offer if CalOptima and your school cannot come to an agreement or if CalOptima's needs change.

Applicant Name (*Print*): _ ________________ **Applicant Signature**: ______________________________

Date: _______________

CalOptima HR Only

Received By: _________________________________ Date: ________________

Application is Complete: Yes ☐ No ☐

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

CEO Approval: Michael Schrader _______

Effective Date:	05/01/14
Last Review Date:	~~09/07/17~~ 11/02/17
Last Revised Date:	~~09/07/17~~ 11/02/17

~~*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

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

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

III. PROCEDURE

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

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

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of 11/02/17~~09/07/17~~)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 11/02/17: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 09/07/17: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 08/03/17: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 06/01/17: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 05/04/17: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 03/02/17: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 12/01/16: Regular Meeting of the CalOptima Board of Directors
~~G.~~H. 11/03/16: Regular Meeting of the CalOptima Board of Directors
~~H.~~I. 10/06/16: Regular Meeting of the CalOptima Board of Directors
~~I.~~J. 09/01/16: Regular Meeting of the CalOptima Board of Directors
~~J.~~K. 08/04/16: Regular Meeting of the CalOptima Board of Directors
~~K.~~L. 06/02/16: Regular Meeting of the CalOptima Board of Directors
~~L.~~M. 03/03/16: Regular Meeting of the CalOptima Board of Directors

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1 ~~M.~~N. 12/03/15: Regular Meeting of the CalOptima Board of Directors
2 ~~N.~~O. 10/01/15: Regular Meeting of the CalOptima Board of Directors
3 ~~O.~~P. 06/04/15: Regular Meeting of the CalOptima Board of Directors
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2 **VIII. REVIEW/REVISION HISTORY**
3

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
Revised	09/07/2017	GA.8058	Salary Schedule	Administrative
Revised	11/02/2017	GA.8058	Salary Schedule	Administrative

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1 **IX. GLOSSARY**
2
3 Not Applicable
4

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

CEO Approval: Michael Schrader _______

Effective Date:	05/01/14
Last Review Date:	11/02/17
Last Revised Date:	11/02/17

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).

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.

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

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.

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1
2 B. The Chief Executive Officer (CEO) is authorized and directed to take all steps necessary and proper
3 to implement the salary schedule for all other employees not inconsistent therewith.
4
5 **III. PROCEDURE**
6
7 A. The Human Resources Department (HR) will ensure that the salary schedule, meeting the
8 requirements above, are available at CalOptima's offices and immediately accessible for public
9 review during normal business hours or posted on CalOptima's internet website.
10
11 B. HR shall retain the salary schedule for not less than five (5) years.
12
13 C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness
14 of the salary schedule to market pay levels.
15
16 D. Any adjustments to the salary schedule requires that the Executive Director of HR make a
17 recommendation to the CEO for approval, with the CEO taking the recommendation to the
18 CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO
19 compensation, shall be effective unless and until approved by the CalOptima Board of Directors.
20
21 **IV. ATTACHMENTS**
22
23 A. CalOptima - Salary Schedule (Revised as of 11/02/17)
24
25 **V. REFERENCES**
26
27 A. Title 2, California Code of Regulations, §570.5
28
29 **VI. REGULATORY AGENCY APPROVALS**
30
31 None to Date
32
33 **VII. BOARD ACTIONS**
34
35 A. 11/02/17: Regular Meeting of the CalOptima Board of Directors
36 B. 09/07/17: Regular Meeting of the CalOptima Board of Directors
37 C. 08/03/17: Regular Meeting of the CalOptima Board of Directors
38 D. 06/01/17: Regular Meeting of the CalOptima Board of Directors
39 E. 05/04/17: Regular Meeting of the CalOptima Board of Directors
40 F. 03/02/17: Regular Meeting of the CalOptima Board of Directors
41 G. 12/01/16: Regular Meeting of the CalOptima Board of Directors
42 H. 11/03/16: Regular Meeting of the CalOptima Board of Directors
43 I. 10/06/16: Regular Meeting of the CalOptima Board of Directors
44 J. 09/01/16: Regular Meeting of the CalOptima Board of Directors
45 K. 08/04/16: Regular Meeting of the CalOptima Board of Directors
46 L. 06/02/16: Regular Meeting of the CalOptima Board of Directors
47 M. 03/03/16: Regular Meeting of the CalOptima Board of Directors
48 N. 12/03/15: Regular Meeting of the CalOptima Board of Directors
49 O. 10/01/15: Regular Meeting of the CalOptima Board of Directors
50 P. 06/04/15: Regular Meeting of the CalOptima Board of Directors

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1
2 **VIII. REVIEW/REVISION HISTORY**
3

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

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1 **IX. GLOSSARY**
2
3 Not Applicable
4

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CalOptima - Annual Base Salary Schedule - Revised November 2, 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	657	$62,400	$81,120	$99,840	
	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	
	Community Partner	K	575	$47,112	$61,360	$75,504	

Back to Agenda

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	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	
*	Director Grievance & Appeals	P	528	$95,264	$128,752	$162,032	
*	Director Health Education & Disease Management	Q	150	$114,400	$154,440	$194,480	

CalOptima - Annual Base Salary Schedule - Revised November 2, 2017
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
*	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	
	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	

CalOptima - Annual Base Salary Schedule - Revised November 2, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
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	
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	

Back to Agenda

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	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	
	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	

Back to Agenda

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	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	
	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 Director Regulatory Affairs and Compliance	R	TBD	$137,280	$185,328	$233,376	
	Sr Manager Human Resources	P	649	$95,264	$128,752	$162,032	

Back to Agenda

CalOptima - Annual Base Salary Schedule - Revised November 2, 2017
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
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 Behavioral Health	N	TBD	$71,760	$93,184	$114,712	New Position
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.

** 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.

Back to Agenda

Summary of Changes to Salary Schedule

For November 2017 Board Meeting:

Title	**Old Wage Grade**	**New Job Code / Wage Grade**	**Notes / Reason**	**Salary Adjustment (% Increase)**	**Month Added/Changed**
Supervisor Behavioral Health	N/A	N	This new position is responsible for the day-to-day operation of the Behavioral Health call center staff.	N/A	November 2017

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

12. Consider Medi-Cal Health Network Rate Adjustment for the Provision of the Screening, Brief Interventions, and Referral to Treatment Services

Contact

Nancy Huang, Controller, (714) 246-8400

Recommended Action

Authorize the Chief Executive Officer (CEO) to adjust rates for Medi-Cal health networks, excluding Kaiser, for the provision of the Screening, Brief Interventions, and Referral to Treatment (SBIRT) services effective January 1, 2018.

Background

In January 2014, the California Department of Health Care Services (DHCS) expanded substance use disorder (SUD) treatment services to require Medi-Cal managed care plans to begin covering SBIRT. CalOptima's contracted primary care physicians screen for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce alcohol misuse. Providers may also refer members aged 18 years and older to mental health and/or alcohol use disorder services as medically necessary to the County of Orange alcohol and drug program.

Discussion

On November 12, 2013, DHCS provided CalOptima with draft capitation rates for the SBIRT benefit. The draft rates provided $1.91 per member per month (PMPM) for the adult, Medi-Cal Expansion (MCE), and seniors and persons with disabilities (SPD) populations, and $0.00 PMPM for children. Since January 2014, CalOptima administered the SBIRT payment as a pass-through payment to the contracted Medi-Cal health networks. Beginning in Fiscal Year (FY) 2016-17, DHCS began lowering capitation rates for the administration of the mental health benefit, including SBIRT. However, CalOptima has continued to pay health networks at the initial rate of $1.91 PMPM for the above mentioned populations.

Staff has reviewed internal claims data for the CalOptima Community Network (CCN), as well as encounter data for contracted Health Maintenance Organizations (HMO), Physician Hospital Consortia (PHC), and Shared Risk Groups (SRGs) to determine the appropriateness of current payment levels for the SBIRT benefit. The following provides a summary of the findings:

	FY 2016			FY 2017		
	Utilizing Members	Average Unit Cost	PMPM	Utilizing Members	Average Unit Cost	PMPM
Encounters (HMO, PHC, SRG)	1,947	$21.39	**$0.01**	2,257	$37.08	**$0.02**
Claims (CCN)	238	$23.35	**$0.01**	311	$25.87	**$0.01**

Upon review of the encounter and claims data, Management proposes to adjust the SBIRT rate for contracted health networks, excluding Kaiser from $1.91 PMPM to $0.30 PMPM, for the adult, MCE, and SPD populations, effective January 1, 2018.

Fiscal Impact
The recommended action to adjust health network capitation rates for the provision of SBIRT services is estimated to reduce medical expenses by approximately $460,000 per month, or $2.76 million for the period of January 1, 2018, through June 30, 2018.

Rationale for Recommendation
Management recommends authorizing the proposed rate adjustment to ensure contracted health networks receive appropriate reimbursement for SBIRT services.

Concurrence
Gary Crockett, Chief Counsel

Attachment
PowerPoint Presentation: SBIRT Capitation

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

Back to Agenda

CalOptima
Better. Together.

SBIRT Capitation

Board of Directors Meeting
November 2, 2017

Nancy Huang
Controller

Back to Agenda

Overview

- SBIRT
  - ➢ Description
  - ➢ Rate Development
- Provider Reimbursement
  - ➢ Health Network Capitation
  - ➢ Direct Contracted Providers
- Cost and Utilization Summary
- Recommended Action

Back to Agenda

Screening, Brief Interventions, and Referral to Treatment (SBIRT)

- Description
  - Approach for delivering early intervention and treatment services to people with, or at risk of developing, alcohol use disorders
  - Delivered in primary care settings
  - Became Medi-Cal managed care benefit effective 1/1/14 for members 18 years & older
- Rate Development
  - One component of the Mental Health supplemental rate
  - Initial rate was based on proxy data from other states
  - FY 2014-15 SBIRT rate: $1.91 PMPM for Non-Dual Adult, SPD, and Medi-Cal Expansion populations
  - Starting FY 2017-18, rates are based on actual experience

Back to Agenda

Provider Reimbursement

- Health Network Capitation
  - Administered as a pass-through payment
    - Increased professional capitation by $1.91 PMPM for Non-Dual Adult, SPD, and Medi-Cal Expansion populations
  - Rate adjustment effective 1/1/14
    - Rate has not changed since initial implementation

- Direct Contracted Providers
  - Payment based on CalOptima Medi-Cal fee schedule
  - Paid on a fee-for-service basis

Cost and Utilization Summary

	FY 2016			FY 2017		
	Utilizing Mbrs	Average Unit Cost	Cost PMPM	Utilizing Mbrs	Average Unit Cost	Cost PMPM
Encounters (HMO, PHC, SRG)	1,947	$21.39	$0.01	2,257	$37.08	$0.02
Claims (CCN)	238	$23.35	$0.01	311	$25.87	$0.01

- Findings:
  - ➢ Actual costs for SBIRT services are extremely low at $0.01-$0.02 PMPM
  - ➢ Driven by minimal utilization
    - ▪ Utilizing members account for 0.75% of Adult population in FY17
  - ➢ Low utilization consistent over past two fiscal years

Recommended Action

- Adjust SBIRT Capitation to $0.30 PMPM for Non-Dual Adult, SPD, and Medi-Cal Expansion populations for contracted health networks, excluding Kaiser
  - Effective date of adjustment: 1/1/18
  - Priced to reflect actual risk to health networks
  - Rate is still significantly higher than actual cost
- Continue to pay direct contract providers at the CalOptima Medi-Cal Fee Schedule rates
- Fiscal Impact
  - Estimated medical expense reduction of $460,000 per month or $2.76 million from 1/1/18 – 6/30/18

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

13. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium (PHC) Health Network Physician Contracts for AMVI Care Health Network, Family Choice Network, and Orange County Advantage Medical Group to Modify the Professional Capitation Rate

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 contract amendments of the CalOptima Medi-Cal Physician Hospital Consortium (PHC) Health Network Physician Contracts, for AMVI Care Health Network, Family Choice Network, and Orange County Advantage Medical Group to revise the professional capitation rate associated with Screening, Brief Intervention and Referral to Treatment (SBIRT) services effective January 1, 2018, to the extent authorized by the Board in a separate action.

Background/Discussion

Effective January 1, 2014, the State of California added a Screening, Brief Intervention, and Referral to Treatment (SBIRT) benefit for adult Medi-Cal beneficiaries. The purpose of SBIRT benefit is to deliver early intervention and treatment services to people with, or at risk of developing, alcohol use disorders.

SBIRT is a three part process:

- Universal screening assesses alcohol use and identifies people with alcohol use problems.
- Brief intervention is provided when a screening indicates moderate risk. Brief intervention utilizes motivational interviewing techniques focused on raising patients' awareness of alcohol use and its consequences and motivating them toward positive behavioral change.
- Referral to treatment provides a referral to specialty care for persons deemed to be at high risk.

The Department of Health Care Services identified service codes and compensation associated with SBIRT services.

CalOptima amended contracts with the Medi-Cal health networks effective January 1, 2014, to include the SBIRT as a contracted benefit and increased the professional capitation rate to account for the additional costs associated with rendering SBIRT services.

Since the implementation of this benefit, the level of SBIRT services provided by physicians does not support the capitation rate allocated to the SBIRT benefit. The specifics of the SBIRT rate change has been addressed in a separate Board action. Therefore, Staff request authorization to amend health network professional capitation rates to the extent authorized by the Board in a separate action.

Back to Agenda

Fiscal Impact
The recommended action to revise the professional capitation rate associated with SBIRT services is estimated to reduce medical expenses, in aggregate, by $460,000 per month, or $2.76 million for the period of January 1, 2018, through June 30, 2018.

Rationale for Recommendation
CalOptima staff recommends this action to align health network rates with actual utilization of SBIRT services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

14. Consider Authorizing Amendment of the CalOptima Medi-Cal Physician Hospital Consortium (PHC) Health Network Physician Contract for CHOC Physicians Network to Modify the Professional Capitation Rate

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 contract amendments of the CalOptima Medi-Cal Physician Hospital Consortium (PHC) Health Network Physician Contracts, for CHOC Physicians Network to revise the professional capitation rate associated with Screening, Brief Intervention and Referral to Treatment (SBIRT) services effective January 1, 2018, to the extent authorized by the Board in a separate action.

Background/Discussion

Effective January 1, 2014, the State of California added a Screening, Brief Intervention, and Referral to Treatment (SBIRT) benefit for adult Medi-Cal beneficiaries. The purpose of SBIRT benefit is to deliver early intervention and treatment services to people with, or at risk of developing, alcohol use disorders.

SBIRT is a three part process:

- Universal screening assesses alcohol use and identifies people with alcohol use problems.
- Brief intervention is provided when a screening indicates moderate risk. Brief intervention utilizes motivational interviewing techniques focused on raising patients' awareness of alcohol use and its consequences and motivating them toward positive behavioral change.
- Referral to treatment provides a referral to specialty care for persons deemed to be at high risk.

The Department of Health Care Services identified service codes and compensation associated with SBIRT services.

CalOptima amended contracts with the Medi-Cal health networks effective January 1, 2014, to include the SBIRT as a contracted benefit and increased the professional capitation rate to account for the additional costs associated with rendering SBIRT services.

Since the implementation of this benefit, the level of SBIRT services provided by physicians does not support the capitation rate allocated to the SBIRT benefit. The specifics of the SBIRT rate change has been addressed in a separate Board action. Therefore, Staff request authorization to amend health network professional capitation rates to the extent authorized by the Board in a separate action.

Back to Agenda

Fiscal Impact

The recommended action to revise the professional capitation rate associated with SBIRT services is estimated to reduce medical expenses, in aggregate, by $460,000 per month, or $2.76 million for the period of January 1, 2018, through June 30, 2018.

Rationale for Recommendation

CalOptima staff recommends this action to align health network rates with actual utilization of SBIRT services.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader | *10/23/2017*

Authorized Signature | **Date**

Back to Agenda

CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

15. Consider Authorizing Amendment of the CalOptima Medi-Cal Full-Risk Health Network Contracts for Heritage Provider Network, Inc., Monarch Family Healthcare and Prospect Medical Group to Modify the Professional Capitation Rate

Contact

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

Recommended Actions

Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into contract amendments of the CalOptima Medi-Cal Full-Risk Health Network Contracts for Heritage Provider Network, Inc., Monarch Family Healthcare and Prospect Medical Group to revise the professional capitation rate associated with Screening, Brief Intervention and Referral to Treatment (SBIRT) services effective January 1, 2018, to the extent authorized by the Board in a separate action.

Background/Discussion

Effective January 1, 2014, the State of California added a Screening, Brief Intervention, and Referral to Treatment (SBIRT) benefit for adult Medi-Cal beneficiaries. The purpose of SBIRT benefit is to deliver early intervention and treatment services to people with, or at risk of developing, alcohol use disorders.

SBIRT is a three part process:

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- Brief intervention is provided when a screening indicates moderate risk. Brief intervention utilizes motivational interviewing techniques focused on raising patients' awareness of alcohol use and its consequences and motivating them toward positive behavioral change.
- Referral to treatment provides a referral to specialty care for persons deemed to be at high risk.

The Department of Health Care Services identified service codes and compensation associated with SBIRT services.

CalOptima amended contracts with the Medi-Cal health networks effective January 1, 2014, to include the SBIRT as a contracted benefit and increased the professional capitation rate to account for the additional costs associated with rendering SBIRT services.

Since the implementation of this benefit, the level of SBIRT services provided by physicians does not support the capitation rate allocated to the SBIRT benefit. The specifics of the SBIRT rate change has been addressed in a separate Board action. Therefore, Staff request authorization to amend health network professional capitation rates to the extent authorized by the Board in a separate action.

Fiscal Impact

The recommended action to revise the professional capitation rate associated with SBIRT services is estimated to reduce medical expenses, in aggregate, by $460,000 per month, or $2.76 million for the period of January 1, 2018, through June 30, 2018.

Rationale for Recommendation
CalOptima staff recommends this action to align health network rates with actual utilization of SBIRT services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

16. Consider Authorizing Amendment of the CalOptima Medi-Cal Shared Risk Group (SRG) Health Network Contracts for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Network to Modify the Professional Capitation Rate

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 contract amendments of the CalOptima Medi-Cal Share Risk Group (SRG) Health Network Contracts, for Alta Med Health Services, Arta Western Health Network, Noble Mid-Orange County, Talbert Medical Group, and United Care Medical Network to revise the professional capitation rate associated with Screening, Brief Intervention and Referral to Treatment (SBIRT) services effective January 1, 2018, to the extent authorized by the Board in a separate action.

Background/Discussion

Effective January 1, 2014, the State of California added a Screening, Brief Intervention, and Referral to Treatment (SBIRT) benefit for adult Medi-Cal beneficiaries. The purpose of SBIRT benefit is to deliver early intervention and treatment services to people with, or at risk of developing, alcohol use disorders.

SBIRT is a three part process:

- Universal screening assesses alcohol use and identifies people with alcohol use problems.
- Brief intervention is provided when a screening indicates moderate risk. Brief intervention utilizes motivational interviewing techniques focused on raising patients' awareness of alcohol use and its consequences and motivating them toward positive behavioral change.
- Referral to treatment provides a referral to specialty care for persons deemed to be at high risk.

The Department of Health Care Services identified service codes and compensation associated with SBIRT services.

CalOptima amended contracts with the Medi-Cal health networks effective January 1, 2014, to include the SBIRT as a contracted benefit and increased the professional capitation rate to account for the additional costs associated with rendering SBIRT services.

Since the implementation of this benefit, the level of SBIRT services provided by physicians does not support the capitation rate allocated to the SBIRT benefit. The specifics of the SBIRT rate change has been addressed in a separate Board action. Therefore, Staff request authorization to amend health network professional capitation rates to the extent authorized by the Board in a separate action.

Back to Agenda

Fiscal Impact
The recommended action to revise the professional capitation rate associated with SBIRT services is estimated to reduce medical expenses, in aggregate, by $460,000 per month, or $2.76 million for the period of January 1, 2018, through June 30, 2018.

Rationale for Recommendation
CalOptima staff recommends this action to align health network rates with actual utilization of SBIRT services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

17. Consider Recommended Appointments to the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

Contact

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

Recommended Actions

The OneCare Connect Member Advisory Committee (OCC MAC) recommends:

1. Appointment of the following agency-selected non-voting liaison representatives to the OneCare Connect Member Advisory Committee, effective upon Board approval:
    a. Jyothi Atluri, Orange County Social Services Agency Representative.
    b. Amber Nowak, In-Home Supportive Services Public Authority (IHSS PA) Representative.

2. Appointment of the following individual to serve on the OneCare Connect Member Advisory Committee, effective upon Board approval:
    a. Kristin Trom, as the OneCare Connect Member/Family Member Representative, for a term ending June 30, 2019.

Background

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of advisory committees. The Centers for Medicare & Medicaid Services (CMS) and the State of California Department of Health Care Services (DHCS) established requirements for the Cal MediConnect program, including a requirement for a Cal MediConnect Member Advisory Committee. The CalOptima Board of Directors established the OneCare Connect Member Advisory Committee (OCC MAC) by resolution on February 5, 2015 (Resolution No. 15-0205) to report and provide input and recommendations to the CalOptima Board relative to the OneCare Connect program, the Cal MediConnect program administered by CalOptima.

Discussion

Pursuant to Resolution No. 15-0205, the OCC MAC is comprised of voting members, seven of whom are from community organizations and three of whom are OneCare Connect members or family of members. In addition, there are four non-voting liaison members who represent Orange County agencies. Each of the four agencies is asked to identify a representative to serve as a non-voting liaison member to the OCC MAC. The CalOptima Board of Directors is responsible for the appointment of all OCC MAC members.

1. Process to select non-voting liaison candidates:

Following the retirement of OCC MAC Members Jorge Solé, Orange County Social Services Agency (SSA) representative and Lena Berlove, In-Home Supportive Services Public Authority (IHSS PA) representative, CalOptima staff contacted the respective agencies to identify replacements to fill the

Back to Agenda

vacant non-voting liaison seats. Upon consideration of the candidates at the October 26, 2017 OCC MAC meeting, the OCC MAC is recommending appointment and forwarding the candidates to the Board of Directors for consideration.

The recommended non-voting candidates are:

Orange County Social Services Agency
Jyothi Atluri*

Jyothi Atluri is a Deputy Director with the Orange County Social Services Agency, Adult Services programs. Ms. Atluri is responsible for the overall direction, planning, organizing, and management of the operational, program, and administrative activities related to the Adult Services programs, which include Adult Protective Services, In-Home Supportive Services and Program Support. She has held various positions with the County and in the non-profit sector for over 24 years.

In-Home Supportive Services - Public Authority
Amber Nowak*

Amber Nowak is a Program Manager at the Orange County IHSS Public Authority where she oversees IHSS services, including the homecare registry and training for IHSS consumers and providers. Ms. Nowak also has experience working with a variety of vulnerable populations. She has held various positions with the County for over 12 years.

2. Process to select OneCare Connect member/family member candidates:

CalOptima staff conducted a recruitment process in order to fill the vacant OneCare Connect member/family member seat. The recruitment process included sending notification flyers and applications to community-based organizations (CBOs) and conducting targeted community outreach to agencies and CBOs that serve OneCare Connect members. Upon receipt of two applications from interested OneCare Connect members, CalOptima staff submitted them to the OCC MAC Nominations Ad Hoc for review.

The OCC MAC Nominations Ad Hoc, composed of OCC MAC members Ted Chigaros, Christine Chow and Sandy Finestone, evaluated each of the applications for the member candidates and recommended one for consideration by the OCC MAC.

At the October 26, 2017 meeting, the OCC MAC accepted the recommended candidate, as proposed by the Nominations Ad Hoc.

The candidates for the OneCare Connect member/family member seat are:

Kristin Trom*
Keiko Gamez

*Indicates OCC MAC recommendation

Back to Agenda

Kristin Trom has approximately ten years of experience navigating the health care system, first as a dual eligible and now as an OneCare Connect member. Ms. Trom has advocated for members in nursing homes to access State and Federal welfare programs. She also has volunteer experience with CHOC and Orangewood. Ms. Trom would like to assist others experiencing difficulties accessing the system.

Keiko Gamez is a OneCare Connect member who is interested in serving others. She has experienced several difficulties and believes she can make valuable contributions to the Committee. Ms. Gamez also has experience working for a child abuse prevention center.

Fiscal Impact

There is no fiscal impact.

Rationale for Recommendation

The OCC MAC considered and approved the agency-selected candidates and the OneCare Connect MAC member/family member candidate at the October 26, 2017 meeting. OCC MAC forwards the recommended candidates to the Board of Directors for consideration.

Concurrence

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

Attachments

None

/s/ Michael Schrader — *10/23/2017*

Authorized Signature — **Date**

*Indicates OCC MAC recommendation

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

18. Consider Adopting Resolution Establishing a Family Advisory Committee for the Whole-Child Model Medi-Cal Program

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400

Recommended Actions

Rev. 11/2/17

1. Adopt Resolution No. 17-1102-01, establishing the CalOptima Whole-Child Model family advisory committee to provide advice and recommendations to the CalOptima Board of Directors on issues concerning California Children's Services (CCS) and the Whole-Child Model program; and
2. Subject to approval of the California Department of Health Care Services (DHCS), authorize a stipend of up to $50 per committee meeting attended for each family representative appointed to the Whole-Child Model Family Advisory Committee (WCM-FAC).

Background

On September 25, 2016, SB 586 (Hernandez): Children's Services was signed into law. SB 586 authorizes the establishment of the Whole-Child Model that incorporates CCS-covered services for Medi-Cal eligible children and youth into specified county-organized health plans, including CalOptima. A provision of the Whole-Child Model requires each participating health plan to establish a family advisory committee. Accordingly, DHCS is requiring the establishment of a Whole-Child Model family advisory committee to report and provide input and recommendations to CalOptima relative to the Whole-Child Model program. The proposed stipend, subject to DHCS approval, is intended to enable in-person participation by members and family member representatives. It is also anticipated that a representative from the family advisory committees of each Medi-Cal plan will be invited to serve on a statewide stakeholder advisory group.

Since CalOptima's inception, the CalOptima Board of Directors has benefited from stakeholder involvement in the form of standing advisory committees. Under the authority of County of Orange Codified Ordinances, Section 4-11-15, and Article VII of the CalOptima Bylaws, the CalOptima Board of Directors may create committees or advisory boards that may be necessary or beneficial to accomplishing CalOptima's tasks. The advisory committees function solely in an advisory capacity providing input and recommendations concerning the CalOptima programs. CalOptima Whole-Child Model program would also benefit from the advice of a standing family advisory committee.

Discussion

While specific to Whole-Child Model program, the charge of the WCM-FAC would be similar to that of the other CalOptima Board advisory committees, including:

- Provide advice and recommendations to the Board and staff on issues concerning CalOptima Whole-Child Model program as directed by the Board and as permitted under applicable law;

- Engage in study, research and analysis of issues assigned by the Board or generated by staff or the family advisory committee;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model program; and
- Initiate recommendations on issues for study to the CalOptima Board for its approval and consideration, and facilitate community outreach for CalOptima Whole-Child Model program and the Board.

While SB 586 requires plans to establish family advisory committees, committee composition is not explicitly defined. Based on current advisory committee experience, staff recommends including eleven (11) voting members on CalOptima's WCM-FAC, representing CCS family members who reflect the diversity of the CCS families served by the plan, as well as consumer advocates representing CCS families. If necessary, CalOptima will provide an in-person interpreter at the meetings. For the first nomination process to fill the seats, it is proposed that CalOptima's current Member Advisory Committee will be asked to participate in the Family Advisory Committee nominating ad hoc committee. The proposed candidates will then be submitted to the Board for consideration. It is anticipated that subsequent nominations for seats will be reviewed by a WCM-FAC nominating ad hoc committee and will be submitted first to the WCM-FAC, then to the full Board for consideration of the WCM-FAC's recommendations.

CalOptima staff recommends that the WCM-FAC be comprised of eleven (11) voting seats:

1. Seven (7) to ~~N~~ nine (9) of the seats shall be family representatives in one of the following categories, with a priority to family representatives (i.e., if qualifying family representative candidates are available, all nine (9) seats will be filled by family representatives):
   i. Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   ii. CalOptima members age 18 -21 who are current recipients of CCS services; or
   iii. Current CalOptima members over the age of 21 who transitioned from CCS services.
2. Two (2) to four (4) of the seats shall represent the interests of children receiving CCS services, including:
   i. Community-based organizations; or
   ii. Consumer advocates.

While two (2) of the WCM-FAC's eleven seats are designated for community-based organizations or consumer advocates, WCM-FAC candidates representing these two groups may be considered for up to two additional WCM-FAC seats in the event that there are not sufficient family representative candidates to fill these seats.

Rev.
11/2/2017

Except for initial appointments, CalOptima WCM-FAC members will serve two (2) year terms, with no limits on the number of terms a representative may serve provided they continue to meet the above-referenced eligibility criteria. The initial appointments of WCM-FAC members will be divided between one and two-year terms to stagger reappointments. In the first year, five (5) committee member seats will be appointed for a one-year term and six (6) committee member seats will be appointed for a two-year term.

The WCM-FAC Chair and Vice Chair for the first year will be nominated at the second WCM-FAC meeting by committee members. The WCM-FAC's recommendations for these positions will subsequently be submitted to the Board for consideration. After the first year, the Chair and Vice Chair of the WCM-FAC will be appointed by the Board annually from the appointed voting members and may serve two consecutive one-year terms in a particular committee officer position.

The WCM-FAC will develop, review annually and recommend to the Board any revisions to the committee's Mission or Goals and Objectives. The Goals and Objectives will be consistent with those of the CalOptima Whole-Child Model.

The WCM-FAC will meet at least quarterly and will determine the appropriate meeting frequency to provide timely, meaningful input to the Board. At its second meeting, the WCM-FAC will adopt a meeting schedule for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws. Attendance of a simple majority of WCM-FAC seats will constitute a quorum. A quorum must be present for any action to be taken. Members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to scheduled WCM-FAC meetings.

The CalOptima Chief Executive Officer (CEO) will prepare, or cause to be prepared, an agenda for all WCM-FAC meetings prior to posting. Posting procedures must be consistent with the requirements of the Ralph M. Brown Act (California Government Code section 54950 *et seq.*). In addition, minutes of each WCM-FAC meeting will be taken, which will be filed with the Board. The Chair will report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board. CalOptima management will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

In order to enable in-person participation, SB 586 provides plans the option to pay a reasonable per diem payment to family representatives serving on the Family Advisory Committee. Similar to another Medi-Cal Managed Care Plan with an already established family-based advisory committee, and subject to DHCS approval, CalOptima staff recommends that the Board authorize a stipend of up to $50 per meeting for family representatives participating on the WCM-FAC. Only one stipend will be provided per qualifying WCM-FAC member per regularly scheduled meeting. In addition, stipend payments are restricted to family representatives only. Representatives of community-based organizations and consumer advocates are not eligible for stipends. As indicated, payment of the stipends is contingent upon approval by DHCS.

As it is the policy of CalOptima's Board to encourage maximum member and provider involvement in the CalOptima program, it is anticipated that the CalOptima Whole-Child Model will benefit from the establishment of a Family Advisory Committee. This WCM-FAC will report to the Board and will serve solely in an advisory capacity to the Board and CalOptima staff with respect to CalOptima Whole-Child Model. Establishing the WCM-FAC is intended to help to ensure that members' values and needs are integrated into the design, implementation, operation and evaluation of the CalOptima Whole-Child Model.

Fiscal Impact
The fiscal impact of the recommended action to establish the CalOptima WCM-FAC is an unbudgeted item. The projected total cost, including stipends, for meetings from April through June 2018, is $3,575. Unspent budgeted funds approved in the CalOptima Fiscal Year (FY) 2017-18 Operating Budget on June 1, 2017, will fund the cost through June 30, 2018. The estimated annual cost is $13,665. At this time, it is unknown whether additional staff will be necessary to support the advisory committee's work. Management plans to include expenses related to the WCM-FAC in future operating budgets.

Rationale for Recommendation
SB 586 requires that, for implementation of the Whole-Child Model program, a family advisory committee must be established. As proposed, the WCM-FAC will advise CalOptima's Board and staff on operations of the CalOptima Whole-Child Model.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Resolution No. 17-1102-01

Rev.
11/2/17

/s/ Michael Schrader
Authorized Signature

10/23/2017
Date

Back to Agenda

RESOLUTION NUMBER 17-1102-01

RESOLUTION OF THE BOARD OF DIRECTORS ORANGE COUNTY HEALTH AUTHORITY, DBA CALOPTIMA ESTABLISHING POLICY AND PROCEDURES FOR CALOPTIMA WHOLE-CHILD MODEL MEMBER ADVISORY COMMITTEE

WHEREAS, the CalOptima Board of Directors (hereinafter "the Board") would benefit from the advice of broad-based standing advisory committee specifically focusing on the CalOptima Whole-Child Model Plan hereafter "CalOptima Whole-Child Model Family Advisory Committee"; and

WHEREAS, the State of California, Department of Health Care Services (DHCS) has established requirements for implementation of the CalOptima Whole-Child Model program, including a requirement for the establishment of an advisory committee focusing on the Whole-Child Model; and

WHEREAS, the CalOptima Whole-Child Model Family Advisory Committee will serve solely in an advisory capacity to the Board and staff, and will be convened no later than the effective date of the CalOptima Whole-Child Model;

NOW, THEREFORE, BE IT RESOLVED:

Section 1. Committee Established. The CalOptima Whole-Child Model Family Advisory Committee (hereinafter "WCM-FAC") is hereby established to:

- Report directly to the Board;
- Provide advice and recommendations to the Board and staff on issues concerning the CalOptima Whole-Child Model program as directed by the Board and as permitted under the law;
- Engage in study, research and analysis of issues assigned by the Board or generated by the WCM-FAC;
- Serve as liaison between interested parties and the Board and assist the Board and staff in obtaining public opinion on issues relating to CalOptima Whole-Child Model or California Children Services (CCS);
- Initiates recommendations on issues for study to the Board for approval and consideration; and
- Facilitates community outreach for CalOptima and the Board.

Section 2. Committee Membership. The WCM-FAC shall be comprised of Eleven (11) voting members, representing or representing the interests of CCS families. In making appointments and re-appointments, the Board shall consider the ethnic and cultural diversity and special needs of the CalOptima Whole-Child Model population. Nomination and input from interested groups and community-based organizations will be given due consideration. Except as noted below, members are appointed for a term of two (2) full years, with no limits on the number of terms. All voting member appointments (and reappointments) will be made by the Board. During the first year, five (5) WCM-FAC members will serve a one -year term

Back to Agenda

and six (6) will serve a two-year term, resulting in staggered appointments being selected in subsequent years.

The WCM-FAC shall be composed of eleven (11) voting seats:

1. Seven (7) to nine (9) of the seats shall be family representatives in the following categories:
   - Authorized representatives, including parents, foster parents, and caregivers, of a CalOptima member who is a current recipient of CCS services;
   - CalOptima members age 18-21 who are current recipients of CCS services; or
   - Current CalOptima members over the age of 21 who transitioned from CCS services.

Rev. 11/2/2017

2. Two (2) to four (4) of the seats shall represent the interests of children with CCS, including:
   - Community-based organizations (CBOs); or
   - Consumer advocates.

