NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, FEBRUARY 1, 2018
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Lisa Bartlett, Alternate

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

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

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

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

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
   a. Behavioral Health Transition
   b. Children's Health Insurance Program
   c. Continuing Resolution
   d. State Budget Proposal
   e. Medi-Cal Rates
   f. Proposition 56 Revenue
   g. Medical Loss Ratio Audit
   h. California Children's Services/Whole-Child Model
   i. Health Homes Program

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 December 7, 2017 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the November 9, 2017 Meeting of the CalOptima Board of Directors' Provider Advisory Committee, the November 9, 2017 Meeting of the CalOptima Board of Directors' Member Advisory Committee, and the November 16, 2017 Meeting of the CalOptima Board of Directors' OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee

REPORTS

3. Consider Adoption of Resolution Approving Updated Human Resources Policies

4. Consider Authorizing Contracting with or Amending Contracts with Community Health Centers Associated with St. Joseph Health to Serve as the Primary Care Provider for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly

5. Consider Authorizing Contracting with or Amending Contracts with Community Based Physicians Associated with St. Joseph Health, Excluding St. Joseph Health-Affiliated Community Health Centers, for Primary Care Physicians Services for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly

6. Consider Authorizing Rate Methodology for Contracted Ambulatory Surgery Centers (ASCs) for Medi-Cal Services; Consider Ratifying Existing ASC Contracts and Authorizing Contracts with Additional ASCs Based on Proposed Methodology

7. Consider Authorizing Amendment to Contract with Liberty Dental Plan of California, Inc. for Dental Services Provided to OneCare and OneCare Connect Members

8. Consider Authorizing Contracts with Alternative Care Settings to Support Expansion and Growth of CalOptima Program of All-Inclusive Care for the Elderly

9. Consider Authorizing Amendment of Existing Contract with Verscend Technologies

10. Consider Making an Exception to CalOptima's Supplemental Compensation Policy by Ratifying Employee Overpayments Related to Bilingual Pay

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposal for Community Grants

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

13. Consider Vendor Selection and Contracting for State Legislative Advocacy Services

ADVISORY COMMITTEE UPDATES

14. Member Advisory Committee Update

15. Provider Advisory Committee Update

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

INFORMATION ITEMS

17. December 2017 and November 2017 Financial Summaries

18. Compliance Report

19. Federal and State Legislative Advocates Reports

20. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, March 1, 2018 at 2:00 p.m.

MEMORANDUM

DATE:	February 1, 2018
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee

Behavioral Health Transition
Effective January 1, CalOptima assumed responsibility for administering Medi-Cal behavioral health benefits for members. CalOptima's successful efforts to contract with hundreds of providers offering mental health and Applied Behavior Analysis services ensured that the vast majority of members were able to continue seeing their existing providers. Fewer than 300 members requested continuity of care arrangements. Under a continuity of care arrangement, a member may continue to see the same provider for up to a year if the provider agrees to accept the standard rate through a member-specific Letter of Agreement. Further, CalOptima has hired nearly all the necessary clinical and customer service staff needed to administer the behavioral health benefits and looks forward to the opportunity to better coordinate physical and mental health, which can improve outcomes for members.

Children's Health Insurance Program (CHIP)
On January 22, Congress reauthorized six years of funding for CHIP. This is good news for approximately 112,000 of our Medi-Cal members who are eligible because of CHIP, which provides coverage for children age 0–19 whose parents earn up to 266 percent of the federal poverty level. Prior to this decision, as part of the Affordable Care Act (ACA), California was required to maintain CHIP eligibility levels and enrollment through 2019 in what's known as a maintenance of effort provision. Therefore, the lapse in federal funding would not have caused our members to lose eligibility, but it could have caused budget concerns at the state level.

Continuing Resolution (CR)
The important reauthorization of CHIP was part of a larger CR that funds the federal government through February 8. The CR specifies that, in the short term, funding for Medicare and CHIP will continue without disruption. Regarding Medicaid, states already have sufficient funding through the second quarter. In the event of another government shutdown, the U.S. Department of Health & Human Services has a contingency plan that covers all three public health programs.

State Budget Proposal
On January 10, Gov. Brown released his proposed FY 2018–19 state budget, which starts on July 1, 2018. Given California's positive fiscal outlook, the budget includes a $6.2 billion surplus that the governor plans to put into reserves. Spending for Medi-Cal in FY 2018–19 will be relatively stable, with a total budget of $101.5 billion, which correlates to a flat statewide enrollment

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projection of 13.5 million beneficiaries. When releasing his budget proposal, Gov. Brown acknowledged that it does not account for the potential impact of federal actions on health care, such as the recent passage of the tax bill or future efforts affecting ACA. Hearings on the budget proposal will take place during the next few months, followed by the release of the May Revision, which will consider any federal changes to health care programs and an updated financial picture based on April tax returns and 2019 federal tax law.

Medi-Cal Rates

Alongside the state budgeting process, the Department of Health Care Services (DHCS) follows a routine rate-setting process for Medi-Cal. For FY 2018–19, we expect draft rates for both our Classic and Expansion populations by May. Historically, the state has been paying managed care plans more for Expansion members that gained coverage through the ACA even though their health needs and utilization of services are similar to the Classic population. More recently, the state has been gradually adjusting those rates downward, and CalOptima has been passing on the reduction to providers. We anticipate this will be the case for FY 2018–19, and we have been notifying health networks accordingly. Specific guidance is not yet available. However, Medi-Cal health plan financial leaders across the state expect the Expansion rate to be similar to the Classic rate for adult Temporary Assistance for Needy Families (TANF) members. To prepare for the next fiscal year, we have informed health networks that they may want to develop their budgets with this assumption in mind.

Proposition 56 Revenue

While a reduction to Expansion rates is expected for the upcoming fiscal year, Medi-Cal providers can anticipate retroactive supplemental payments for certain services rendered in this fiscal year. Due to the Proposition 56 tobacco tax approved by voters in 2016, California is collecting $2 more in taxes on each pack of cigarettes. Recently, DHCS provided CalOptima with an estimate of add-on capitation, which we will pay to providers based on specific procedure codes used by primary care physicians and psychiatrists. Tobacco tax dollars are also boosting benefits and reimbursement in Denti-Cal. Starting in 2018, the program restored services for adults that were previously eliminated and raised rates for dentists by 40 percent.

Medical Loss Ratio (MLR) Audit

In January, DHCS released final instructions and data templates for the MLR audit of Medi-Cal Expansion. Importantly, the regulator clarified that all capitation payments made by a contractor to delegated entities for Expansion members are attributable to services and considered allowed medical expenses. This is consistent with how CalOptima records medical expenses. The MLR corridor amounts were also announced: MLR less than 85 percent, contractor shall return the difference; MLR greater than 95 percent, DHCS shall make additional payments to the contractor; and MLR between 85 percent and 95 percent, no MLR adjustment will be made to/from the contractor. The data is to be reported for two periods: 18 months (January 1, 2014, through June 30, 2015) and 12 months (July 1, 2015, through June 30, 2016). Our response is due March 9. CalOptima has reserved an appropriate level in anticipation of potential recoupment from the state.

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California Children's Services (CCS)/Whole-Child Model (WCM)
CalOptima has begun the yearlong process of transitioning the CCS program from a Medi-Cal carve-out administered by the Orange County Health Care Agency to the fully integrated WCM, overseen by CalOptima. This affects more than 13,000 Orange County children, all of whom have significant medical conditions. Transparency in this effort is a priority, and CalOptima has already held meetings with health network leaders and the general stakeholder community. In fact, our January meeting featuring Jacey Cooper, DHCS assistant deputy director, drew more than 100 attendees. Further, six family-focused forums are planned for this month to engage parents with children in the CCS program. In the spring, CalOptima staff will ask your Board to consider actions necessary to effectuate this change, including CalOptima's proposed approach of using our existing delivery system to provide CCS services. To guide our efforts, we are launching a WCM Family Advisory Committee, and individuals can apply until February 28 using the forms here. Overall, CalOptima is committed to a smooth transition that provides children with CCS conditions continued access to familiar providers essential to their care.

Health Homes Program
The Centers for Medicare & Medicaid Services recently approved California's proposal to create health homes to improve care for Medi-Cal beneficiaries with chronic health conditions. DHCS' Health Homes Program will begin the first phase of implementation in July 2018, and Orange County is expected to participate beginning January 1, 2019. The Orange County Health Care Agency is leading this effort, and CalOptima will be a participating entity.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

December 7, 2017

A Regular Meeting of the CalOptima Board of Directors was held on December 7, 2017, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 2:00 p.m. Supervisor Bartlett led the Pledge of Allegiance.

ROLL CALL

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

Members Absent: Alexander Nguyen, M.D.

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

Chair Yost made the following announcement: Agenda Item 6, Consider Ratification and Amendment of Contract with Housecall Doctors Medical Group, was pulled from the agenda.

PRESENTATIONS/INTRODUCTIONS

Chief Executive Officer Michael Schrader introduced CalOptima member Jacque Ruddy, who won a $1,000 scholarship offered by CalOptima's Employee Activity Committee, and was selected as the winner of the Association of Community Affiliated Plans' (ACAP) national scholarship; a brief video produced by ACAP was presented. Ms. Ruddy expressed her appreciation for the high quality of care she received as a CalOptima member, and thanked the CalOptima Employee Activity Committee and the Board of Directors for their support as she works toward completing her Master of Social Work degree.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

Mr. Schrader provided a brief update on the status of the transition of the California Children's Services program from the Orange County Health Care Agency to CalOptima effective January 1, 2019, and the transition of Medi-Cal Behavioral Health Services to CalOptima effective January 1, 2018. Mr. Schrader noted that CalOptima continues to advocate for the reauthorization of the Children's Health Insurance Program (CHIP), which is currently in the U.S. Senate for consideration.

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PUBLIC COMMENTS

Brian Worthington, Byram Healthcare – Oral re: Agenda Item 15, Consider Authorizing Extension of Disposable Incontinence Supplies Contracts with Caremax RM Corporation, Schraders' Medical Supply, Inc., and Byram Healthcare Centers; Consider Authorizing Request for Proposal Process.

CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the November 2, 2017 Regular Meeting of the CalOptima Board of Directors
   b. Receive and File Minutes of the September 20, 2017 Regular Meeting of the CalOptima Board of Directors' Quality Assurance Committee, the September 21, 2017 Regular Meeting of the CalOptima Board of Directors' Finance and Audit Committee, the September 14, 2017 Joint Meeting of the CalOptima Board of Directors' Member and Provider Advisory Committees, the August 10, 2017 and October 12, 2017 Meetings of the CalOptima Board of Directors' Provider Advisory Committee, and the July 27, 2017 and October 26, 2017 Meetings of the CalOptima Board of Directors' OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee

3. Consider Approval of the Annual Investment Policy for Calendar Year 2018

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

5. Consider Approval of Updates to Policy for Acceptable Use of Company-Issued Mobile Phones

6. Consider Ratification and Amendment of Contract with Housecall Doctors Medical Group
This item was pulled from the agenda.

7. Consider Revision to the Fiscal Year 2017-18 Board of Directors' Quality Assurance Committee Meeting Schedule

Supervisor Bartlett pulled Consent Calendar Item 5 for discussion.

5. Consider Approval of Updates to Policy for Acceptable Use of Company-Issued Mobile Phones
Supervisor Bartlett suggested that staff evaluate whether allocating funds to allow employees to purchase a mobile phone for company use may provide cost savings for the organization. Len Rosignoli, Chief Information Officer, noted that staff is developing a policy related to employee use of personal mobile phones for work purposes, which will be presented to the Board for consideration at a future meeting.

Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors approved the proposed updates to policy GA.5005d, Acceptable Use of a Company-Issued Mobile Phone for Business Purposes as presented. (Motion carried 8-0-0; Director Nguyen absent)***

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

REPORTS

8. Consider Ratification of the Extension of the Contract with Liberty Dental Plan of California, Inc., for Dental Services Provided to OneCare and OneCare Connect Members for the 2018 Calendar Year

Director Khatibi directed staff to conduct an expedited procurement process for supplemental dental services for OneCare and OneCare Connect members, if needed, to ensure continuity of care.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors ratified the extension of the Liberty Dental Plan of California, Inc., contract for OneCare and OneCare Connect members for calendar year 2018 under the existing terms and conditions. (Motion carried 8-0-0; Director Nguyen absent)***

9. Consider Authorizing Contracting with or Amending Contracts with 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)

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

Michelle Laughlin, Executive Director, Network Operations, requested narrowing the recommended action to enter into contracts, or amend contracts with Community Based Physicians (CBPs), except those associated with St. Joseph Health System, to serve as primary care providers for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly, as part of implementation of said waiver. Staff will present recommendations regarding contracts with CBPs associated with St. Joseph Health System at a future Board meeting.

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors, subject to approval by the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) of Board-authorized waiver request, authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into contracts, or amend contracts with Community Based Physicians (CBPs), except those associated with St. Joseph Health System, to serve as primary care providers for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE), as part of implementation of said waiver. (Motion carried 5-0-0; Supervisors Bartlett and Do recused; Directors Nguyen and Schoeffel absent)***

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10. Consider Authorizing and Directing Execution of Amendments to the Agreement with the California Department of Health Care Services (DHCS) for the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute Amendment A04 to the PACE Agreement between DHCS and CalOptima regarding the extension of the contract termination date to December 31, 2018, and incorporation of revised language reflecting the Americans with Disabilities Act for section 508 compliance, previously approved at the August 3, 2017 Board meeting; and authorized and directed the Chairman of the Board to execute a future rate amendment to the DHCS PACE Agreement related to revised capitation rates for calendar year 2017. (Motion carried 8-0-0; Director Nguyen absent)***

11. Consider Authorizing and Directing Execution of Amendment(s) to CalOptima's Primary Agreement for the Medi-Cal Program with the California Department of Health Care Services (DHCS)

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute an Amendment to the Primary Agreement for the Medi-Cal program between DHCS and CalOptima related to rate changes and to incorporate language related to the Medicaid Mental Health Parity Rule, Transportation, and American Indian Health Services. (Motion carried 8-0-0; Director Nguyen absent)***

12. Consider Authorizing and Directing Execution of the 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 Director Berger, seconded and carried, the Board of Directors authorized and directed the Chairman of the Board of Directors to execute a new Three-Way Agreement between CalOptima, the California Department of Health Care Services and the Centers for Medicare & Medicaid Services for the Cal MediConnect Program that removes language pertaining to In-Home Supportive Services (IHSS) and incorporates other regulatory updates. (Motion carried 8-0-0; Director Nguyen absent)***

13. Consider Appointment to the CalOptima Board of Directors' Provider Advisory Committee

Ms. Laughlin presented the recommended action to appoint Mary R. Hale, Orange County Health Care Agency (OCHCA) Behavioral Health Director, as the OCHCA Representative on the Provider Advisory Committee, effective upon Board approval.

Director Sanchez recognized Alan Edwards, M.D., OCHCA Medical Director, for his years of service as the OCHCA Representative on the Provider Advisory Committee, and announced that Dr. Edwards recently passed away after a long illness. On behalf of the Board of Directors, Chair Yost extended condolences to the family of Dr. Edwards.