If nine or more qualified candidates initially apply for family representative seats, nine of the eleven committee seats will be filled with family representatives. Initially, and on an on-going basis, only in circumstances when there are insufficient applicants to fill all of the designated family representative seats with qualifying family representatives, up to two of the nine seats designated for family members may be filled with representatives of CBOs or consumer advocates.

It is anticipated that a representative from the CalOptima WCM-FAC may be invited to serve on a statewide stakeholder advisory group.

Section 3. Chair and Vice Chair. The Chair and Vice Chair for the WCM-FAC will be appointed by the Board annually from the appointed members. The Chair, or in the Chair's absence, the Vice Chair, shall preside over WCM-FAC meetings. The Chair and Vice Chair may each serve up to two consecutive terms in a particular WCM-FAC officer position, or until their successor is appointed by the Board.

Section 4. Committee Mission, Goals and Objectives. The WCM-FAC will develop, review annually, and make recommendations to the Board on any revisions to the committee's Mission or Goals and Objectives.

Section 5. Meetings. The WCM-FAC will meet at least quarterly. A yearly meeting schedule will be adopted at the second regularly scheduled meeting for the remainder of the fiscal year. Thereafter, a yearly meeting schedule will be adopted prior to the first regularly scheduled meeting of each year. All meetings must be conducted in accordance with CalOptima's Bylaws.

Attendance by the occupants of a simple majority of WCM-FAC seats shall constitute a quorum. A quorum must be present in order for any action to be taken by the WCM-FAC. Committee members are allowed excused absences from meetings. Notification of absence must be received by CalOptima staff prior to the scheduled WCM-FAC meeting.

The CalOptima Chief Executive Officer (CEO) shall prepare, or cause to be prepared, and post, or cause to be posted, an agenda for all WCM-FAC meetings. Agenda contents and posting procedures must be consistent with the requirements of the Ralph M. Brown Act (Government Code section 54950 *et seq.*).

WCM-FAC minutes will be taken at each meeting and filed with the Board.

Section 6. Reporting. The Chair is required to report verbally or in writing to the Board at least twice annually. The Chair will also report to the Board, as requested, on issues specified by the Board.

Section 7. Staffing. CalOptima will provide staff support to the WCM-FAC to assist and facilitate the operations of the committee.

Section 8. Ad Hoc Committees. Ad hoc committees may be established by the WCM-FAC Chair from time to time to formulate recommendations to the full WCM-FAC on specific issues. The scope and purpose of each such ad hoc will be defined by the Chair and disclosed at WCM-FAC meetings. Each ad hoc committee will terminate when the specific task for which it was created is complete. An ad hoc committee must include fewer than a majority of the voting committee members.

Section 9. Stipend. Subject to DHCS approval, family representatives participating on the WCM-FAC are eligible to receive a stipend for their attendance at regularly scheduled and ad hoc WCM-FAC meetings. Only one stipend is available per qualifying WCM-FAC member per regularly scheduled meeting. WCM-FAC members representing community-based organizations and consumer advocates are not eligible for WCM-FAC stipends.

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 2nd day of November, 2017.
AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

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

Contact

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

Recommended Action

Authorize and direct the Chairman of the Board of Directors (Board) to execute an Amendment to the Primary Agreement between the California Department of Health Care Services (DHCS) and CalOptima related to the addition of an aid code related to the Medi-Cal Access Program (MCAP) for Pregnant Women.

Background

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

Discussion

Aid Code Additions

Aid Code 0E

The Medi-Cal Access Program (MCAP) for pregnant women currently provides services to about 3,000 pregnant women. Eligible pregnant women are assigned the tracking aid code 0D and receive full medical benefits through their contracted health plans. DHCS's stated goal was to integrate MCAP into the managed care delivery system by October 1, 2016, but the timeframe was extended to allow for the Centers for Medicare & Medicaid Services (CMS) approval.

Effective July 1, 2017, DHCS began to enroll newly eligible pregnant women into Medi-Cal managed care plans (MCPs), including CalOptima, using aid code 0E. Aid code 0E is assigned to newly eligible members only, and women currently in other equivalent pregnancy-related aid codes will remain in those aid codes until their delivery is complete. Aid code 0E will mirror the full-scope pregnancy aid code M7 with respect to payment and eligibility criteria. Aid code M7 is currently a covered aid code under CalOptima's Primary Agreement with the DHCS. Aid code

0E is therefore expected to be considered an Adult & Family/Optional Targeted Low-Income Child aid code for payment purposes. Further technical details regarding the aid code are available in DHCS Operating Instruction Letter (OIL) #302-16 [*appended*].

DHCS has informed CalOptima Staff that it intends to include language authorizing aid code 0E into a forthcoming contract amendment for CalOptima, but has not specified timing or additional content of that contract amendment. In order to be prepared to promptly execute such an amendment, Staff is requesting that the Board authorize and direct the Chairman to execute an amendment that contains the addition of aid code OE. Staff will return to the Board for authority to execute the amendment in the event that it includes any additional substantive language or provisions.

Staff estimates that DHCS's action in transitioning coverage for this group of pregnant individuals from Fee-for-Service Medi-Cal to Managed Care Plans will result in approximately 300 additional pregnant Medi-Cal members being enrolled in CalOptima during FY 17/18. On average, costs associated with providing care to pregnant Medi-Cal members exceed the revenue received by CalOptima, in the form of capitation rates from DHCS. Since the incoming population consists of only pregnant members, the financial impact is negative for FY 17/18. However, we should be whole for the overall Adult & Family Aid Code category, to which this new aid code belongs, along with several others.

Fiscal Impact

The recommended action to execute an amendment to the primary agreement between DHCS and CalOptima to add an aid code related to MCAP for pregnant women is an unbudgeted item. Staff estimates the net fiscal impact specific to this newly eligible population will result in a negative operating variance of $618,000 through June 30, 2018. Management will update projected enrollment, revenue and medical expenses related to this population group in future operating budgets.

Rationale for Recommendation

The added aid code will ensure that CalOptima is authorized to provide services for and receive capitation payments for populations deemed eligible by the state of California.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Appendix summary of amendments to Agreements with DHCS

/s/ Michael Schrader *10/23/2017*

Authorized Signature **Date**

Back to Agenda

APPENDIX TO AGENDA ITEM 19

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

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, 2015 and included language that incorporates provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)**-**compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014
A-21 provided revised 2013-2014 capitation rates.	November 7, 2013
A-22 revised capitation rates for Fiscal Year (FY) 2013-14 and added an aid code to implement Express Lane/CalFresh Eligibility	November 6, 2014
A-23 revised ACA 1202 rates for January – June 2014, established base capitation rates for FY 2014-2015, added an aid code related to the OTLIC and AIM programs, and contained language revisions related to supplemental payments for coverage of Hepatitis C medications.	December 4, 2014
A-24 revises capitation rates to include SB 239 Hospital Quality Assurance Fees for the period January 1, 2014 to June 30, 2014.	May 7, 2015
A-25 extends the contract term to December 31, 2016. DHCS is obtaining a continuation of the services identified in the original agreement.	May 7, 2015
A-26 adjusts the 2013-2014 Intergovernmental Transfer (IGT) rates.	May 7, 2015
A-27 adjusts 2013-2014 capitation rates for Optional Expansion and SB 239.	May 7, 2015
A-28 incorporates language requirements and supplemental payments for BHT into primary agreement.	October 2, 2014

Amendments to Primary Agreement	Board Approval
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

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

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

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

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

CalOptima Board Action Agenda Referral

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

Report Item

20. Consider Amendment of the AltaMed Health Services, AMVI/Prospect Medical Group, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Monarch HealthCare, Noble Community Medical Associates and United Care Medical Group OneCare Shared Risk Health Network Contracts to Extend These Agreements for the Period January 1, 2018 through December 31, 2018

Contact

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

Recommended Action

Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into amendments to extend the AltaMed Health Services, AMVI/Prospect Medical Group, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Monarch HealthCare, Noble Community Medical Associates and United Care Medical Group OneCare shared risk health network contracts to extend these agreements for the period January 1, 2018 through December 31, 2018.

Background and Discussion

CalOptima is required to submit an annual bid to Centers for Medicare and Medicaid services ("CMS") for the OneCare program. At the May 2017 meeting, the CalOptima Board of Directors authorized submission of the OneCare bid for calendar year 2018. The bid has been accepted by CMS. Staff now seeks authority to extend contracts through December 31, 2018.

CalOptima contracts with eight health networks for OneCare. At the November 3, 2016, meeting, the Board extended each of these contracts for the period January 1, 2017 through December 31, 2017. Staff is seeking Board authorization to extend these contracts through December 31, 2018.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2017-18 Operating Budget approved by the Board on June 1, 2017 includes OneCare health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $4.75 million annually in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts, from January 1, 2018 through June 30, 2018, is a budgeted item with no additional fiscal impact.

Management will include expenses for the period of July 1, 2018, through December 31, 2018, related to the contract renewals in the CalOptima FY 2018-19 Operating Budget

Rationale for Recommendation

CalOptima staff recommends this action to maintain and continue the contractual relationship with the provider network.

Back to Agenda

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

21. Consider Authorizing Amendment of the AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Orange County Advantage Medical Group, Prospect Health Plan and United Care Medical Group Cal MediConnect (OneCare Connect) Health Network Contracts

Contact

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

Recommended Actions

Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into amendments to the AltaMed Health Services, AMVI Care Health Network, DaVita Medical Group ARTA Western California, DaVita Medical Group Talbert California, Family Choice Medical Group, Fountain Valley Regional Hospital and Medical Center, Heritage Provider Network, Monarch Health Plan, Noble Community Medical Associates, Orange County Advantage Medical Group, Prospect Health Plan and United Care Medical Group OneCare Connect health network contracts to extend these agreements through December 31, 2018, along with an additional one year extension option, exercisable at CalOptima's discretion, and add any necessary language provisions based on changes to the three-way Cal MediConnect contract between CalOptima, the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid services (CMS) or other regulatory requirements.

Background and Discussion

As a County Organized Health System (COHS), CalOptima contracts with DHCS and CMS to provide health care services to Cal MediConnect (OneCare Connect) beneficiaries in Orange County. The Board authorized execution of the Agreement with CMS and DHCS at its December 5, 2013 meeting.

OneCare Connect (OCC) was launched on June 1, 2015 in Orange County. In support of this program, CalOptima contracted with delegated health networks to manage services to the network's assigned membership. These contracts currently expire on December 31, 2017.

At its September 2017 meeting, the Board authorized the execution of a new three-way agreement between CalOptima, CMS and DHCS to extend the CMC program for an additional two years, through December 31, 2019.

In addition to extending the agreement for an additional two-year period, the three-way agreement includes revisions to ensure consistency with demonstrations in other states.

Back to Agenda

Staff recommends extending the CMC health network agreements through December 31, 2018, with a second year extension as an option, exercisable at CalOptima's discretion, to be in alignment with CalOptima's three-way CMC contract with the DHCS and CMS. In addition to extending the health network contracts, the amendments will include provisions to address technical revisions and any other new/revised requirements from the new three-way agreement that are applicable to the OneCare Connect health network.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2017-18 Operating Budget approved by the Board on June 1, 2017, includes OneCare Connect health network capitation expenses that were consistent with forecasted enrollment. Staff included approximately $104 million in the budget. Since the rates and terms of the contracts will not change, the recommended action to renew the existing health network contracts from January 1, 2018, through June 30, 2018, is a budgeted item with no additional fiscal impact.

Management will include revenue and expenses for the period of July 1, 2018, through December 31, 2019, related to the contract renewals in future operating budgets.

Rationale for Recommendation

CalOptima Staff recommends authorizing extension and amendment of the health network contracts in order to maintain and continue the contractual relationship with the health networks serving CalOptima's CMC members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader | *10/23/2017*

Authorized Signature | **Date**

Back to Agenda

CalOptima Board Action Agenda Referral

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

Report Item

22. Consider Authorizing Expenditures in Support of CalOptima's Participation in the Family Voices of California's (FVCA) 2018 Annual Health Summit, in Preparation for the Upcoming Transition of the California Children's Services (CCS) Benefit to CalOptima

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 $2,400 for CalOptima's participation in the FVCA 2018 Annual Health Summit on February 26-27 in Sacramento, which would cover the cost of three Orange County CCS families attending the Summit;
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the events and expenditures.

Background

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

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

Discussion

California Children's Services (CCS) is a statewide program providing medical care, medical case management, physical/occupational therapy and financial assistance for approximately 180,000 medically fragile children under 21 who meet the defined criteria. CCS serves approximately 13,000 Orange County residents, with nearly 12,000 of them being CalOptima's members. Under Senate Bill 586, the bill would authorize the Department of Health Care Services (DHCS) to begin transitioning CCS into specified county organized health system (COHS) counties, including Orange County, no sooner than July 1, 2017 under the Whole Child Model. Per DHCS' latest guidance, Orange County is scheduled to transition no sooner than January 1, 2019.

FVCA is a statewide collaborative of parent advocates focused on improving policies that ensure quality health care for children with special needs. FVCA also operates seven parent-run centers, providing information and support so families can make informed decisions about their children's health care. FVCA has been an influential advocacy organization working closely with DHCS and the Legislature on redesigning the CCS program. Specifically, FVCA has reached out to Medi-Cal managed care plans, including CalOptima, to begin working together to ensure the CCS transition from FFS to managed care is done in a responsible manner.

CalOptima sponsored the FVCA Annual Summit for the first time last year at the $2,500 level, which provided sponsorship for two (2) Orange County families to attend the Summit. CalOptima's sponsorship allowed Family Voices to provide all accommodations – including airfare, transportation, and lodging – so that parents of CalOptima members could attend the summit. CalOptima staff selected these members to attend based on recommendations by Family Support Network (FSN), a community organization dedicated to providing services and resources that help children with special needs. The parents of CCS-eligible children who attended last year's summit expressed their appreciation for the opportunity to learn about issues and policies affecting children with special health care needs and develop strategies to ensure access to affordable and family-centered care to support Orange County families.

Staff recommends authorizing $2,400 for participation in the FVCA 2018 Annual Health Summit in Sacramento. CalOptima's sponsorship will allow three Orange County family members of CCS-eligible children to attend the summit. Staff believes that participation will strengthen CalOptima's partnership with FVCA and ensure that Orange County CCS families are engaged with the changes to the program, so the transition takes place in a seamless manner. Participation from CCS family advocates is integral as CalOptima implements the CCS transition and develops the Family Advisory Committee (FAC); a statutory requirement in Senate Bill 586 to ensure that CCS families' concerns are represented and the needs of children with complex care needs are addressed. CalOptima participates in the Orange County Care Coordination Collaborative for Kids (OCCC3 for Kids), a partnership of public and private organizations working to improve systems of care for children with special health care needs. OCC3's voluntary members include more than thirty (30) key organizations involved in children's health and wellbeing in Orange County with representatives from CCS, Regional Center of Orange County, Family Support Network, the Center for Autism and Neurodevelopmental Disorders, Orange County Health Care Agency Public Health Nursing, Orange County Department of Education among others. This year, as proposed, the funding provided by CalOptima will be used to cover the cost of participation (including airfare, transportation and accommodations) for three (3) CCS families selected by OCCC3 for Kids (in which CalOptima staff participates) to attend the FVCA Annual Summit based on family member interest and criteria set by OCCC3.

The $2,400 financial commitment will provide sponsorship for three (3) Orange County families to attend the event and marketing benefits, including CalOptima's logo on all marketing materials for the event, the FVCA website, social media, follow-up materials and publications, as well as admittance to the summit. The summit will bring together families, advocates, state agency representatives, Medi-Cal managed care plans, health policy advocates, legislative representatives and CCS providers to address

issues that affect this vulnerable population. Last year's summit drew 185 participants, including 98 family members throughout California. Orange County families with children enrolled in the CCS program have expressed interest in attending the event. Sponsors for this event include Lucile Packard Foundation for Children's Health, California Children's Hospital Association, The California Wellness Foundation, Stanford Children's Health, Central California Alliance for Health, Children's Hospital Los Angeles, Children's Specialty Care Coalition, CenCalHealth, Miller Children's and Women's Hospital Long Beach, Disability Rights California, State Council on Developmental Disabilities, Together We Grow, Benioff Children's Hospital and Valley Children's Healthcare.

Fiscal Impact

Funding for the recommended action of up to $2,400 to allow for three Orange County families to participate in the FVCA 2018 Annual Health Summit 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 action in order to send three member families to an event related to the anticipated transition of the CCS benefit in Orange County into Medi-Cal managed care sometime after January 1, 2019.

Concurrence

Gary Crockett, Chief Counsel

Attachment

FVCA Sponsorship Packet

/s/ Michael Schrader | *10/23/2017*

Authorized Signature | **Date**

FAMILY VOICES of California

The voice of families
The vision of quality health care
The future for children and youth with special health care needs

Alpha Resource Center
Family First Program
4501 Cathedral Oaks Road
Santa Barbara, CA 93110
805/683-2145 F: 805/967-3647
info@alphasb.org

Eastern Los Angeles Family Resource Center
1000 South Fremont Ave.
Suite 6050, Unit 35
Alhambra, CA 91803
626-300-9171 F: 626-300-9164
info@elafrc.org

Family Resource Network
5232 Claremont Avenue
Oakland, CA 94618
510/547-7322 F: 510/658.8354
frn@frnoakland.org

Rowell Family Empowerment of Northern California, Inc.
962 Maraglia
Redding, CA 96002
530/226-5129 F: 530/226-5141
Toll: 877/227-3471
wendyl@rfenc.org

Support for Families of Children with Disabilities
1663 Mission Street, 7th Floor
San Francisco, CA 94103
415/282-7494 F: 415/282-1226
info@supportforfamilies.org

Westside Family Resource and Empowerment Center
5901 Green Valley Circle #320
Culver City, CA 90230-6953
310/258-4063 F: (310) 338-9664
family@westsiderc.org

FAMILY VOICES OF CALIFORNIA
1663 Mission Street, 7th Floor
San Francisco, CA 94103
415/282-7494 F: 415/282-1226
info@familyvoicesofca.org
www.familyvoicesofca.org

August 17, 2017

Tiffany Kaaiakamanu
Manager, Community Relations
CalOptima
505 City Parkway West
Orange, CA 92868

Re: **Request for Sponsorship for 2018 Family Voices of CA Health Summit**

Dear Tiffany:

I am writing on behalf of Family Voices of California FVCA) to request sponsorship support for our 2018 Annual Health Summit and Legislative Advocacy Day, to be held February 26-27, 2018 in Sacramento. Again, we would like to thank you sincerely for your sponsorship in 2017 which helped make our last Summit event a huge success. We hope we can count on your support again for 2018.

The full day Summit, scheduled for Monday, February 26, 2018 will bring together families, advocates, state agency representatives, health policy advocates, legislative representatives, providers and insurers. Speakers help participants become informed about issues in California that significantly affect the health care of children with special needs; in break-out sessions and discussions, participants work to develop strategies to ensure that California families are able to access affordable and family-centered care for their children and youth with special health care needs (CYSHCN).

On the following day, Tuesday, February 27, the Health Summit participants will gather at the State Capitol to learn how to impact legislation that could provide access to quality, affordable health care for CYSHCN. Participants meet with legislators to discuss policy issues and exchange information to continue the dialogue beyond the Summit. As parents and youth discuss the special health care needs of their families, they put a personal face on the impact of legislation and budget decisions.

For our 2018 Summit, we would like to increase the number of families and professionals and hope to have many California counties represented. With your help, we can do this and make a difference for children and youth with special health care needs. Sponsors will be prominently recognized in program materials, outreach on the Family Voices of California website, and in follow-up materials and publications.

Thank you for your consideration of this request!

Sincerely,

Pip Marks
Project Director
Family Voices of California

Back to Agenda

The full day Summit, scheduled for Monday, February 26, 2018 will bring together families, advocates, state agency representatives, health policy advocates, legislative representatives, providers and insurers. Speakers help participants become informed about issues in California that significantly affect the health care of children with special needs; in break-out sessions and discussions, participants work to develop strategies to ensure that California families are able to access affordable and family-centered care for their children and youth with special health care needs (CYSHCN).

On the following day, Tuesday, February 27, the Health Summit participants will gather at the State Capitol to learn how to impact legislation that could provide access to quality, affordable health care for CYSHCN. Participants meet with legislators to discuss policy issues and exchange information to continue the dialogue beyond the Summit. As parents and youth discuss the special health care needs of their families, they put a personal face on the impact of legislation and budget decisions.

For our 2018 Summit, we would like to increase the number of families and professionals and hope to have many California counties represented. With your help, we can do this and make a difference for children and youth with special health care needs. Sponsors will be prominently recognized in program materials, outreach on the Family Voices of California website, and in follow-up materials and publications.

Thank you for your consideration of this request!

Sincerely,
Pip

Pip Marks
Family Voices of CA Project Director
1663 Mission Street, 7th Floor
San Francisco, CA 94103
Phone: 415-282-7494 Ext. 123
pipmarks@familyvoicesofca.org
www.familyvoicesofca.org

Health Summit Sponsorship Commitment

February 26-27, 2018
Courtyard Marriott, Sacramento

Please return Sponsorship Commitment to Pip Marks by MAIL OR EMAIL:
1663 Mission Street, Suite 700, San Francisco, CA 94103
pipmarks@familyvoicesofca.org

☐ **YES!** I am interested in **sponsoring** the Family Voices Health Summit
(Cost per family = $800)

☐ **$15,000**
Listed as **Lead Presenting Sponsor** in all press releases; full page insert in event program; logo will be displayed on FVCA Website, all Summit materials if logo and sponsorship pledge is received by January 1, 2018

☐ **$10,000**
Listed as **Major Sponsor** in press release; logo will be displayed on FVCA Website and Summit materials if logo and sponsorship is received by January 1, 2018

☐ **$5,000**
Listed as Significant Sponsor in program; logo displayed on FVCA Website and Summit materials if logo and sponsorship is received by January 1, 2018

☐ **$1,000**
Listed as Valued Sponsor in program if logo and sponsorship are received by January 1, 2018

☐ **$800**
Listed as Supportive Sponsor in program if logo and sponsorship are received by January 1, 2018

☐ **$Other**
Please list amount you wish to donate

TOTAL SPONSORSHIP CONTRIBUTION $____________________

Back to Agenda

COMPLETE THE FOLLOWING CONTACT AND PAYMENT INFORMATION:

Contact Name:____

Company/Agency:_____________________________________

Address:____

____

Phone:____

Email:____

PAYMENT DETAILS

☐ Please make check payable to Support for Families of Children with Disabilities
(MEMO: FVCA HEALTH SUMMIT)
Please send to:
FVCA, 1663 Mission Street, Suite 700, San Francisco, CA 94103
Attention: Pip Marks

OUR 2017 HEALTH SUMMIT FAMILY MEMBER ATTENDEES AND FVCA
THANK YOU FOR YOUR WONDERFUL SUPPORT!!!

Back to Agenda

AGENDA ITEM 23 TO FOLLOW CLOSED SESSION

Consider Chief Executive Officer Performance Review, Compensation, and Amendment to Employment Contract

Back to Agenda

CalOptima
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Board of Directors Meeting
November 2, 2017

Provider Advisory Committee (PAC) Update

October 12, 2017 PAC Meeting

Fourteen (14) PAC members were in attendance at the October PAC meeting.

Ladan Khamseh, Chief Operating Officer, updated the PAC on the behavioral health Medi-Cal transition from Magellan and noted that CalOptima is holding daily meetings and hiring staff. She also revisited the topic of Knox-Keene Licensure. This license is not a requirement for CalOptima. However, CalOptima is evaluating the possibility of adopting an Independent Medical Review (IMR) process. Ms. Khamseh noted that staff may be bringing an update on this topic as soon as to the Board's next Finance and Audit Committee meeting in November.

Richard Bock, M.D., Deputy Chief Medical Officer, announced that NCQA has again named CalOptima the number one (1) Medi-Cal health plan in California for the fourth straight year in a row. Once again, CalOptima achieved a "Commendable" status. He also informed the PAC that Caryn Ireland, CalOptima's former Executive Director of Quality Initiatives has retired, and that recruitment efforts are underway to fill her position. Dr. Bock introduced Sandeep Mital, Manager, Quality Analytics who gave a verbal report on the Data Collection workgroup that was created to help solve data issues related to the Pay for Value and HEDIS Programs. The health networks and CalOptima are collaborating to ensure all data is captured including the State's California Immunization Registry (CAIR).

PAC also received an update on CalOptima's financial performance through the month of August 2017 from Interim Chief Financial Officer, Nancy Huang.

Michelle Laughlin, Executive Director Network Operations, provided the PAC with an update on the Magellan transition. CalOptima's goal is to contract with the majority, if not all, of the providers currently providing ABA and Behavioral Health services for CalOptima members. CalOptima staff has met with the ABA providers and updated them on the rate structure effective January 1, 2018. While the rates, overall, will be lower than those paid by Magellan, CalOptima plans to pay as much as the rates received from the state for these services allow. for these services. Michael Schrader, CEO, shared that 22% of the cost is attributed to Mild to Moderate Behavioral Health Services. The remaining cost is the cost of ABA services. The PAC and CalOptima staff discussed that Orange County has the highest number of members per capita in California that receive ABA services.

Phil Tsunoda, Executive Director, Public Policy and Public Affairs, provided the PAC with an update on the Children's Health Insurance Program (CHIP) in Orange County and noted that a reauthorization that was signed in to law in 2015, which funded CHIP through September 30, 2017. The current funding is split between the Federal and State at 88%/12%. Mr. Tsunoda discussed various scenarios that are being looked at to fund this program including going back to the original split of 65%/35% between the Federal and State.

Back to Agenda

Other updates included the Drug Medi-Cal program referral process by the County from Edwin Poon, PhD, Director, Behavioral Health. He informed the PAC that 37% of the total referrals are for Alcohol and Drug Residential services; 17% for outpatient behavioral health therapy and 50% for Magellan (mild to moderate) therapy services. Candice Gomez, Executive Director, Program Implementation, provided the PAC with a status on the transition plan for the Whole Child Care Model effective 1/1/2019. The PAC members had questions regarding the provider network and the reimbursement after the program transitions to CalOptima.

PAC members discussed holding another joint MAC/PAC meeting in March 2018. Members felt the dialogue between the two committees was beneficial and would like to continue meeting to discuss mutual objectives.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's current activities.

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Board of Directors Meeting
November 2, 2017

Joint Member Advisory Committee (MAC) and Provider Advisory Committee (PAC) Update

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September 14, 2017 Joint MAC and PAC Committee Meeting

Eleven (11) PAC members and nine (9) MAC members attended the September 14, 2017 Joint MAC and PAC meeting.

Michael Schrader, Chief Executive Officer updated the MAC and the PAC on the CalOptima behavioral health transition plan. He noted that CalOptima would be ready on January 1, 2018 to provide administrative functions for the Medi-Cal behavioral health line of business.

Susan Price, Director Care Coordination, County of Orange presented on the Homeless Initiatives at the County is working to address this important issue. This presentation generated much dialogue between the members of the MAC and the PAC.

A presentation on Drug Medi-Cal and Substance Use Disorder was presented by Sandra Fair, Administrative Manager II, Orange County Healthcare Agency. This presentation included discussion of the 5-year Drug Medi-Cal Pilot project and expanded substance use disorder services requirements which were approved through a waiver. The presentation also generated questions from both the MAC and the PAC members.

Patty Mouton, Vice President, Outreach & Advocacy of Alzheimer's of Orange County and member of the MAC, presented the Orange County Strategic Plan for Aging. Ms. Mouton noted that by 2040 nearly 1 in 4 residents in Orange County will be 65 and older. The strategic plan will help the County prepare for the growing numbers of older residents and the issues they may face.

At the conclusion of the meeting, both MAC and PAC agreed they would like to have more joint meetings in the future to open up dialogue on how to best serve the needs of the CalOptima members.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's activities.

Back to Agenda

Board of Directors Meeting
November 2, 2017

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

A quorum was not reached at the OneCare Connect Member Advisory Committee (OCC MAC) meetings on August 24, 2017 and September 28, 2017. CalOptima staff sent several meeting reminders prior to the meetings to confirm attendance and received the requisite number of confirmed members to reach quorum at each meeting. However, there were unexpected absences at each meeting. In addition, OCC MAC Chair Gio Corzo routinely reminds committee members about the importance of attending meetings. A quorum is six voting members.

OCC MAC will provide a full report at the next Board of Directors meeting.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

Back to Agenda

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Board of Directors Meeting
November 2, 2017

Special Member Advisory Committee Update

September 14, 2017 Special Member Advisory Committee (MAC) Meeting

On September 14, 2017, the MAC convened a Special MAC meeting to discuss a proposed structure and composition of the Whole Child Model (WCM) advisory committee. Sesha Mudunuri, Executive Director, Operations, reported that the California Children's Services (CCS) will be transitioning the Whole Child Model (WCM) to CalOptima and requires the establishment of a family advisory committee. Mr. Mudunuri explained that CalOptima staff reached out to community stakeholders to obtain feedback on the structure and composition of the WCM family advisory committee.

Based on feedback, CalOptima staff proposed the WCM Family Advisory Committee should report directly to the Board of Directors and should be composed of CCS families/recipients. After considerable discussion, MAC members recommended that the WCM Family Advisory Committee should report directly to the Board of Directors and include a combination of CCS families/recipients and community stakeholders/advocates. MAC members concurred that the CCS individuals served should be empowered and have a voice on the committee, but it would be beneficial to include stakeholders/advocates to bring balance to the committee, bring validation from a systemic perspective and increase the synergy on the committee.

The MAC appreciates the opportunity to provide the CalOptima Board with input and updates on the MAC's activities.

Back to Agenda

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Financial Summary
September 2017

Board of Directors Meeting

November 2, 2017

Greg Hamblin

Chief Financial Officer

Back to Agenda

FY 2017-18: Consolidated Enrollment

- September 2017 MTD:
  - Overall enrollment was 796,181 member months
    - Actual lower than budget by 6,192 or 0.8%
      - Medi-Cal: unfavorable variance of 6,013 members
        - TANF unfavorable variance of 9,620 members
        - SPD unfavorable variance of 1,982 members
        - Medi-Cal Expansion (MCE) favorable variance of 5,343 members
        - LTC favorable variance of 246 members
      - OneCare Connect: unfavorable variance of 251 members
    - 1,810 or 0.2% decrease from prior month
      - Medi-Cal: decrease of 1,871 from August
      - OneCare Connect: increase of 36 from August
      - OneCare: increase of 18 from August
      - PACE: increase of 7 from August

Back to Agenda

FY 2017-18: Consolidated Enrollment

- September 2017 YTD:
  - Overall enrollment was 2,381,858 member months
    - Actual lower than budget by 24,277 or 1.0%
      - Medi-Cal: unfavorable variance of 23,813 members or 1.0%
        - TANF unfavorable variance of 30,767 members
        - SPD unfavorable variance of 6,716 members
        - MCE favorable variance of 13,090 members
        - LTC favorable variance of 580 members
      - OneCare Connect: unfavorable variance of 648 members or 1.4%
      - OneCare: favorable variance of 183 members or 4.6%
      - PACE: favorable variance of 1 member or 0.2%

Back to Agenda

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FY 2017-18: Consolidated Revenues

- September 2017 MTD:
  - Actual higher than budget by $22.1 million or 8.0%
    - Medi-Cal: favorable to budget by $17.5 million or 7.2%
      - Unfavorable volume variance of $1.9 million
      - Favorable price variance of $19.4 million due to:
        - $9.5 million of fiscal year 2018 Coordinated Care Initiative (CCI) including In-Home Supportive Services (IHSS) revenue
        - $2.0 million of fiscal year 2018 Behavior Health Treatment (BHT) revenue
        - $2.1 million of fiscal year 2018 LTC related revenue from non-LTC aid code
        - $1.2 million of fiscal year 2018 Non-Medical Transportation revenue
        - $3.7 million of fiscal year 2016 revenue true up to final DHCS rates

Back to Agenda

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FY 2017-18: Consolidated Revenues (cont.)

- September 2017 MTD:
  - OneCare Connect: favorable to budget by $6.9 million or 25.0%
    - Unfavorable volume variance of $0.4 million due to lower enrollment
    - Favorable price related variance of $7.4 million due to CMS' annual adjustments
  - OneCare: unfavorable to budget by $2.5 million or 178.6%
    - $2.8 million due to prior year Health Network recoupment due to encounter data correction
  - PACE: favorable to budget by $0.1 million or 8.7%

Back to Agenda

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FY 2017-18: Consolidated Revenues (cont.)

- September 2017 YTD:
  - Actual higher than budget by $33.8 million or 4.1%
    - Medi-Cal: favorable to budget by $29.9 million or 4.1%
      - Unfavorable volume variance of $7.4 million
      - Favorable price variance of $37.4 million due to:
        - $19.0 million for CCI and IHSS revenue
        - $14.5 million for prior year revenue
        - $4.5 million for Autism revenue
    - OneCare Connect: favorable to budget by $5.7 million or 6.9%
      - Unfavorable volume variance of $1.1 million
      - Favorable price variance of $6.8 million
    - OneCare: Unfavorable to budget by $2.3 million or 55.9%
      - Favorable volume variance of $0.2 million
      - Unfavorable price variance of $2.5 million
        - $2.8 million due to Health Network recoupment
    - PACE: favorable to budget by $0.5 million or 11.5%

Back to Agenda

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FY 2017-18: Consolidated Medical Expenses

- September 2017 MTD:
  - Actual higher than budget by $18.9 million or 7.3%
    - Medi-Cal: unfavorable variance of $19.4 million
      - MLTSS unfavorable variance of $8.5 million
        - IHSS unfavorable variance of $4.9 million
        - Nursing facilities expenses unfavorable variance of $2.8 million
      - Professional Claims unfavorable variance of $5.7 million
      - Provider Capitation unfavorable variance of $3.0 million
      - Facilities expenses unfavorable variance of $1.6 million
    - OneCare Connect: unfavorable variance of $2.7 million
      - Favorable volume variance of $0.4 million
      - Unfavorable price variance of $3.1 million

Back to Agenda

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FY 2017-18: Consolidated Medical Expenses (cont.)