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Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors appointed Mary R. Hale, Orange County Health Care Agency Behavioral Health Director as the OCHCA liaison representative to the Board of Directors' Provider Advisory Committee. (Motion carried 8-0-0; Director Nguyen absent)***

14. Consider Adoption of Resolution Approving Revised CalOptima 2018 Compliance Plan and Authorizing the Chief Executive Officer to Approve Revised and Retired Office of Compliance Policies and Procedures

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors adopted Resolution No. 17-1207, Approving Revised CalOptima 2018 Compliance Plan, and authorized the Chief Executive Officer to approve revised and retired Office of Compliance Policies and Procedures. (Motion carried 8-0-0; Director Nguyen absent)***

15. Consider Authorizing Extension of Disposable Incontinence Supplies (DIS) Contracts with Caremax RM Corporation, Schraders' Medical Supply, Inc., and Byram Healthcare Centers; Consider Authorizing Request for Proposal Process

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to extend the existing disposable incontinence supplies (DIS) contracts expiring December 31, 2017, with Caremax RM Corporation, Schraders' Medical Supply, Inc., and Byram Healthcare Centers for a one-year period; and authorized the Chief Executive Officer to complete a Request for Proposal (RFP) process for DIS, and to select and contract with vendor(s) selected via the RFP process effective January 1, 2019. (Motion carried 8-0-0; Director Nguyen absent)***

16. Consider Authorizing Extension of Contract with American Logistics for Non-Medical Transportation Services

Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to amend CalOptima's contract with American Logistics for non-medical transportation for CalOptima Medi-Cal members to extend this agreement through December 31, 2018; all other terms and conditions will remain the same. (Motion carried 8-0-0; Director Nguyen absent)***

17. Consider Authorizing Extension of the Coordination and Provision of Behavioral Health Care Services Contract Between CalOptima and the County of Orange, Through its Division the Orange County Health Care Agency, that Expires December 31, 2017

Due to potential conflicts of interest, Director Schoeffel did not participate in this item and left the room during the discussion and vote. Director Sanchez did not participate in the discussion on this item due to his position of Director of the Orange County Health Care Agency, and left the room during the discussion and vote.

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Ms. Laughlin requested revising the recommended action, based on further discussions with the County's Contracting Department, to reflect extension of the agreement through December 31, 2020, with two one-year extension options.

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors authorized the Chief Executive Officer or his designee, with the assistance of legal counsel, to enter into an amendment to the OneCare and OneCare Connect Coordination and Provision of Behavioral Healthcare Services Contract between CalOptima and the County of Orange through its division, the Orange County Health Care Agency, to extend the agreement through December 31, 2020, with two one-year extension options, exercisable upon approval by the CalOptima Board and the County of Orange. (Motion carried 7-0-0; Directors Nguyen and Schoeffel absent)***

18. Consider Approval of Proposed New Behavioral Health Policies and Forms to Support the Administration of Behavioral Health (BH) Services for Medi-Cal Members Within CalOptima Internal Operations

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors approved CalOptima Policy GG:1548, Authorization for Applied Behavioral Analysis for Autism Spectrum Disorder, and approved CalOptima Policy GG:1549, Authorization for Psychological Testing for Mental Health Condition. (Motion carried 8-0-0; Director Nguyen absent)***

19. Consider Authorizing Amendment of the Data Center Collocation Facility Contract with the County of Orange

Due to potential conflicts of interest, Director Schoeffel did not participate in this item and left the room during the discussion and vote.

Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the existing contract with the County of Orange covering the use of the County of Orange Data Center Collocation facility to address updated pricing and to extend the term for an additional five years with two additional options to extend for one-year periods. (Motion carried 7-0-0; Directors Nguyen and Schoeffel absent)***

20. Consider Authorization of Extension of Existing Contract with Edelstein Gilbert Robson & Smith for State Legislative Advocacy Services

Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to extend the existing contract with state legislative advocate Edelstein Gilbert Robson & Smith for six months, through June 30, 2018. (Motion carried 8-0-0; Director Nguyen absent)***

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21. Consider Authorizing the Pursuit of Proposals with Qualifying Funding Partners to Secure Medi-Cal Funds Through the Voluntary Intergovernmental Transfer (IGT) Rate Range Program for Rate Year 2017-18 (IGT 8)

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors: 1) Authorized submission of a proposal to the California Department of Health Care Services (DHCS) to participate in the Voluntary Intergovernmental Transfer (IGT) Rate Range Program for Rate Year 2017-18 (IGT 8); 2) Authorized pursuit of IGT funding partnerships with the University of California-Irvine, the Children and Families Commission, the County of Orange, the City of Orange, and the City of Newport Beach to participate in the upcoming Voluntary IGT Rate Range Program for Rate Year 2017-18 (IGT 8), and; 3) Authorized the CalOptima Board Chair and/or Vice Chair to execute agreements with these entities and their designated providers as necessary to seek IGT 8 funds. (Motion carried 8-0-0; Director Nguyen absent)***

22. Consider Actions Related to CalOptima's Development Agreement with the City of Orange
Phil Tsunoda, Public Policy and Public Affairs Executive Director, presented the recommended actions to: 1) Receive and file the Property and Associated Development Rights Request for Information (RFI) results, dated April 21, 2017; 2) Authorize the Chief Executive Officer to complete a Request for Proposal process to select a real estate development consultant to assist CalOptima in extending the current Development Agreement with the City of Orange, which covers an office tower of up to 10 stories and a 1,528 space parking structure; developing a plan for moving forward with a parking structure; and conducting analysis and making recommendations on permissible options for further development of the site (e.g., Mixed-Use, etc.), along with potential costs and funding mechanisms that would be associated with the exercise of each option.

Supervisor Bartlett commented on the homelessness issues in the county and the nexus between health care and housing, and suggested seeking amendment of CalOptima's current development agreement with the City of Orange to change it from commercial office space and parking to affordable, permanent supportive housing with wraparound services, a parking structure to be used by the residents and CalOptima staff, and to issue a Request for Proposal for consultant services to evaluate a revised development agreement allowing for other potential uses including urban mixed-use that would include affordable and transitional housing.

Chief Counsel Gary Crockett noted that CalOptima's enabling statute, California Welfare and Institutions Code section 14087.54, includes provisions limiting the use of "any payment or reserve from the Medi-Cal program" to the administration of the Medi-Cal program itself. Consequently, alternative funding (i.e., from a source other than CalOptima) would be an essential element of any recommendation to use the development rights for some purpose not specifically related to CalOptima's administration obligations under the Medi-Cal program.

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

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Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors: 1) Received and filed the Property and Associated Development Rights Request for Information (RFI) results dated April 21, 2017, that relate to property covered by CalOptima's existing development agreement at the 505 City Parkway West project site; 2) Authorized the Chief Executive Officer to: a) Contact the City of Orange (City) to explore: (i) Extending CalOptima's existing development agreement for as long as possible (e.g., through 2026), and (ii) Broadening CalOptima's rights under the development agreement from commercial/office to include urban mixed use, including transitional housing; b) After confirming that the City is amenable to the proposed changes: (i) Initiate an RFI process on development options for the site assuming the use of no Medi-Cal dollars and including a parking structure; and (ii) Seek assistance from the County of Orange Real Estate (Development Services) Department, as appropriate. (Motion carried 8-0-0; Director Nguyen absent)***

23. Consider Approving Palliative Care Policy and Procedure (P&P) and Authorizing Execution of Agreement with the Department of Health Care Services to Fund the P&P's Implementation

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors approved CalOptima Policy GG.1550, Palliative Care Services, and authorized and directed the Chairman of the CalOptima Board of Directors to execute a stand-alone agreement with the Department of Health Care Services to fund implementation of the palliative care policy and procedure. (Motion carried 8-0-0; Director Nguyen absent)***

ADVISORY COMMITTEE UPDATES

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

Patty Mouton, OCC MAC Vice Chair, reported on the activities at the October 26, 2017 meeting, including receiving an update on the challenges and best practices of Physician Orders for Life-Sustaining Treatment (POLST) in Orange County, and efforts to improve older adult health. At the OCC MAC meeting held on November 16, 2017, the Committee received an update on Whole Person Care and the Community Referral Network, and the Ombudsman Service Program.