- September 2017 YTD:
  - ➢ Actual higher than budget by $43.4 million or 5.5%
    - ▪ Medi-Cal: unfavorable variance of $44.0 million
      - Favorable volume variance of $7.1 million
      - Unfavorable price variance of $51.0 million
        - ➢ MLTSS expense $23.1 million higher than budget
        - ➢ Professional Claims $6.6 million higher than budget
        - ➢ Facilities $6.2 million higher than budget
        - ➢ Provider Capitation $5.9 million higher than budget
    - ▪ OneCare Connect: unfavorable variance of $2.8 million
      - Favorable volume variance of $1.1 million
      - Unfavorable price variance of $3.9 million
- Medical Loss Ratio (MLR):
  - ➢ September 2017 MTD: Actual: 93.3% Budget: 93.9%
  - ➢ September 2017 YTD: Actual: 96.2% Budget: 94.8%

Back to Agenda

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FY 2017-18: Consolidated Administrative Expenses

- September 2017 MTD:
  - Actual lower than budget by $2.1 million or 18.0%
    - Salaries and Benefits: favorable variance of $0.8 million
    - Other categories: favorable variance of $1.4 million

- September 2017 YTD:
  - Actual lower than budget by $8.0 million or 22.0%
    - Salaries and Benefits: favorable variance of $2.7 million driven by lower than budgeted FTE
    - Other categories: favorable variance of $5.2 million

- Administrative Loss Ratio (ALR):
  - September 2017 MTD: Actual: 3.3% Budget: 4.3%
  - September 2017 YTD: Actual: 3.3% Budget: 4.4%

Back to Agenda

FY 2017-18: Change in Net Assets

- September 2017 MTD:
  - $11.3 million surplus
  - $6.2 million favorable to budget
    - Higher than budgeted revenue of $22.1 million
    - Higher than budgeted medical expenses of $18.9 million
    - Lower than budgeted administrative expenses of $2.1 million
    - Higher than budgeted investment and other income of $0.9 million

- September 2017 YTD:
  - $11.3 million surplus
  - $4.1 million favorable to budget
    - Higher than budgeted revenue of $33.8 million
    - Higher than budgeted medical expenses of $43.4 million
    - Lower than budgeted administrative expenses of $8.0 million
    - Higher than budgeted investment and other income of $5.7 million

Back to Agenda

Enrollment Summary: September 2017

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
62,289	62,630	(341)	(0.5%)	Aged	185,000	186,724	(1,724)	(0.9%)
625	618	7	1.1%	BCCTP	1,877	1,854	23	1.2%
47,116	48,764	(1,648)	(3.4%)	Disabled	141,249	146,264	(5,015)	(3.4%)
327,786	329,785	(1,999)	(0.6%)	TANF Child	982,305	989,784	(7,479)	(0.8%)
96,310	103,931	(7,621)	(7.3%)	TANF Adult	288,774	312,062	(23,288)	(7.5%)
3,514	3,268	246	7.5%	LTC	10,384	9,804	580	5.9%
241,644	236,301	5,343	2.3%	MCE	721,589	708,499	13,090	1.8%
779,284	**785,297**	**(6,013)**	**(0.8%)**	**Medi-Cal**	**2,331,178**	**2,354,991**	**(23,813)**	**(1.0%)**
15,265	**15,516**	**(251)**	**(1.6%)**	**OneCare Connect**	**45,859**	**46,507**	**(648)**	**(1.4%)**
228	**226**	**2**	**0.9%**	**PACE**	**664**	**663**	**1**	**0.2%**
1,404	**1,334**	**70**	**5.2%**	**OneCare**	**4,157**	**3,974**	**183**	**4.6%**
796,181	**802,373**	**(6,192)**	**(0.8%)**	**CalOptima Total**	**2,381,858**	**2,406,135**	**(24,277)**	**(1.0%)**

Financial Highlights: September 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
796,181	802,373	(6,192)	(0.8%)	Member Months	2,381,858	2,406,135	(24,277)	(1.0%)
297,732,356	275,642,096	22,090,259	8.0%	Revenues	859,083,252	825,259,966	33,823,286	4.1%
277,812,491	258,936,834	(18,875,657)	(7.3%)	Medical Expenses	826,083,672	782,662,834	(43,420,838)	(5.5%)
9,744,789	11,884,562	2,139,773	18.0%	Administrative Expenses	28,137,763	36,094,325	7,956,562	22.0%
10,175,076	**4,820,699**	**5,354,376**	**111.1%**	**Operating Margin**	**4,861,818**	**6,502,807**	**(1,640,989)**	**(25.2%)**
1,103,744	231,157	872,586	377.5%	Non Operating Income (Loss)	6,446,929	736,245	5,710,684	775.6%
11,278,819	**5,051,857**	**6,226,963**	**123.3%**	**Change in Net Assets**	**11,308,747**	**7,239,053**	**4,069,695**	**56.2%**
93.3%	93.9%	0.6%		Medical Loss Ratio	96.2%	94.8%	(1.3%)	
3.3%	4.3%	1.0%		Administrative Loss Ratio	3.3%	4.4%	1.1%	
3.4%	1.7%	1.7%		Operating Margin Ratio	0.6%	0.8%	(0.2%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

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Consolidated Performance Actual vs. Budget: September (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
4.5	4.4	0.1	Medi-Cal	(0.2)	7.0	(7.3)
4.8	0.5	4.3	OCC	3.9	0.1	3.8
0.6	(0.1)	0.7	OneCare	0.6	(0.5)	1.1
0.2	0.0	0.2	PACE	0.6	(0.2)	0.8
10.2	**4.8**	**5.3**	**Operating**	**4.8**	**6.5**	**(1.7)**
1.1	0.2	0.9	Inv./Rental Inc, MCO tax	6.5	0.7	5.6
1.1	**0.2**	**0.9**	**Non-Operating**	**6.5**	**0.7**	**5.6**
11.3	**5.1**	**6.2**	**TOTAL**	**11.3**	**7.2**	**4.1**

Back to Agenda

Consolidated Revenue & Expense: September 2017 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	537,640	241,644	779,284	15,265	1,404	228	796,181
REVENUES							
Capitation Revenue	$ 150,153,121	$ 112,403,119	$ 262,556,241	$ 34,652,381	$ (1,094,261)	$ 1,617,995	$ 297,732,356
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	150,153,121	112,403,119	262,556,241	34,652,381	(1,094,261)	1,617,995	297,732,356
MEDICAL EXPENSES							
Provider Capitation	39,521,013	50,516,924	90,037,937	12,661,156	(2,247,990)	-	100,451,103
Facilities	21,198,993	23,496,321	44,695,314	3,586,012	62,118	184,354	48,527,798
Ancillary	-	-	-	568,797	3,266	-	572,063
Skilled Nursing	-	-	-	-	4,755	-	4,755
Professional Claims	13,845,447	5,597,700	19,443,147	-	-	346,516	19,789,663
Prescription Drugs	17,144,885	17,703,599	34,848,484	4,855,851	433,808	106,728	40,244,871
MLTSS Facility Payments	54,232,017	2,632,094	56,864,111	5,271,733	-	(368)	62,135,476
Medical Management	1,724,254	840,902	2,565,156	939,878	11,324	365,196	3,881,553
Reinsurance & Other	1,076,858	693,939	1,770,797	141,469	7,278	285,664	2,205,208
Total Medical Expenses	148,743,468	101,481,478	250,224,946	28,024,897	(1,725,441)	1,288,089	277,812,491
Medical Loss Ratio	**99.1%**	**90.3%**	**95.3%**	**80.9%**	**157.7%**	**79.6%**	**93.3%**
GROSS MARGIN	**1,409,654**	**10,921,641**	**12,331,295**	**6,627,484**	**631,180**	**329,906**	**19,919,864**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,107,223	746,311	21,015	60,691	5,935,240
Professional fees			172,881	17,875	0	2,935	193,691
Purchased services			903,190	85,998	12,483	6,246	1,007,918
Printing and Postage			406,533	83,461	(1,478)	68	488,584
Depreciation and Amortization			617,605	-	-	2,168	619,773
Other expenses			1,104,253	37,915	(0)	22,718	1,164,886
Indirect cost allocation, Occupancy expense			(493,564)	825,539	(23,161)	25,882	334,696
Total Administrative Expenses			7,818,122	1,797,098	8,859	120,709	9,744,789
Admin Loss Ratio			**3.0%**	**5.2%**	**-0.8%**	**7.5%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			4,513,173	4,830,386	622,321	209,196	10,175,076
INVESTMENT INCOME			-	-	-	-	1,105,625
NET RENTAL INCOME			-	-	-	-	8,604
NET GRANT INCOME			(10,546)	-	-	-	(10,546)
OTHER INCOME			60	-	-	-	60
CHANGE IN NET ASSETS			**$ 4,502,687**	**$ 4,830,386**	**$ 622,321**	**$ 209,196**	**$ 11,278,819**
BUDGETED CHANGE IN ASSETS			4,418,128	539,315	(108,323)	(28,421)	5,051,857
VARIANCE TO BUDGET - FAV (UNFAV)			84,559	4,291,071	730,643	237,617	6,226,963

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Back to Agenda

Consolidated Revenue & Expense: September 2017 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	1,609,589	721,589	2,331,178	45,859	4,157	664	2,381,858
REVENUES							
Capitation Revenue	$ 447,628,650	$ 317,030,364	$ 764,659,014	$ 87,771,776	1,789,381	$ 4,863,081	$ 859,083,252
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	447,628,650	317,030,364	764,659,014	87,771,776	1,789,381	4,863,081	859,083,252
MEDICAL EXPENSES							
Provider Capitation	116,660,817	150,511,678	267,172,495	33,890,040	(1,456,604)	-	299,605,931
Facilities	65,186,053	72,037,091	137,223,144	9,113,530	836,510	818,515	147,991,699
Ancillary	-	-	-	1,891,519	85,461	-	1,976,980
Skilled Nursing	-	-	-	-	52,555	-	52,555
Professional Claims	34,331,176	13,827,753	48,158,929	-	-	974,238	49,133,167
Prescription Drugs	53,038,033	55,184,173	108,222,206	15,102,448	1,420,929	328,933	125,074,516
MLTSS Facility Payments	162,706,147	7,489,698	170,195,846	15,375,481	-	16,390	185,587,717
Medical Management	6,422,964	1,933,895	8,356,860	3,139,968	51,302	1,091,944	12,640,073
Reinsurance & Other	1,726,651	971,988	2,698,639	570,027	21,350	731,018	4,021,034
Total Medical Expenses	440,071,842	301,956,277	742,028,118	79,083,014	1,011,502	3,961,037	826,083,672
Medical Loss Ratio	**98.3%**	**95.2%**	**97.0%**	**90.1%**	**56.5%**	**81.5%**	**96.2%**
GROSS MARGIN	**7,556,809**	**15,074,087**	**22,630,896**	**8,688,762**	**777,879**	**902,044**	**32,999,581**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			15,468,566	2,236,999	75,591	207,960	17,989,116
Professional fees			561,068	18,376	0	9,040	588,484
Purchased services			2,376,469	259,764	38,574	12,424	2,687,231
Printing and Postage			822,006	148,718	8,572	4,995	984,291
Depreciation and Amortization			1,372,600	-	-	6,432	1,379,032
Other expenses			3,268,243	147,882	(0)	53,886	3,470,010
Indirect cost allocation, Occupancy expense			(1,026,800)	1,994,395	40,659	31,344	1,039,598
Total Administrative Expenses			22,842,152	4,806,133	163,396	326,081	28,137,763
Admin Loss Ratio			**3.0%**	**5.5%**	**9.1%**	**6.7%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			(211,256)	3,882,629	614,483	575,962	4,861,818
INVESTMENT INCOME			-	-	-	-	6,460,129
NET RENTAL INCOME			-	-	-	-	15,244
NET GRANT INCOME			(28,863)	-	-	-	(28,863)
OTHER INCOME			419	-	-	-	419
CHANGE IN NET ASSETS			**$ (239,700)**	**$ 3,882,629**	**$ 614,483**	**$ 575,962**	**$ 11,308,747**
BUDGETED CHANGE IN ASSETS			7,033,341	102,010	(452,152)	(180,391)	7,239,053
VARIANCE TO BUDGET - FAV (UNFAV)			(7,273,041)	3,780,619	1,066,634	756,354	4,069,695

Back to Agenda

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Balance Sheet:
As of September 2017

ASSETS			LIABILITIES & FUND BALANCES	
Current Assets			Current Liabilities	
	Operating Cash	$761,478,642	Accounts payable	$19,618,674
	Investments	1,041,355,043	Medical claims liability	1,422,870,300
	Capitation receivable	385,861,846	Accrued payroll liabilities	11,089,422
	Receivables - Other	24,750,232	Deferred revenue	156,973,782
	Prepaid Expenses	4,978,217	Deferred lease obligations	178,046
			Capitation and withholds	437,934,816
	Total Current Assets	**2,218,423,981**	**Total Current Liabilities**	**2,048,665,040**
Capital Assets	Furniture and equipment	34,039,048	Other employment benefits liability	29,105,495
	Building/Leasehold improvements	5,527,436		
	505 City Parkway West	49,433,337	Net Pension Liabilities	15,959,420
		88,999,822	Long Term Liabilities	100,000
	Less: accumulated depreciation	(36,454,633)		
	Capital assets, net	**52,545,189**	**TOTAL LIABILITIES**	**2,093,829,955**
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	23,363,148	Tangible net equity (TNE)	92,041,987
	Long term investments	513,727,647	Funds in excess of TNE	632,725,153
	Total Board-designated Assets	537,090,795		
	Total Other Assets	**537,390,795**	**Net Assets**	**724,767,140**
	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		**2,819,937,104**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,819,937,104**

Back to Agenda

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Board Designated Reserve and TNE Analysis As of September 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,756,598				
	Tier 1 - Logan Circle	146,506,854				
	Tier 1 - Wells Capital	146,471,481				
Board-designated Reserve						
		439,734,933	304,283,513	474,137,298	135,451,420	(34,402,366)
TNE Requirement	Tier 2 - Logan Circle	97,355,862	92,041,987	92,041,987	5,313,875	5,313,875
	Consolidated:	537,090,795	396,325,500	566,179,285	140,765,295	(29,088,491)
	Current reserve level	*1.90*	*1.40*	*2.00*		

Back to Agenda

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UNAUDITED FINANCIAL STATEMENTS

September 2017

Back to Agenda

Table of Contents

Financial Highlights 3
Financial Dashboard 4
Statement of Revenues and Expenses – Consolidated Month to Date 5
Statement of Revenues and Expenses – Consolidated Year to Date 6
Statement of Revenues and Expenses – Consolidated LOB Month to Date 7
Statement of Revenues and Expenses – Consolidated LOB Year to Date 8
Highlights – Overall 9
Enrollment Summary 10
Enrollment Trended by Network Type 11
Highlights – Enrollment 12
Statement of Revenues and Expenses – Medi-Cal 13
Highlights – Medi-Cal 14
Statement of Revenues and Expenses – OneCare Connect 15
Highlights – OneCare Connect 16
Statement of Revenues and Expenses – OneCare 17
Statement of Revenues and Expenses – PACE 18
Statement of Revenues and Expenses – Building: 505 City Parkway 19
Highlights – OneCare, PACE & 505 City Parkway 20
Balance Sheet 21
Board Designated Reserve & TNE Analysis 22
Statement of Cash Flow 23
Highlights – Balance Sheet & Statement of Cash Flow 24
Statement of Revenues and Expenses – CalOptima Foundation 25
Balance Sheet – CalOptima Foundation 26
Highlights – CalOptima Foundation 27
Budget Allocation Changes 28

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the Three Months Ended September 30, 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
796,181	802,373	(6,192)	(0.8%)	Member Months	2,381,858	2,406,135	(24,277)	(1.0%)
297,732,356	275,642,096	22,090,259	8.0%	Revenues	859,083,252	825,259,966	33,823,286	4.1%
277,812,491	258,936,834	(18,875,657)	(7.3%)	Medical Expenses	826,083,672	782,662,834	(43,420,838)	(5.5%)
9,744,789	11,884,562	2,139,773	18.0%	Administrative Expenses	28,137,763	36,094,325	7,956,562	22.0%
10,175,076	**4,820,699**	**5,354,376**	**111.1%**	**Operating Margin**	**4,861,818**	**6,502,807**	**(1,640,989)**	**(25.2%)**
1,103,744	231,157	872,586	377.5%	Non Operating Income (Loss)	6,446,929	736,245	5,710,684	775.6%
11,278,819	**5,051,857**	**6,226,963**	**123.3%**	**Change in Net Assets**	**11,308,747**	**7,239,053**	**4,069,695**	**56.2%**
93.3%	93.9%	0.6%		Medical Loss Ratio	96.2%	94.8%	(1.3%)	
3.3%	4.3%	1.0%		Administrative Loss Ratio	3.3%	4.4%	1.1%	
3.4%	1.7%	1.7%		Operating Margin Ratio	0.6%	0.8%	(0.2%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

CalOptima
Financial Dashboard
For the Three Months Ended September 30, 2017

MONTH - TO - DATE

Enrollment

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	779,284	785,297	↓	(6,013)	(0.8%)
OneCare Connect	15,265	15,516	↓	(251)	(1.6%)
OneCare	1,404	1,334	↑	70	5.2%
PACE	228	226	↑	2	0.9%
Total	796,181	802,373	↓	(6,192)	(0.8%)

Change in Net Assets (000)

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ 4,503	$ 4,418	↑	$ 85	1.9%
OneCare Connect	4,830	539	↑	4,291	795.7%
OneCare	622	(108)	↑	731	674.5%
PACE	209	(28)	↑	238	836.1%
505 Bldg.	9	(19)	↑	27	145.7%
Investment Income & Other	1,106	250	↑	856	342.2%
Total	$ 11,279	$ 5,052	↑	$ 6,227	123.3%

MLR

	Actual	Budget		% Point Var
Medi-Cal	95.3%	94.2%	↓	(1.1)
OneCare Connect	80.9%	91.3%	↑	10.4
OneCare	157.7%	100.8%	↓	(56.8)

Administrative Cost (000)

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ 7,818	$ 9,762	↑	$ 1,944	19.9%
OneCare Connect	1,797	1,878	↑	81	4.3%
OneCare	9	97	↑	88	90.8%
PACE	121	148	↑	28	18.7%
Total	$ 9,745	$ 11,885	↑	$ 2,140	18.0%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	869	900	31
OneCare Connect	224	237	13
OneCare	3	3	0
PACE	52	61	9
Total	1,149	1,202	53

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	896	872	24
OneCare Connect	68	65	3
OneCare	468	445	24
PACE	4	4	1
Total	1,437	1,386	51

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	2,331,178	2,354,991	↓	(23,813)	(1.0%)
OneCare Connect	45,859	46,507	↓	(648)	(1.4%)
OneCare	4,157	3,974	↑	183	4.6%
PACE	664	663	↑	1	0.2%
Total	2,381,858	2,406,135	↓	(24,277)	(1.0%)

Change in Net Assets (000)

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ (240)	$ 7,033	↓	$ (7,273)	(103.4%)
OneCare Connect	3,883	102	↑	3,781	3706.1%
OneCare	614	(452)	↑	1,067	235.9%
PACE	576	(180)	↑	756	419.3%
505 Bldg.	15	(14)	↑	29	210.8%
Investment Income & Other	6,460	750	↑	5,710	761.4%
Total	$ 11,309	$ 7,239	↑	$ 4,070	56.2%

MLR

	Actual	Budget		% Point Var
Medi-Cal	97.0%	95.0%	↓	(2.0)
OneCare Connect	90.1%	92.9%	↑	2.8
OneCare	56.5%	103.8%	↑	47.3

Administrative Cost (000)

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ 22,842	$ 29,602	↑	$ 6,760	22.8%
OneCare Connect	4,806	5,751	↑	945	16.4%
OneCare	163	299	↑	135	45.3%
PACE	326	442	↑	116	26.3%
Total	$ 28,138	$ 36,094	↑	$ 7,957	22.0%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	2,619	2,701	82
OneCare Connect	683	711	29
OneCare	9	9	(0)
PACE	155	187	32
Total	3,466	3,608	142

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	890	872	18
OneCare Connect	67	65	2
OneCare	438	442	(3)
PACE	4	4	1
Total	1,400	1,382	17

Back to Agenda

CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended September 30, 2017

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	796,181		802,373		(6,192)	
Revenues						
Medi-Cal	$ 262,556,241	$ 336.92	$ 245,035,514	$ 312.03	$ 17,520,727	$ 24.89
OneCare Connect	34,652,381	2,270.05	27,725,650	1,786.91	6,926,731	483.15
OneCare	(1,094,261)	(779.39)	1,392,751	1,044.04	(2,487,012)	(1,823.43)
PACE	1,617,995	7,096.47	1,488,181	6,584.87	129,814	511.60
Total Operating Revenue	297,732,356	373.95	275,642,096	343.53	22,090,259	30.42
Medical Expenses						
Medi-Cal	250,224,946	321.10	230,855,487	293.97	(19,369,459)	(27.12)
OneCare Connect	28,024,897	1,835.89	25,308,698	1,631.14	(2,716,199)	(204.76)
OneCare	(1,725,441)	(1,228.95)	1,404,542	1,052.88	3,129,983	2,281.83
PACE	1,288,089	5,649.51	1,368,107	6,053.57	80,019	404.06
Total Medical Expenses	277,812,491	348.93	258,936,834	322.71	(18,875,657)	(26.22)
Gross Margin	19,919,864	25.02	16,705,262	20.82	3,214,603	4.20
Administrative Expenses						
Salaries and Benefits	5,935,240	7.45	6,700,747	8.35	765,507	0.90
Professional fees	193,691	0.24	365,938	0.46	172,247	0.21
Purchased services	1,007,918	1.27	1,986,216	2.48	978,298	1.21
Printing and Postage	488,584	0.61	527,371	0.66	38,787	0.04
Depreciation and Amortization	619,773	0.78	463,298	0.58	(156,475)	(0.20)
Other	1,164,886	1.46	1,500,575	1.87	335,689	0.41
Indirect cost allocation, Occupancy expense	334,696	0.42	340,417	0.42	5,721	0.00
Total Administrative Expenses	9,744,789	12.24	11,884,562	14.81	2,139,773	2.57
Income (Loss) From Operations	10,175,076	12.78	4,820,699	6.01	5,354,376	6.77
Investment income						
Interest income	2,173,776	2.73	250,000	0.31	1,923,776	2.42
Realized gain/(loss) on investments	(111,504)	(0.14)	-	-	(111,504)	(0.14)
Unrealized gain/(loss) on investments	(956,647)	(1.20)	-	-	(956,647)	(1.20)
Total Investment Income	1,105,625	1.39	250,000	0.31	855,625	1.08
Net Rental Income	8,604	0.01	(18,843)	(0.02)	27,447	0.03
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(10,546)	(0.01)	-	-	(10,546)	(0.01)
QAF/IGT	-	-	-	-	-	-
Other Income	60	0.00	-	-	60	0.00
Change In Net Assets	**11,278,819**	**14.17**	**5,051,857**	**6.30**	**6,226,963**	**7.87**
Medical Loss Ratio	**93.3%**		**93.9%**		**0.6%**	
Administrative Loss Ratio	**3.3%**		**4.3%**		**1.0%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

Back to Agenda

CalOptima - Consolidated
Statement of Revenue and Expenses
For the Three Months Ended September 30, 2017

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	2,381,858		2,406,135		(24,277)	
Revenues						
Medi-Cal	$ 764,659,014	$ 328.01	$ 734,734,640	$ 311.99	$ 29,924,374	$ 16.02
OneCare Connect	87,771,776	1,913.95	82,109,442	1,765.53	5,662,334	148.42
OneCare	1,789,381	430.45	4,056,262	1,020.70	(2,266,881)	(590.25)
PACE	4,863,081	7,323.92	4,359,622	6,575.60	503,459	748.32
Total Operating Revenue	859,083,252	360.68	825,259,966	342.98	33,823,286	17.70
Medical Expenses						
Medi-Cal	742,028,118	318.31	698,099,171	296.43	(43,928,947)	(21.87)
OneCare Connect	79,083,014	1,724.48	76,256,306	1,639.67	(2,826,708)	(84.81)
OneCare	1,011,502	243.33	4,209,708	1,059.31	3,198,206	815.99
PACE	3,961,037	5,965.42	4,097,649	6,180.47	136,612	215.05
Total Medical Expenses	826,083,672	346.82	782,662,834	325.28	(43,420,838)	(21.55)
Gross Margin	32,999,581	13.85	42,597,132	17.70	(9,597,552)	(3.85)
Administrative Expenses						
Salaries and Benefits	17,989,116	7.55	20,698,743	8.60	2,709,627	1.05
Professional fees	588,484	0.25	1,175,315	0.49	586,831	0.24
Purchased services	2,687,231	1.13	5,663,224	2.35	2,975,993	1.23
Printing and Postage	984,291	0.41	1,589,613	0.66	605,322	0.25
Depreciation and Amortization	1,379,032	0.58	1,389,894	0.58	10,861	(0.00)
Other	3,470,010	1.46	4,556,286	1.89	1,086,276	0.44
Indirect cost allocation, Occupancy expense	1,039,598	0.44	1,021,250	0.42	(18,348)	(0.01)
Total Administrative Expenses	28,137,763	11.81	36,094,325	15.00	7,956,562	3.19
Income (Loss) From Operations	4,861,818	2.04	6,502,807	2.70	(1,640,989)	(0.66)
Investment income						
Interest income	6,304,054	2.65	750,000	0.31	5,554,054	2.33
Realized gain/(loss) on investments	(186,138)	(0.08)	-	-	(186,138)	(0.08)
Unrealized gain/(loss) on investments	342,214	0.14	-	-	342,214	0.14
Total Investment Income	6,460,129	2.71	750,000	0.31	5,710,129	2.40
Net Rental Income	15,244	0.01	(13,755)	(0.01)	28,999	0.01
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(28,863)	(0.01)	-	-	(28,863)	(0.01)
QAF/IGT	-	-	-	-	-	-
Other Income	419	0.00	-	-	419	0.00
Change In Net Assets	**11,308,747**	**4.75**	**7,239,053**	**3.01**	**4,069,695**	**1.74**
Medical Loss Ratio	**96.2%**		**94.8%**		**(1.3%)**	
Administrative Loss Ratio	**3.3%**		**4.4%**		**1.1%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

Back to Agenda

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended September 30, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	537,640	241,644	779,284	15,265	1,404	228	796,181
REVENUES							
Capitation Revenue	$ 150,153,121	$ 112,403,119	$ 262,556,241	$ 34,652,381	$ (1,094,261)	$ 1,617,995	$ 297,732,356
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	150,153,121	112,403,119	262,556,241	34,652,381	(1,094,261)	1,617,995	297,732,356
MEDICAL EXPENSES							
Provider Capitation	39,521,013	50,516,924	90,037,937	12,661,156	(2,247,990)	-	100,451,103
Facilities	21,198,993	23,496,321	44,695,314	3,586,012	62,118	184,354	48,527,798
Ancillary	-	-	-	568,797	3,266	-	572,063
Skilled Nursing	-	-	-	-	4,755	-	4,755
Professional Claims	13,845,447	5,597,700	19,443,147	-	-	346,516	19,789,663
Prescription Drugs	17,144,885	17,703,599	34,848,484	4,855,851	433,808	106,728	40,244,871
MLTSS Facility Payments	54,232,017	2,632,094	56,864,111	5,271,733	-	(368)	62,135,476
Medical Management	1,724,254	840,902	2,565,156	939,878	11,324	365,196	3,881,553
Reinsurance & Other	1,076,858	693,939	1,770,797	141,469	7,278	285,664	2,205,208
Total Medical Expenses	148,743,468	101,481,478	250,224,946	28,024,897	(1,725,441)	1,288,089	277,812,491
Medical Loss Ratio	**99.1%**	**90.3%**	**95.3%**	**80.9%**	**157.7%**	**79.6%**	**93.3%**
GROSS MARGIN	**1,409,654**	**10,921,641**	**12,331,295**	**6,627,484**	**631,180**	**329,906**	**19,919,864**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,107,223	746,311	21,015	60,691	5,935,240
Professional fees			172,881	17,875	0	2,935	193,691
Purchased services			903,190	85,998	12,483	6,246	1,007,918
Printing and Postage			406,533	83,461	(1,478)	68	488,584
Depreciation and Amortization			617,605	-	-	2,168	619,773
Other expenses			1,104,253	37,915	(0)	22,718	1,164,886
Indirect cost allocation, Occupancy expense			(493,564)	825,539	(23,161)	25,882	334,696
Total Administrative Expenses			7,818,122	1,797,098	8,859	120,709	9,744,789
Admin Loss Ratio			**3.0%**	**5.2%**	**-0.8%**	**7.5%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			4,513,173	4,830,386	622,321	209,196	10,175,076
INVESTMENT INCOME			-	-	-	-	1,105,625
NET RENTAL INCOME			-	-	-	-	8,604
NET GRANT INCOME			(10,546)	-	-	-	(10,546)
OTHER INCOME			60	-	-	-	60
CHANGE IN NET ASSETS			**$ 4,502,687**	**$ 4,830,386**	**$ 622,321**	**$ 209,196**	**$ 11,278,819**
BUDGETED CHANGE IN ASSETS			4,418,128	539,315	(108,323)	(28,421)	5,051,857
VARIANCE TO BUDGET - FAV (UNFAV)			84,559	4,291,071	730,643	237,617	6,226,963

Back to Agenda

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Three Months Ended September 30, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	1,609,589	721,589	2,331,178	45,859	4,157	664	2,381,858
REVENUES							
Capitation Revenue	$ 447,628,650	$ 317,030,364	$ 764,659,014	$ 87,771,776	1,789,381	$ 4,863,081	$ 859,083,252
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	447,628,650	317,030,364	764,659,014	87,771,776	1,789,381	4,863,081	859,083,252
MEDICAL EXPENSES							
Provider Capitation	116,660,817	150,511,678	267,172,495	33,890,040	(1,456,604)	-	299,605,931
Facilities	65,186,053	72,037,091	137,223,144	9,113,530	836,510	818,515	147,991,699
Ancillary	-	-	-	1,891,519	85,461	-	1,976,980
Skilled Nursing	-	-	-	-	52,555	-	52,555
Professional Claims	34,331,176	13,827,753	48,158,929	-	-	974,238	49,133,167
Prescription Drugs	53,038,033	55,184,173	108,222,206	15,102,448	1,420,929	328,933	125,074,516
MLTSS Facility Payments	162,706,147	7,489,698	170,195,846	15,375,481	-	16,390	185,587,717
Medical Management	6,422,964	1,933,895	8,356,860	3,139,968	51,302	1,091,944	12,640,073
Reinsurance & Other	1,726,651	971,988	2,698,639	570,027	21,350	731,018	4,021,034
Total Medical Expenses	440,071,842	301,956,277	742,028,118	79,083,014	1,011,502	3,961,037	826,083,672
Medical Loss Ratio	**98.3%**	**95.2%**	**97.0%**	**90.1%**	**56.5%**	**81.5%**	**96.2%**
GROSS MARGIN	**7,556,809**	**15,074,087**	**22,630,896**	**8,688,762**	**777,879**	**902,044**	**32,999,581**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			15,468,566	2,236,999	75,591	207,960	17,989,116
Professional fees			561,068	18,376	0	9,040	588,484
Purchased services			2,376,469	259,764	38,574	12,424	2,687,231
Printing and Postage			822,006	148,718	8,572	4,995	984,291
Depreciation and Amortization			1,372,600	-	-	6,432	1,379,032
Other expenses			3,268,243	147,882	(0)	53,886	3,470,010
Indirect cost allocation, Occupancy expense			(1,026,800)	1,994,395	40,659	31,344	1,039,598
Total Administrative Expenses			22,842,152	4,806,133	163,396	326,081	28,137,763
Admin Loss Ratio			**3.0%**	**5.5%**	**9.1%**	**6.7%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			(211,256)	3,882,629	614,483	575,962	4,861,818
INVESTMENT INCOME			-	-	-	-	6,460,129
NET RENTAL INCOME			-	-	-	-	15,244
NET GRANT INCOME			(28,863)	-	-	-	(28,863)
OTHER INCOME			419	-	-	-	419
CHANGE IN NET ASSETS			**$ (239,700)**	**$ 3,882,629**	**$ 614,483**	**$ 575,962**	**$ 11,308,747**
BUDGETED CHANGE IN ASSETS			7,033,341	102,010	(452,152)	(180,391)	7,239,053
VARIANCE TO BUDGET - FAV (UNFAV)			(7,273,041)	3,780,619	1,066,634	756,354	4,069,695

Back to Agenda

CalOptima
A Public Agency
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September 30, 2017 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $11.3 million, $6.2 million favorable to budget
- Operating surplus is $10.2 million with a surplus in non-operating of $1.1 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $11.3 million, $4.1 million favorable to budget
- Operating surplus is $4.8 million, $1.7 million unfavorable to budget

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
4.5	4.4	0.1	Medi-Cal	(0.2)	7.0	(7.3)
4.8	0.5	4.3	OCC	3.9	0.1	3.8
0.6	(0.1)	0.7	OneCare	0.6	(0.5)	1.1
0.2	0.0	0.2	PACE	0.6	(0.2)	0.8
10.2	**4.8**	**5.3**	**Operating**	**4.8**	**6.5**	**(1.7)**
1.1	0.2	0.9	Inv./Rental Inc, MCO tax	6.5	0.7	5.6
1.1	**0.2**	**0.9**	**Non-Operating**	**6.5**	**0.7**	**5.6**
11.3	**5.1**	**6.2**	**TOTAL**	**11.3**	**7.2**	**4.1**

CalOptima

Enrollment Summary

For the Three Months Ended September 30, 2017

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
62,289	62,630	(341)	(0.5%)	Aged	185,000	186,724	(1,724)	(0.9%)
625	618	7	1.1%	BCCTP	1,877	1,854	23	1.2%
47,116	48,764	(1,648)	(3.4%)	Disabled	141,249	146,264	(5,015)	(3.4%)
327,786	329,785	(1,999)	(0.6%)	TANF Child	982,305	989,784	(7,479)	(0.8%)
96,310	103,931	(7,621)	(7.3%)	TANF Adult	288,774	312,062	(23,288)	(7.5%)
3,514	3,268	246	7.5%	LTC	10,384	9,804	580	5.9%
241,644	236,301	5,343	2.3%	MCE	721,589	708,499	13,090	1.8%
779,284	**785,297**	**(6,013)**	**(0.8%)**	**Medi-Cal**	**2,331,178**	**2,354,991**	**(23,813)**	**(1.0%)**
15,265	**15,516**	**(251)**	**(1.6%)**	**OneCare Connect**	**45,859**	**46,507**	**(648)**	**(1.4%)**
228	**226**	**2**	**0.9%**	**PACE**	**664**	**663**	**1**	**0.2%**
1,404	**1,334**	**70**	**5.2%**	**OneCare**	**4,157**	**3,974**	**183**	**4.6%**
796,181	**802,373**	**(6,192)**	**(0.8%)**	**CalOptima Total**	**2,381,858**	**2,406,135**	**(24,277)**	**(1.0%)**

Actual	Budget	Variance	%	**Enrollment (By Network)**	Actual	Budget	Variance	%
171,630	174,134	(2,504)	(1.4%)	HMO	514,117	522,150	(8,033)	(1.5%)
223,489	226,676	(3,187)	(1.4%)	PHC	670,215	680,869	(10,654)	(1.6%)
202,477	210,008	(7,531)	(3.6%)	Shared Risk Group	609,434	630,984	(21,550)	(3.4%)
181,688	174,481	7,207	4.1%	Fee for Service	537,412	520,992	16,420	3.2%
779,284	**785,297**	**(6,015)**	**(0.8%)**	**Medi-Cal**	**2,331,178**	**2,354,991**	**(23,813)**	**(1.0%)**
15,265	**15,516**	**(251)**	**(1.6%)**	**OneCare Connect**	**45,859**	**46,507**	**(648)**	**(1.4%)**
228	**226**	**2**	**0.9%**	**PACE**	**664**	**663**	**1**	**0.2%**
1,404	**1,334**	**70**	**5.2%**	**OneCare**	**4,157**	**3,974**	**183**	**4.6%**
796,181	**802,373**	**(6,192)**	**(0.8%)**	**CalOptima Total**	**2,381,858**	**2,406,135**	**(24,277)**	**(1.0%)**