25. Member Advisory Committee (MAC) Update

MAC Chair Sally Molnar reported on the informational updates received at the meeting held on November 9, 2017, including: Applied Behavioral Analysis provider accessibility and availability upon the transition of behavioral health services to CalOptima effective January 1, 2018; 2016 Medi-Cal Healthcare Effectiveness Data and Information Set (HEDIS) results; Consumer Assessment of Healthcare Providers and Systems (CAHPS) member experience findings; and palliative care services for Medi-Cal members.

26. Provider Advisory Committee (PAC) Update

Teri Miranti, PAC Chair, provided an overview of the activities at the November 9, 2017 meeting, including updates on the transition of behavioral health services to CalOptima, PACE membership, the status of the Children's Health Insurance Program, palliative care, and a presentation by MOMS

of Orange County on maternal mood and anxiety disorders. PAC members also reviewed the first quarter progress of the 2017-18 Goals and Objectives.

INFORMATION ITEMS

The following Information Items were accepted as presented:
27. October 2017 Financial Summary
28. Compliance Report
29. Federal and State Legislative Advocates Reports
30. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS

Board members commented on the homelessness issue in the county and the potential role of CalOptima, recent mergers in the health care industry, and extended their wishes for a safe and happy holiday.

ADJOURNMENT

Hearing no further business, Chair Yost adjourned the meeting at 4:06 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: February 1, 2018

MINUTES

SPECIAL MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

December 7, 2017

A Special Meeting of the CalOptima Board of Directors was held on December 7, 2017, at CalOptima, 505 City Parkway West, Orange, California. Chair Paul Yost, M.D., called the meeting to order at 4:08 p.m.

ROLL CALL

Members Present:	Paul Yost, M.D., Chair; Lee Penrose, Vice Chair; Supervisor Lisa Bartlett, Ria Berger, Ron DiLuigi, Supervisor Andrew Do, Richard Sanchez (non-voting)
Members Absent:	Alexander Nguyen, M.D., Scott Schoeffel, Dr. Nikan Khatibi
Others Present:	Michael Schrader, Chief Executive Officer; Gary Crockett, Chief Counsel; Richard Helmer, M.D., Chief Medical Officer; Ladan Khamseh, Chief Operating Officer; Suzanne Turf, Clerk of the Board

PUBLIC COMMENTS

There were no requests for public comment.

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 4:09 p.m. pursuant to Government Code section 54956.9, subdivision (d)(2), CONFERENCE WITH LEGAL COUNSEL – ANTICIPATED LITIGATION: One case.

The Board reconvened to open session at 5:05 p.m. with no reportable actions taken.

ADJOURNMENT

Hearing no further business, the meeting adjourned at 5:05 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

Approved: February 1, 2018

Back to Agenda

MINUTES

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

November 9, 2017

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, November 9, 2017, at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Miranti, PAC Chair, called the meeting to order at 8:06 a.m., and Member Pimentel led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Teri Miranti, Chair; Anjan Batra, M.D.; Donald Bruhns; Theodore Caliendo, M.D.; Steve Flood; Jena Jensen; Pamela Kahn, R.N.; Craig G. Myers; John Nishimoto, O.D; George Orras, Ph.D., FAAP; Mary Pham, Pharm.D, CHC; Pamela Pimentel, R.N.; Jacob Sweidan, M.D.
Members Absent:	Suzanne Richards, MBA, FACHE, Vice Chair
Others Present:	Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Richard Bock, M.D., Deputy Chief Medical Officer; Gary Crockett, Chief Counsel; Greg Hamblin, Chief Financial Officer; Michelle Laughlin, Executive Director, Network Operations; Phil Tsunoda, Executive Director, Public Policy and Public Affairs; Tracy Hitzeman, Executive Director, Clinical Operations; Cheryl Simmons, Staff to the Provider Advisory Committee; Melissa Tober, Orange County Health Care Agency; Roseann Peters, Lestonnac Free Clinic

MINUTES

Approve the Minutes of the October 12, 2017 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Pimentel, seconded and carried, the Committee approved the minutes of the October 12, 2017 meeting. (Motion carried 13-0-0; Vice Chair Richards absent)***

PUBLIC COMMENTS

No requests for public comment were received.

Back to Agenda

REPORTS

A. **Consider Recommendation of Agency-Appointed Representative from Orange County Health Care Agency (OCHCA).**

Member Alan Edwards, M.D., notified CalOptima of his resignation from the PAC due to his retirement from the OCHCA effective immediately. The OCHCA has named Mary R. Hale, Director, Behavioral Health as the representative for the OCHCA's standing seat. The recommendation will be presented to the Board of Directors for consideration at the December 7, 2017 meeting.

Action: ***On motion of Member Myers, seconded and carried, the Committee recommended Board of Directors' approval of the OCHCA recommendation of Mary R. Hale to replace Dr. Alan Edwards as the OCHCA Representative on the PAC. Motion carried 13-0-0; (Vice Chair Richards absent).***

PAC Chair Miranti reordered the agenda to hear Agenda Item VII.A, Community Referral Network Presentation before continuing with the CEO and Management Reports.

PRESENTATION

Community Referral Network

Melissa Tober, Manager of Strategic Projects at the OCHCA, provided an update on the Whole Person Care Pilot (WPC) that went into effect on July 1, 2017, Ms. Roseann Peters, Program Manager at the Lestonnac Free Clinic, presented information on the new Community Referral Network. This Community Referral Network is funded by various foundations located in Orange County as well as by the WPC program. The mission of the Community Referral Network is to bridge service gaps, create a stronger network of services, and achieve a healthy, empowered community. This network will be used to increase awareness of underutilized services that are available to underserved populations.

CEO AND MANAGEMENT REPORTS

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, discussed three top PACE initiatives that combine giving PACE participants the choice of keeping their PCP or enrolling with a community-based physician for services at CalOptima's PACE Center clinic, utilizing a network of 15 satellite sites located throughout the Orange County area, and reviewing plans to coordinate an expansion of the service area into South Orange County, which would allow qualifying low-income seniors who live in that part of the county to enroll in the PACE program.

Chief Medical Officer Update

Richard Bock, M.D., Deputy Chief Medical Officer, announced that DHCS has awarded CalOptima the highest quality award in California among the public plans. Dr. Bock noted that October was National Pharmacy Month, and he thanked Member Pham for inviting him to the Orange County Pharmacy Association's event and acknowledged the excellent work being done

in county by pharmacists, especially with the challenges being faced due to the high cost of medications. Dr. Bock also discussed the Pay for Value program (P4V) and noted that the first P4V checks would be issued soon. Dr. Bock also briefly discussed the opioid epidemic, and the PAC requested in-depth update on the on-going opioid epidemic at the December PAC meeting.

Chief Financial Officer Update

Michael Schrader introduced Greg Hamblin as CalOptima's new Chief Financial Officer. Mr. Hamblin presented the September 2017 financial report, and summarized CalOptima's financial performance and current reserve levels. Mr. Hamblin also reviewed the Health Network enrollment figures for September 2017.

Network Operation Update

Michelle Laughlin, Executive Director, Network Operations, provided an update on the Magellan transition. Ms. Laughlin noted that as of November 8, 2017, 85% of mental health providers had been contracted, and 80% of the Applied Behavioral Analysis (ABA) providers had returned signed contracts. She also noted that CalOptima will offer continuity of care for each to member whose current provider does not contract with CalOptima before the January 1, 2018 transition.

Federal and State Budget Update

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 has expired. The U.S. House of Representatives approved a bill that extends funding for five years and creates a phased reduction in federal funding from the current rate of 88%federal/12%state to 65% federal/35% state across the five-year period. The bill is now in the Senate for consideration.

INFORMATION ITEMS

Palliative Care Presentation

Tracy Hitzeman, Executive Director, Clinical Operations, provided an update on Palliative Care. Ms. Hitzeman discussed how the Palliative Care program began with Senate Bill 1004 in 2014, which required the Department of Health Care Services (DHCS) to establish standards and provide technical assistance to ensure delivery of palliative care services by managed health care plans. Ms. Hitzeman reviewed the DHCS established goals for palliative care and the targeted population. She noted that health networks would be responsible for all SB 1004 palliative care services for their assigned members effective January 1, 2018. She also noted that CalOptima does not plan to prescribe delivery requirements other than as required by the legislation, the All Plan Letter, and outlined in CalOptima's policies and procedures.