Back to Agenda

CalOptima
Enrollment Trend by Network Type
Fiscal Year 2017

Network Type	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	MMs
HMO													
Aged	4,058	4,045	4,051	-	-	-	-	-	-	-	-	-	12,154
BCCTP	1	1	1	-	-	-	-	-	-	-	-	-	3
Disabled	6,749	6,740	6,729	-	-	-	-	-	-	-	-	-	20,218
TANF Child	61,492	61,733	61,361	-	-	-	-	-	-	-	-	-	184,586
TANF Adult	30,429	30,420	30,313	-	-	-	-	-	-	-	-	-	91,162
LTC	3	4	6	-	-	-	-	-	-	-	-	-	13
MCE	68,020	68,792	69,169	-	-	-	-	-	-	-	-	-	205,981
	170,752	171,735	171,630	-	-	-	-	-	-	-	-	-	514,117
PHC													
Aged	1,480	1,493	1,530	-	-	-	-	-	-	-	-	-	4,503
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	7,318	7,264	7,258	-	-	-	-	-	-	-	-	-	21,840
TANF Child	162,801	163,976	163,202	-	-	-	-	-	-	-	-	-	489,979
TANF Adult	12,604	12,571	12,410	-	-	-	-	-	-	-	-	-	37,585
LTC	-	-	1	-	-	-	-	-	-	-	-	-	1
MCE	38,398	38,821	39,088	-	-	-	-	-	-	-	-	-	116,307
	222,601	224,125	223,489	-	-	-	-	-	-	-	-	-	670,215
Shared Risk Group													
Aged	3,809	3,756	3,831	-	-	-	-	-	-	-	-	-	11,396
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	8,108	8,058	8,035	-	-	-	-	-	-	-	-	-	24,201
TANF Child	72,723	72,861	72,102	-	-	-	-	-	-	-	-	-	217,686
TANF Adult	32,775	32,737	32,316	-	-	-	-	-	-	-	-	-	97,828
LTC	-	1	2	-	-	-	-	-	-	-	-	-	3
MCE	85,799	86,330	86,191	-	-	-	-	-	-	-	-	-	258,320
	203,214	203,743	202,477	-	-	-	-	-	-	-	-	-	609,434
Fee for Service (Dual)													
Aged	48,036	48,599	48,846	-	-	-	-	-	-	-	-	-	145,481
BCCTP	25	22	25	-	-	-	-	-	-	-	-	-	72
Disabled	20,343	20,528	20,516	-	-	-	-	-	-	-	-	-	61,387
TANF Child	3	3	2	-	-	-	-	-	-	-	-	-	8
TANF Adult	1,205	1,226	1,184	-	-	-	-	-	-	-	-	-	3,615
LTC	3,002	3,124	3,126	-	-	-	-	-	-	-	-	-	9,252
MCE	2,816	2,848	2,758	-	-	-	-	-	-	-	-	-	8,422
	75,430	76,350	76,457	-	-	-	-	-	-	-	-	-	228,237
Fee for Service (Non-Dual)													
Aged	3,580	3,855	4,031	-	-	-	-	-	-	-	-	-	11,466
BCCTP	601	602	599	-	-	-	-	-	-	-	-	-	1,802
Disabled	4,466	4,559	4,578	-	-	-	-	-	-	-	-	-	13,603
TANF Child	27,513	31,414	31,119	-	-	-	-	-	-	-	-	-	90,046
TANF Adult	18,753	19,744	20,087	-	-	-	-	-	-	-	-	-	58,584
LTC	372	364	379	-	-	-	-	-	-	-	-	-	1,115
MCE	43,457	44,664	44,438	-	-	-	-	-	-	-	-	-	132,559
	98,742	105,202	105,231	-	-	-	-	-	-	-	-	-	309,175
MEDI-CAL TOTAL													
Aged	60,963	61,748	62,289	-	-	-	-	-	-	-	-	-	185,000
BCCTP	627	625	625	-	-	-	-	-	-	-	-	-	1,877
Disabled	46,984	47,149	47,116	-	-	-	-	-	-	-	-	-	141,249
TANF Child	324,532	329,987	327,786	-	-	-	-	-	-	-	-	-	982,305
TANF Adult	95,766	96,698	96,310	-	-	-	-	-	-	-	-	-	288,774
LTC	3,377	3,493	3,514	-	-	-	-	-	-	-	-	-	10,384
MCE	238,490	241,455	241,644	-	-	-	-	-	-	-	-	-	721,589
	770,739	781,155	779,284	-	-	-	-	-	-	-	-	-	2,331,178
PACE	215	221	228	-	-	-	-	-	-	-	-	-	664
OneCare	1,367	1,386	1,404	-	-	-	-	-	-	-	-	-	4,157
OneCare Connect	15,365	15,229	15,265	-	-	-	-	-	-	-	-	-	45,859
TOTAL	787,686	797,991	796,181	-	-	-	-	-	-	-	-	-	2,381,858

Back to Agenda

ENROLLMENT:

Overall MTD enrollment was 796,181
- Unfavorable to budget by 6,192 or 0.8%
- Decreased 1,810 or 0.2% from prior month
- Increased 8 from prior year (September 2016)

Medi-Cal enrollment was 779,284
- Unfavorable to budget by 6,013
    - Expansion favorable by 5,343
    - LTC favorable by 246
    - TANF unfavorable by 9,620
    - SPD unfavorable by 1,982
- Decreased 1,871 from prior month

OneCare Connect enrollment was 15,265
- Unfavorable to budget by 251
- Increased 36 from prior month

OneCare enrollment was 1,404
- Favorable to budget by 70
- Increased 18 from prior month

PACE enrollment was 228
- Favorable to budget by 2
- Increased 7 from prior month

Back to Agenda

CalOptima - Medi-Cal Total
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2017

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
779,284	785,297	(6,013)	(0.8%)	Member Months	2,331,178	2,354,991	(23,813)	(1.0%)
				Revenues				
262,556,241	245,035,514	17,520,727	7.2%	Capitation revenue	764,659,014	734,734,640	29,924,374	4.1%
262,556,241	245,035,514	17,520,727	7.2%	Total Operating Revenues	764,659,014	734,734,640	29,924,374	4.1%
				Medical Expenses				
90,037,937	87,045,071	(2,992,866)	(3.4%)	Provider capitation	267,172,495	261,247,767	(5,924,728)	(2.3%)
44,695,314	43,119,980	(1,575,334)	(3.7%)	Facilities	137,223,144	130,990,901	(6,232,243)	(4.8%)
19,443,147	13,709,671	(5,733,476)	(41.8%)	Professional Claims	48,158,929	41,581,177	(6,577,752)	(15.8%)
34,848,484	35,235,371	386,887	1.1%	Prescription drugs	108,222,206	106,778,349	(1,443,857)	(1.4%)
56,864,111	48,363,013	(8,501,098)	(17.6%)	MLTSS	170,195,846	147,124,420	(23,071,426)	(15.7%)
2,565,156	3,067,364	502,208	16.4%	Medical Management	8,356,860	9,431,505	1,074,646	11.4%
1,770,797	315,017	(1,455,780)	(462.1%)	Reinsurance & other	2,698,639	945,052	(1,753,587)	(185.6%)
250,224,946	230,855,487	(19,369,459)	(8.4%)	Total Medical Expenses	742,028,118	698,099,171	(43,928,947)	(6.3%)
12,331,295	14,180,027	(1,848,732)	(13.0%)	Gross Margin	22,630,896	36,635,469	(14,004,573)	(38.2%)
				Administrative Expenses				
5,107,223	5,726,728	619,505	10.8%	Salaries, wages & employee benefits	15,468,566	17,660,484	2,191,918	12.4%
172,881	309,272	136,391	44.1%	Professional fees	561,068	1,005,315	444,247	44.2%
903,190	1,713,222	810,031	47.3%	Purchased services	2,376,469	4,844,242	2,467,773	50.9%
406,533	398,736	(7,797)	(2.0%)	Printing and postage	822,006	1,196,207	374,201	31.3%
617,605	461,246	(156,359)	(33.9%)	Depreciation & amortization	1,372,600	1,383,738	11,138	0.8%
1,104,253	1,431,480	327,227	22.9%	Other operating expenses	3,268,243	4,348,497	1,080,254	24.8%
(493,564)	(278,785)	214,780	77.0%	Indirect cost allocation	(1,026,800)	(836,354)	190,445	22.8%
7,818,122	9,761,899	1,943,777	19.9%	Total Administrative Expenses	22,842,152	29,602,128	6,759,976	22.8%
				Operating Tax				
23,826,565	10,907,321	(12,919,244)	(118.4%)	Tax Revenue	44,233,971	32,711,431	(11,522,541)	(35.2%)
10,449,463	0	(10,449,463)	0.0%	Premium tax expense	30,856,870	0	(30,856,870)	0.0%
13,377,102	10,907,321	(2,469,781)	(22.6%)	Sales tax expense	13,377,102	32,711,431	19,334,329	59.1%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
4,929	291,249	(286,320)	(98.3%)	Grant Revenue	74,179	873,747	(799,568)	(91.5%)
0	258,276	258,276	100.0%	Grant expense - Service Partner	58,863	774,828	715,966	92.4%
15,474	32,973	17,499	53.1%	Grant expense - Administrative	44,179	98,919	54,740	55.3%
(10,546)	0	(10,546)	0.0%	Total Net Grant Income	(28,863)	0	(28,863)	0.0%
60	0	60	0.0%	Other income	419	0	419	0.0%
4,502,687	4,418,128	84,559	1.9%	Change in Net Assets	(239,700)	7,033,341	(7,273,041)	(103.4%)
95.3%	94.2%	-1.1%	-1.2%	Medical Loss Ratio	97.0%	95.0%	-2 0%	-2.1%
3.0%	4.0%	1 0%	25.3%	Admin Loss Ratio	3.0%	4.0%	1 0%	25.9%

Back to Agenda

<u>MEDI-CAL INCOME STATEMENT – SEPTEMBER MONTH:</u>

REVENUES of $262.6 million are favorable to budget by $17.5 million, driven by:

- Unfavorable volume related variance of: $1.9 million

- Favorable price related variance of $19.4 million due to:
  - $9.5 million of fiscal year 2018 Coordinated Care Initiative (CCI) including In-Home Supportive Services revenue (IHSS)
  - $2.1 million of fiscal year 2018 LTC revenue from non-LTC aid code
  - $2.0 million of fiscal year 2018 Behavioral Health Treatment (BHT) Revenue
  - $1.2 million of fiscal year 2018 Non-Medical Transportation revenue
  - $3.7 million of fiscal year 2016 revenue true up to final DHCS contract rates

MEDICAL EXPENSES: Overall $250.2 million, unfavorable to budget by $19.4 million due to:

- **Managed Long Term Services and Support (MLTSS)** are unfavorable to budget $8.5 million due to:
  - LTC unfavorable variance of $4.9 million adjustment of IHSS expense corresponding with the favorable CCI revenue variance above
  - Nursing facility unfavorable variance of $2.8 million

- **Provider Capitation** is unfavorable $3.0 million due to BHT Capitation

- **Facilities** expenses are unfavorable to budget $1.6 million due to Hospital Shared Risk Pool and $1.8 million from Inpatient fees

- **Professional claims** is unfavorable $5.7 million

- **Other Medical Expenses** is unfavorable $1.7 million due to Non-Medical Transportation services

ADMINISTRATIVE EXPENSES are $7.8 million, favorable to budget $1.9 million, driven by:

- Purchased Services: $0.8 million favorable to budget

- Salary & Benefits: $0.6 million favorable to budget due to open positions

- Other Non-Salary: $0.5 million favorable to budget

CHANGE IN NET ASSETS is $4.5 million for the month, favorable to budget by $.0.1 million

Back to Agenda

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2017

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
15,265	15,516	(251)	(1.6%)	Member Months	45,859	46,507	(648)	(1.4%)
				Revenues				
7,298,774	7,500,163	(201,389)	(2.7%)	Medi-Cal Capitation revenue	21,962,242	22,527,283	(565,041)	(2.5%)
19,595,816	14,931,770	4,664,046	31.2%	Medicare Capitation revenue part C	48,193,411	43,269,766	4,923,645	11.4%
7,757,790	5,293,717	2,464,073	46.5%	Medicare Capitation revenue part D	17,616,123	16,312,393	1,303,730	8.0%
34,652,381	27,725,650	6,926,731	25.0%	Total Operating Revenue	87,771,776	82,109,442	5,662,334	6.9%
				Medical Expenses				
12,661,156	8,656,546	(4,004,610)	(46.3%)	Provider capitation	33,890,040	25,078,855	(8,811,185)	(35.1%)
3,586,012	4,950,756	1,364,744	27.6%	Facilities	9,113,530	15,149,091	6,035,561	39.8%
568,797	609,231	40,434	6.6%	Ancillary	1,891,519	1,862,241	(29,278)	(1.6%)
5,271,733	4,182,131	(1,089,602)	(26.1%)	Long Term Care	15,375,481	12,692,500	(2,682,981)	(21.1%)
4,855,851	5,632,870	777,019	13.8%	Prescription drugs	15,102,448	17,449,965	2,347,517	13.5%
939,878	1,164,097	224,219	19.3%	Medical management	3,139,968	3,678,283	538,315	14.6%
141,469	113,067	(28,402)	(25.1%)	Other medical expenses	570,027	345,371	(224,656)	(65.0%)
28,024,897	25,308,698	(2,716,199)	(10.7%)	Total Medical Expenses	79,083,014	76,256,306	(2,826,708)	(3.7%)
6,627,484	2,416,952	4,210,532	174.2%	Gross Margin	8,688,762	5,853,136	2,835,626	48.4%
				Administrative Expenses				
746,311	860,788	114,477	13.3%	Salaries, wages & employee benefits	2,236,999	2,700,121	463,122	17.2%
17,875	38,333	20,458	53.4%	Professional fees	18,376	115,000	96,625	84.0%
85,998	239,868	153,870	64.1%	Purchased services	259,764	719,604	459,840	63.9%
83,461	103,801	20,340	19.6%	Printing and postage	148,718	311,402	162,683	52.2%
37,915	50,420	12,505	24.8%	Other operating expenses	147,882	151,716	3,834	2.5%
825,539	584,428	(241,111)	(41.3%)	Indirect cost allocation, Occupancy Expense	1,994,395	1,753,283	(241,111)	(13.8%)
1,797,098	1,877,637	80,539	4.3%	Total Administrative Expenses	4,806,133	5,751,126	944,993	16.4%
				Operating Tax				
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
4,830,386	539,315	4,291,071	795.7%	Change in Net Assets	3,882,629	102,010	3,780,619	3,706.1%
80.9%	91.3%	10.4%	11.4%	Medical Loss Ratio	90.1%	92.9%	2.8%	3.0%
5.2%	6.8%	1.6%	23.4%	Admin Loss Ratio	5.5%	7.0%	1.5%	21.8%

Back to Agenda

ONECARE CONNECT INCOME STATEMENT – SEPTEMBER MONTH:

REVENUES of $34.7 million are favorable to budget by $6.9 million driven by:

- Unfavorable volume related variance of $0.4 million due to lower enrollment
- Favorable price related variance of $7.4 million due to CMS' annual adjustments

MEDICAL EXPENSES are unfavorable to budget $2.7 million due to:

- Favorable volume related variance of $0.4 million due to lower enrollment
- Unfavorable price related variance of $3.1 million due to increase Provider Capitation from CMS' annual adjustments and In-Home Supportive Services (IHSS) expense

ADMINISTRATIVE EXPENSES are favorable to budget by $0.1 million

CHANGE IN NET ASSETS is $4.8 million, $4.3 million favorable to budget

Back to Agenda

CalOptima - OneCare
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2017

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
1,404	1,334	70	5 2%	Member Months	4,157	3,974	183	4.6%
				Revenues				
71,085	46,356	24,729	53 3%	Medi-Cal Capitation revenue	210,469	138,078	72,391	52.4%
(1,507,568)	883,360	(2,390,928)	(270.7%)	Medicare Part C Revenue	534,581	2,511,102	(1,976,521)	(78.7%)
342,223	463,035	(120,812)	(26.1%)	Medicare Part D Revenue	1,044,331	1,407,082	(362,751)	(25.8%)
(1,094,261)	1,392,751	(2,487,012)	(178.6%)	Total Operating Revenue	1,789,381	4,056,262	(2,266,881)	(55.9%)
				Medical Expenses				
(2,247,990)	387,765	2,635,755	679.7%	Provider capitation	(1,456,604)	1,108,650	2,565,254	231.4%
62,118	432,679	370,561	85.6%	Inpa ient	836,510	1,321,044	484,534	36.7%
3,266	46,891	43,625	93 0%	Ancillary	85,461	142,484	57,023	40.0%
4,755	40,461	35,706	88 2%	Skilled nursing facilities	52,555	122,938	70,383	57.3%
433,808	467,255	33,447	7 2%	Prescription drugs	1,420,929	1,422,493	1,564	0.1%
11,324	21,911	10,588	48 3%	Medical management	51,302	69,051	17,750	25.7%
7,278	7,580	302	4 0%	Other medical expenses	21,350	23,048	1,698	7.4%
(1,725,441)	1,404,542	3,129,983	222 8%	Total Medical Expenses	1,011,502	4,209,708	3,198,206	76.0%
631,180	(11,791)	642,971	5,453.1%	Gross Margin	777,879	(153,446)	931,325	606.9%
				Administrative Expenses				
21,015	19,840	(1,175)	(5.9%)	Salaries, wages & employee benefits	75,591	61,082	(14,510)	(23.8%)
0	13,333	13,333	100 0%	Professional fees	0	40,000	40,000	100.0%
12,483	11,990	(493)	(4.1%)	Purchased services	38,574	35,970	(2,604)	(7 2%)
(1,478)	19,288	20,766	107.7%	Prin ing and postage	8,572	65,363	56,791	86.9%
(0)	171	171	100 0%	Other operating expenses	(0)	563	563	100.0%
(23,161)	31,910	55,070	172.6%	Indirect cost allocation, Occupancy Expense	40,659	95,729	55,070	57.5%
8,859	96,532	87,672	90 8%	Total Administrative Expenses	163,396	298,706	135,309	45.3%
622,321	(108,323)	730,643	674 5%	Change in Net Assets	614,483	(452,152)	1,066,634	235.9%
157.7%	100.8%	-56.8%	-56.4%	Medical Loss Ra io	56.5%	103.8%	47.3%	45.5%

Back to Agenda

CalOptima - PACE
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2017

Month Actual	Month Budget	Month $ Variance	Month % Variance		Year - To - Date Actual	Year - To - Date Budget	Year - To - Date $ Variance	Year - To - Date % Variance
228	226	2	0 9%	Member Months	664	663	1	0.2%
				Revenues				
1,159,382	1,144,024	15,357	1 3%	Medi-Cal capitation revenue	3,577,305	3,353,997	223,309	6.7%
404,685	272,040	132,645	48 8%	Medicare part C revenue	1,074,037	790,012	284,025	36.0%
53,928	72,117	(18,188)	(25.2%)	Medicare part D revenue	211,739	215,613	(3,875)	(1.8%)
1,617,995	1,488,181	129,814	8.7%	Total Operating Revenues	4,863,081	4,359,622	503,459	11.5%
				Medical Expenses				
365,196	420,089	54,893	13.1%	Clinical salaries & benefits	1,091,944	1,256,369	164,425	13.1%
184,354	316,407	132,053	41.7%	Claims payments to hospitals	818,515	947,331	128,816	13.6%
346,516	260,882	(85,633)	(32.8%)	Professional Claims	974,238	782,152	(192,086)	(24.6%)
106,728	109,786	3,059	2 8%	Prescription drugs	328,933	329,153	219	0.1%
(368)	11,842	12,210	103.1%	Long-term care facility payments	16,390	35,534	19,144	53.9%
103,299	90,353	(12,946)	(14.3%)	Patient Transportation	285,630	270,884	(14,745)	(5.4%)
0	0	0	0 0%	Reinsurance	0	0	0	0.0%
182,365	158,748	(23,617)	(14.9%)	Other Expenses	445,388	476,226	30,838	6.5%
1,288,089	1,368,107	80,019	5 8%	Total Medical Expenses	3,961,037	4,097,649	136,612	3.3%
329,906	120,074	209,832	174 8%	Gross Margin	902,044	261,973	640,070	244.3%
				Administrative Expenses				
60,691	93,391	32,700	35 0%	Salaries, wages & employee benefits	207,960	277,056	69,097	24.9%
2,935	5,000	2,065	41 3%	Professional fees	9,040	15,000	5,960	39.7%
6,246	21,136	14,890	70.4%	Purchased services	12,424	63,408	50,984	80.4%
68	5,547	5,479	98 8%	Printing and postage	4,995	16,642	11,646	70.0%
2,168	2,052	(116)	(5.7%)	Depreciation & amortization	6,432	6,156	(276)	(4.5%)
22,718	18,504	(4,214)	(22.8%)	Other operating expenses	53,886	55,511	1,625	2.9%
25,882	2,864	(23,018)	(803.7%)	Indirect cost allocation, Occupancy Expense	31,344	8,592	(22,752)	(264.8%)
120,709	148,495	27,785	18.7%	Total Administrative Expenses	326,081	442,365	116,283	26.3%
				Operating Tax				
3,183	0	3,183	0 0%	Tax Revenue	24,957	0	24,957	0.0%
3,183	0	(3,183)	0 0%	Premium tax expense	24,957	0	(24,957)	0.0%
0	0	0	0 0%	Total Net Operating Tax	0	0	0	0.0%
209,196	(28,421)	237,617	836.1%	Change in Net Assets	575,962	(180,391)	756,354	419.3%
79 6%	91.9%	12.3%	13.4%	Medical Loss Ratio	81.5%	94.0%	12 5%	13.3%
7 5%	10.0%	2.5%	25 2%	Admin Loss Ratio	6.7%	10.1%	3.4%	33.9%

Back to Agenda

CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
27,825	0	27,825	0.0%	Rental income	75,938	42,774	33,164	77.5%
27,825	0	27,825	0.0%	Total Operating Revenue	75,938	42,774	33,164	77.5%
				Administrative Expenses				
29,467	23,186	(6,282)	(27.1%)	Purchase services	88,572	69,558	(19,014)	(27.3%)
160,336	161,474	1,138	0.7%	Depreciation & amortization	479,301	484,421	5,120	1.1%
14,913	9,117	(5,797)	(63.6%)	Insurance expense	44,740	27,350	(17,390)	(63.6%)
118,583	158,122	39,539	25.0%	Repair and maintenance	332,462	474,365	141,903	29.9%
26,713	0	(26,713)	0.0%	Other Operating Expense	160,186	0	(160,186)	0.0%
(330,792)	(333,055)	(2,263)	(0.7%)	Indirect allocation, Occupancy Expense	(1,044,567)	(999,165)	45,402	4.5%
19,220	18,843	(377)	(2.0%)	Total Administrative Expenses	60,694	56,529	(4,165)	(7.4%)
8,604	(18,843)	27,447	145.7%	Change in Net Assets	15,244	(13,755)	28,999	210.8%

Back to Agenda

OTHER STATEMENTS – SEPTEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $622.3 thousand, $730.6 thousand favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $209.2 thousand, $237.6 thousand favorable to budget

505 CITY PARKWAY BUILDING INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $8.6 thousand, in line with budget

CalOptima
BALANCE SHEET
September 30, 2017

ASSETS

Current Assets		
	Operating Cash	$761,478,642
	Investments	1,041,355,043
	Capitation receivable	385,861,846
	Receivables - Other	24,750,232
	Prepaid Expenses	4,978,217
	Total Current Assets	**2,218,423,981**
Capital Assets	Furniture and equipment	34,039,048
	Building/Leasehold improvements	5,527,436
	505 City Parkway West	49,433,337
		88,999,822
	Less: accumulated depreciation	(36,454,633)
	Capital assets, net	**52,545,189**
Other Assets	Restricted deposit & Other	300,000
	Board-designated assets	
	Cash and cash equivalents	23,363,148
	Long term investments	513,727,647
	Total Board-designated Assets	537,090,795
	Total Other Assets	**537,390,795**
	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		**2,819,937,104**

LIABILITIES & FUND BALANCES

Current Liabilities		
	Accounts payable	$19,618,674
	Medical claims liability	1,422,870,300
	Accrued payroll liabilities	11,089,422
	Deferred revenue	156,973,782
	Deferred lease obligations	178,046
	Capitation and withholds	437,934,816
	Total Current Liabilities	**2,048,665,040**
Other employment benefits liability		29,105,495
Net Pension Liabilities		15,959,420
Long Term Liabilities		100,000
TOTAL LIABILITIES		**2,093,829,955**
Deferred inflows of Resources - Excess Earnings		-
Deferred inflows of Resources - Changes in Assumptions		1,340,010
Tangible net equity (TNE)		92,041,987
Funds in excess of TNE		632,725,153
Net Assets		**724,767,140**
TOTAL LIABILITIES, INFLOWS & FUND BALANCES		**2,819,937,104**

Back to Agenda

CalOptima
Board Designated Reserve and TNE Analysis
as of September 30, 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,756,598				
	Tier 1 - Logan Circle	146,506,854				
	Tier 1 - Wells Capital	146,471,481				
Board-designated Reserve						
		439,734,933	304,283,513	474,137,298	135,451,420	(34,402,366)
TNE Requirement	Tier 2 - Logan Circle	97,355,862	92,041,987	92,041,987	5,313,875	5,313,875
	Consolidated:	537,090,795	396,325,500	566,179,285	140,765,295	(29,088,491)
	Current reserve level	*1.90*	*1.40*	*2.00*		

Back to Agenda

CalOptima
Statement of Cash Flows
September 30, 2017

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	11,278,818	11,308,748
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	619,773	1,379,032
Changes in assets and liabilities:		
Prepaid expenses and other	790,353	676,430
Catastrophic reserves		
Capitation receivable	(78,962,957)	132,936,657
Medical claims liability	317,363,337	176,444,280
Deferred revenue	32,325,722	53,000,657
Payable to providers	(148,870,570)	(142,904,894)
Accounts payable	(9,287,025)	(19,056,279)
Other accrued liabilities	(86,173)	1,029,075
Net cash provided by/(used in) operating activities	125,171,279	214,813,705
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(57,861,455)	41,070,709
Change in property and equipment	221,260	376,805
Change in Board designated reserves	353,471	(1,952,421)
Net cash provided by/(used in) investing activities	(57,286,724)	39,495,093
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	67,884,555	254,308,797
CASH AND CASH EQUIVALENTS, beginning of period	$693,594,087	507,169,844
CASH AND CASH EQUIVALENTS, end of period	**$ 761,478,642**	**$ 761,478,642**

Back to Agenda

BALANCE SHEET:

ASSETS increased $202.7 million from August

- **Net Capitation Receivables** increased $75.9 million based upon payment receipt timing and receivables
- **Cash and Cash Equivalents** increased by $67.9 million due to receipt of Quality Assurance Fees (QAF)
- **Short-term Investments** increased $57.9 million due to payment receipt timing and cash funding requirements

LIABILITIES increased $202.7 million from August

- **Medical Claims Liability** by line of business increased $317.4 million due to Quality Assurance Fees (QAF)
- **Deferred Revenue** increased $32.3 million due to DHS overpayments for FY17 and FY18
- **Pharmacy Incentive and Shared Risk Pools** decreased $148.9 million due to payment of FY15 Hospital Shared Risk

NET ASSETS are $724.8 million, an increase of $11.3 million from August

Back to Agenda

CalOptima Foundation
Statement of Revenues and Expenses
For the Three Months Ended September 30, 2017
Consolidated

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
				Revenues				
0	0	0	0.0%	Total Operating Revenue	0	0	0	0.0%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	0	18,553	18,553	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	8,954	8,954	100.0%
0	0	0	0.0%	Travel	0	0	0	0.0%
0	0	0	0.0%	Supplies	0	0	0	0.0%
0	0	0	0.0%	Contractual	0	0	0	0.0%
2,083	231,923	229,840	99.1%	Other	6,249	695,769	689,520	99.1%
2,083	241,092	239,009	99.1%	Total Operating Expenditures	6,249	723,276	717,027	99.1%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
(2,083)	(241,092)	(239,009)	(99.1%)	Program Income	(6,249)	(723,276)	(717,027)	(99.1%)

Back to Agenda

CalOptima Foundation
Balance Sheet
September 30, 2017

ASSETS		LIABILITIES & NET ASSETS	
Operating cash	2,868,139	Accounts payable-Current	6,249
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,868,139**	Grants-Foundation	0
		Total Current Liabilities	6,249
		Total Liabilities	**6,249**
		Net Assets	**2,861,890**
TOTAL ASSETS	**2,868,139**	**TOTAL LIABILITIES & NET ASSETS**	**2,868,139**

Back to Agenda

CALOPTIMA FOUNDATION – SEPTEMBER MONTH

INCOME STATEMENT:

Income Statement:

Operating Revenue

No activity.

Operating Expenses

CalOptima Foundation operating expenses were $6K for audit fees YTD.

* Expense categories includes: professional fees, staff services, travel and miscellaneous supplies.

* Major Actual to Budget variance was in "Other" category - $689K favorable variance YTD.

- FY18 budget was allocated monthly based on the remaining $2.8M fund balance.
- Actual recognized expenses were much lower than budgeted anticipated CalOptima support activities.

Balance Sheet:

Assets

* Cash - $2.86M remains from the FY14. $3.0M transferred by CalOptima for grants and programs in support of providers and community.

Liabilities

Payable to CalOptima - $6K for audit fees - Foundation.

Back to Agenda

Budget Allocation Changes

Reporting Changes for September 2017

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	IS - Infrastructure - Professional Fee (Virtualization Architecture Assessment)	IS - Infrastructure - Professional Fee (On-Site Staff for the Phone System)	$48,600	Re-Purpose $48,600 from Professional Fees (Virtualiza ion Architecture Assessment) to pay for an on-site staff for the phone system	2018
July	Medi-Cal	Facilities - Purchased Services (Restacking Services)	Facilities - Purchased Services (Reconfiguration Services)	$15,000	Re-Purpose $15,000 from Purchased Services (Restacking Services) to reconfiguration and breakdown of furniture for the mail room and the Rover Rock Offices and other related expenses	2018
August	Medi-Cal	Health Educa ion & Disease Mgmt. - Purchased Services (Adult Weight Management Vendor)	Health Education & Disease Mgmt. - Purchased Services (Ansafone)	$30,000	Re-Purpose $30,000 from Purchased Services (Adult Weight Management Vendor) to pay for Ansafone services	2018
August	Medi-Cal	Health Educa ion & Disease Mgmt. - Purchased Services (Pediatric Weight Management Vendor)	Health Education & Disease Mgmt. - Purchased Services (Captivate contract and other initiatives)	$25,000	Re-Purpose $25,000 from Purchased Services (Pediatric Weight Management Vendor) to pay for Captivate contract and other initia ives	2018
August	PACE	PACE Administrative - Purchased Services (Encounter Reporting & Translation Services)	PACE Administrative - Purchased Services (Satisfaction Survey)	$12,208	Re-Purpose $12,208 from Purchased Services (Encounter Reporting & Translation Services) to pay for Satisfaction Survey	2018
August	Medi-Cal	Facilities - Capital Project (Upgrade CalOptima and Building Access System)	Facilities - Capital Project (Mail Room/Basement/ Property Management Office)	$15,000	Reallocate $15,000 from Capital Project (Upgrade CalOptima and Building Access System) to Capital Project (Mail Room/Basement/Property Management Office)	2018
September	Medi-Cal	Other G&A - Other Operating Expenses	Facilities - Building Repair and Maintenance	$65,000	Reallocate $65,000 from Other G&A (other operating expenses) to cover cost to conduct a review/study from soil engineer and the necessary repairs of he east entry sinkhole.	2018
September	OCC	Health Educa ion & Disease Management - Member Communications	Health Education & Disease Management - Purchased Services	$12,000	Reallocate $12,000 within medical management activities budget for addi ional funding needed on CareNet in OneCare Connect.	2018

CalOptima

A Public Agency

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Financial Summary

August 2017

Board of Directors Meeting

November 2, 2017

Greg Hamblin

Chief Financial Officer

Back to Agenda

FY 2017-18: Consolidated Enrollment

- August 2017 MTD:
  - Overall enrollment was 797,991 member months
    - Actual lower than budget by 4,055 or 0.5%
      - Medi-Cal: unfavorable variance of 3,842 members
        - TANF unfavorable variance of 7,263 members
        - SPD unfavorable variance of 2,093 members
        - Medi-Cal Expansion (MCE) favorable variance of 5,289 members
        - LTC favorable variance of 225 members
      - OneCare Connect: unfavorable variance of 274 members
    - 10,305 or 1.3% increase from prior month
      - Medi-Cal: increase of 10,416 from July
      - OneCare Connect: decrease of 136 from July
      - OneCare: increase of 19 from July
      - PACE: increase of 6 from July

Back to Agenda

FY 2017-18: Consolidated Enrollment

- August 2017 YTD:
  - ➢ Overall enrollment was 1,585,677 member months
    - ▪ Actual lower than budget by 18,085 or 1.1%
      - Medi-Cal: unfavorable variance of 17,800 members
        - ➢ TANF unfavorable variance of 21,146 members
        - ➢ SPD unfavorable variance of 4,734 members
        - ➢ MCE favorable variance of 7,747 members
        - ➢ LTC favorable variance of 334 members
      - OneCare Connect: unfavorable variance of 397 members or 1.3%
      - OneCare: favorable variance of 113 members or 4.3%
      - PACE: unfavorable variance of 1 member or 0.2%

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FY 2017-18: Consolidated Revenues

- August 2017 MTD:
  - ➢ Actual higher than budget by $8.7 million or 3.1%
    - ▪ Medi-Cal: favorable to budget by $8.7 million or 3.6%
      - Unfavorable volume variance of $1.2 million
      - Favorable price variance of $9.9 million due to:
        - ➢ $5.8 million of Fiscal Year (FY) 2018 revenue for In-Home Supportive Services (IHSS) and Behavioral Health Treatment (BHT)
        - ➢ $1.9 million of FY 2016 and 2017 LTC related revenue recognized for members with Non-LTC aid codes
        - ➢ $1.1 million FY 2017 revenue for Coordinated Care Initiative (CCI)
    - ▪ OneCare Connect: unfavorable to budget by $0.5 million or 1.7%
      - Unfavorable volume variance of $0.5 million due to lower enrollment

Back to Agenda

FY 2017-18: Consolidated Revenues (con't.)

- August 2017 YTD:
  - ➢ Actual higher than budget by $11.7 million or 2.1%
    - ▪ Medi-Cal: favorable to budget by $12.4 million or 2.5%
      - Unfavorable volume variance of $5.6 million
      - Favorable price variance of $18.0 million due to:
        - ➢ $11.7 million from prior year revenue
        - ➢ $2.4 million from FY 2018 revenue for BHT
    - ▪ OneCare Connect: unfavorable to budget by $1.3 million or 2.3%
      - Unfavorable volume variance of $0.7 million
      - Unfavorable price variance of $0.6 million
    - ▪ OneCare: favorable to budget by $0.2 million or 8.3%
    - ▪ PACE: favorable to budget by $0.4 million or 13.0%

Back to Agenda

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FY 2017-18: Consolidated Medical Expenses

- August 2017 MTD:
  - Actual higher than budget by $15.5 million or 5.9%
    - Medi-Cal: unfavorable variance of $14.8 million
      - MLTSS unfavorable variance of $8.5 million
        - IHSS unfavorable variance of $4.8 million
        - Nursing facilities expenses unfavorable variance of $3.5 million
      - Inpatient facilities expenses unfavorable variance of $3.6 million
      - Provider Capitation unfavorable variance of $2.0
    - OneCare Connect: unfavorable variance of $0.5 million
      - Favorable volume variance of $0.5 million
      - Unfavorable price variance of $1.0 million

Back to Agenda

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FY 2017-18: Consolidated Medical Expenses (Cont.)