Women's Mental Health Issues

Pamela Pimentel, PAC member representing the Allied Health, and Chief Executive Officer, MOMS of Orange County, presented on Maternal Mood and Anxiety Disorders. Ms. Pimentel noted that in 2017, the Centers for Disease Control (CDC) estimated that more than 20% of all births are negatively impacted by maternal depression and anxiety. She also discussed the

current screenings and treatments options that were available to all women (including CalOptima members) in Orange County.

PAC Member Updates

Chair Miranti reviewed the first quarter progress on the PAC Goals and Objectives for 2017-18 and asked the members to submit any changes to the Staff to the PAC. Chair Miranti reminded the PAC members that the next meeting is scheduled for December 14, 2017.

ADJOURNMENT

There being no further business before the Committee, Chair Miranti adjourned the meeting at 10:00 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: December 14, 2017

Back to Agenda

MINUTES

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

November 9, 2017

A Regular Meeting of the CalOptima Board of Directors' Member Advisory Committee (MAC) was held on November 9, 2017, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Sally Molnar called the meeting to order at 2:36 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Sally Molnar, Chair; Suzanne Butler, Sandy Finestone, Connie Gonzalez, Donna Grubaugh, Patty Mouton, Jaime Muñoz, Ilia Rolon, Christina Sepulveda, Christine Tolbert

Members Absent: Carlos Robles, Sr. Mary Therese Sweeney, Velma Shivers, Mallory Vega, Lisa Workman

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Dr. Richard Bock, Chief Medical Officer; Phil Tsunoda, Executive Director, Public Affairs; Candice Gomez, Executive Director, Program Implementation; Donald Sharps, MD, Medical Director; Michelle Laughlin, Executive Director, Network Operations; Sesha Mudunuri, Executive Director, Operations; Tracy Hitzeman, Executive Director, Clinical Operations; Belinda Abeyta, Director, Customer Service;

Chair Molnar introduced new MAC member, Ilia Rolon, Family Support representative.

MINUTES

Approve the Minutes of the September 14, 2017, Regular Meeting of the CalOptima Board of Directors' Joint Member Advisory Committee and Provider Advisory Committee (PAC)

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

Approve the Minutes of the September 14, 2017 Special Meeting of the CalOptima Board of Directors' Member Advisory Committee

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

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PUBLIC COMMENT

There were no requests for public comment.

Chair Molnar reordered the agenda to hear item VII.C. Accessing and Monitoring Availability of Applied Behavioral Analysis (ABA) Providers.

Accessing and Monitoring Availability of Applied Behavioral Analysis Providers

Donald Sharps, M.D., Medical Director, Behavioral Health, discussed CalOptima's efforts to enhance Applied Behavioral Analysis (ABA) provider accessibility and availability upon the transition of behavioral health services to CalOptima, effective January 1, 2018. To address the access issue that began in January of this year with Magellan, CalOptima will determine provider availability by implementing a system that sends a blast email to providers to inquire about appointment availability. Additional information on new member cases will include age, special needs and preferred hours. From the responding providers, CalOptima will choose providers based on quality and claims data. CalOptima will also address the increased ABA service requests during the after-school hours of 3:00 p.m. to 5:00 p.m., which is a concern for all medical providers. Michelle Laughlin, Network Operations Executive Director, added that to date, CalOptima has approximately 85% of members covered for ABA providers and 44 of 72 contracts for the ABA vendors.

PRESENTATION

Community Referral Network and Whole Person Care Overview

Melissa Tober, Orange County Health Care Agency, provided an overview on Whole Person Care (WPC), which is a coordinated effort by physical, behavioral health and social services to improve health and well-being of homeless Medi-Cal beneficiaries. Ms. Tober explained that several collaborative partners in Orange County provide services to the target populations that include homeless persons and homeless persons living with a serious mental illness (SMI). In addition, WPC's services to the homeless and SMI populations include resources to seek out and secure housing opportunities, housing sustainability services, such as peer support, and outreach and engagement staff that work with WPC providers to link members to behavioral health services.

Roseann Peters, Lestonnac Free Clinic, presented on the Community Referral Network (CRN), which is a web-based referral system designed to facilitate collaborative relationships with community clinics, hospitals, and social service agencies to provide holistic care for their clients. CRN facilitates referrals, allowing organizations to quickly and accurately refer clients for a variety of services including medical, dental, and more than 75 types of social services. Ms. Peters explained that CRN creates awareness of underutilized services that are available to underserved populations.

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CHIEF EXECUTIVE OFFICER AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer Update

Michael Schrader, Chief Executive Officer, reported on CalOptima's efforts to expand the Program of All-Inclusive Care for the Elderly (PACE) into South Orange County. Mr. Schrader explained that CalOptima is awaiting approval from the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) to expand the service area. Approval of an expanded service area is contingent upon strategies being in place to provide the PACE model of care countywide.

Chief Medical Officer Update

Dr. Richard Bock, Deputy Chief Medical Officer, reported that CalOptima will begin administering the Medi-Cal behavioral health benefit and ABA therapies effective January 1, 2018.

Dr. Bock reported that the Pharmacy department is working on the new CMS regulations regarding medication therapy management and the DHCS requirements for drug utilization review. CalOptima is also continuing the opioid reduction initiatives in conjunction with the Orange County Health Care Agency, to provide treatment to those who are already addicted to opioids through medication assisted treatment.

Dr. Bock reported that CalOptima received commendable accreditation from the National Committee for Quality Assurance (NCQA) and was rated the top Medi-Cal managed care plan in California.

Dr. Bock reported that CalOptima is finalizing the pay-per-value distributions to qualifying health networks and physicians within the CalOptima Community Network to help incentivize and reward them for their performance in quality improvement.

Chief Operating Officer (COO) Update

Ladan Khamseh, COO, reported that CalOptima mailed approximately 1,300 letters to members with Medicare Part B as part of the annual Qualified Medicare Beneficiary (QMB) program. In collaboration with the Social Security Administration and the Social Services Agency, CalOptima outreaches to members with Medicare Part B to provide information on how they could potentially qualify for Medicare Part A.

Network Operations Update

Michelle Laughlin, Executive Director, Network Operations, reported that CalOptima is currently at 85% coverage of behavioral health providers for the transition. She added that most members that use ABA services will be able to retain their provider. In addition, CalOptima is currently working on the continuity of care letters of agreement, informing members that they can remain with the same provider if their existing provider will accept CalOptima's rates.

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Federal and State Legislative Update

Phil Tsunoda, Executive Director, Public Affairs, reported that that the House of Representatives voted to reauthorize the Children's Health Insurance Program (CHIP) for an additional five years. CalOptima currently has approximately 109,000 children that are members through the CHIP program. Funding for the CHIP program expired at the end of September and Congress has been working to reauthorize funding for the program. The bill is now in the U.S. Senate for consideration. Mr. Schrader sent a letter of support from CalOptima to California's two US senators urging their support to reauthorize funding for the CHIP program. CalOptima asked for MAC's support to reach out to California's senators to ensure Senate passage.

INFORMATION ITEMS

MAC Member Updates

Chair Molnar reported that based on MAC's input at the Special MAC meeting on September 14, 2017, the Whole Child Model Family Advisory Committee (WCM FAC) will include two (2) to four (4) community representatives and seven (7) to nine (9) family members.

Chair Molnar asked MAC members if they were interested in convening another Joint MAC/PAC meeting in early 2018. Upon MAC members concurrence, Chair Molnar asked for volunteers to serve on an ad hoc to develop the agenda. Chair Molnar and Members Patty Mouton and Christine Tolbert agreed to serve.

Chair Molnar reported that MAC is on track with the FY 2017-18 MAC Goals & Objectives, which were established to align with the CalOptima Strategic Plan.