- August 2017 YTD:
  - Actual higher than budget by $24.5 million or 4.7%
    - Medi-Cal: unfavorable variance of $24.6 million
      - Favorable volume variance of $5.3 million
      - Unfavorable price variance of $29.9 million
        - MLTSS expense $15.7 million higher than budget
        - Facilities $5.7 million higher than budget
        - Provider Capitation $2.6 million higher than budget
        - Pharmacy $2.6 million higher than budget
    - OneCare Connect: unfavorable variance of $0.1 million
      - Favorable volume variance of $0.7 million
      - Unfavorable price variance of $0.8 million

- Medical Loss Ratio (MLR):
  - August 2017 MTD: Actual: 97.7% Budget: 95.2%
  - August 2017 YTD: Actual: 97.7% Budget: 95.3%

Back to Agenda

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FY 2017-18: Consolidated Administrative Expenses

- August 2017 MTD:
  - Actual lower than budget by $2.5 million or 20.3%
    - Salaries and Benefits: favorable variance of $0.8 million
    - Other categories: favorable variance of $1.6 million

- August 2017 YTD:
  - Actual lower than budget by $5.8 million or 24.0%
    - Salaries and Benefits: favorable variance of $1.9 million driven by lower than budgeted FTE
    - Other categories: favorable variance of $3.9 million

- Administrative Loss Ratio (ALR):
  - August 2017 MTD: Actual: 3.4% Budget: 4.4%
  - August 2017 YTD: Actual: 3.3% Budget: 4.4%

Back to Agenda

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FY 2017-18: Change in Net Assets

- August 2017 MTD:
  - $0.6 million deficit
  - $2.0 million unfavorable to budget
    - Higher than budgeted revenue of $8.7 million
    - Higher than budgeted medical expenses of $15.5 million
    - Lower than budgeted administrative expenses of $2.5 million
    - Higher than budgeted investment and other income of $2.4 million

- August 2017 YTD:
  - $0.03 million surplus
  - $2.2 million unfavorable to budget
    - Higher than budgeted revenue of $11.7 million
    - Higher than budgeted medical expenses of $24.5 million
    - Lower than budgeted administrative expenses of $5.8 million
    - Higher than budgeted investment and other income of $4.8 million

Back to Agenda

Enrollment Summary: August 2017

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
61,748	62,241	(493)	(0.8%)	Aged	122,711	124,094	(1,383)	(1.1%)
625	618	7	1.1%	BCCTP	1,252	1,236	16	1.3%
47,149	48,756	(1,607)	(3.3%)	Disabled	94,133	97,500	(3,367)	(3.5%)
329,987	329,930	57	0.0%	TANF Child	654,519	660,002	(5,483)	(0.8%)
96,698	104,018	(7,320)	(7.0%)	TANF Adult	192,464	208,128	(15,664)	(7.5%)
3,493	3,268	225	6.9%	LTC	6,870	6,536	334	5.1%
241,455	236,166	5,289	2.2%	MCE	479,945	472,198	7,747	1.6%
781,155	**784,997**	**(3,842)**	**(0.5%)**	**Medi-Cal**	**1,551,894**	**1,569,694**	**(17,800)**	**(1.1%)**
15,229	**15,503**	**(274)**	**(1.8%)**	**OneCare Connect**	**30,594**	**30,991**	**(397)**	**(1.3%)**
221	**221**	**-**	**0.0%**	**PACE**	**436**	**437**	**(1)**	**(0.2%)**
1,386	**1,325**	**61**	**4.6%**	**OneCare**	**2,753**	**2,640**	**113**	**4.3%**
797,991	**802,046**	**(4,055)**	**(0.5%)**	**CalOptima Total**	**1,585,677**	**1,603,762**	**(18,085)**	**(1.1%)**

Back to Agenda

Financial Highlights: August 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
797,991	802,046	(4,055)	(0.5%)	Member Months	1,585,677	1,603,762	(18,085)	(1.1%)
284,547,240	275,879,325	8,667,915	3.1%	Revenues	561,350,897	549,617,870	11,733,027	2.1%
278,134,217	262,632,565	(15,501,652)	(5.9%)	Medical Expenses	548,271,181	523,725,999	(24,545,181)	(4.7%)
9,661,211	12,121,658	2,460,446	20.3%	Administrative Expenses	18,392,974	24,209,763	5,816,789	24.0%
(3,248,189)	**1,125,102**	**(4,373,290)**	**(388.7%)**	**Operating Margin**	**(5,313,258)**	**1,682,108**	**(6,995,365)**	**(415.9%)**
2,633,276	252,544	2,380,732	942.7%	Non Operating Income (Loss)	5,343,186	505,088	4,838,098	957.9%
(614,913)	**1,377,646**	**(1,992,559)**	**(144.6%)**	**Change in Net Assets**	**29,928**	**2,187,196**	**(2,157,268)**	**(98.6%)**
97.7%	95.2%	(2.5%)		Medical Loss Ratio	97.7%	95.3%	(2.4%)	
3.4%	4.4%	1.0%		Administrative Loss Ratio	3.3%	4.4%	1.1%	
(1.1%)	0.4%	(1.5%)		Operating Margin Ratio	(0.9%)	0.3%	(1.3%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

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Consolidated Performance Actual vs. Budget: August (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(2.8)	1.2	(4.0)	Medi-Cal	(4.7)	2.6	(7.4)
(0.5)	0.2	(0.7)	OCC	(0.9)	(0.4)	(0.5)
0.0	(0.1)	0.2	OneCare	0.0	(0.3)	0.3
0.0	(0.1)	0.1	PACE	0.4	(0.2)	0.5
(3.3)	**1.1**	**(4.4)**	**Operating**	**(5.3)**	**1.7**	**(7.0)**
2.6	0.3	2.4	Inv./Rental Inc, MCO tax	5.4	0.5	4.9
2.6	**0.3**	**2.4**	**Non-Operating**	**5.4**	**0.5**	**4.9**
(0.6)	**1.4**	**(2.0)**	**TOTAL**	**0.0**	**2.2**	**(2.2)**

Back to Agenda

Consolidated Revenue & Expense: August 2017 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	539,700	241,455	781,155	15,229	1,386	221	797,991
REVENUES							
Capitation Revenue	$ 150,327,277	$ 103,315,440	$ 253,642,718	$ 27,626,525	$ 1,535,068	$ 1,742,929	$ 284,547,240
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	150,327,277	103,315,440	253,642,718	27,626,525	1,535,068	1,742,929	284,547,240
MEDICAL EXPENSES							
Provider Capitation	38,887,350	50,182,746	89,070,096	11,382,360	390,925	-	100,843,381
Facilities	27,764,330	19,785,152	47,549,482	3,047,055	379,430	431,796	51,407,762
Ancillary	-	-	-	737,987	50,680	-	788,667
Skilled Nursing	-	-	-	-	20,532	-	20,532
Professional Claims	5,433,906	8,024,702	13,458,608	-	-	384,026	13,842,634
Prescription Drugs	18,199,847	19,041,545	37,241,392	5,212,857	561,978	128,743	43,144,970
Long-term Care Facility Payments	55,304,866	2,366,672	57,671,538	4,872,269	-	27,961	62,571,767
Medical Management	2,034,983	946,460	2,981,443	1,135,771	11,685	393,206	4,522,105
Reinsurance & Other	429,574	158,626	588,200	168,246	5,408	230,544	992,398
Total Medical Expenses	148,054,855	100,505,902	248,560,758	26,556,546	1,420,637	1,596,276	278,134,217
Medical Loss Ratio	**98.5%**	**97.3%**	**98.0%**	**96.1%**	**92.5%**	**91.6%**	**97.7%**
GROSS MARGIN	**2,272,422**	**2,809,538**	**5,081,960**	**1,069,980**	**114,431**	**146,652**	**6,413,023**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,386,053	762,105	26,871	75,577	6,250,606
Professional fees			215,842	501	0	4,548	220,891
Purchased services			864,750	84,426	15,356	320	964,852
Printing and Postage			247,873	52,460	3,608	4,712	308,653
Depreciation and Amortization			378,999	-	-	2,168	381,167
Other expenses			1,062,310	80,580	(0)	27,293	1,170,183
Indirect cost allocation, Occupancy expense			(254,222)	584,428	31,910	2,744	364,860
Total Administrative Expenses			7,901,605	1,564,499	77,746	117,362	9,661,211
Admin Loss Ratio			**3.1%**	**5.7%**	**5.1%**	**6.7%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			(2,819,645)	(494,519)	36,685	29,290	(3,248,189)
INVESTMENT INCOME			-	-	-	-	2,645,171
NET RENTAL INCOME			-	-	-	-	3,470
NET GRANT INCOME			(15,651)	-	-	-	(15,651)
OTHER INCOME			286	-	-	-	286
CHANGE IN NET ASSETS			**$ (2,835,010)**	**$ (494,519)**	**$ 36,685**	**$ 29,290**	**$ (614,913)**
BUDGETED CHANGE IN ASSETS			1,172,168	156,700	(124,254)	(79,512)	1,377,646
VARIANCE TO BUDGET - FAV (UNFAV)			(4,007,178)	(651,219)	160,940	108,802	(1,992,559)

Back to Agenda

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Consolidated Revenue & Expense: August 2017 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	1,071,949	479,945	1,551,894	30,594	2,753	436	1,585,677
REVENUES							
Capitation Revenue	$ 297,475,529	$ 204,627,244	$ 502,102,773	$ 53,119,395	2,883,642	$ 3,245,086	$ 561,350,897
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	297,475,529	204,627,244	502,102,773	53,119,395	2,883,642	3,245,086	561,350,897
MEDICAL EXPENSES							
Provider Capitation	77,139,805	99,994,753	177,134,558	21,228,884	791,386	-	199,154,828
Facilities	51,854,341	40,673,489	92,527,830	5,527,518	774,392	634,161	99,463,901
Ancillary	-	-	-	1,322,722	82,195	-	1,404,917
Skilled Nursing	-	-	-	-	47,799	-	47,799
Professional Claims	12,618,448	16,097,334	28,715,782	-	-	627,722	29,343,504
Prescription Drugs	35,893,148	37,480,574	73,373,722	10,246,598	987,121	222,205	84,829,645
Long-term Care Facility Payments	108,474,130	4,857,605	113,331,735	10,103,748	-	16,758	123,452,240
Medical Management	4,698,710	1,092,994	5,791,704	2,200,090	39,978	726,748	8,758,520
Reinsurance & Other	649,793	278,049	927,842	428,558	14,072	445,354	1,815,825
Total Medical Expenses	291,328,374	200,474,798	491,803,172	51,058,117	2,736,943	2,672,949	548,271,181
Medical Loss Ratio	**97.9%**	**98.0%**	**97.9%**	**96.1%**	**94.9%**	**82.4%**	**97.7%**
GROSS MARGIN	**6,147,155**	**4,152,446**	**10,299,601**	**2,061,278**	**146,699**	**572,138**	**13,079,716**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			10,361,343	1,490,688	54,576	147,268	12,053,876
Professional fees			388,187	501	0	6,105	394,792
Purchased services			1,473,279	173,766	26,091	6,178	1,679,313
Printing and Postage			415,473	65,258	10,050	4,927	495,707
Depreciation and Amortization			754,994	-	-	4,264	759,259
Other expenses			2,163,989	109,967	(0)	31,168	2,305,124
Indirect cost allocation, Occupancy expense			(533,235)	1,168,856	63,820	5,462	704,903
Total Administrative Expenses			15,024,030	3,009,035	154,537	205,372	18,392,974
Admin Loss Ratio			**3.0%**	**5.7%**	**5.4%**	**6.3%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			(4,724,429)	(947,757)	(7,838)	366,766	(5,313,258)
INVESTMENT INCOME			-	-	-	-	5,354,504
NET RENTAL INCOME			-	-	-	-	6,640
NET GRANT INCOME			(18,317)	-	-	-	(18,317)
OTHER INCOME			359	-	-	-	359
CHANGE IN NET ASSETS			**$ (4,742,387)**	**$ (947,757)**	**$ (7,838)**	**$ 366,766**	**$ 29,928**
BUDGETED CHANGE IN ASSETS			2,615,212	(437,305)	(343,829)	(151,970)	2,187,196
VARIANCE TO BUDGET - FAV (UNFAV)			(7,357,599)	(510,452)	335,991	518,736	(2,157,268)

Back to Agenda

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Balance Sheet: As of August 2017

ASSETS		
Current Assets		
	Operating Cash	$693,594,087
	Investments	983,493,588
	Capitation receivable	309,923,565
	Receivables - Other	21,725,557
	Prepaid Expenses	5,768,570
	Total Current Assets	**2,014,505,367**
Capital Assets	Furniture and equipment	33,437,912
	Leasehold improvements	6,148,441
	505 City Parkway West	49,422,364
		89,008,717
	Less: accumulated depreciation	(35,622,495)
	Capital assets, net	**53,386,222**
Other Assets	Restricted deposit & Other	300,000
	Board-designated assets	
	Cash and cash equivalents	28,937,963
	Long term investments	508,506,303
	Total Board-designated Assets	537,444,266
	Total Other Assets	**537,744,266**
	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		**2,617,212,995**

LIABILITIES & FUND BALANCES		
Current Liabilities		
	Accounts payable	$28,940,352
	Medical claims liability	1,105,506,963
	Accrued payroll liabilities	11,054,769
	Deferred revenue	124,648,060
	Deferred lease obligations	184,405
	Capitation and withholds	586,805,387
	Total Current Liabilities	**1,857,139,935**
Other employment benefits liability		28,932,498
Net Pension Liabilities		16,212,231
Long Term Liabilities		100,000
TOTAL LIABILITIES		**1,902,384,664**
Deferred inflows of Resources - Excess Earnings		-
Deferred inflows of Resources - Changes in Assumptions		1,340,010
Tangible net equity (TNE)		91,440,932
Funds in excess of TNE		622,047,388
Net Assets		**713,488,320**
TOTAL LIABILITIES, INFLOWS & FUND BALANCES		**2,617,212,995**

Back to Agenda

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Board Designated Reserve and TNE Analysis
As of August 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,822,740				
	Tier 1 - Logan Circle	146,507,294				
	Tier 1 - Wells Capital	146,597,541				
Board-designated Reserve						
		439,927,574	311,866,164	484,712,063	128,061,410	(44,784,488)
TNE Requirement	Tier 2 - Logan Circle	97,516,691	91,440,932	91,440,932	6,075,759	6,075,759
	Consolidated:	537,444,266	403,307,097	576,152,995	134,137,169	(38,708,730)
	Current reserve level	*1.87*	*1.40*	*2.00*		

Back to Agenda

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UNAUDITED FINANCIAL STATEMENTS

August 2017

Back to Agenda

Table of Contents

Financial Highlights 3
Financial Dashboard 4
Statement of Revenues and Expenses – Consolidated Month to Date 5
Statement of Revenues and Expenses – Consolidated Year to Date 6
Statement of Revenues and Expenses – Consolidated LOB Month to Date 7
Statement of Revenues and Expenses – Consolidated LOB Year to Date 8
Highlights – Overall 9
Enrollment Summary 10
Enrollment Trended by Network Type 11
Highlights – Enrollment 12
Statement of Revenues and Expenses – Medi-Cal 13
Highlights – Medi-Cal 14
Statement of Revenues and Expenses – OneCare Connect 15
Highlights – OneCare Connect 16
Statement of Revenues and Expenses – OneCare 17
Statement of Revenues and Expenses – PACE 18
Statement of Revenues and Expenses – Building: 505 City Parkway 19
Highlights – OneCare, PACE & 505 City Parkway 20
Balance Sheet 21
Investments 22
Statement of Cash Flow 23
Highlights – Balance Sheet & Statement of Cash Flow 24
Statement of Revenues and Expenses – CalOptima Foundation 25
Balance Sheet – CalOptima Foundation 26
Highlights – CalOptima Foundation 27
Budget Allocation Changes 28

Back to Agenda

CalOptima - Consolidated
Financial Highlights
For the Two Months Ended August 31, 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
797,991	802,046	(4,055)	(0.5%)	Member Months	1,585,677	1,603,762	(18,085)	(1.1%)
284,547,240	275,879,325	8,667,915	3.1%	Revenues	561,350,897	549,617,870	11,733,027	2.1%
278,134,217	262,632,565	(15,501,652)	(5.9%)	Medical Expenses	548,271,181	523,725,999	(24,545,181)	(4.7%)
9,661,211	12,121,658	2,460,446	20.3%	Administrative Expenses	18,392,974	24,209,763	5,816,789	24.0%
(3,248,189)	**1,125,102**	**(4,373,290)**	**(388.7%)**	**Operating Margin**	**(5,313,258)**	**1,682,108**	**(6,995,365)**	**(415.9%)**
2,633,276	252,544	2,380,732	942.7%	Non Operating Income (Loss)	5,343,186	505,088	4,838,098	957.9%
(614,913)	**1,377,646**	**(1,992,559)**	**(144.6%)**	**Change in Net Assets**	**29,928**	**2,187,196**	**(2,157,268)**	**(98.6%)**
97.7%	95.2%	(2.5%)		Medical Loss Ratio	97.7%	95.3%	(2.4%)	
3.4%	4.4%	1.0%		Administrative Loss Ratio	3.3%	4.4%	1.1%	
(1.1%)	0.4%	(1.5%)		Operating Margin Ratio	(0.9%)	0.3%	(1.3%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

Back to Agenda

CalOptima
Financial Dashboard
For the Two Months Ended August 31, 2017

MONTH - TO - DATE

Enrollment

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	781,155	784,997	↓	(3,842)	(0.5%)
OneCare Connect	15,229	15,503	↓	(274)	(1.8%)
OneCare	1,386	1,325	↑	61	4.6%
PACE	221	221	↑	-	0.0%
Total	797,991	802,046	↓	(4,055)	(0.5%)

Change in Net Assets (000)

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ (2,835)	$ 1,172	↓	$ (4,007)	(341.9%)
OneCare Connect	(495)	157	↓	(651)	(415.6%)
OneCare	37	(124)	↑	161	129.5%
PACE	29	(80)	↑	109	136.8%
505 Bldg.	3	3	↑	1	36.4%
Investment Income & Other	2,645	250	↑	2,395	958.1%
Total	$ (615)	$ 1,378	↓	$ (1,993)	(144.6%)

MLR

	Actual	Budget		% Point Var
Medi-Cal	98.0%	95.5%	↓	(2.5)
OneCare Connect	96.1%	92.6%	↓	(3.5)
OneCare	92.5%	101.9%	↑	9.3

Administrative Cost (000)

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ 7,902	$ 9,945	↑	$ 2,044	20.5%
OneCare Connect	1,564	1,930	↑	365	18.9%
OneCare	78	98	↑	20	20.5%
PACE	117	149	↑	32	21.3%
Total	$ 9,661	$ 12,122	↑	$ 2,460	20.3%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	874	900	26
OneCare Connect	226	237	11
OneCare	3	3	0
PACE	53	61	8
Total	1,156	1,202	46

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	894	872	22
OneCare Connect	67	65	2
OneCare	463	442	21
PACE	4	4	1
Total	1,428	1,382	46

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	1,551,894	1,569,694	↓	(17,800)	(1.1%)
OneCare Connect	30,594	30,991	↓	(397)	(1.3%)
OneCare	2,753	2,640	↑	113	4.3%
PACE	436	437	↓	(1)	(0.2%)
Total	1,585,677	1,603,762	↓	(18,085)	(1.1%)

Change in Net Assets (000)

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ (4,742)	$ 2,615	↓	$ (7,358)	(281.3%)
OneCare Connect	(948)	(437)	↓	(510)	(116.7%)
OneCare	(8)	(344)	↑	336	97.7%
PACE	367	(152)	↑	519	341.3%
505 Bldg.	7	5	↑	2	30.5%
Investment Income & Other	5,355	500	↑	4,855	970.9%
Total	$ 30	$ 2,187	↓	$ (2,157)	(98.6%)

MLR

	Actual	Budget		% Point Var
Medi-Cal	97.9%	95.4%	↓	(2.5)
OneCare Connect	96.1%	93.7%	↓	(2.4)
OneCare	94.9%	105.3%	↑	10.4

Administrative Cost (000)

	Actual	Budget		Fav / (Unfav)	
Medi-Cal	$ 15,024	$ 19,840	↑	$ 4,816	24.3%
OneCare Connect	3,009	3,873	↑	864	22.3%
OneCare	155	202	↑	48	23.6%
PACE	205	294	↑	88	30.1%
Total	$ 18,393	$ 24,210	↑	$ 5,817	24.0%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	1,750	1,801	51
OneCare Connect	460	474	15
OneCare	6	6	(0)
PACE	102	123	20
Total	2,318	2,403	85

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	887	872	15
OneCare Connect	67	65	1
OneCare	424	440	(16)
PACE	4	4	1
Total	1,382	1,381	1

Back to Agenda

CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended August 31, 2017

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	797,991		802,046		(4,055)	
Revenues						
Medi-Cal	$ 253,642,718	$ 324.70	$ 244,910,840	$ 311 99	$ 8,731,878	$ 12.71
OneCare Connect	27,626,525	1,814.07	28,111,826	1,813 32	(485,301)	0.76
OneCare	1,535,068	1,107.55	1,404,794	1,060 22	130,274	47.33
PACE	1,742,929	7,886.55	1,451,865	6,569 53	291,063	1,317.03
Total Operating Revenue	284,547,240	356.58	275,879,325	343 97	8,667,915	12.61
Medical Expenses						
Medi-Cal	248,560,758	318.20	233,793,336	297 83	(14,767,422)	(20.37)
OneCare Connect	26,556,546	1,743.81	26,025,609	1,678.75	(530,937)	(65.07)
OneCare	1,420,637	1,024.99	1,431,286	1,080 22	10,649	55.23
PACE	1,596,276	7,222.97	1,382,334	6,254 91	(213,942)	(968.06)
Total Medical Expenses	278,134,217	348.54	262,632,565	327.45	(15,501,652)	(21.09)
Gross Margin	6,413,023	8.04	13,246,760	16 52	(6,833,737)	(8.48)
Administrative Expenses						
Salaries and Benefits	6,250,606	7.83	7,088,010	8 84	837,404	1.00
Professional fees	220,891	0.28	380,938	0.47	160,048	0.20
Purchased services	964,852	1.21	1,825,729	2 28	860,877	1.07
Printing and Postage	308,653	0.39	527,371	0.66	218,718	0.27
Depreciation and Amortization	381,167	0.48	463,298	0 58	82,131	0.10
Other	1,170,183	1.47	1,495,895	1 87	325,712	0.40
Indirect cost allocation, Occupancy expense	364,860	0.46	340,417	0.42	(24,443)	(0.03)
Total Administrative Expenses	9,661,211	12.11	12,121,658	15.11	2,460,446	3.01
Income (Loss) From Operations	(3,248,189)	(4.07)	1,125,102	1.40	(4,373,290)	(5.47)
Investment income						
Interest income	2,200,390	2.76	250,000	0 31	1,950,390	2.45
Realized gain/(loss) on investments	(34,456)	(0.04)	-	-	(34,456)	(0.04)
Unrealized gain/(loss) on investments	479,236	0.60	-	-	479,236	0.60
Total Investment Income	2,645,171	3.31	250,000	0 31	2,395,171	3.00
Net Rental Income	3,470	0.00	2,544	0 00	926	0.00
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(15,651)	(0.02)	-	-	(15,651)	(0.02)
QAF/IGT	-	-	-	-	-	-
Other Income	286	0.00	-	-	286	0.00
Change In Net Assets	**(614,913)**	**(0.77)**	**1,377,646**	**1.72**	**(1,992,559)**	**(2.49)**
Medical Loss Ratio	**97.7%**		**95.2%**		**(2.5%)**	
Administrative Loss Ratio	**3.4%**		**4.4%**		**1.0%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

Back to Agenda

CalOptima - Consolidated
Statement of Revenue and Expenses
For the Two Months Ended August 31, 2017

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	1,585,677		1,603,762		(18,085)	
Revenues						
Medi-Cal	$ 502,102,773	$ 323.54	$ 489,699,126	$ 311 97	$ 12,403,648	$ 11.57
OneCare Connect	53,119,395	1,736.27	54,383,792	1,754 83	(1,264,397)	(18.56)
OneCare	2,883,642	1,047.45	2,663,511	1,008 91	220,131	38.55
PACE	3,245,086	7,442.86	2,871,441	6,570 80	373,645	872.05
Total Operating Revenue	561,350,897	354.01	549,617,870	342.71	11,733,027	11.31
Medical Expenses						
Medi-Cal	491,803,172	316.91	467,243,684	297.67	(24,559,488)	(19.24)
OneCare Connect	51,058,117	1,668.89	50,947,608	1,643 95	(110,509)	(24.94)
OneCare	2,736,943	994.17	2,805,166	1,062 56	68,223	68.40
PACE	2,672,949	6,130.62	2,729,542	6,246 09	56,593	115.47
Total Medical Expenses	548,271,181	345.76	523,725,999	326 56	(24,545,181)	(19.20)
Gross Margin	13,079,716	8.25	25,891,871	16.14	(12,812,154)	(7.90)
Administrative Expenses						
Salaries and Benefits	12,053,876	7.60	13,997,996	8.73	1,944,120	1.13
Professional fees	394,792	0.25	809,377	0 50	414,584	0.26
Purchased services	1,679,313	1.06	3,677,008	2 29	1,997,695	1.23
Printing and Postage	495,707	0.31	1,062,242	0.66	566,535	0.35
Depreciation and Amortization	759,259	0.48	926,596	0 58	167,337	0.10
Other	2,305,124	1.45	3,055,711	1 91	750,587	0.45
Indirect cost allocation, Occupancy expense	704,903	0.44	680,833	0.42	(24,069)	(0.02)
Total Administrative Expenses	18,392,974	11.60	24,209,763	15.10	5,816,789	3.50
Income (Loss) From Operations	(5,313,258)	(3.35)	1,682,108	1 05	(6,995,365)	(4.40)
Investment income						
Interest income	4,130,277	2.60	500,000	0 31	3,630,277	2.29
Realized gain/(loss) on investments	(74,634)	(0.05)	-	-	(74,634)	(0.05)
Unrealized gain/(loss) on investments	1,298,861	0.82	-	-	1,298,861	0.82
Total Investment Income	5,354,504	3.38	500,000	0 31	4,854,504	3.07
Net Rental Income	6,640	0.00	5,088	0 00	1,551	0.00
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(18,317)	(0.01)	-	-	(18,317)	(0.01)
QAF/IGT	-	-	-	-	-	-
Other Income	359	0.00	-	-	359	0.00
Change In Net Assets	**29,928**	**0.02**	**2,187,196**	**1.36**	**(2,157,268)**	**(1.34)**
Medical Loss Ratio	**97.7%**		**95.3%**		**(2.4%)**	
Administrative Loss Ratio	**3.3%**		**4.4%**		**1.1%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

Back to Agenda

CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended August 31, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	539,700	241,455	781,155	15,229	1,386	221	797,991
REVENUES							
Capitation Revenue	$ 150,327,277	$ 103,315,440	$ 253,642,718	$ 27,626,525	$ 1,535,068	$ 1,742,929	$ 284,547,240
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	150,327,277	103,315,440	253,642,718	27,626,525	1,535,068	1,742,929	284,547,240
MEDICAL EXPENSES							
Provider Capitation	38,887,350	50,182,746	89,070,096	11,382,360	390,925	-	100,843,381
Facilities	27,764,330	19,785,152	47,549,482	3,047,055	379,430	431,796	51,407,762
Ancillary	-	-	-	737,987	50,680	-	788,667
Skilled Nursing	-	-	-	-	20,532	-	20,532
Professional Claims	5,433,906	8,024,702	13,458,608	-	-	384,026	13,842,634
Prescription Drugs	18,199,847	19,041,545	37,241,392	5,212,857	561,978	128,743	43,144,970
Long-term Care Facility Payments	55,304,866	2,366,672	57,671,538	4,872,269	-	27,961	62,571,767
Medical Management	2,034,983	946,460	2,981,443	1,135,771	11,685	393,206	4,522,105
Reinsurance & Other	429,574	158,626	588,200	168,246	5,408	230,544	992,398
Total Medical Expenses	148,054,855	100,505,902	248,560,758	26,556,546	1,420,637	1,596,276	278,134,217
Medical Loss Ratio	**98.5%**	**97.3%**	**98.0%**	**96.1%**	**92.5%**	**91.6%**	**97.7%**
GROSS MARGIN	**2,272,422**	**2,809,538**	**5,081,960**	**1,069,980**	**114,431**	**146,652**	**6,413,023**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,386,053	762,105	26,871	75,577	6,250,606
Professional fees			215,842	501	0	4,548	220,891
Purchased services			864,750	84,426	15,356	320	964,852
Printing and Postage			247,873	52,460	3,608	4,712	308,653
Depreciation and Amortization			378,999	-	-	2,168	381,167
Other expenses			1,062,310	80,580	(0)	27,293	1,170,183
Indirect cost allocation, Occupancy expense			(254,222)	584,428	31,910	2,744	364,860
Total Administrative Expenses			7,901,605	1,564,499	77,746	117,362	9,661,211
Admin Loss Ratio			**3.1%**	**5.7%**	**5.1%**	**6.7%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			(2,819,645)	(494,519)	36,685	29,290	(3,248,189)
INVESTMENT INCOME			-	-	-	-	2,645,171
NET RENTAL INCOME			-	-	-	-	3,470
NET GRANT INCOME			(15,651)	-	-	-	(15,651)
OTHER INCOME			286	-	-	-	286
CHANGE IN NET ASSETS			**$ (2,835,010)**	**$ (494,519)**	**$ 36,685**	**$ 29,290**	**$ (614,913)**
BUDGETED CHANGE IN ASSETS			1,172,168	156,700	(124,254)	(79,512)	1,377,646
VARIANCE TO BUDGET - FAV (UNFAV)			(4,007,178)	(651,219)	160,940	108,802	(1,992,559)

Back to Agenda

CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Two Months Ended August 31, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	1,071,949	479,945	1,551,894	30,594	2,753	436	1,585,677
REVENUES							
Capitation Revenue	$ 297,475,529	$ 204,627,244	$ 502,102,773	$ 53,119,395	2,883,642	$ 3,245,086	$ 561,350,897
Other Income	-	-	-	-	-	-	-
Total Operating Revenues	297,475,529	204,627,244	502,102,773	53,119,395	2,883,642	3,245,086	561,350,897
MEDICAL EXPENSES							
Provider Capitation	77,139,805	99,994,753	177,134,558	21,228,884	791,386	-	199,154,828
Facilities	51,854,341	40,673,489	92,527,830	5,527,518	774,392	634,161	99,463,901
Ancillary	-	-	-	1,322,722	82,195	-	1,404,917
Skilled Nursing	-	-	-	-	47,799	-	47,799
Professional Claims	12,618,448	16,097,334	28,715,782	-	-	627,722	29,343,504
Prescription Drugs	35,893,148	37,480,574	73,373,722	10,246,598	987,121	222,205	84,829,645
Long-term Care Facility Payments	108,474,130	4,857,605	113,331,735	10,103,748	-	16,758	123,452,240
Medical Management	4,698,710	1,092,994	5,791,704	2,200,090	39,978	726,748	8,758,520
Reinsurance & Other	649,793	278,049	927,842	428,558	14,072	445,354	1,815,825
Total Medical Expenses	291,328,374	200,474,798	491,803,172	51,058,117	2,736,943	2,672,949	548,271,181
Medical Loss Ratio	**97.9%**	**98.0%**	**97.9%**	**96.1%**	**94.9%**	**82.4%**	**97.7%**
GROSS MARGIN	**6,147,155**	**4,152,446**	**10,299,601**	**2,061,278**	**146,699**	**572,138**	**13,079,716**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			10,361,343	1,490,688	54,576	147,268	12,053,876
Professional fees			388,187	501	0	6,105	394,792
Purchased services			1,473,279	173,766	26,091	6,178	1,679,313
Printing and Postage			415,473	65,258	10,050	4,927	495,707
Depreciation and Amortization			754,994	-	-	4,264	759,259
Other expenses			2,163,989	109,967	(0)	31,168	2,305,124
Indirect cost allocation, Occupancy expense			(533,235)	1,168,856	63,820	5,462	704,903
Total Administrative Expenses			15,024,030	3,009,035	154,537	205,372	18,392,974
Admin Loss Ratio			**3.0%**	**5.7%**	**5.4%**	**6.3%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			(4,724,429)	(947,757)	(7,838)	366,766	(5,313,258)
INVESTMENT INCOME			-	-	-	-	5,354,504
NET RENTAL INCOME			-	-	-	-	6,640
NET GRANT INCOME			(18,317)	-	-	-	(18,317)
OTHER INCOME			359	-	-	-	359
CHANGE IN NET ASSETS			**$ (4,742,387)**	**$ (947,757)**	**$ (7,838)**	**$ 366,766**	**$ 29,928**
BUDGETED CHANGE IN ASSETS			2,615,212	(437,305)	(343,829)	(151,970)	2,187,196
VARIANCE TO BUDGET - FAV (UNFAV)			(7,357,599)	(510,452)	335,991	518,736	(2,157,268)

Back to Agenda

CalOptima
A Public Agency
Better. Together.

August 31, 2017 Unaudited Financial Statements

SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is ($0.6) million, $2.0 million unfavorable to budget
- Operating deficit is $3.3 million with a surplus in non-operating of $2.6 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $0.0 million, $2.2 million unfavorable to budget
- Operating Deficit is $5.3 million, $7.0 million unfavorable to budget

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(2.8)	1.2	(4.0)	Medi-Cal	(4.7)	2.6	(7.4)
(0.5)	0.2	(0.7)	OCC	(0.9)	(0.4)	(0.5)
0.0	(0.1)	0.2	OneCare	0.0	(0.3)	0.3
0.0	(0.1)	0.1	PACE	0.4	(0.2)	0.5
(3.3)	**1.1**	**(4.4)**	**Operating**	**(5.3)**	**1.7**	**(7.0)**
2.6	0.3	2.4	Inv./Rental Inc, MCO tax	5.4	0.5	4.8
2.6	**0.3**	**2.4**	**Non-Operating**	**5.4**	**0.5**	**4.8**
(0.6)	**1.4**	**(2.0)**	**TOTAL**	**0.0**	**2.2**	**(2.2)**

CalOptima

Enrollment Summary

For the Two Months Ended August 31, 2017

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
61,748	62,241	(493)	(0.8%)	Aged	122,711	124,094	(1,383)	(1.1%)
625	618	7	1.1%	BCCTP	1,252	1,236	16	1.3%
47,149	48,756	(1,607)	(3.3%)	Disabled	94,133	97,500	(3,367)	(3.5%)
329,987	329,930	57	0.0%	TANF Child	654,519	660,002	(5,483)	(0.8%)
96,698	104,018	(7,320)	(7.0%)	TANF Adult	192,464	208,128	(15,664)	(7.5%)
3,493	3,268	225	6.9%	LTC	6,870	6,536	334	5.1%
241,455	236,166	5,289	2.2%	MCE	479,945	472,198	7,747	1.6%
781,155	**784,997**	**(3,842)**	**(0.5%)**	**Medi-Cal**	**1,551,894**	**1,569,694**	**(17,800)**	**(1.1%)**
15,229	**15,503**	**(274)**	**(1.8%)**	**OneCare Connect**	**30,594**	**30,991**	**(397)**	**(1.3%)**
221	**221**	**-**	**0.0%**	**PACE**	**436**	**437**	**(1)**	**(0.2%)**
1,386	**1,325**	**61**	**4.6%**	**OneCare**	**2,753**	**2,640**	**113**	**4.3%**
797,991	**802,046**	**(4,055)**	**(0.5%)**	**CalOptima Total**	**1,585,677**	**1,603,762**	**(18,085)**	**(1.1%)**
				Enrollment (By Network)				
171,735	174,050	(2,315)	(1.3%)	HMO	342,487	348,016	(5,529)	(1.6%)
224,125	226,957	(2,832)	(1.2%)	PHC	446,726	454,195	(7,469)	(1.6%)
203,743	210,328	(6,585)	(3.1%)	Shared Risk Group	406,957	420,976	(14,019)	(3.3%)
181,552	173,664	7,888	4.5%	Fee for Service	355,724	346,511	9,213	2.7%
781,155	**784,997**	**(3,844)**	**(0.5%)**	**Medi-Cal**	**1,551,894**	**1,569,694**	**(17,800)**	**(1.1%)**
15,229	**15,503**	**(274)**	**(1.8%)**	**OneCare Connect**	**30,594**	**30,991**	**(397)**	**(1.3%)**
221	**221**	**0**	**0.0%**	**PACE**	**436**	**437**	**(1)**	**(0.2%)**
1,386	**1,325**	**61**	**4.6%**	**OneCare**	**2,753**	**2,640**	**113**	**4.3%**
797,991	**802,046**	**(4,055)**	**(0.5%)**	**CalOptima Total**	**1,585,677**	**1,603,762**	**(18,085)**	**(1.1%)**

ENROLLMENT:

Overall MTD enrollment was 797,991

- Unfavorable to budget by 4,055 or 0.5%
- Increased 10,305 or 1.3% from prior month
- Increased 2,500 or 0.3% from prior year (August 2016)

Medi-Cal enrollment was 781,155

- Unfavorable to budget by 3,842
  - Expansion favorable by 5,289
  - LTC favorable by 225
  - TANF unfavorable by 7,263
  - SPD unfavorable by 2,093
- Increased 10,416 from prior month

OneCare Connect enrollment was 15,229

- Unfavorable to budget by 274
- Decreased 136 from prior month

OneCare enrollment was 1,386

- Favorable to budget by 61
- Increased 19 from prior month

PACE enrollment was 221

- Equal to budget
- Increased 6 from prior month

Back to Agenda

CalOptima
Enrollment Trend by Network Type
Fiscal Year 2017

Network Type	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	MMs
HMO													
Aged	4,058	4,045	-	-	-	-	-	-	-	-	-	-	8,103
BCCTP	1	1	-	-	-	-	-	-	-	-	-	-	2
Disabled	6,749	6,740	-	-	-	-	-	-	-	-	-	-	13,489
TANF Child	61,492	61,733	-	-	-	-	-	-	-	-	-	-	123,225
TANF Adult	30,429	30,420	-	-	-	-	-	-	-	-	-	-	60,849
LTC	3	4	-	-	-	-	-	-	-	-	-	-	7
MCE	68,020	68,792	-	-	-	-	-	-	-	-	-	-	136,812
	170,752	171,735	-	-	-	-	-	-	-	-	-	-	342,487
PHC													
Aged	1,480	1,493	-	-	-	-	-	-	-	-	-	-	2,973
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	7,318	7,264	-	-	-	-	-	-	-	-	-	-	14,582
TANF Child	162,801	163,976	-	-	-	-	-	-	-	-	-	-	326,777
TANF Adult	12,604	12,571	-	-	-	-	-	-	-	-	-	-	25,175
LTC	-	-	-	-	-	-	-	-	-	-	-	-	-
MCE	38,398	38,821	-	-	-	-	-	-	-	-	-	-	77,219
	222,601	224,125	-	-	-	-	-	-	-	-	-	-	446,726
Shared Risk Group													
Aged	3,809	3,756	-	-	-	-	-	-	-	-	-	-	7,565
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	8,108	8,058	-	-	-	-	-	-	-	-	-	-	16,166
TANF Child	72,723	72,861	-	-	-	-	-	-	-	-	-	-	145,584
TANF Adult	32,775	32,737	-	-	-	-	-	-	-	-	-	-	65,512
LTC	-	1	-	-	-	-	-	-	-	-	-	-	1
MCE	85,799	86,330	-	-	-	-	-	-	-	-	-	-	172,129
	203,214	203,743	-	-	-	-	-	-	-	-	-	-	406,957
Fee for Service (Dual)													
Aged	48,036	48,599	-	-	-	-	-	-	-	-	-	-	96,635
BCCTP	25	22	-	-	-	-	-	-	-	-	-	-	47
Disabled	20,343	20,528	-	-	-	-	-	-	-	-	-	-	40,871
TANF Child	3	3	-	-	-	-	-	-	-	-	-	-	6
TANF Adult	1,205	1,226	-	-	-	-	-	-	-	-	-	-	2,431
LTC	3,002	3,124	-	-	-	-	-	-	-	-	-	-	6,126
MCE	2,816	2,848	-	-	-	-	-	-	-	-	-	-	5,664
	75,430	76,350	-	-	-	-	-	-	-	-	-	-	151,780
Fee for Service (Non-Dual)													
Aged	3,580	3,855	-	-	-	-	-	-	-	-	-	-	7,435
BCCTP	601	602	-	-	-	-	-	-	-	-	-	-	1,203
Disabled	4,466	4,559	-	-	-	-	-	-	-	-	-	-	9,025
TANF Child	27,513	31,414	-	-	-	-	-	-	-	-	-	-	58,927
TANF Adult	18,753	19,744	-	-	-	-	-	-	-	-	-	-	38,497
LTC	372	364	-	-	-	-	-	-	-	-	-	-	736
MCE	43,457	44,664	-	-	-	-	-	-	-	-	-	-	88,121
	98,742	105,202	-	-	-	-	-	-	-	-	-	-	203,944
MEDI-CAL TOTAL													
Aged	60,963	61,748	-	-	-	-	-	-	-	-	-	-	122,711
BCCTP	627	625	-	-	-	-	-	-	-	-	-	-	1,252
Disabled	46,984	47,149	-	-	-	-	-	-	-	-	-	-	94,133
TANF Child	324,532	329,987	-	-	-	-	-	-	-	-	-	-	654,519
TANF Adult	95,766	96,698	-	-	-	-	-	-	-	-	-	-	192,464
LTC	3,377	3,493	-	-	-	-	-	-	-	-	-	-	6,870
MCE	238,490	241,455	-	-	-	-	-	-	-	-	-	-	479,945
	770,739	781,155	-	-	-	-	-	-	-	-	-	-	1,551,894
PACE	215	221	-	-	-	-	-	-	-	-	-	-	436
OneCare	1,367	1,386	-	-	-	-	-	-	-	-	-	-	2,753
OneCare Connect	15,365	15,229	-	-	-	-	-	-	-	-	-	-	30,594
TOTAL	787,686	797,991	-	-	-	-	-	-	-	-	-	-	1,585,677

Back to Agenda

CalOptima - Medi-Cal Total
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
781,155	784,997	(3,842)	(0.5%)	Member Months	1,551,894	1,569,694	(17,800)	(1.1%)
				Revenues				
253,642,718	244,910,840	8,731,878	3.6%	Capitation revenue	502,102,773	489,699,126	12,403,648	2 5%
253,642,718	244,910,840	8,731,878	3.6%	Total Operating Revenues	502,102,773	489,699,126	12,403,648	2 5%
				Medical Expenses				
89,070,096	87,082,693	(1,987,403)	(2.3%)	Provider capitation	177,134,558	174,202,695	(2,931,863)	(1.7%)
47,549,482	43,988,048	(3,561,434)	(8.1%)	Facilities	92,527,830	87,870,921	(4,656,909)	(5 3%)
13,458,608	14,005,278	546,669	3.9%	Professional Claims	28,715,782	27,871,506	(844,276)	(3 0%)
37,241,392	35,974,823	(1,266,569)	(3.5%)	Prescription drugs	73,373,722	71,542,978	(1,830,743)	(2 6%)
57,671,538	49,191,024	(8,480,514)	(17.2%)	MLTSS	113,331,735	98,761,407	(14,570,328)	(14 8%)
2,981,443	3,236,453	255,010	7.9%	Medical Management	5,791,704	6,364,142	572,438	9 0%
588,200	315,017	(273,183)	(86.7%)	Reinsurance & other	927,842	630,035	(297,807)	(47 3%)
248,560,758	233,793,336	(14,767,422)	(6.3%)	Total Medical Expenses	491,803,172	467,243,684	(24,559,488)	(5 3%)
5,081,960	11,117,504	(6,035,543)	(54.3%)	Gross Margin	10,299,601	22,455,442	(12,155,840)	(54.1%)
				Administrative Expenses				
5,386,053	6,060,059	674,007	11.1%	Salaries, wages & employee benefits	10,361,343	11,933,756	1,572,413	13 2%
215,842	324,272	108,430	33.4%	Professional fees	388,187	696,043	307,856	44 2%
864,750	1,552,735	687,985	44.3%	Purchased services	1,473,279	3,131,020	1,657,742	52 9%
247,873	398,736	150,863	37.8%	Printing and postage	415,473	797,471	381,999	47 9%
378,999	461,246	82,247	17.8%	Depreciation & amortization	754,994	922,492	167,497	18 2%
1,062,310	1,427,073	364,763	25.6%	Other operating expenses	2,163,989	2,917,017	753,027	25 8%
(254,222)	(278,785)	(24,562)	(8.8%)	Indirect cost allocation	(533,235)	(557,570)	(24,334)	(4.4%)
7,901,605	9,945,336	2,043,731	20.5%	Total Administrative Expenses	15,024,030	19,840,230	4,816,199	24 3%
				Operating Tax				
10,272,188	10,903,764	631,575	5.8%	Tax Revenue	20,407,406	21,804,109	1,396,703	6.4%
10,272,188	0	(10,272,188)	0.0%	Premium tax expense	20,407,406	0	(20,407,406)	0 0%
0	10,903,764	10,903,764	100.0%	Sales tax expense	0	21,804,109	21,804,109	100 0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0 0%
				Grant Income				
0	291,249	(291,249)	(100.0%)	Grant Revenue	69,250	582,498	(513,248)	(88.1%)
0	258,276	258,276	100.0%	Grant expense - Service Partner	58,863	516,552	457,690	88 6%
15,651	32,973	17,322	52.5%	Grant expense - Administrative	28,705	65,946	37,241	56 5%
(15,651)	0	(15,651)	0.0%	Total Net Grant Income	(18,317)	0	(18,317)	0 0%
286	0	286	0.0%	Other income	359	0	359	0 0%
(2,835,010)	1,172,168	(4,007,178)	(341.9%)	Change in Net Assets	(4,742,387)	2,615,212	(7,357,599)	(281 3%)
98.0%	95.5%	(2 5%)	(2.7%)	Medical Loss Ratio	97.9%	95.4%	(2.5%)	(2.7%)
3.1%	4.1%	0 9%	23.3%	Admin Loss Ratio	3.0%	4.1%	1.1%	26.1%

Back to Agenda

MEDI-CAL INCOME STATEMENT – AUGUST MONTH:

REVENUES of $253.6 million are favorable to budget by $8.7 million, driven by:

- Unfavorable volume related variance of: $1.2 million
- Favorable price related variance of $9.9 million due to:
  - $5.8 million for fiscal year 2018 In-Home Supportive Services (IHSS) and Behavioral Health Treatment (BHT) Revenue
  - $1.8 million of fiscal year 2016 and 2017 LTC related revenue recognized for members with Non-LTC aid codes
  - $1.1 million of fiscal year 2017 Coordinated Care Initiative (CCI) revenue
  - $0.6 million of fiscal year 2017 BHT Revenue

MEDICAL EXPENSES: Overall $248.6 million, unfavorable to budget by $14.8 million due to:

- **Managed Long Term Services and Support (MLTSS)** are unfavorable to budget $8.5 million due to:
  - LTC unfavorable variance of $4.8 million adjustment of IHSS expense corresponding with the favorable CCI revenue variance above
  - Nursing facility unfavorable variance of $3.5 million
- **Provider Capitation** is unfavorable $2.0 million due to BHT Capitation
- **Facilities** expenses are unfavorable to budget $3.6 million due to Hospital Shared Risk Pool

ADMINISTRATIVE EXPENSES are $7.9 million, favorable to budget $2.0 million, driven by:

- Purchased Services: $0.7 million favorable to budget
- Salary & Benefits: $0.7 million favorable to budget due to open positions
- Other Non-Salary: $0.7 million favorable to budget

CHANGE IN NET ASSETS is $(2.8) million for the month, unfavorable to budget by $4.0 million

Back to Agenda

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2017

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
15,229	15,503	(274)	(1.8%)	Member Months	30,594	30,991	(397)	(1.3%)
				Revenues				
7,294,907	7,504,995	(210,088)	(2.8%)	Medi-Cal Capitation revenue	14,663,468	15,027,120	(363,652)	(2.4%)
20,331,618	20,606,831	(275,213)	(1.3%)	Medicare Capitation revenue	38,455,927	39,356,672	(900,745)	(2.3%)
27,626,525	28,111,826	(485,301)	(1.7%)	Total Operating Revenue	53,119,395	54,383,792	(1,264,397)	(2.3%)
				Medical Expenses				
11,382,360	8,699,199	(2,683,161)	(30.8%)	Provider capitation	21,228,884	16,422,309	(4,806,575)	(29.3%)
3,047,055	5,104,085	2,057,030	40.3%	Facilities	5,527,518	10,198,335	4,670,817	45.8%
737,987	626,764	(111,223)	(17.7%)	Ancillary	1,322,722	1,253,010	(69,712)	(5.6%)
4,872,269	4,255,750	(616,519)	(14.5%)	Long Term Care	10,103,748	8,510,369	(1,593,379)	(18.7%)
5,212,857	5,989,825	776,968	13.0%	Prescription drugs	10,246,598	11,817,095	1,570,497	13.3%
1,135,771	1,234,856	99,085	8.0%	Medical management	2,200,090	2,514,186	314,096	12.5%
168,246	115,130	(53,116)	(46.1%)	Other medical expenses	428,558	232,304	(196,254)	(84.5%)
26,556,546	26,025,609	(530,937)	(2.0%)	Total Medical Expenses	51,058,117	50,947,608	(110,509)	(0.2%)
1,069,980	2,086,217	(1,016,237)	(48.7%)	Gross Margin	2,061,278	3,436,184	(1,374,906)	(40.0%)
				Administrative Expenses				
762,105	912,939	150,834	16.5%	Salaries, wages & employee benefits	1,490,688	1,839,334	348,645	19.0%
501	38,333	37,833	98.7%	Professional fees	501	76,667	76,166	99.3%
84,426	239,868	155,442	64.8%	Purchased services	173,766	479,736	305,971	63.8%
52,460	103,801	51,340	49.5%	Printing and postage	65,258	207,601	142,343	68.6%
80,580	50,148	(30,432)	(60.7%)	Other operating expenses	109,967	101,296	(8,671)	(8.6%)
584,428	584,428	(0)	(0.0%)	Indirect cost allocation, Occupancy Expense	1,168,856	1,168,856	(0)	(0.0%)
1,564,499	1,929,517	365,018	18.9%	Total Administrative Expenses	3,009,035	3,873,489	864,454	22.3%
				Operating Tax				
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
(494,519)	156,700	(651,219)	(415.6%)	Change in Net Assets	(947,757)	(437,305)	(510,452)	(116.7%)
96.1%	92.6%	(3.5%)	(3.8%)	Medical Loss Ratio	96.1%	93.7%	(2.4%)	(2.6%)
5.7%	6.9%	1.2%	17.5%	Admin Loss Ratio	5.7%	7.1%	1.5%	20.5%

Back to Agenda

ONECARE CONNECT INCOME STATEMENT – AUGUST MONTH:

REVENUES of $27.6 million are unfavorable to budget by $0.5 million driven by:

- Unfavorable volume related variance of $0.5 million due to lower enrollment

MEDICAL EXPENSES are unfavorable to budget $0.5 million due to:

- Favorable volume related variance of $0.5 million due to lower enrollment
- Unfavorable price related variance of $1.0 million due to increase Provider Capitation and In-Home Supportive Services (IHSS) expense

ADMINISTRATIVE EXPENSES are favorable to budget by $0.4 million

CHANGE IN NET ASSETS is ($0.5) million, $0.7 million unfavorable to budget

Back to Agenda

CalOptima - OneCare
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2017

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
1,386	1,325	61	4.6%	Member Months	2,753	2,640	113	4.3%
				Revenues				
1,535,068	1,404,794	130,274	9 3%	Capitation revenue	2,883,642	2,663,511	220,131	8.3%
1,535,068	1,404,794	130,274	9 3%	Total Operating Revenue	2,883,642	2,663,511	220,131	8.3%
				Medical Expenses				
390,925	387,813	(3,112)	(0.8%)	Provider capitation	791,386	720,885	(70,501)	(9.8%)
379,430	445,235	65,805	14 8%	Inpa ient	774,392	888,365	113,973	12.8%
50,680	47,968	(2,712)	(5.7%)	Ancillary	82,195	95,593	13,398	14.0%
20,532	41,429	20,897	50.4%	Skilled nursing facilities	47,799	82,477	34,678	42.0%
561,978	479,338	(82,640)	(17.2%)	Prescription drugs	987,121	955,238	(31,883)	(3.3%)
11,685	21,820	10,136	46 5%	Medical management	39,978	47,140	7,162	15.2%
5,408	7,683	2,275	29.6%	Other medical expenses	14,072	15,468	1,396	9.0%
1,420,637	1,431,286	10,649	0.7%	Total Medical Expenses	2,736,943	2,805,166	68,223	2.4%
114,431	(26,492)	140,923	531 9%	Gross Margin	146,699	(141,655)	288,354	203.6%
				Administrative Expenses				
26,871	21,071	(5,800)	(27.5%)	Salaries, wages & employee benefits	54,576	41,241	(13,335)	(32.3%)
0	13,333	13,333	100 0%	Professional fees	0	26,667	26,667	100.0%
15,356	11,990	(3,366)	(28.1%)	Purchased services	26,091	23,980	(2,111)	(8.8%)
3,608	19,288	15,679	81 3%	Prin ing and postage	10,050	46,075	36,025	78.2%
(0)	171	171	100.1%	Other opera ing expenses	(0)	392	392	100.1%
31,910	31,910	(0)	(0.0%)	Indirect cost allocation, Occupancy Expense	63,820	63,819	(1)	(0.0%)
77,746	97,762	20,017	20 5%	Total Administrative Expenses	154,537	202,174	47,637	23.6%
36,685	(124,254)	160,940	129 5%	Change in Net Assets	(7,838)	(343,829)	335,991	97.7%
92.5%	101.9%	9.3%	9 2%	Medical Loss Ra io	94.9%	105.3%	10.4%	9.9%
5.1%	7.0%	1.9%	27 2%	Admin Loss Ra io	5.4%	7.6%	2.2%	29.4%

Back to Agenda

CalOptima - PACE
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
221	221	0	0 0%	Member Months	436	437	(1)	(0.2%)
				Revenues				
1,360,956	1,116,976	243,980	21 8%	Medi-Cal capitation revenue	2,417,924	2,209,972	207,951	9.4%
381,972	334,889	47,083	14.1%	Medicare capitation revenue	827,163	661,469	165,694	25.0%
1,742,929	1,451,865	291,063	20 0%	Total Operating Revenues	3,245,086	2,871,441	373,645	13.0%
				Medical Expenses				
393,206	426,833	33,627	7 9%	Clinical salaries & benefits	726,748	836,280	109,532	13.1%
431,796	319,054	(112,742)	(35.3%)	Claims payments to hospitals	634,161	630,924	(3,237)	(0.5%)
384,026	263,589	(120,437)	(45.7%)	Professional Claims	627,722	521,269	(106,453)	(20.4%)
128,743	110,915	(17,828)	(16.1%)	Prescription drugs	222,205	219,366	(2,839)	(1.3%)
27,961	11,791	(16,170)	(137.1%)	Long-term care facility payments	16,758	23,693	6,935	29.3%
91,421	91,299	(122)	(0.1%)	Patient Transportation	182,331	180,532	(1,799)	(1.0%)
0	0	0	0 0%	Reinsurance	0	0	0	0.0%
139,123	158,853	19,730	12.4%	Other Expenses	263,023	317,477	54,455	17.2%
1,596,276	1,382,334	(213,942)	(15.5%)	Total Medical Expenses	2,672,949	2,729,542	56,593	2.1%
146,652	69,531	77,121	110 9%	Gross Margin	572,138	141,900	430,238	303.2%
				Administrative Expenses				
75,577	93,940	18,363	19 5%	Salaries, wages & employee benefits	147,268	183,665	36,397	19.8%
4,548	5,000	452	9 0%	Professional fees	6,105	10,000	3,895	39.0%
320	21,136	20,816	98 5%	Purchased services	6,178	42,272	36,094	85.4%
4,712	5,547	835	15.1%	Printing and postage	4,927	11,094	6,167	55.6%
2,168	2,052	(116)	(5.7%)	Depreciation & amortization	4,264	4,104	(160)	(3.9%)
27,293	18,503	(8,790)	(47.5%)	Other operating expenses	31,168	37,007	5,839	15.8%
2,744	2,864	120	4 2%	Indirect cost allocation, Occupancy Expense	5,462	5,728	266	4.6%
117,362	149,043	31,680	21 3%	Total Administrative Expenses	205,372	293,870	88,498	30.1%
				Operating Tax				
21,775	0	21,775	0 0%	Tax Revenue	21,775	0	21,775	0.0%
21,775	0	(21,775)	0 0%	Premium tax expense	21,775	0	(21,775)	0.0%
0	0	0	0 0%	Total Net Operating Tax	0	0	0	0.0%
29,290	(79,512)	108,802	136 8%	Change in Net Assets	366,766	(151,970)	518,736	341.3%
91 6%	95.2%	3.6%	3 8%	Medical Loss Ratio	82.4%	95.1%	12.7%	13.3%
6.7%	10.3%	3.5%	34.4%	Admin Loss Ratio	6.3%	10.2%	3 9%	38.2%

Back to Agenda

CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2017

Month Actual	Month Budget	Month $ Variance	Month % Variance		Year - To - Date Actual	Year - To - Date Budget	Year - To - Date $ Variance	Year - To - Date % Variance
				Revenues				
24,056	21,387	2,669	12.5%	Rental income	48,113	42,774	5,339	12.5%
24,056	21,387	2,669	12.5%	Total Operating Revenue	48,113	42,774	5,339	12.5%
				Administrative Expenses				
29,597	23,186	(6,411)	(27.7%)	Purchase services	59,105	46,372	(12,733)	(27.5%)
159,482	161,474	1,991	1.2%	Depreciation & amortization	318,965	322,947	3,983	1.2%
14,913	9,117	(5,797)	(63.6%)	Insurance expense	29,827	18,233	(11,593)	(63.6%)
106,731	158,122	51,391	32.5%	Repair and maintenance	213,880	316,243	102,363	32.4%
64,167	0	(64,167)	0.0%	Other Operating Expense	133,473	0	(133,473)	0.0%
(354,303)	(333,055)	21,248	6.4%	Indirect allocation, Occupancy Expense	(713,775)	(666,110)	47,665	7.2%
20,586	18,843	(1,744)	(9.3%)	Total Administrative Expenses	41,473	37,686	(3,787)	(10.1%)
3,470	2,544	926	36.4%	Change in Net Assets	6,640	5,088	1,551	30.5%

Back to Agenda

OTHER STATEMENTS – AUGUST MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $36.7 thousand, $160.9 thousand favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $29.3 thousand, $108.8 thousand favorable to budget

505 CITY PARKWAY BUILDING INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $3.5 thousand; $0.1 thousand favorable to budget

Back to Agenda

CalOptima
BALANCE SHEET
August 31, 2017

ASSETS			LIABILITIES & FUND BALANCES	
Current Assets			Current Liabilities	
	Operating Cash	$693,594,087	Accounts payable	$28,940,352
	Investments	983,493,588	Medical claims liability	1,105,506,963
	Capitation receivable	309,923,565	Accrued payroll liabilities	11,054,769
	Receivables - Other	21,725,557	Deferred revenue	124,648,060
	Prepaid Expenses	5,768,570	Deferred lease obligations	184,405
			Capitation and withholds	586,805,387
	Total Current Assets	**2,014,505,367**	**Total Current Liabilities**	**1,857,139,935**
Capital Assets	Furniture and equipment	33,437,912	Other employment benefits liability	28,932,498
	Leasehold improvements	6,148,441		
	505 City Parkway West	49,422,364	Net Pension Liabilities	16,212,231
		89,008,717	Long Term Liabilities	100,000
	Less: accumulated depreciation	(35,622,495)		
	Capital assets, net	**53,386,222**	**TOTAL LIABILITIES**	**1,902,384,664**
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	28,937,963	Tangible net equity (TNE)	91,440,932
	Long term investments	508,506,303	Funds in excess of TNE	622,047,388
	Total Board-designated Assets	537,444,266		
	Total Other Assets	**537,744,266**	**Net Assets**	**713,488,320**
	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		**2,617,212,995**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,617,212,995**

Back to Agenda

CalOptima
Board Designated Reserve and TNE Analysis
as of August 31, 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,822,740				
	Tier 1 - Logan Circle	146,507,294				
	Tier 1 - Wells Capital	146,597,541				
Board-designated Reserve						
		439,927,574	311,866,164	484,712,063	128,061,410	(44,784,488)
TNE Requirement	Tier 2 - Logan Circle	97,516,691	91,440,932	91,440,932	6,075,759	6,075,759
	Consolidated:	537,444,266	403,307,097	576,152,995	134,137,169	(38,708,730)
	Current reserve level	*1.87*	*1.40*	*2.00*		

Back to Agenda

CalOptima
Statement of Cash Flows
August 31, 2017

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	(614,913)	29,928
Adjustments to reconcile change in net assets		
to net cash provided by operating activities		
Depreciation and amortization	540,650	1,078,224
Changes in assets and liabilities:		
Prepaid expenses and other	(584,730)	(113,924)
Catastrophic reserves		
Capitation receivable	244,469,024	211,899,614
Medical claims liability	(150,520,242)	(140,919,057)
Deferred revenue	13,685,528	20,674,935
Payable to providers	(2,694,938)	5,965,676
Accounts payable	11,162,888	(9,769,254)
Other accrued liabilities	225,912	1,115,249
Net cash provided by/(used in) operating activities	115,669,179	89,961,391
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	58,596,372	98,932,164
Purchase of property and equipment	(211,752)	(163,420)
Change in Board designated reserves	(1,089,602)	(2,305,892)
Net cash provided by/(used in) investing activities	57,295,018	96,462,852
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	172,964,196	186,424,242
CASH AND CASH EQUIVALENTS, beginning of period	$520,629,891	507,169,844
CASH AND CASH EQUIVALENTS, end of period	**$ 693,594,087**	**$ 693,594,087**

Back to Agenda

BALANCE SHEET:

ASSETS decreased $128.8 million from July

- **Net Capitation Receivables** decreased $245.5 due to payment receipt of prior year's outstanding Capitation receivable
- **Short-term Investments** decreased $58.6 million due to payment receipt timing and cash funding requirements
- **Cash and Cash Equivalents** increased by $173.0 million based upon payment receipt timing and receivables

LIABILITIES decreased $128.1 million from July

- **Medical Claims Liability** by line of business decreased $150.5 million due DHS recoupment
- **Deferred Revenue** increased $13.7 million due to DHS overpayments for FY17 and FY18
- **Accrued Expenses** increased $9.8 million based on the timing of sales tax payments and an earlier fiscal year-end processing cut-off
- **Capitation Payable** decreased $7.7 driven by timing of Capitation payments

NET ASSETS are $713.5 million

Back to Agenda

CalOptima Foundation
Statement of Revenues and Expenses
For the Two Months Ended August 31, 2017
Consolidated

Month Actual	Month Budget	Month $ Variance	Month % Variance		YTD Actual	YTD Budget	YTD $ Variance	YTD % Variance
				Revenues				
0	0	0	0.0%	Total Operating Revenue	0	0	0	0.0%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	0	12,368	12,368	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	5,970	5,970	100.0%
0	0	0	0.0%	Travel	0	0	0	0.0%
0	0	0	0.0%	Supplies	0	0	0	0.0%
0	0	0	0.0%	Contractual	0	0	0	0.0%
2,083	231,923	229,840	99.1%	Other	4,166	463,846	459,680	99.1%
2,083	241,092	239,009	99.1%	Total Operating Expenditures	4,166	482,184	478,018	99.1%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
(2,083)	(241,092)	(239,009)	(99.1%)	Program Income	(4,166)	(482,184)	(478,018)	(99.1%)

Back to Agenda

CalOptima Foundation
Balance Sheet
August 31, 2017

ASSETS		LIABILITIES & NET ASSETS	
Operating cash	2,868,139	Accounts payable-Current	4,166
Grants receivable	0	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,868,139**	Grants-Foundation	0
		Total Current Liabilities	4,166
		Total Liabilities	**4,166**
		Net Assets	**2,863,973**
TOTAL ASSETS	**2,868,139**	**TOTAL LIABILITIES & NET ASSETS**	**2,868,139**

Back to Agenda

CALOPTIMA FOUNDATION – AUGUST MONTH

INCOME STATEMENT:

Income Statement:

Operating Revenue

No activity.

Operating Expenses

CalOptima Foundation operating expenses were $4K for audit fees YTD.

* Expense categories includes: professional fees, staff services, travel and miscellaneous supplies.

* Major Actual to Budget variance was in "Other" category - $459K favorable variance YTD.

- FY18 budget was allocated monthly based on the remaining $2.8M fund balance.
- Actual recognized expenses were much lower than budgeted anticipated CalOptima support activities.

Balance Sheet:

Assets

* Cash - $2.86M remains from the FY14 $3.0M transferred by CalOptima for grants and programs in support of providers and community.

Liabilities

Payable to CalOptima - $4K for audit fees - Foundation.

Back to Agenda

Budget Allocation Changes

Reporting Changes for August 2017

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	Medi-Cal	IS - Infrastructure - Professional Fee (Virtualization Architecture Assessment)	IS - Infrastructure - Professional Fee (On-Site Staff for the Phone System)	$48,600	Re-Purpose $48,600 from Professional Fees (Virtualization Architecture Assessment) to pay for an on-site staff for the phone system	2018
July	Medi-Cal	Facilities - Purchased Services (Restacking Services)	Facilities - Purchased Services (Reconfiguration Services)	$15,000	Re-Purpose $15,000 from Purchased Services (Restacking Services) to reconfiguration and breakdown of furniture for the mail room and the Rover Rock Offices and other related expenses	2018
August	Medi-Cal	Health Educa ion & Disease Mgmt. - Purchased Services (Adult Weight Management Vendor)	Health Education & Disease Mgmt. - Purchased Services (Ansafone)	$30,000	Re-Purpose $30,000 from Purchased Services (Adult Weight Management Vendor) to pay for Ansafone services	2018
August	Medi-Cal	Health Educa ion & Disease Mgmt. - Purchased Services (Pediatric Weight Management Vendor)	Health Education & Disease Mgmt. - Purchased Services (Captivate contract and other initiatives)	$25,000	Re-Purpose $25,000 from Purchased Services (Pediatric Weight Management Vendor) to pay for Captivate contract and other initiatives	2018
August	PACE	PACE Administrative - Purchased Services (Encounter Reporting & Translation Services)	PACE Administrative - Purchased Services (Satisfaction Survey)	$12,208	Re-Purpose $12,208 from Purchased Services (Encounter Reporting & Translation Services) to pay for Satisfaction Survey	2018
August	Medi-Cal	Facilities - Capital Project (Upgrade CalOptima and Building Access System)	Facilities - Capital Project (Mail Room/Basement/ Property Management Office)	$15,000	Reallocate $15,000 from Capital Project (Upgrade CalOptima and Building Access System) to Capital Project (Mail Room/Basement/Property Management Office)	2018

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

Back to Agenda

CalOptima
A Public Agency
Better. Together.

Board of Directors Meeting
November 2, 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

- 2016 CMS Financial Audit: On August 24, 2017, the Centers for Medicare & Medicaid Services (CMS) notified CalOptima that its OneCare program contract has been selected for a 2016 financial audit. By way of background, at least one-third of Medicare Advantage Organizations (MAOs) are selected for CMS' annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CMS contracts with several CPA firms to conduct the audits. The CPA firms will request records and supporting documentation for, but not limited to, the following items --- claims data, solvency, enrollment, base year entries on the bids, medical and/or drug expenses, related party transactions, general administrative expenses, and direct and indirect remuneration (DIR). The audit date(s) have yet to be determined.

2. OneCare Connect

- DMHC Audit of Medicaid-Based Services in OneCare Connect: 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. 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. On 10/4/17, CalOptima received notification that all deficiencies from the audit report have been reviewed and closed with no further action necessary.

- 2017 Performance Measure Validation (PMV) Activity: 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). On September 18, 2017, HSAG validated the data collection and reporting processes used by CalOptima to report the health risk assessment and interdisciplinary care plan completion rates for our OneCare Connect membership. CalOptima is currently pending results from HSAG.

Back to Agenda

- Compliance Program Effectiveness (CPE) Audit (applicable to OneCare Connect and OneCare): CalOptima is required to conduct an independent audit on the effectiveness of its Compliance program on an annual basis, and to share the results with its governing body. As such, CalOptima has engaged an independent consultant to conduct the audit to ensure that its Compliance Program is administering the elements of an effective compliance program as outlined in the CMS Medicare Parts C and D Program Audit Protocols. The audit will start in late September and continue through November 2017.

3. Medi-Cal

- 2017 Medi-Cal Audit: The Department of Health Care Services (DHCS) conducted its annual audit of CalOptima's Medi-Cal program from February 6-14, 2017. The audit covered the period from February 1, 2016 through January 31, 2017. On August 28, 2017, DHCS sent CalOptima a draft report regarding the audit, which identified four (4) draft findings in the areas of utilization management, case management and coordination of care, and member rights. DHCS held an exit conference at CalOptima on August 30, 2017 in order to review the draft findings. Once DHCS sends CalOptima a final audit report, CalOptima will have thirty (30) calendar days to submit a corrective action plan (CAP) to DHCS regarding the findings.

B. Regulatory Compliance Notices

1. CalOptima did not receive any notices of non-compliance from its regulators for the months of September and October 2017.

C. Updates on Internal and Health Network Audits

1. Internal Audits: Medi-Cal [a\]

- Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
May 2017	10%	N/A	N/A	0%	10%	70%	89%	60%	73%	92%	Nothing to Report	Nothing to Report	Nothing to Report
June 2017	40%	N/A	N/A	0%	10%	93%	98%	100%	67%	89%	100%	33%	100%
July 2017	60%	N/A	N/A	0%	93%	87%	94%	100%	80%	90%	Nothing to Report	Nothing to Report	Nothing to Report

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- ➢ 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 reason:
  - – Failure to describe why the request did not meet criteria in lay language.