CalOptima Cultural and Linguistics Services Overview

Carlos Soto, Manager, Cultural and Linguistics Services (C&L), provided an overview of CalOptima's C&L department. Mr. Soto reported on C&L goals and objectives for FY 2017-2018.

Healthcare Effectiveness Data and Information Set (HEDIS) 2017 Results Update

Kelly Rex-Kimmet, Director, Quality Analytics, provided an overview of CalOptima's performance based on 2016 HEDIS results across all lines of business. In general, CalOptima showed improvement in quality with declining scores in member experience.
DHCS requires CalOptima to maintain a minimum performance level on several clinical measures and CalOptima has met or exceeded all of them. This was the baseline year for OneCare Connect. Ms. Rex-Kimmet reported that next steps include implementing strategies on low performing areas. She added that member and provider incentive pilot projects focused on women's health screenings will continue through the end of the year. CalOptima's goal is to maintain or exceed the current NCQA commendable accreditation rating and top Medi-Cal managed health care plan in California.

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Palliative Care Update

Tracy Hitzeman, Executive Director, Clinical Operations, reported that per Senate Bill 1004, DHCS is required to establish standards and provide technical assistance to ensure delivery of palliative care services by managed care plans, effective January 1, 2018. Ms. Hitzeman explained that palliative care is defined as patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. In addition, palliative care addresses physical, intellectual, emotional, social and spiritual needs and facilitates patient autonomy, access to information and choice. Health networks will be responsible for all SB 1004 palliative care services for their assigned members. CalOptima anticipates additional guidance from DHCS mid-November to include reporting requirements and quality measures. In addition, CalOptima is awaiting approval on its policies and procedures.

ADJOURNMENT

Chair Molnar announced that the next MAC meeting is Thursday, January 11, 2018 at 2:30 p.m.

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

/s/ Eva Garcia
Eva Garcia
Program Assistant

Approved: January 11, 2018

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MINUTES

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

November 16, 2017

The Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee (OCC MAC) was held on November 16, 2017, at CalOptima, 505 City Parkway West, Orange, California.

CALL TO ORDER

Chair Gio Corzo called the meeting to order at 3:10 p.m., and led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present: Gio Corzo, Chair; Christine Chow, Josefina Diaz, Sandy Finestone, Sara Lee, Richard Santana, Kristin Trom, Jyothi Atluri (non-voting), Amber Nowak (non-voting), Erin Ulibarri (non-voting)

Members Absent: Ted Chigaros, John Dupies, Patty Mouton, Vice Chair; George Crits (non-voting)

Others Present: Michael Schrader, Chief Executive Officer; Ladan Khamseh, Chief Operating Officer; Dr. Bock, Chief Medical Officer; Phil Tsunoda, Executive Director, Public Affairs; Candice Gomez, Executive Director, Program Implementation; Dr. Fonda, Medical Director; Sesha Mudunuri, Executive Director, Operations Customer Service; Albert Cardenas, Director, Customer Service, Medicare; Belinda Abeyta, Director, Customer Service, Medi-Cal; Becki Melli, Customer Service; Eva Garcia, Program Assistant

INTRODUCTION

Chair Gio Corzo introduced new members of OneCare Connect Member Advisory Committee (OCC MAC) Kristin Trom, OneCare Connect member representative; Jyothi Atluri, Social Services Agency representative and Amber Nowak, In-Home Supportive Services Public Authority representative.

MINUTES

Approve the Minutes of the October 26, 2017 Regular Meeting of the CalOptima Board of Directors' OneCare Connect Member Advisory Committee

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

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PUBLIC COMMENT

There were no requests for public comment.

INFORMATION ITEMS

Orange County Whole Person Care Overview

Melissa Tolbert, Orange County Health Care Agency, provided an overview on Whole Person Care (WPC), which is a coordinated effort by physical, behavioral health and social services to improve health and well-being of homeless Medi-Cal beneficiaries. Ms. Tober explained that several collaborative partners in Orange County provide services to the target populations that include persons who are homeless and persons who are homeless and living with a serious mental illness (SMI). WPC objectives include the following: 1) to reduce inappropriate or unnecessary emergency room visits/inpatient utilization; 2) to meet social, medical and behavioral needs in real-time; 3) to increase readiness for coordinated entry process; and 4) to improve/increase success in housing placement. In addition, WPC's services to the homeless and SMI populations include resources to seek out and secure housing opportunities, housing sustainability services, such as peer support, and outreach and engagement staff that work with WPC providers to link members to behavioral health services.

Community Referral Network Overview

Roseann Peters, Lestonnac Free Clinic, presented on the Community Referral Network (CRN), which is a web-based referral system designed to facilitate collaborative relationships with community clinics, hospitals, and social service agencies to provide holistic care for their clients. CRN facilitates referrals, allowing organizations to quickly and accurately refer clients for a variety of services including medical, dental, and more than 75 types of social services. Ms. Peters explained that CRN creates awareness of underutilized services that are available to underserved populations.

CEO AND MANAGEMENT TEAM DISCUSSION

Chief Executive Officer (CEO) Update

Michael Schrader, Chief Executive Officer, reported on CalOptima's efforts to expand the Program of All-Inclusive Care for the Elderly (PACE) into south county. Mr. Schrader explained that CalOptima is awaiting approval from the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) to expand the service area. 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. CalOptima is actively working on meeting these objectives. PACE serves frail seniors who qualify for placement in a skilled nursing facility (SNF), but prefer to live at home with sufficient support. PACE combines the services of a Community Based Adult Services (CBAS) program with those of a primary care clinic. Mr. Schrader reported that PACE's enrollment is growing at approximately five (5) net members per month.

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Chief Medical Officer (CMO) Update

Dr. Richard Bock, Chief Medical Officer, provided an update on the transition of the administration of Medi-Cal covered behavioral health benefits into CalOptima internal operations, effective January 1, 2018. He noted that the development of the provider network is well underway with CalOptima outreaching to providers who collectively deliver 90 percent of the services.

Dr. Bock reported that the Pharmacy department is working on the new CMS regulations regarding medication therapy management and the DHCS requirements for drug utilization review. CalOptima is continuing the opioid reduction initiatives. In addition, CalOptima is working with the Orange County Health Care Agency to get treatment for those who are already addicted to opioids through medication assisted treatment.

Dr. Bock reported that CalOptima received commendable accreditation from the National Committee for Quality Assurance (NCQA) and was rated the top Medi-Cal managed care plan in California.

Federal and Legislative Update

Philip Tsunoda, Executive Director, Government Affairs, reported that the House of Representatives voted to reauthorize the Children's Health Insurance Program (CHIP) for an additional five years. The CHIP program provides Medi-Cal coverage for children ages 0-19 years whose parents' incomes are up to 266% of the federal poverty level. CalOptima currently has approximately 109,000 children that are members through the CHIP program. Funding for the CHIP program expired at the end of September and congress has been working to reauthorize funding for the program. The bill is now in the US senate. Mr. Schrader sent a letter of support from CalOptima to California's two US senators urging their support to reauthorize funding for the CHIP program. CalOptima asked for OCC MAC's support to reach out to California's senators to ensure Senate passage.

INFORMATION ITEMS

Quarterly Ombudsman Update

Member Sara Lee presented the Quarterly Ombudsman update, reporting that the Ombudsman Service Program (OSP) at Legal Aid Society of Orange County continues to assist members with OneCare Connect (OCC) enrollment issues and potential OCC disenrollment. Member Lee explained that assistance given by OSP, includes the following: 1) assisting members to avoid a share of cost (SOC) and helping them maintain OCC coverage by placing them in a working disabled program; 2) educating members about the benefits of OCC, such as the role of the Personal Care Coordinator and supplemental dental benefits; and 3) advising members about the Limited Income Newly Eligible Transition Program – Humana (LINET) when they are disenrolled from OCC. Member Lee reported that the 60-day deeming process, effective September 1, 2017, helps members maintain enrollment allowing the OSP advocate to resolve the member's eligibility issues. In response to Member Lee's question about conflicting

Medicare and Medi-Cal appeal's decisions, Albert Cardenas, Director of Medicare Customer Service, responded that CalOptima follows the Medi-Cal regulations for Medicaid-based services and the Medicare regulations for Medicare-based services. In addition, per new law effective July 1, 2017, the member must exhaust the internal health plan appeal process before requesting a State Hearing for Medicaid based services.