- Medi-Cal Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2017	100%	100%	100%	100%
June 2017	100%	100%	100%	100%
July 2017	100%	100%	100%	90%

- ➢ The compliance rate for denied claims accuracy has decreased from 100% in June 2017 to 90% in July 2017 due to missing denial code and reason on explanation of benefits.

- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Letter Accuracy	Determination Timeliness	Acknowledgement Timeliness
May 2017	95%	95%	95%
June 2017	100%	100%	100%
July 2017	100%	75%	100%

- ➢ The compliance rate for determination timeliness has decreased from 100% in June 2017 to 75% in July 2017 due to provider dispute resolutions processed outside of the forty five (45) working days from the date of receipt.

 a\ “N/A” indicates that the category is not applicable to that file type. “Nothing to Report” indicates that there were no files submitted for review for that file type.

Back to Agenda

- 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
May 2017	100%	100%
June 2017	100%	98%
July 2017	98%	100%

➢ The compliance rate for the Medi-Cal call center has decreased from 100% in June 2017 to 98% in July 2017 due to incomplete documentation on calls.

2. Internal Audits: OneCare

- OneCare Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
May 2017	0%
June 2017	0%
July 2017	0%

➢ No claims were rejected in error due to formulary restrictions from May through July 2017.

- OneCare Pharmacy: Coverage determination timeliness is reviewed on a monthly basis to ensure that coverage determinations are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
May 2017	100%
June 2017	100%
July 2017	100%

➢ The compliance rate for coverage determination timeliness remains consistent at 100% from May through July 2017.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- OneCare Utilization Management

  - Due to low membership for the months of May 2017 through July 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
May 2017	100%	100%	100%	100%
June 2017	100%	100%	100%	100%
July 2017	100%	100%	100%	89%

  - The compliance rate for denied claims accuracy has decreased from 100% in June 2017 to 89% in July 2017 due to claims processed incorrectly as denials.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
May 2017	100%	100%	100%	100%
June 2017	100%	100%	100%	100%
July 2017	50%	100%	100%	100%

  - The compliance rate for determination timeliness has decreased from 100% in June 2017 to 50% in July 2017 due to provider dispute resolutions processed outside of the thirty (30) calendar days from the date of receipt.

- OneCare Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Customer Service
May 2017	100%
June 2017	100%
July 2017	99%

  - No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

3. Internal Audits: OneCare Connect [a\]

- OneCare Connect Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
May 2017	0%
June 2017	0%
July 2017	0%

➢ No claims were rejected in error due to formulary restrictions from May through July 2017.

- OneCare Connect Pharmacy: Coverage determination timeliness is reviewed on a monthly basis to ensure that coverage determinations are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
May 2017	99%
June 2017	100%
July 2017	100%

➢ No significant trends to report.

- 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
May 2017	40%	N/A	40%	90%	35%	70%	73%	89%	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
June 2017	78%	N/A	61%	0%	50%	80%	67%	89%	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
July 2017	80%	N/A	100%	70%	95%	70%	67%	89%	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)

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- OneCare Connect Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2017	100%	100%	100%	90%
June 2017	90%	100%	100%	100%
July 2017	80%	100%	100%	90%

  - ➢ The compliance rate for paid claims timeliness has decreased from 90% in June 2017 to 80% in July 2017 due to claims being processed after thirty (30) calendar days from date of receipt.

  - ➢ The compliance rate for denied claims accuracy has decreased from 100% in June 2017 to 90% in July 2017 due to claims being denied in error.

- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
May 2017	100%	86%	86%	100%
June 2017	100%	100%	100%	100%
July 2017	95%	100%	100%	100%

  - ➢ The compliance rate for determination timeliness has decreased from 100% in June 2017 to 95% in July 2017 due to the determination for provider dispute resolutions being made after thirty (30) calendar days from the date of receipt.

- OneCare Connect Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Connect Customer Service
May 2017	100%
June 2017	100%
July 2017	100%

  - ➢ No significant trends to report.

 a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

4. Internal Audits: PACE

- PACE Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2017	100%	90%	100%	90%
June 2017	100%	100%	100%	100%
July 2017	90%	100%	100%	100%

➢ The compliance rate for paid claims timeliness has decreased from 100% in June 2017 to 90% in July 2017 due to claims not being processed timely within the thirty (30) calendar days from the date of receipt.

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check LAG
May 2017	100%	100%	100%	100%
June 2017	100%	100%	100%	100%
July 2017	100%	100%	67%	N/A

➢ The compliance rate for acknowledgement timeliness has decreased from 100% in June 2017 to 67% in July 2017 due to the acknowledgement of provider dispute resolutions being made after the thirty (30) calendar days from the date of receipt.

 a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

5. Health Network Audits: Medi-Cal [a\]

- 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
May 2017	77%	83%	82%	89%	79%	84%	91%	75%	89%	98%	67%	39%	66%
June 2017	85%	84%	89%	77%	84%	87%	92%	88%	100%	100%	54%	34%	41%
July 2017	74%	100%	84%	73%	67%	83%	89%	100%	92%	89%	78%	33%	56%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent – 72 Hours; Routine – 5 business days)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)
  - Failure to meet timeframe for member 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 in referral 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 peer-to-peer discussion with medical reviewer

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2017	100%	99%	96%	91%
June 2017	100%	99%	98%	95%
July 2017	100%	100%	100%	92%

➢

➢ The compliance rate for denied claims accuracy decreased from 95% in June 2017 to 92% in July 2017 due to emergency room claims being denied incorrectly.

- Medi-Cal Claims: Misclassified Hospital Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
May 2017	97%	100%
June 2017	99%	99%
July 2017	100%	98%

➢ No significant trend to report.

- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2017	100%	100%	100%	100%
June 2017	100%	100%	100%	100%
July 2017	100%	100%	100%	100%

➢ No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

6. Health Network Audits: OneCare [a\]

- 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
May 2017	100%	N/A	76%	88%	72%	75%	61%	92%
June 2017	100%	N/A	77%	89%	70%	67%	56%	92%
July 2017	83%	100%	78%	88%	84%	67%	56%	90%

➢ The lower scores for timeliness were due to the following reasons:
- Failure to meet timeframe for decision making (Expedited – 72 hours)
- Failure to meet timeframe for member oral and written notifications (Expedited – 72 hours)
- Failure to meet timeframe for provider notification (Expedited – 72 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 describe why the request did not meet criteria in lay language
- Failure to provide description of requested services in lay language
- Failure to use CMS approved template

- OneCare Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
May 2017	100%	100%
June 2017	100%	99%
July 2017	100%	100%

➢ No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2017	100%	100%	100%	89%
June 2017	100%	100%	100%	84%
July 2017	100%	99%	100%	95%

➢ No significant trends to report.

7. Health Network Audits: OneCare Connect [a\]

- 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
May 2017	88%	100%	80%	87%	86%	50%	76%	77%	100%	100%	89%	0%	N/A	75%
June 2017	88%	100%	83%	82%	81%	51%	71%	79%	0%	N/A	38%	50%	100%	64%
July 2017	78%	100%	75%	78%	78%	51%	70%	79%	0%	N/A	38%	100%	N/A	38%

➢ 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)

➢ The lower letter scores were due to the following reasons:
- Failure to provide letter in member preferred language
- Failure to provide description of services in lay language
- Failure to provide alternative direction in referral 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 enrollee of delayed decision and anticipated decision date
- Failure to provide notification to provider of delayed decision and anticipated decision date

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

- Failure to provide peer-to-peer discussion with medical reviewer

- OneCare Connect Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
May 2017	100%	100%
June 2017	100%	99%
July 2017	100%	96%

➢ The compliance score for misclassified denied claims decreased from 99% in June 2017 to 96% in July 2017 due to duplicate claims selected for review.

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
May 2017	91%	96%	96%	96%
June 2017	95%	95%	100%	94%
July 2017	99%	97%	100%	97%

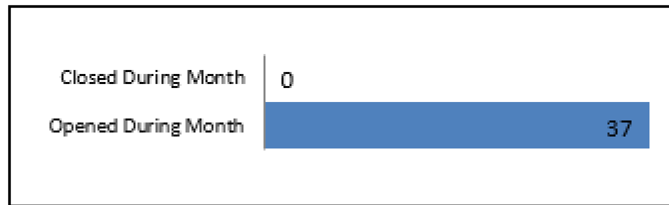
➢ No significant trends to report.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

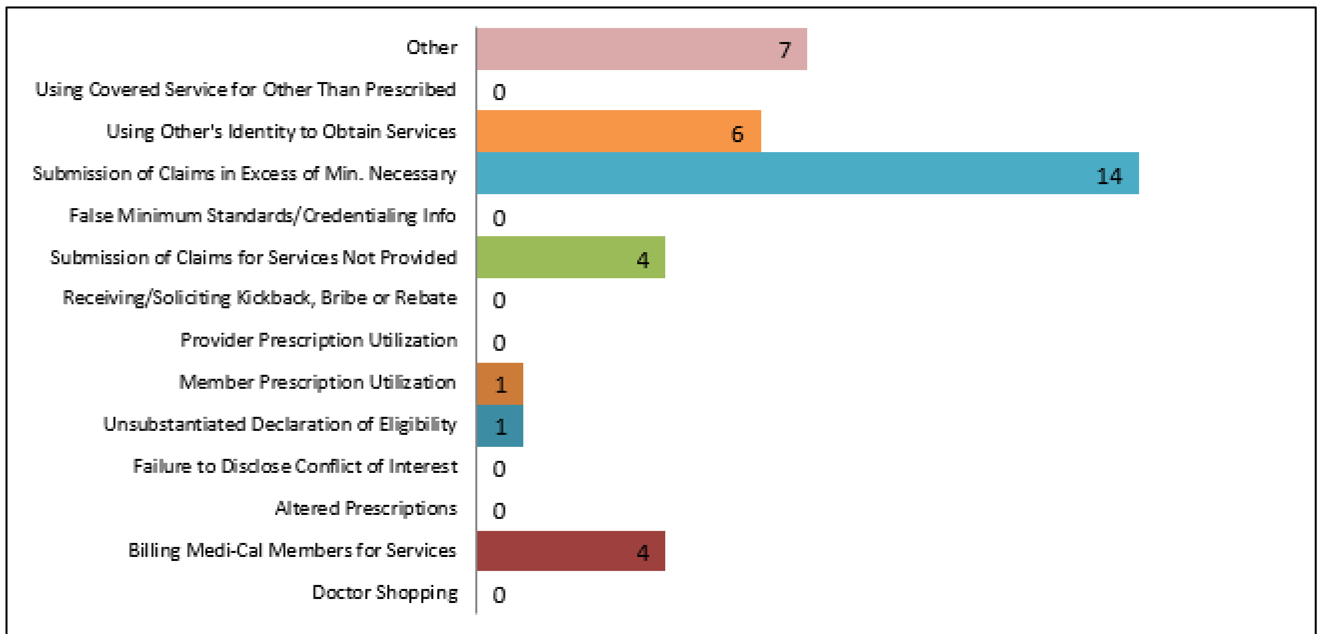
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations
(August and September 2017)

Case Status
Case status at the end of
August and September 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.

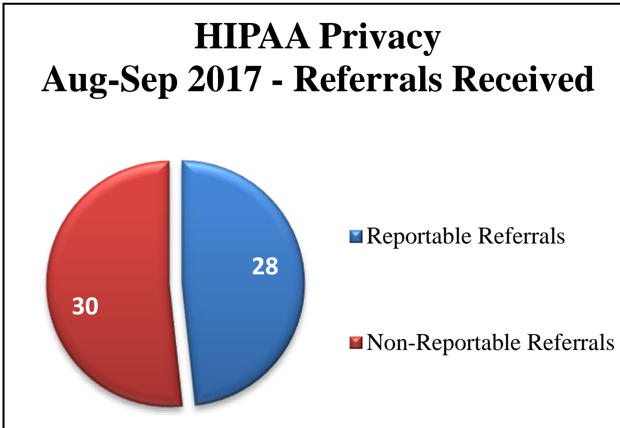
Types of FWA Cases: (Received in August and September 2017)

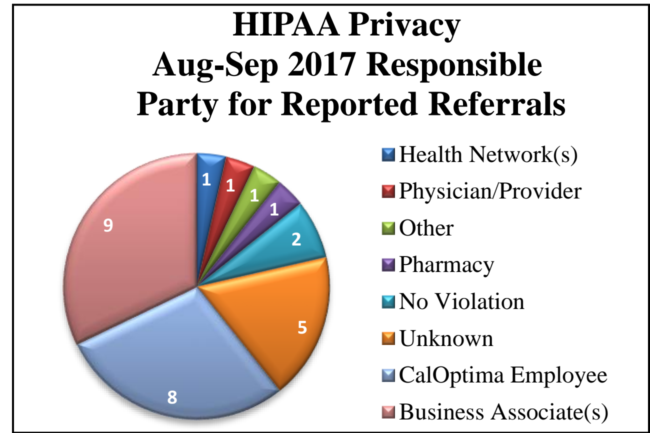


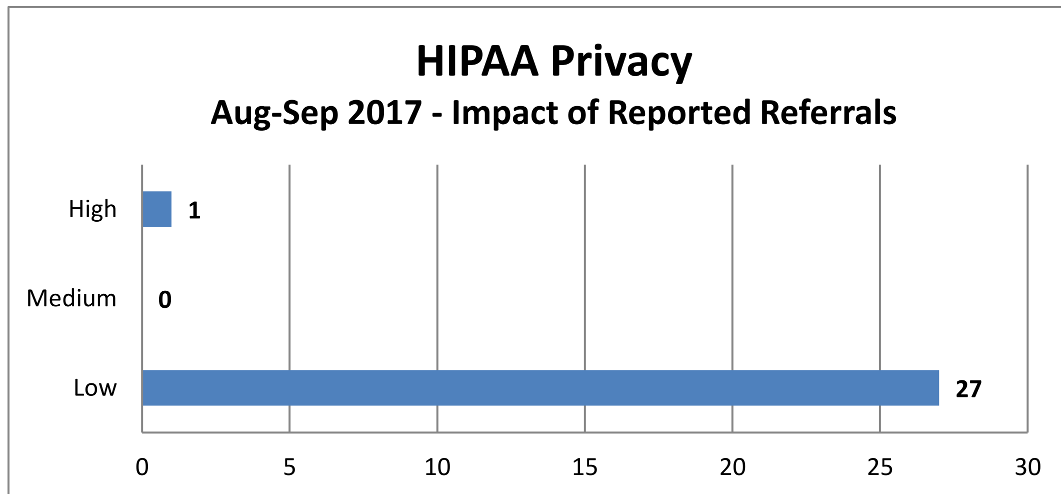
a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

E. Privacy Update (August and September 2017)







PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	27
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	1
Total Number of Referrals Reported	**28**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

Back to Agenda

CalOptima

Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting

November 2, 2017

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

Back to Agenda

Akin Gump
STRAUSS HAUER & FELD LLP

MEMORANDUM

October 9, 2017

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: November Board of Directors Report

Following the failure of the Senate's effort to pass the Graham-Cassidy bill to repeal and replace the Affordable Care Act, Congress engaged in a burst of legislative activity to try to beat a September 30 deadline for the expiration of funding for a number of programs, including the Children's Health Insurance Program (CHIP). This federal legislative summary reviews the Senate consideration of Graham-Cassidy and the ongoing effort to extend funding for CHIP.

Repeal and Replace Revisited

When the Senate adjourned for the August recess following its failure to move forward with legislation to repeal and replace the ACA, Congressional leaders and observers expected to face a daunting September agenda that included funding the government beyond the end of the fiscal year on September 30, raising the debt ceiling, reauthorizing the Federal Aviation Administration, and extending funding for the Children's Health Insurance Program, among other items. While there was roughly a calendar month to accomplish all this, there were only 12 legislative days in which both the House and Senate would be in session at the same time due to the Jewish holidays. The degree of legislative difficulty was unusually high in order to avoid a government shutdown and default.

However, on Wednesday, September 6, 2017, President Trump surprised everyone, including, according to public reports, his own staff, Senate Majority Leader Mitch McConnell, and Speaker Paul Ryan, by agreeing to a deal with Senate Minority Leader Charles Schumer and House Minority Leader Nancy Pelosi that continued government funding and lifted the debt ceiling for three months. This surprise deal upended traditional political alignments, and, among its many side effects, relieved much of the pressure that would have come with a drawn out negotiation testing the September 30 deadline. Prior to this deal, it was expected that Congress would be working on a final deal up until the last possible moment. This, of course, is how Congress has operated for most of its similar deadlines since the 2010 midterm elections. Now, after quickly passing the "Trump-Schumer-Pelosi" deal, Congress unexpectedly had the space for new agenda items.

The vacuum was quickly filled in the Senate by talk of reviving the repeal and replace of the ACA, and the last proposal standing that had not been voted down at the end of July was a concept put forward by Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA).

Back to Agenda

The Graham-Cassidy Proposal
On September 13, 2017, Senators Graham and Cassidy released the legislative text of their proposal. Like the previous Senate proposals, it was drafted as an amendment to the House-passed American Health Care Act (AHCA) and was intended to be offered during the remaining minutes of the reconciliation debate that had not been exhausted following the last vote in the Senate on so-called "skinny repeal" at the end of July.

The basic concept of Graham-Cassidy, as the proposal came to be known, was to take the ACA's funding for providing healthcare, including the Medicaid expansion, the premium tax credits, and the cost-sharing subsidies, and redistribute it to states in the form of a single block grant, allowing them to decide how to provide coverage for their citizens. The distribution formula for the new block grant shifted the funding away from states that expanded their Medicaid programs towards states that did not. This combined block grant would begin in 2020 and, due to the requirement in the Senate that reconciliation bills not increase the deficit outside the ten year budget window, would end in 2026. As a result, the Graham-Cassidy proposal does not authorize the distribution of the new block grant formula for the years following 2026, creating an enormous funding cliff for states.

Due to this structure of consolidating, shifting, and ending the ACA funding, Graham-Cassidy was actually a far more dramatic restructuring of the individual market than the previously considered bills. The previously considered bills, AHCA and the Better Care Reconciliation Act (BCRA), left intact the individual insurance exchanges, albeit with less generous and more restrictive tax credits and more flexibility for states to determine what coverage mandates and consumer protections may be in place. The opponents of those bills attacked that flexibility as undermining some of the ACA's most popular provisions, including protections for people with pre-existing conditions, the elimination of caps on annual and lifetime coverage, and the guarantee of essential health benefits, like maternal care and preventive services. The Graham-Cassidy proposal sought to sidestep this weakness by delegating the issue to the states, but without clearly saying what kind of coverage states would be required to provide with the money. The bill says that states had to use the block grant to provide "adequate and affordable" coverage, but in other areas of the bill, its provisions seemed to assume that insurers would be able to charge policyholders more based on their health status. This left the bill open to the same charge as earlier versions, and would be a central feature of the public debate.

The Medicaid provisions of Graham-Cassidy are fairly similar to AHCA and BCRA but differ most significantly in its treatment of the Medicaid expansion population. The AHCA and BCRA phased out the enhanced federal match for expansion enrollees (the former far more rapidly than the latter) beginning in 2020 and 2021 respectively. However, Graham-Cassidy would have

repealed states' authority to extend Medicaid to adults under 138% of the federal poverty level immediately on January 1, 2020, and assumes that adults over that threshold will be taken care of through the new State Block Grant program the bill creates. Like the AHCA and BCRA, Graham-Cassidy also converted Medicaid financing into a per capita cap system beginning in 2020

The Medicaid per capita cap structure in Graham-Cassidy is largely the same as BCRA although there is a minor difference in the growth rate of the cap for elderly and disabled adults beyond 2025. Rather than growing at the very slow rate of general inflation (CPI-U), it grows at the not as slow rate of medical inflation (CPI-M) for these two categories only. In addition, expansion adults may not be covered by Medicaid under Graham-Cassidy, but rather are expected to be taken care of through the private market.

According Avalere, the independent health care consulting firm, Graham-Cassidy[1] would result in a net loss of $215 billion to states compared to current law from 2020 to 2026. That cost would rapidly balloon in the following years if the block grants expire. The cumulative loss from years 2020 to 2027 would be $489 billion and from 2020 to 2036 would be $4.1 trillion. Due to the nature of the funding formula, California would have seen the greatest funding loss of all the states. Avalere estimates that from 2020-2026, California would lose roughly $78 billion in federal health care funding and $129 billion from 2020 to 2027.

Stakeholder and Public Reaction
Once it became clear that consideration of Graham-Cassidy was sincere, the public debate shifted rapidly from uninterested to strongly opposed. With all Democrats in opposition, Senate Republicans once again faced the same math as over the summer: they could only afford to lose two votes. All eyes were on the three Republican Senators that voted against the last set of bills: Senators John McCain (R-AZ), Susan Collins (R-ME), and Lisa Murkowski (R-AK).

However, Senator Rand Paul (R-KY) was actually the first to publicly oppose the bill. He argued that Graham-Cassidy did not go far enough in repealing the ACA, saying he could only support a block grant of the ACA if the bill block granted federal health funding at pre-2009 levels. In short, he viewed Graham-Cassidy as potentially cementing "Obamacare's" increased spending. Since the block grant was the essential feature of the bill, his vote was considered unobtainable.

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[1] Avalere, September 20, 2017: Graham-Cassidy-Heller-Johnson Bill would Reduce Federal Funding to States by $215 billion. http://avalere.com/expertise/life-sciences/insights/graham-cassidy-heller-johnson-bill-would-reduce-federal-funding-to-sta

Back to Agenda

The public debate took another surprising turn when on September 20, 2017, comedian and late night television host Jimmy Kimmel used his monologue to say that Graham-Cassidy failed the so-called "Kimmel Test". The Kimmel Test was actually created by Senator Cassidy, who after seeing Kimmel's emotional monologue this summer regarding his son's difficult birth and pre-existing condition, said that any bill to repeal and replace the ACA would have to maintain its protections for pre-existing conditions. Cassidy later appeared on Kimmel's show and repeated it. When Kimmel learned that the new Graham-Cassidy bill in fact failed the Kimmel Test, he used his show's monologue for three days straight to criticize the bill and Senator Cassidy personally in dramatic and comedic fashion.

In a rare occurrence, the health care community united in opposition to the bill. On September 13, 2017, six provider groups, including the American Academy of Family Physicians, American Academy of Pediatrics, and American Psychiatric Association, published a letter[2] in opposition. On September 18, 2017, sixteen patient advocacy groups published a letter[3] opposing Graham-Cassidy, including the American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, ALS Association, and March of Dimes. On September 19, the American Medical Association published their own letter[4] and a day later the nation's largest insurance plans added their opposition with a letter[5] from America's Health Insurance Plans and a statement[6] from Blue Cross Blue Shield.

CalOptima and its affiliated trade associations also added its voice to those concerns about the impact of the Graham-Cassidy proposal. This included letters to the members of the House representing Orange County as well the offices of Senators Feinstein (D-CA) and Harris (D-CA) from CalOptima CEO Michael Schrader "strongly" urging opposition to Graham-Cassidy. In addition, CalOptima was a signatory to a letter opposing the proposal with 14 other CEOs of large Medicaid plans, and three of its trade associations (the Local Health Plans of California, Medicaid Health Plans of America, and Association for Community Affiliated Plans) sent Congressional letters in opposition to the bill.

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[2] Provider group letter: http://www.aafp.org/dam/AAFP/documents/advocacy/coverage/aca/LT-Senate-GrahamCassidyProposal-091217.pdf

[3] Patient group letter: http://newsroom.heart.org/news/sixteen-patient-and-provider-groups-oppose-grahamcassidy-bill

[4] AMA letter: https://www.ama-assn.org/ama-urges-senate-oppose-graham-cassidy-legislation

[5] AHIP letter: https://www.ahip.org/wp-content/uploads/2017/09/AHIP-Letter-to-Leaders-McConnell-and-Schumer-re-Graham-Cassidy-Heller-Johnson-Proposal-9-20-2017.pdf

[6] BCBS Statement: https://www.bcbs.com/news/press-releases/blue-cross-blue-shield-association-statement-graham-cassidy-health-care-reform

Back to Agenda

On September 22, 2017, Senator John McCain, long thought to be on the fence about supporting the bill due to his famously close friendship with Senator Lindsey Graham, issued a statement opposing the Graham-Cassidy proposal. "I cannot in good conscience vote for the Graham-Cassidy proposal," he said. "I believe we could do better working together, Republicans and Democrats, and have not yet really tried."

On Monday, September 25, the Senate Finance Committee held a hearing on the proposal, drawing hundreds of activists in attendance. Ultimately, Capitol Police made 181 arrests of Graham-Cassidy protestors, many of whom were on Medicaid and disabled. The Committee also received an overwhelming 26,000 letters as comment on the bill, the vast majority of which told personal stories in opposition to Graham-Cassidy.

With Senators Collins and Murkowski all but officially declared in opposition, the bill was on its last legs. Senator Collins made it official on the evening of September 25, 2017. She issued a statement detailing three main concerns and noting that the preliminary analysis from the Congressional Budget Office confirmed her fears about the bill's likely impact.

On Tuesday, September 26, 2017, Senate Majority Leader Mitch McConnell told reporters that the Senate would not vote on Graham-Cassidy.

Earlier this month, a ruling from the Senate Parliamentarian declared that the budget reconciliation instructions for fiscal year 2017 may not be used to pass a bill using reconciliation (and its simple majority) after the fiscal year. In other words, in order to pass a repeal of the Affordable Care Act with only 50 votes after September 30, 2017, Senate Republicans would have to pass a new budget resolution with instructions on developing health care legislation and write a new bill. While some Republicans have called for them to do just that, until then, the effort to repeal the ACA appears, for now, to be behind the United States Congress.

Repeal and Replace Returns?

Despite the inability of the Republican-led Senate to reach agreement among its 52 members on the AHCA, BCRA, so-called 'skinny repeal,' and Graham-Cassidy, the pressure to fulfill its oft-repeated promise to repeal and replace "Obamacare" requires that the ability to do so be preserved into the future. As a result, the House and Senate looked to the FY2018 budget resolution as the next opportunity to see if reconciliation could be used again next year for health care legislation. The conflicting priority, however, is tax reform, which Congressional Republicans are also planning to pass through reconciliation and bypass a filibuster from the Senate minority. Yet, due to the different ideological makeup of the Republican conference in

Back to Agenda

each body, the House and Senate budget resolutions treat reconciliation instructions for health care differently.

Although released on July 18, 2017, the House FY18 budget resolution was stalled until it was assured support from all corners of the House Republican Conference whose more conservative members often struggle to support budget resolutions that fail to reduce government spending as quickly as they would like. Yet, on October 5, 2017, the House passed H.Con.Res 71, the FY2018 budget resolution, with 219 votes, eking out a majority with only several votes to spare. No Democrats voted for the resolution. While eighteen House Republicans voted against it, none were from Orange County. The resolution included reconciliation instructions for eleven committees, including the House Ways & Means Committee and the House Energy & Commerce Committee, which together have jurisdiction over all ACA-related policy. In other words, if this resolution were agreed to by the Senate, then Congress could write and pass legislation repealing and replacing the ACA with a mere simple majority in the Senate.

The Senate Budget Committee, however, pursued a different path. The FY18 budget resolution released by the Chairman of that committee included reconciliation instructions for only two committees: the Committee on Energy and Natural Resources and Committee on Finance. It did not include reconciliation instructions for the Senate Health, Education, Labor, and Pensions (HELP) Committee. The instructions for the Energy and Natural Resources Committee were widely interpreted as supporting legislation to allow for drilling in the Alaskan National Wildlife Refuge, and the instructions for the Finance Committee were widely interpreted as supporting tax reform.

The Senate Finance Committee has jurisdiction over Medicaid, Medicare, and taxes, among many other areas. The Senate HELP Committee has jurisdiction over private health insurance markets and public health programs. The lack of reconciliation instructions for the HELP Committee means that, if it were agreed to by the House, certain changes to the ACA in the jurisdiction of that committee, such as changes to the individual insurance marketplace, could not be passed in the Senate by a simple majority vote. However, the reconciliation instructions for the Finance Committee could potentially be used to make changes to the Medicaid provisions of the ACA, which are in its jurisdiction. Since the reconciliation instructions are written so broadly, the Finance Committee could hypothetically produce a reconciliation bill that addresses both taxes and health care issues.

While the lack of instructions for the Senate HELP Committee is a strong indicator that the Senate intends to focus on tax reform, it is important to recognize that some risk to Medicaid still remains under the Senate budget resolution.

Back to Agenda

The Senate Budget Committee passed its FY18 budget resolution out of committee on October 5, 2017, and the full Senate is expected to consider it the week of October 16, 2017. Following Senate approval of its budget resolution, House and Senate Budget Committee leaders will have to reach agreement on a budget resolution and pass identical versions in their respective chambers. As a concurrent resolution, the budget resolution is not presented to the President for his signature into law, but rather is used as an internal directive to other Congressional Committees on how much money to appropriate for the upcoming year or what kind of programs to authorize.

Akin Gump will continue to monitor the budget resolution for its reconciliation instructions and report to CalOptima.

Children's Health Insurance Program (CHIP) Funding

On September 30, federal funding for CHIP expired, putting at risk the health coverage of millions of children across the United States. Although Congress missed this deadline, it did so with the knowledge that states could continue to use its existing federal allotment until it is exhausted. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), four states' allotments will become exhausted during the month of December, while California's allotment is expected to exhaust in January.

Since passage of the CHIP funding in the Senate will require Democratic support, the leaders of the Senate Finance Committee, Chairman Orrin Hatch (R-UT) and Ranking Member Ron Wyden (D-OR) sought to and did reach a bipartisan agreement. On September 12, 2017, they announced a deal to extend CHIP funding for five years and phase-down the additional 23 percent funding "bump" established by the ACA. Under the deal, the bump would be maintained for FY2018 and FY2019 but cut in half to 11.5 percent in FY2020 and eliminated for FY2021. Phasing down the funding bump will return the federal CHIP matching rate to its traditional enhanced level. The Senators did not outline how they planned to pay for – either in reducing spending or raising revenue – the funding CHIP funding extension.

On the following day, Senators Graham and Cassidy released the updated text of their proposal to repeal and replace the ACA, putting on hold any bipartisan health care negotiations like extending funding for CHIP. However, following the failure Graham-Cassidy, the Senate quickly resumed its CHIP work and held a markup in the Senate Finance Committee on October 4, 2017, to move the bill out of committee. To hold the bipartisan agreement together, Senators Hatch and Wyden agreed to address the issue of offsets at a later date and convinced the members of their committee to refrain from requesting recorded votes on any amendments. A number of

Back to Agenda

controversial amendments were offered and Senators spoke on behalf of those amendments, but they were all withdrawn with pledges to seek their enactment on the full Senate floor.

The House, where the majority has greater ability to pass its agenda if it can maintain internal cohesion, also held a markup on October 4. Although the bipartisan leadership of the House Energy & Commerce committee was engaged in negotiations prior to the markup, no agreement could be reached. Legislative text was only shared with the committee's Democrats less than two days before the markup, which was only a few hours before it was released publicly.

The House Republican proposal mirrored the Senate bipartisan agreement in its funding length and funding bump phase down (i.e., five years with bump cut in half in FY2020 and eliminated in FY2021). However, the House Republican proposal included provisions to lower spending or raise revenues in order to pay for the extended CHIP funding. The bill would raise the roughly $8.2 billion by:

- Cutting the ACA's Prevention and Public Health Fund by $6.35 billion over 10 years;
- Shortening the grace period for ACA enrollees who fail to make premium payments from 90 days to 30 days;
- Increasing Medicare premiums for high earners making at least $500,000 annually; and
- Allowing states to cut Medicaid payments for prenatal care and preventive services for children in circumstances when another insurer could instead be liable for the costs (Right now Medicaid pays for those services, no questions asked, regardless of whether another insurer might technically be obligated to cover the costs. The GOP plan would instead allow states to withhold payments while they try to ascertain whether another insurer should be on the hook for the bill).

At the markup, Democrats objected strenuously to the reduction in the Prevention and Public Health Fund and the other offsets that were included in the bill over Democratic objections. Ultimately, following several hours of partisan debate, the CHIP funding extension was passed out of the House Energy & Commerce Committee on a strictly party line vote that night. The Committee then went on to pass bills reauthorizing other expiring programs in its jurisdiction, including funding for community health centers, teaching health centers, and the Special Diabetes Program. Funding for community health centers was extended for two years at $3.6 billion.

At this time, both the House and Senate bills to extend funding for CHIP have been reported out of their respective committees and are likely to be considered by their full chambers soon. Our understanding based on conversations with staff for members of House and Senate leadership is

that the goal is to pass legislation extending funding for the CHIP program in combination with an extension of other expiring programs by the end of the month of October.

Akin Gump will continue to support and advocate for CalOptima throughout the legislative debate round extending funding for CHIP in the weeks ahead.