ADJOURNMENT

Chair Corzo announced that the next OCC MAC Meeting is Thursday, December 14, 2017. In 2018, OCC MAC will begin meeting bimonthly with the first meeting on February 22, 2018.

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

/s/ Eva Garcia
Eva Garcia
Program Assistant

Approved: December 14, 2017

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
3. 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
Adopt Resolution Approving CalOptima's Updated Human Resources Policies: GA.8044 Telework Program, and GA.8058 Salary Schedule.

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

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

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

	Policy No./Name	Summary of Changes	Reason for Change
1.	GA.8044 Telework Program	• Minor language and formatting changes • Procedural changes to reflect newly implemented processes and procedures • Add clarifications on eligibility, expectations and requirements • Add an agreement to address employees who occasionally work off-site • Revise definitions consistent with HR policies	-Annual review with minor updates and formatting changes - Clarify eligibility, expectations and requirements - Establish guidelines and expectations for employees who are not teleworkers but work occasionally off-site -Need to update new terms, definitions and/or revised definitions

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	Policy No./Name	Summary of Changes	Reason for Change
2.	GA.8058 Salary Schedule	• This policy focuses solely on CalOptima's Salary Schedule and requirements under CalPERS regulations. • Attachment 1 – Salary Schedule has been revised in order to reflect recent changes, including the addition of new positions. 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. (2 positions)

Staffing Adjustments
Staff recommends upgrading an existing HR Compensation Specialist to Compensation Specialist Senior position and upgrading of an existing Financial Analyst position to a Senior Manager Financial Analysis for the purposes of recruitment and retention needs. These upgrades are technically, new positions; management has no current plans to fill the two positions being vacated.

Fiscal Impact
Staff estimates the fiscal impact for the upgraded positions, HR Compensation Specialist Sr and Sr Manager Financial Analysis, is $50,758 annually or $21,149 for the period of February 1, 2018, through June 30, 2018. Funding for the upgraded positions is from unspent budgeted funds for salaries and benefits approved in the CalOptima Fiscal Year 2017-18 Operating Budget.

Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 18-0201, Approve Updated Human Resources Policies
2. Revised CalOptima Policies:
   a. GA.8044 Telework Program (redlined and clean copies) with revised Attachment A and new Attachment B
   b. GA.8058 Salary Schedule (redlined and clean copies) with revised Attachment A
3. Summary of Changes to Salary Schedule

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

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RESOLUTION NO. 18-0201

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.8044 Telework 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 1st day of February, 2018.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

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

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Policy #: GA.8044
Title: **Telework Program**
Department: Human Resources
Section: Not Applicable
CEO Approval: Michael Schrader

Effective Date: 03/01/12
Last Review Date: 02/01/18
Last Revised Date: ~~12/03/15~~ ~~12/03/15~~ 02/01/18

~~*Board Approved Policy*~~

I. PURPOSE

~~To develop~~ This policy describes guidelines for a work structure that: 1) permits an employee to perform their work ~~full-time~~ from a Remote Work Location, unless business needs require otherwise; 2) increases quality of life for employees; 3) reduces operation and overhead costs; 4) supports recruitment and retention of skilled employees; and 5) promotes a ~~mentality~~culture of managing by results.

~~II. DEFINITIONS~~

~~Term~~	~~Definition~~
~~9/80 Work Schedule~~	~~The 9/80 alternate work schedule consists of eight (8) work days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.~~
~~Central Worksite~~	~~CalOptima's primary physical location of business.~~

~~Term~~	~~Definition~~
~~Protected Health Information (PHI)~~	~~Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.~~ ~~This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to:~~ ~~1. The past, present, or future physical or mental health or condition of a Member;~~ ~~2.~~1. ~~The provision of health care to a Member; or~~ ~~3.~~1. ~~Past, present, or future Payment for the provision of health care to a Member.~~
~~Remote Work Location or Remote Workplace~~	~~The Teleworker's residence.~~
~~Teleworker~~	~~An employee who meets CalOptima's Teleworker eligibility criteria and is approved to work full-time from a Remote Work Location, unless business needs require otherwise.~~

~~III.~~II. POLICY

A. Telework is a workplace arrangement in which an eligible ~~employees work~~employee works his or her entire work schedule away from the Central Worksite at a Remote Work Location, unless business needs require otherwise. ~~A~~

1. A partial teleworking arrangement is not allowed. A Teleworker may not elect to routinely work a portion of his or her scheduled days at the Central Worksite and the remainder from the Remote Work Location.

~~A.~~B. Telework is not a universal employee benefit or entitlement, but rather, an alternative method of meeting the work needs of the organization through a flexible work structure~~.~~. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the telework program based on business needs.

C. Telework is voluntary unless specifically stated as a condition of employment and may be terminated at any time by either the Teleworker or CalOptima, with or without cause.

D. ~~An~~The total number of employees in telework positions at any point in time may equal but not exceed the maximum number telework positions as directed by the CalOptima Board of Directors.

E. Telework positions may be identified as follows:

1. Human Resources (HR) may designate a position as a telework position if it is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework.

2. HR may reserve a number of telework positions for use in granting reasonable work accommodations, for employees transitioning back to work after a qualifying leave of absence, or for other exigencies, which would require the approval of the Executive Director of HR.

3. A department leader may designate one (1) or more positions as suitable for teleworking if the duties and responsibilities of the position can be performed remotely at the same or higher level of productivity and quality compared to working at the Central Worksite.

F. Remote Work exception to the Telework policy: When special circumstances require it, an employee's manager has the discretion to allow an ~~exempt~~ employee~~, who is required to be present at his or her home for an unusual and reasonable purpose~~, to work from ~~home~~ a Remote Work Location on an occasional basis.

1. Occasional is defined as rare, infrequent and not regularly scheduled for brief periods (usually a day or part of a day); with no specific or implied expectation from an employee that he or she will be allowed to work from ~~home.~~a Remote Work Location routinely. This is not considered or counted as a ~~teleworking~~telework position~~; however, all~~.

~~B.~~2. All employees who occasionally work from ~~home~~a Remote Work Location must abide by the same requirements as employees who telework, including, but not limited to, the applicable conditions set forth in this policy concerning terms of employment, work schedule and accessibility, dependent care, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI, establishing a Remote Work Location, security of CalOptima assets, inspection, etc. ~~Furthermore, for departments which permit employees to work from home, to be eligible to work occasionally from home, the employee must execute the Telework Agreement, along with the Teleworker Home Inspection Checklists, and submit the signed documents to the Human Resources Department.~~

3. Furthermore, for departments which permit employees to work from a Remote Work Location, to be eligible to work occasionally from a Remote Work Location, the employee must execute the CalOptima Occasional Off-site Work Agreement and submit the signed document to the Human Resources Department prior to being permitted to work from a Remote Work Location.

~~C.~~A. ~~Telework is voluntary unless specifically stated as a condition of employment and may be terminated at any time by either the Teleworker or CalOptima, with or without cause.~~

~~D. Other than those additional duties and obligations expressly imposed on a Teleworker under this policy, the duties, obligations, responsibilities and conditions of a Teleworker's employment with CalOptima shall remain unchanged. In addition, a Teleworker's salary and benefits shall remain unchanged.~~

~~E.~~G. Terms of Employment

1. ~~A Teleworker's~~The conditions of employment, such as employee salary, benefits and employer-sponsored insurance coverage, will remain the same for an employee designated as a Teleworker as for non-telework ~~employees~~employee.