Back to Agenda

Akin Gump
STRAUSS HAUER & FELD LLP

CalOptima Board of Directors Meeting
Federal Advocacy Update

November 2, 2017

Presented by: Josh Teitelbaum & Geoff Verhoff

Akin Gump Strauss Hauer & Feld LLP

Back to Agenda

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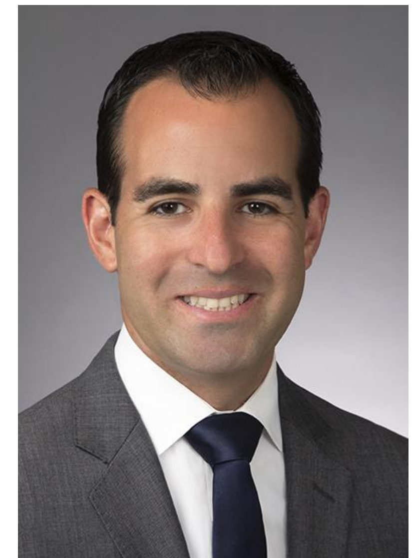


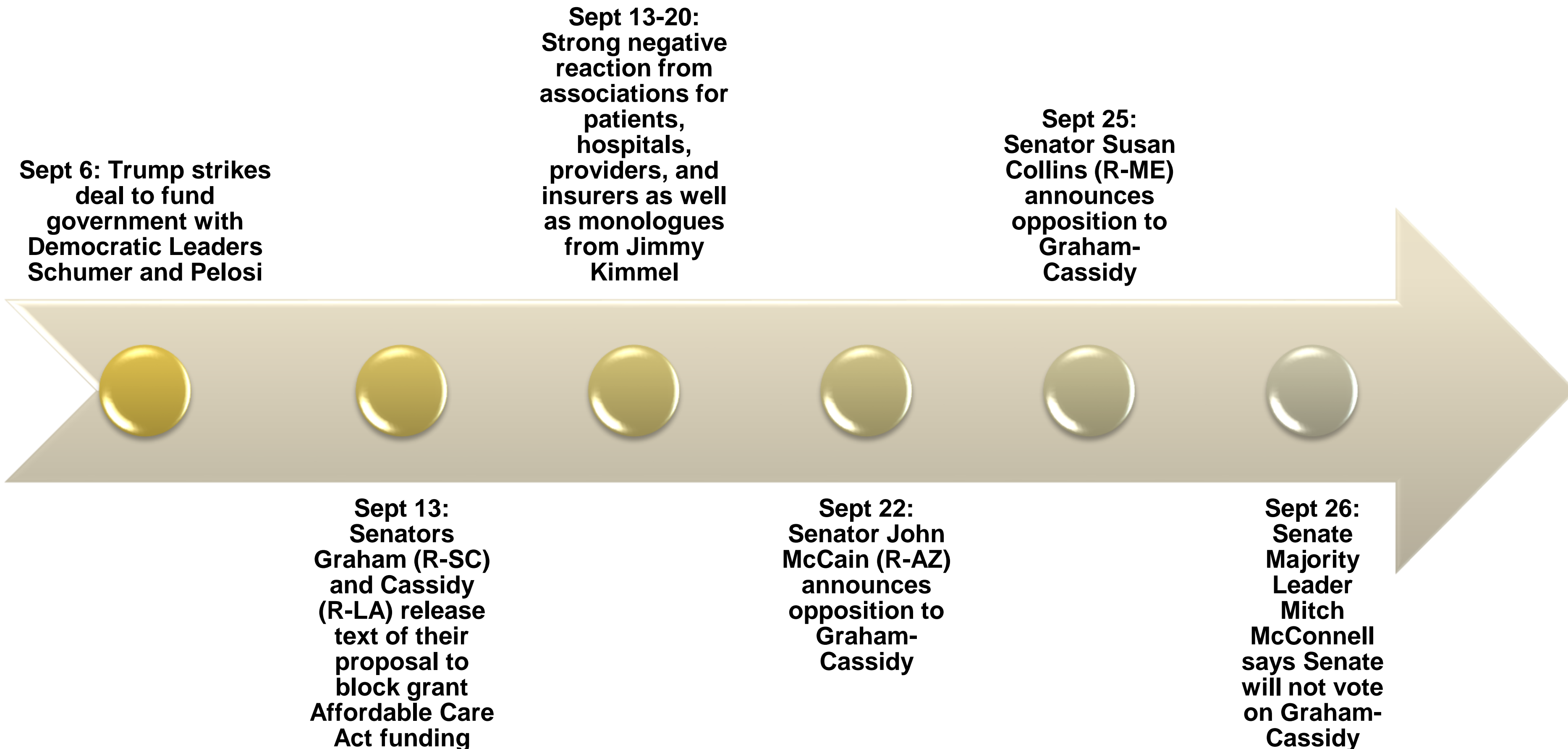
Back to Agenda

November Board of Directors Meeting Agenda

- Affordable Care Act Developments
  - A Review of the Repeal Effort
  - Policy Changes to the Individual Market
    - Executive Order on Association Health Plans
    - Cost-Sharing Reduction Payments
- Children's Health Insurance Program Reauthorization
- Other Health Care Policy
  - Special Needs Plan Reauthorization
  - Community Health Center Funding

Back to Agenda

The Consideration of 'Graham-Cassidy'



Back to Agenda

Affordable Care Act

- Executive Actions Affecting the Individual Market
  - Executive order on association health plans
  - Failure to fund cost-sharing reduction payments (CSRs)
- Legislative Action
  - Bipartisan negotiations between Senators Alexander (R-TN) and Murray (D-WA)
  - Funding for CSR payments
  - Repeal of the Independent Payment Advisory Board (IPAB)?

Back to Agenda

Children's Health Insurance Program

- A soft deadline
  - September 30 funding expiration
  - The use of existing funding until exhausted
  - California's federal CHIP allotment to be exhausted in January
- CHIP Policy
  - Length of funding extension
  - Phase-down of ACA 'bump'
  - Maintenance of effort requirements
- The battle for offsets
- House consideration
- Senate consideration

Back to Agenda

Other Health Care Policy

- Special Needs Plan (SNP) reauthorization
  - SNPs for Dual Eligibles (D-SNPs) authorization expires end of 2018
  - CHRONIC Care Act permanently authorizes D-SNPs
- Community Health Center funding
  - Federal funding expired September 30th
  - CHAMPION Act extends funding in House
- General government funding
  - Federal appropriations expire December 8th
  - Without action, federal government facing a shutdown

Back to Agenda

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Donald B. Gilbert   Michael R. Robson   Trent E. Smith   Alan L. Edelstein OF COUNSEL

CALOPTIMA
YEAR END LEGISLATIVE REPORT
by Don Gilbert and Trent Smith
October 6, 2017

The Legislature concluded its work in the 2017 Legislative Session on September 15. That date marks the end of the first year of the two-year session. All introduced bills that were not acted on in 2017 are technically still alive and can be dealt with when the Legislature reconvenes after January 3, 2018.

During the fall, legislators will return to their districts to meet with constituents, travel on legislative business, and begin the process of evaluating legislation to introduce in 2018.

2017 Year In Review
Political pundits would agree that the 2017 Legislative Session was an enormously busy one in terms of significant legislative output. True to Governor Brown's history during his second life as Governor, he shaped legislative activity to match his priorities and his timeline. Helped by the fact that Democrats control more than two-thirds of the votes in each house of the Legislature, the following major policies were enacted in 2017:

Spring – Infrastructure Revenue and Spending Package
In May the Legislature adopted a 10 year, $52 billion transportation infrastructure spending plan to repair local roads and state highways, invest in public transit and rail, and reduce congestion on trade and commute corridors, while ensuring revenues are not diverted to other uses and creating accountability in the expenditures.

Revenues to pay for this would come from taxes and fees on those who use the roads and highways. Drivers will see an increase in the diesel excise tax by 20 cents, the diesel sales tax will increase by 5.75 percent, the gasoline excise tax will increase by 12 cents, and there will be a new annual vehicle fee based on the value of a vehicle, and a new fee on zero emission vehicles.

Summer – Greenhouse Gas Emissions Law, Cap-and-Trade Spending Authority
The Legislature adopted AB 398 by Assemblyman Eduardo Garcia to extend the cap-and-trade program through the year 2030. This was a major political accomplishment for the Governor that came about through intensive negotiations between businesses that emit greenhouse gas emissions, environmental advocacy groups, labor, and Republican legislators which ensured a two-thirds vote to bring certainty to the carbon auction marketplace for the upcoming compliance period and going forward through 2030.

With this market certainty, auction revenues are expected to stabilize and increase over time, which will annually raise billions of dollars in revenue. In 2017, this revenue is being used to

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Back to Agenda

reduce carbon emissions from mobile and other sources. However, because it passed with a two-thirds vote, in future years these revenues can be spent on anything the Legislature desires.

Fall – Housing Package

On the last day of Session, the Legislature passed a package of bills designed to provide new revenue to subsidize affordable housing and to streamline local permitting for housing development.

SB 2 by Senator Atkins would impose a $75 fee on the recording of certain types of real estate documents with the fee capped at $225 for multiple documents. The author estimates that the bill will generate roughly $250 million each year which will be directed at reducing homelessness and increasing affordable housing.

SB 3 by Senator Beall would place a $4 billion bond before the voters on the November 2018 ballot. If passed, this bond would expend:

- $1.5 billion into the Multifamily Housing Program
- $1 billion into the CalVet Farm and Home Loan Program
- $300 million into Infill Infrastructure Grant Financing
- $300 million into the Joe Serna, Jr. Farmworker Housing Grant Program
- $300 million into the Local Housing Trust Match Grant Program
- $300 million into CalHome
- $150 million into the CalHFA Home Purchase Assistance
- $150 million into the Transit-Oriented Development Program

Both SB 2 and SB 3 have been sent to the Governor and are expected to be signed into law.

Healthcare

Throughout the year we closely followed the debate in Congress as to whether the Affordable Care Act (ACA) would be repealed or modified. There was a great concern that state funding for Medicaid services would be substantially reduced. This fear created a black cloud over the health care budget and policy debates in Sacramento. The Governor's January Budget proposal assumed there would be no change in federal funding, but it was still difficult to ignore the possibility that Congress could act to abolish or amend the ACA.

Early in 2017, we lobbied to keep the Coordinated Care Initiative (CCI). It was well known that the Governor and the Department of Health Care Services (DHCS) were considering cancelling the pilot program, which coordinates care for people who are eligible for both Medicare and Medicaid services. The Governor was concerned that the program was not generating projected savings. We lobbied the Department of Finance and DHCS. We also asked several Orange County legislators to write or call the Governor's office to share their support for keeping the program. Ultimately, the Governor decided to remove In Home Support Services (IHSS) from the program, thereby reestablishing the Cal Medi-Connect program. CalOptima and most of the other CCI plans supported the Governor's proposal, but the counties opposed as the cost to provide IHSS services would become the responsibility of the counties. Eventually, the Governor and the counties negotiated a larger share of state dollars to cover IHSS services and the counties removed their opposition.

Back to Agenda

Also, early in 2017, we closely followed SB 202 by Senator Dodd. This measure proposed increasing the personal needs allowance amount from $35 to $80 per month for Medi-Cal enrollees receiving care in a nursing facility or a Program of All-Inclusive Care for the Elderly (PACE) organization. Unfortunately, this bill was held in the Senate Appropriations Committee because of the potential cost to the state.

Among the many health care bills, SB 17 by Senator Hernandez was one of the most heavily lobbied bills in 2017. This measure requires drug manufacturers to notify specified purchasers in writing at least 90 days prior to the planned effective date, if it is increasing a drug price by more than 16 percent over a two-year period. The bill also requires health plans and insurers that report rate information through the existing large and small group rate review process to also report specified information related to prescription drug pricing to the Department of Managed Health Care (DMHC) and California Department of Insurance (CDI). These agencies would then be required to prepare a consumer-friendly report that demonstrates the overall impact of drug costs on health care premiums.

SB 17 was supported by labor unions and commercial health plans that are concerned with the high costs of prescription drugs and the impact they have on the overall rising costs of health care. The bill was strongly opposed by pharmaceutical manufacturers. Negotiations and heavy lobbying took place all year long. Eventually, the bill passed to the Governor's desk with bipartisan support in the last days of the session.

Another bill of interest was SB 538 by Senator Monning which prohibited various contract provisions between hospitals and health plans. According to the author, his bill sought to prohibit anti-competitive contract provisions that dominant hospital systems imposed on health plans to maintain market power and to inflate prices charged to consumers, workers, and employers. The bill was supported by a unique coalition of health plans, businesses, and labor unions. Hospitals opposed the bill. SB 538 passed out of the Senate but did not receive a hearing in the Assembly Health Committee. SB 538 can be pursued further in 2018.

Meanwhile, health plans and public hospitals negotiated for most of the year on a new financing mechanism required under federal regulations. The final agreement was amended into SB 171 by Senator Hernandez. The bill also establishes a medical loss ratio (MRL) of 85 percent for Medi-Cal managed care plans and requires a plan to remit any profits in excess of 15 percent. This matter will not impact County Organized Health Systems (COHS), as they all maintain an MRL well under 10 percent.

AB 205 by Assemblyman Wood was amended with language needed to comply with additional federal guidelines, including new time and distance standards to ensure network adequacy. This bill also includes new standards for plan grievances and appeals. Both bills are awaiting the Governor's signature.

Another bill of interest was SB 323 by Senator Mitchell, which authorizes a federally qualified health center (FQHC) or rural health clinic (RHC) to enroll as a Drug Medi-Cal (DMC) certified provider and receive reimbursement for such services. It also allows a FQHC and RHC to contract with one or more mental health plans (MHP) that contract with DHCS to provide

Back to Agenda

specialty mental health (SMH) services to Medi-Cal beneficiaries. SB 323 had no opposition and received unanimous support. The bill is sitting on the Governor's desk awaiting his review.

We also watched closely AB 275 by Assemblyman Wood. The bill requires that before closing or changing its level of service, a long-term health care facility must provide 60 days' notice to the affected residents or their guardians and a 60 day written notice to the State Long-Term Care Ombudsman. AB 275 was introduced in response to the unexpected closure of long-term care facilities on the North Coast last year. Governor Brown signed AB 275 into law earlier this year.

In June, SB 4 by Senator Mendoza was substantially amended, removing language focused on transportation and inserting language to codify the structure of the CalOptima Board of Directors. We immediately reached out to the author's office to get more information on who was sponsoring the bill. We learned that the Orange County Tax Payers Association was sponsoring the bill and that several healthcare provider groups were supporting. While CalOptima did not have a position on the bill, we remained in close contract with the author's office. Throughout the remainder of the session we reported to CalOptima on the progress of the bill, including when various amendments were being considered and when new supporters and opposition was joining the debate. We also observed the various committee and floor debates and reported votes to CalOptima. Ultimately, SB 4 only received one "NO" vote through the entire process and the bill was signed into law by Governor Brown on October 5.

Another bill that arose late in the session was AB 1250 by Assemblyman Jones-Sawyer. This bill prohibits a county from contracting for personal services currently or customarily performed by county employees except in narrow circumstances. The bill is sponsored by public employee labor unions and is intended to prevent counties from contracting out services just for the purpose of saving money. Counties are vigorously opposing the bill. AB 1250 is drafted so broadly that public health plans became concerned that it could jeopardize many of their service contracts with providers. While we doubt this is the intent of the bill, the concern was heightened in the last policy committee when the author took an amendment to exclude Santa Clara Health Plan. He took this amendment to gain the vote of a Senator from Santa Clara. Public health plans became concerned that if AB 1250 specifically excludes Santa Clara then other public health plans must be impacted by the bill. We worked closely with the Local Health Plans of California (LHPC) to oppose AB 1250. Negotiations continued until the last few days of session, but ultimately the bill stalled in the Senate. We expect that it will come back for further consideration in 2018.

Another bill we monitored this year was AB 1372 by Assemblyman Levine. This bill would permit a certified crisis stabilization unit (CSU) to provide medically necessary crisis stabilization services to individuals beyond the 24-hour limit currently in law when an individual needs inpatient psychiatric care or outpatient care and there is no bed placement readily available. The sponsors, the County Behavioral Health Directors Association of California, argued that CSUs provide a location for individuals undergoing a mental health crisis to receive short-term treatment. During an individual's time in a CSU, staff provide supportive care and attempted to secure referrals for appropriate long-term or inpatient care. The current 24-hour limitation at these facilities binds the hands of behavioral health workers, often forcing them to stop care for their patients. AB 1372 would help reduce unnecessary emergency room visits by granting CSUs more time to be able to find appropriate and effective care for their patients.

Back to Agenda

AB 1372 was supported by several counties. However, this bill received late opposition from the DHCS and the California Association of Hospitals. As a result, the bill was not brought up for a final vote. Further negotiations will take place over the fall.

Back to Agenda

2017–18 Legislative Tracking Matrix

FEDERAL BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Action/Position
HR 1628 (Black)	**ACA Repeal/Replace:** "Graham-Cassidy" would replace the Medicaid FMAP with per capita caps, repeal the Medicaid expansion by 2020, and combine state exchange and state Medicaid expansion dollars into a block grant.	**09/13/2017** Draft text released by Senator Cassidy	Sent letter of opposition
	Senate Amendment 271: "Repeal Now, Replace Later" would repeal Medicaid expansion beginning in 2020.	**07/26/2017** Failed Senate	
	Senate Amendment 270: "Better Care Reconciliation Act" would replace Medicaid FMAP with per capita caps and phase-down federal funding for Medicaid expansion beginning in 2021.	**07/25/2017** Failed Senate	Sent letter of concern
	The American Health Care Act 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 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 benefits" for Medicaid plans, and 4) Potentially decreased funding and additional restrictions for CMS waivers.	**05/04/2017** Passed House, referred to Senate	Sent letter of concern
HR 3168 (Tiberi)	**Five Year D-SNP Re-authorization:** This bill would, among other things, 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.	**07/13/2017** Passed House Committee on Ways and Means	Sent letter of support
HR 3921 (Burgess)	**Five Year CHIP Re-authorization:** This bill would extend funding for the Children's Health Insurance Program (CHIP) for five years. The CHIP enhanced FMAP (E-FMAP), which accounts for 88 percent of California's CHIP budget, would be extended for two years. States would receive an 11.5 percent reduction in CHIP funding in federal FY (FFY) 2020 and 2021, which would result in reverting back to the pre-ACA CHIP funding formula of 65 percent federal dollars and 35 percent state dollars.	**10/04/2017** Passed House Committee on Energy and Commerce	Sent letter of support
S 191 (Cassidy)	**ACA Repeal/Replace:** The Patient Freedom Act would repeal several mandates in the Affordable Care Act (ACA), such as the individual and employer mandates, and the essential health benefit requirements. The bill retains most of the ACA consumer protections, such as prohibiting discrimination and pre-existing conditions exclusions. 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, 2) A state-based health care system with no federal financial assistance, or 3) Continue under current system at funding no more than option one.	**01/23/2017** Referred to Senate Committee on Finance	Watch

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Action/Position
S 870 (Hatch)	**Permanent D-SNP Re-authorization:** This bill would, among other things, 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.	**09/26/2017** Passed Senate, referred to the House	Sent letter of support
S 1804 (Sanders)	**Medicare for All:** This bill would replace the current U.S. health care system with a single-payer system, known as Medicare for All. This system would provide comprehensive health care services for all U.S. residents, sunset the current Medicare and Medicaid programs, and enroll all eligible individuals into the new universal plan. No financial analysis or CBO score is currently available.	**09/13/2017** Referred to Senate Committee on Finance	Watch
S 1827 (Hatch)	**Five Year CHIP Re-authorization:** This bill would extend CHIP funding for five years. The CHIP enhanced FMAP (E-FMAP), which accounts for 88 percent of California's CHIP budget, would be extended for two years. States would receive an 11.5 percent reduction in CHIP funding in federal FY (FFY) 2020 and 2021, which would result in reverting back to the pre-ACA CHIP funding formula of 65 percent federal dollars and 35 percent state dollars.	**10/04/2017** Passed Senate Committee on Finance	Support

STATE BILLS

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Action/Position
AB 15 (Maienschein)	**Denti-Cal Rate Increase:** This bill would require the Department of Health Care Services (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.	**05/26/2017** Held under submission	Watch
AB 97 (Ting)	**State Budget:** This bill enacts California's Budget for FY 17-18. The bill allocates $183.3 billion, $105 billion of which is for the Medi-Cal program.	**06/27/2017** Signed into law	Watch
AB 120 (Ting)	**State Budget:** This "junior budget bill" contains specific state Medi-Cal appropriations and budget instructions. 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 205 (Wood)	**Mega-Reg:** This bill would implement certain provisions of the CMS Medicaid managed care rules (Mega-Reg) by making changes at the state level regarding Medi-Cal managed care plans. Specifically, this bill would change the grievance and appeals process for plans by lengthening the amount of time members have to request a state fair hearing from 90 days to 120 days. It would also establish new time and distance standards for members to access primary and specialty care services.	**09/14/2017** Passed Legislature, referred to Governor	Watch
AB 675 (Ridley-Thomas)	**IHSS Funding:** 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
AB 1074 (Maienschein)	**Behavioral Health Providers**: This bill expands the definition of autism service providers, potentially affecting CalOptima's behavioral health treatment (BHT) provider network.	**09/30/2017** Signed into law	Watch
SB 4 (Mendoza)	**CalOptima Board of Directors:** This bill codifies the current seat designations on the CalOptima Board of Directors, and modifies the Board member removal process.	**10/04/2017** Signed into law	Watch

Bill Number (Author)	Bill Summary	Bill Status	CalOptima Action/Position
SB 97 (Committee on Budget and Fiscal Review)	**Cal MediConnect Extension, Medi-Cal Benefits:** This bill enacts the health care trailer bill language related to the state FY 17-18 budget bill. Most importantly for CalOptima, it extends the Cal MediConnect (CMC) program, including CalOptima's OneCare Connect program, until December 31, 2019. IHSS administration will be transferred back to the counties but will still remain available to OneCare Connect members. The bill also includes language that restores certain dental benefits on January 1, 2018 and certain Medi-Cal optical benefits on January 1, 2020.	**07/10/2017** Signed into law	Sent letters of support for Cal MediConnect Extension
SB 152 (Hernandez)	**CCS:** 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 (2 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.	**07/17/2017** Ordered to inactive file	Watch
SB 171 (Hernandez)	**Meg-Reg:** This bill would implement certain provisions of the Mega-Reg by making changes at the state level regarding Medi-Cal managed care plans. Specifically, this bill would require plans to adopt an 85 percent medical loss ratio (MLR) by July 1, 2019. It would also require plans to modify their payment structures to designated public hospitals.	**09/14/2017** Passed Legislature, referred to Governor	Watch
SB 223 (Atkins)	**Medi-Cal Languages:** 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.	**09/14/2017** Passed Legislature, referred to Governor	Watch
SB 608 (Hernandez)	**Hospital QAF:** This bill will modify the hospital quality assurance fee to bring it into compliance with Mega-Reg requirements. The current language of the bill only reflects a portion of the California Hospital Association's proposal to reform the QAF. The bill's language is likely to be substantially amended in the next legislative session.	**09/01/2017** Held under submission	Watch

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 Federal Legislative Dates

January 3	115th Congress convenes
January 20	Presidential Inauguration
April 10–21	Spring recess
July 28–September 1	Summer recess
September 30	Spending expires for federal fiscal year 2016–17
September 30	CHIP funding expires under current law, pending Congressional action
September 30	2017 budget resolution expires
November 20–24	Fall recess

2017 State Legislative Dates

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

Back to Agenda

CalOptima
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Board of Directors Meeting
November 2, 2017

CalOptima Community Outreach Summary — October 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 a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors as indicated pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in a number of community meetings including coalitions/collaboratives, committees and advisory groups focused on community health issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

Summary of Public Activities
During October, CalOptima participated in 56 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
10/02/17	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting
10/03/17	• Orange County Aging Services Collaborative Meeting • Anaheim Human Services Network Meeting • Orange County Healthy Aging Initiative Meeting
10/06/17	• Covered Orange County General Meeting

Back to Agenda

Date	Events/Meetings
	• Help Me Grow Advisory Meeting
10/09/17	• Orange County Veterans and Military Families Collaborative Meeting • Fullerton Collaborative Meeting
10/10/17	• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting • Buena Clinton Neighborhood Coalition Meeting • Susan G. Komen Orange County — Unidos Contra el Cancer del Seno Coalition Meeting • San Clemente Youth Wellness and Prevention Coalition Meeting
10/11/17	• Buena Park Collaborative Meeting • Anaheim Homeless Collaborative Meeting
10/12/17	• FOCUS Collaborative Meeting
10/13/17	• Senior Citizen Advisory Council Meeting
10/17/17	• Placentia Community Collaborative Meeting
10/18/17	• Covered Orange County Steering Committee Meeting • Minnie Street Family Resource Center Professional Roundtable • Orange County Promotoras Meeting • La Habra Move More Eat Healthy Plan Meeting • Orange County Communications Workgroup
10/19/17	• Orange County Children's Partnership Committee Meeting • Surf City Senior Providers Networking Meeting • Orange County Women's Health Project Advisory Board Meeting
10/23/17	• Stanton Collaborative Meeting • Community Health Research Exchange
10/24/17	• Orange County Senior Roundtable • Santa Ana Building Healthy Community Meeting
10/25/17	• Orange County Human Trafficking Task Force General Meeting
10/26/17	• Disability Coalition of Orange County • Orange County Care Coordination for Kids

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff Attended	Events/Meetings
10/01/17	1	• Walk to End Stigma Against Mental Illness hosted by Orange County Association for Vietnamese Mental Health Awareness and Support (Sponsorship Fee: $500 included agency's name mentioned on TV and one table for outreach)

Back to Agenda

	4	• 2017 Mid-Autumn Festival hosted by Vietnamese Cultural Center and the Office of Supervisor Andrew Do (Sponsorship Fee: $6,000 included 1,500 lanterns for children attending the event, agency's logo and name on all marketing materials, recognition during event, tables for outreach)
	1	• Senior Health and Information Fair hosted by the City of Santa Ana Senior Center
10/06/17	1	• API Mental Health Awareness Empowerment Conference hosted by VietCARE and Cal State Fullerton (Sponsorship Fee: $500 included featuring agency as supporting sponsor in event program, recognition and logo in all social media, and publications, event program, outreach booth, complimentary tickets and luncheon for three staff)
10/07/17	2	• NAMI Walks Orange County hosted by NAMI Orange County (Sponsorship Fee: $1,000 included listing on host website, logo on event t-shirts, brochure, website and resource table at the event)
10/12/17	1	• Whole Health and Resource Fair hosted by Mental Health Association of Orange County Wellness Center West
	1	• Annual Community Resource and Health Fair hosted by Garden Grove Unified School District Clinton Corner Family Campus and Children & Families Commission of Orange County
	1	• Resource Fair hosted by Active Learning
10/13/17	1	• Health Fair hosted by the City of Brea Senior Center
10/14/17	2	• 2017 Diocesan Ministries Celebration and Resource Fair hosted by Diocese of Orange (Registration Fee: $450 included a quarter page ad in event booklet and one table for outreach)
	1	• Annual Parent Conference hosted by Santa Ana Unified School District
10/15/17	3	• Free Health Fair hosted by Vietnamese Physician Association of Southern California
10/18/17	1	• Annual Job Fair hosted by Wellness Center Central • Annual Community Resource and Health Fair hosted by Garden Grove Unified School District Clinton Corner and Family Campus and Children & Families Commission of Orange County
10/20/17	1	• 5th Orange County Women's Health Summit hosted by Orange County Women's Health Project (Sponsorship Fee: $1,000 included speaking engagement opportunity, two tickets for staff to attend summit, and one table for outreach)
10/21/17	1	• 2017 OASIS Senior Health and Resource Fair hosted by the City of Newport Beach OASIS Senior Center
	1	• Grow Your Health Senior Wellness Expo hosted by the City of Yorba Linda (Sponsorship Fee: $250 included verbal recognition throughout event, premier

Back to Agenda

		complimentary exhibitor space at event, inclusion in event guide, and recognition in the city's bulletin)
	1	• 14th Annual Senior Health and Wellness Expo hosted by City of Stanton and Rowntree Gardens (Sponsorship Fee: $50 included company name listed in event program and one table for outreach)
	1	• Annual Youth Leadership Conference hosted by Casa Youth Shelters (Sponsorship Fee: $500 included company logo on marketing materials, host website, social media and an outreach table at the event)
	1	• Free Family Festival: Harvesting Opportunities hosted by North Orange Continuing Education
10/25/17	1 1	• Medicare Info Fair hosted by City of Cypress Senior Center (Registration Fee: $50 included one resource table) • Annual Resource Fair hosted by CHOC Children's Hospital
10/26/17	1	• Medicare Marketplace 2017 hosted by Community Civic Association of Laguna Woods
10/28/17	1	• My Health, My Family, My Community Health Fair hosted by Cal State Fullerton Center for Healthy Neighborhoods

CalOptima organized or convened the following 18 community stakeholder events, meeting and presentations:

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
10/03/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (Spanish)
10/04/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You • Community-based organization for the City of Huntington Beach Senior Center — Topic: CalOptima Overview
10/05/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You
10/06/17	• County Community Service Center Health Education Seminar — Topic: Understanding Social Security Programs and Benefits (Vietnamese)
10/10/17	• CalOptima New Member Orientation for Medi-Cal Members (English and Spanish) • CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (Spanish)
10/16/17	• Community-based organization for Mariposa Villa Senior Community Apartment — Topic: CalOptima Overview
10/17/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (Spanish)

10/18/17	• CalOptima New Member Orientation for Medi-Cal Members (Korean and Farsi) • CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You
10/20/17	• County Community Service Center Health Education Seminar — Topic: Understanding Social Security Programs and Benefits (Vietnamese)
10/21/17	• CalOptima PACE Health and Wellness Event
10/24/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You (Spanish) • Community-based organization for the Wellness Center West — Topic: CalOptima Overview
10/25/17	• CalOptima Health Education Workshop — Topic: Healthy Weight Healthy You
10/26/17	• CalOptima New Member Orientation for Medi-Cal Members (Chinese and Arabic) • CalOptima New Member Orientation for Medi-Medi Members (Vietnamese)

CalOptima provided zero endorsements for events during this reporting period (e.g., letters of support, program/public activity event with support, or use of name/logo).

Back to Agenda

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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.

November				
Thursday, 11/2 9-11am	++Homeless Provider Forum	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Covenant Presbyterian Church 1855 Orange Olive Rd. Orange
Thursday, 11/2 9-10:30am	++Refugee Forum of Orange County	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Access California Services 631 S. Brookhurst St. Anaheim
Thursday, 11/2 9:30-10:30am	*New Member Orientation Presentation in Vietnamese	**Steering Committee Meeting: Open to Collaborative Members**	N/A	County Community Service Center 15496 Magnolia Ave. Westminster
Friday, 11/3 9-10:30am	++Covered Orange County General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	The Village 1505 E. 17th St. Santa Ana
Friday, 11/3 11am-12pm	*Health Education Seminar Medicare 101: Understanding Your Benefits and Options Presentation in Vietnamese	**Community Presentation Open to the Public**	N/A	County Community Service Center 15496 Magnolia St. Westminster
Saturday, 11/4 7:30am-2pm	+Alzheimer's Orange County Annual Alzheimer's Latino Conference	**Conference Health/Resource Fair Open to the Public**	Sponsorship $2,500 2 Staff	Templo Calvario 2501 W. 5th St. Santa Ana

** CalOptima Hosted*

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

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Saturday, 11/4 9am-1pm	+Nhan Hoa Comprehensive Health Care Clinic	**Health/Resource Fair Open to the Public**	1 Staff	Nhan Hoa Comprehensive Health Care Clinic 7761 Garden Grove Blvd. Garden Grove
Monday, 11/6 1-4pm	++OCHCA Mental Health Services Act Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Delhi Center 505 E. Central Ave. Santa Ana
Tuesday, 11/7 9:30-11am	++Collaborative to Assist Motel Families	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Anaheim Downtown Community Center 250 E. Center St. Anaheim
Wednesday, 11/8 9am-12pm	++City of La Habra, Institute for Healthcare Advancement, La Habra Collaborative Senior Week Health and Wellness Fair	**Health/Resource Fair Open to the Public**	Registration $75 1 Staff	La Habra Community Center 101 W. La Habra Blvd. La Habra
Tuesday, 11/8 11:30am-12:30pm	++Buena Clinton Neighborhood Coalition	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Buena Clinton Youth and Family Center 12661 Sunswept Ave. Garden Grove
Thursday, 11/8 1-2pm	*New Member Orientation Presentations in Farsi and Korean	**Community Presentation Open to the Public**	N/A	CalOptima
Wednesday, 11/8 12-1:30pm	++Anaheim Homeless Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Thursday, 11/9 1-2pm	*New Member Orientation Presentations in Chinese and Arabic	**Community Presentation Open to the Public**	N/A	CalOptima
Thursday, 11/9 11:30am-12:30pm	++FOCUS Collaborative Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Magnolia Park Family Resource Center 11402 Magnolia St. Garden Grove

** CalOptima Hosted*

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

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Thursday, 11/9 6-8pm	++State Council on Developmental Disabilities Advisory Committee Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	2000 East Fourth St. Santa Ana
Friday, 11/10 9:30am-11am	+Senior Citizen Advisory Council Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Location varies
Monday, 11/13 1-2pm	++Orange County Veterans and Military Families Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Child Guidance Center 525 N. Cabrillo Park Dr. Santa Ana
Monday, 11/13 2:30-3:30pm	++Fullerton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Fullerton Library 353W. Commonwealth Ave. Fullerton
Tuesday, 11/14 9-10:30am	++OC Strategic Plan for Aging-Social Engagement Committee	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Tuesday, 11/14 11:30am-12:30pm	++Buena Clinton Neighborhood Coalition	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Buena Clinton Youth and Family Center 12661 Sunswept Ave. Garden Grove
Thursday, 11/14 1-2pm	*New Member Orientation Presentations in English and Spanish	**Community Presentation Open to the Public**	N/A	CalOptima
Thursday, 11/14 2-4pm	++Susan G. Komen Unidos Contra el Cancer del Seno Coalition	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Susan G. Komen OC 700 Newport Center Dr. Newport Beach
Tuesday, 11/14 4-5:30pm	++San Clemente Youth Wellness & Prevention Coalition	**Steering Committee Meeting: Open to Collaborative Members**	N/A	San Clemente High School 700 Avenida Pico San Clemente
Wednesday, 11/15 8am-5pm	+California Association of Area Agencies on Aging Annual Meeting and Allied Conference	**Conference Health/Resource Fair Open to the Public *Registration required.***	Registration $500 1 Staff	Sheraton Gateway Hotel 6101 W. Century Blvd.

** CalOptima Hosted*

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

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				La Habra
Wednesday, 11/15 9:15-11am	++Covered OC Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	The Village 1505 E. 17th St. Santa Ana	Wednesday, 9/20 9:15-11am
Wednesday, 11/15 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, 9/20 11am-1pm
Wednesday, 11/15 1-4pm	++Orange County Promotoras	**Steering Committee Meeting: Open to Collaborative Members**	Location varies	Wednesday, 9/20 1-4pm
Wednesday, 11/15 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	Wednesday, 9/20 1:30-3pm
Wednesday, 11/15 3:30-4:30pm	++Orange County Communications Workgroup	**Steering Committee Meeting: Open to Collaborative Members**	N/A	CalOptima
Thursday, 11/16 8am-5pm	+California Association of Area Agencies on Aging Annual Meeting and Allied Conference	**Conference Health/Resource Fair Open to the Public *Registration required.***	Registration $500 1 Staff	Sheraton Gateway Hotel 6101 W. Century Blvd. La Habra
Thursday, 11/16 8:30-10am	++Orange County Children's Partnership Committee	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Orange County Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 11/16 2:30-4:30pm	++Orange County Women's Health Project Advisory Board Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	The Village 1505 E. 17th St. Santa Ana

+ *Exhibitor/Attendee*
++ *Meeting Attendee*

Back to Agenda

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Friday, 11/17 11am-12pm	*Health Education Seminar OneCare Connect Program Overview Presentation in Vietnamese	**Community Presentation Open to the Public**	N/A	County Community Service Center 15496 Magnolia St. Westminster
Tuesday, 11/21 8:30-10am	++North Orange County Senior Collaborative All Members Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	St. Jude Community Services 130 W. Bastanchury Rd. Fullerton
Tuesday, 11/21 10-11:30am	++Placentia Community Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Placentia Presbyterian Church 849 Bradford Ave. Placentia
Tuesday, 11/21 10-11am	++Orange County Cancer Coalition	**Steering Committee Meeting: Open to Collaborative Members**	N/A	American Cancer Society 1940 E. Deere Ave. Santa Ana
Tuesday, 11/21 10-11am	*New Member Orientation Presentations in Chinese and Arabic	**Community Presentation Open to the Public**	N/A	CalOptima
Monday, 11/27 12:30-1:30pm	++Stanton Collaborative Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Stanton Civic Center 7800 Katella Ave. Stanton
Tuesday, 11/28 7:30-9am	++OC Senior Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Orange Senior Center 170 S. Olive Orange
Tuesday, 11/28 3:30-4:30pm	++Santa Ana Building Healthy Communities	**Steering Committee Meeting: Open to Collaborative Members**	N/A	KidWorks 1902 W. Chestnut Ave. Santa Ana
Wednesday, 11/29 10-11am	*New Member Orientation Presentations in Farsi and Korean	**Community Presentation Open to the Public**	N/A	CalOptima
Wednesday, 11/29 10:30-11:30am	++OC Human Trafficking Task Force General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	N/A	Community Service Program 1221 E. Dyer Rd. Santa Ana

** CalOptima Hosted*

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda

Thursday, 11/30 1-2pm	*New Member Orientation Presentations in English and Spanish	**Community Presentation** **Open to the Public**	N/A	CalOptima