2. CalOptima's policies, rules and practices are applicable to a Teleworker's Remote Work Location, including, but not limited to, confidentiality, internal communications, communications with the public, public records requests, employee rights and responsibilities, facilities and equipment management, financial management, information resource management, purchasing of property and services, unlawful harassment, drug and alcohol, and safety. ~~Failure to follow CalOptima's policies, rules and procedures may result in termination of the telework arrangement and/or disciplinary action.~~

3. Telework will be voluntary unless specifically stated as a condition of employment.

4. Other than those additional duties and obligations expressly imposed on a Teleworker under this policy, the duties, obligations, responsibilities and conditions of a Teleworker's employment with CalOptima shall remain unchanged.

~~Termination of Telework Arrangement~~

~~A Teleworker's manager may change the teleworking arrangement at any time based on business needs or changes in the Teleworker's eligibility to telework.~~

~~A Teleworker's manager, working with Human Resources (HR) may initiate a request to terminate the telework arrangement. Requests to terminate the telework arrangement must go through the manager of the Teleworker and be approved by HR.~~

~~The Teleworker's manager, in collaboration with HR, will evaluate changes to a Teleworker's job responsibilities and determine if continued participation in the telework program or return to the Central Worksite is appropriate.~~

~~F.~~H. Teleworker Selection

1. The employee's department manager, with final review and evaluation by HR, shall consider and ensure that the selected employee and their work responsibilities meet the following conditions:

   a. The nature of the work and job responsibilities can be performed effectively away from the Central Worksite.

   b. The nature of resources and tools necessary for an employee's work assignments and job responsibilities can be accessed from the employee's Home Office location while ensuring confidentiality where necessary and compliance with all applicable laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) regulations.

   c. The nature of the work and the employee's job responsibilities do not require daily face-to-face contact with other employees or supervisors, and/or the employee and/or the employee's work does not require supervision that can only be accomplished at the Central Worksite.

   d. The nature of the work is not dependent on accessing equipment, materials, files, etc., that are only available in the Central Worksite.

2. To be eligible for telework, the following considerations will be evaluated:

   a. Employee must be in good standing, with no prior disciplinary action in the last year or on a Performance Improvement Plan, and may be scheduled for full-time or part-time and/or may be exempt or non-exempt (hourly).

   b. Based on business considerations and management discretion, supervisors and managers may be approved for telework only if their entire team teleworks.

   c. If supervisors and managers have staff that does not telework and/or are not eligible for telework, they must be present in the office to supervise their non-telework staff.

   d. Telework is not available for Senior Manager level positions and above, unless the position is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework as determined by the Executive Director of Human Resources, with the approval of the Chief Operating Officer.

~~1.~~3. To participate in the telework program, an employee must meet ~~certain~~additional eligibility and selection criteria established by CalOptima, including the suitability of performing the requirements of the job from a Remote Work Location and the ability of the employee to meet performance expectations in a work environment away from the Central Worksite.

4. To be eligible to work from a Remote Work Location the employee must obtain approval from the employee's supervisor/manager and director prior to submitting the request to HR. Employees are required to sign and submit the CalOptima Telework Agreement, along with all other required documentation, to the HR Department prior to being deployed.

I. Termination of Telework Arrangement

1. A Teleworker may elect at any time to move from working at a Remote Work Location to working at the Central Worksite, contingent on space availability.

   a. The Teleworker must notify and discuss the change with his or her manager and receive approval.

   b. The Teleworker's manager will notify HR of the request to terminate the telework arrangement.

2. A Teleworker's manager may change or end the teleworking arrangement at any time based on business needs, performance or productivity concerns, or changes in the Teleworker's eligibility to telework.

   a. Requests to end the telework arrangement must go through the manager of the Teleworker and be approved by HR.

3. As needed, the Teleworker's manager, in collaboration with HR, may evaluate changes to a Teleworker's job responsibilities and determine if continued participation in the telework program or return to the Central Worksite is appropriate.

~~C.~~J. Work Schedule and Accessibility

1. A Teleworker's schedule ~~will~~of work hours, including breaks, overtime, and deviations from regular work hours, should be approved by ~~his or her~~the Teleworker's manager~~.~~.

   a. A manager ~~will~~shall take into consideration the overall impact of a Teleworker assignment to the department's service delivery, employee productivity, or the progress of individual or team assignments.

   b. A manager shall also take into consideration the overall impact of the Teleworker's total time outside of the Central Worksite. Considerations include, but are not limited to: meetings, consultations, presentations and conferences.

   ~~1.~~c. CalOptima shall also give consideration to the overall effect of a Teleworker's and co-workers' schedules in maintaining adequate manager supervision and communication.

2. The number of hours ~~worked will~~normally scheduled to work by an employee shall not change because of telework.

3. Employees will not be eligible to participate in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one alternative at a time.

4. ~~A~~Before working overtime, a non-exempt (hourly) Teleworker must receive his or her manager's written approval in advance ~~before working overtime. Failure~~.

~~4.~~5. An exempt Teleworker who plans to ~~do so will be grounds for disciplinary action~~deviate from the Teleworker's regular work hours, including working beyond normal working hours and~~/or termination of the telework arrangement unless reasonable cause can be shown why it was not possible to~~ making up time, shall obtain ~~prior~~his or her supervisor's approval~~.~~ in advance, where feasible.

6. Teleworkers will be required to complete their timecard electronically, consistent with employees at the Central Worksite.

7. Meal periods and breaks for a Teleworker will be consistent with those at the Central Worksite.

8. The ~~telework~~Teleworker's manager should ensure that the Teleworker's schedule shall allow adequate time at the Central Worksite for meetings, access to facilities and supplies, and communication with other employees ~~and customers. Telework must not adversely affect service delivery, employee productivity.~~, providers or ~~the progress~~members.

~~5.~~9. When visiting the Central Worksite, a Teleworker will notify their direct supervisor or alternate of their presence in office building, including their physical location and tentative length of ~~an individual or team assignment~~stay.

~~6.~~10. A Teleworker will attend job-related meetings, training sessions, and conferences, as requested by the manager. In addition, management may request a Teleworker to attend "short notice" meetings or to come into the Central Worksite for other CalOptima business related

purposes. A Teleworker's manager will use telephone conference calling whenever possible as an alternative to requesting attendance at short notice meetings.

~~7.~~11. During telework hours, a Teleworker must be reachable via telephone, facsimile, office communicator, and/or e-mail during agreed-upon work hours or specific core hours of accessibility. The manager and Teleworker will agree on how to handle telephone messages, including the feasibility of call forwarding and frequency of checking telephone messages.

~~8.~~12. If the Central Worksite is closed due to an emergency or inclement weather, a Teleworker's manager will contact the Teleworker as soon as possible. A Teleworker may continue to work at the Remote Work Location. If there is an emergency at the Remote Work Location such as a power outage, a Teleworker will notify his or her manager as soon as possible. CalOptima may assign the Teleworker to the Central Worksite.

~~H.~~K. Dependent Care

1. A Teleworker will **not** act as a primary caregiver for dependent(s) during the agreed upon telework hours. Dependents may be present in the home during telework hours if care for the dependent will not require the Teleworker's attention. A Teleworker must make dependent care arrangements to permit concentration on performing work duties and responsibilities to the same extent as if he or she were performing work at the Central Worksite.

L. Deployment Preparation

1. All Teleworkers will complete mandatory pre-deployment documentation and telework orientation prior to final approval for telework deployment. Understanding the policies and procedures of telework is an important determinant of success in the telework program. Teleworkers may be required to complete additional educational or informational programs as deemed needed.

M. Telework Site/ Home Office

1. A Teleworker must maintain a suitable and secure designated workspace inside the Teleworker's residence that is clean, safe, and free from distractions.

   a. A Teleworker must set up a designated workspace as required by standards set by Environmental Health and Safety (EH&S) prior to beginning the Telework assignment.

   b. Preferably, this workspace will be a separate room that is designated as a home office.

   c. The home office location and specified workstation and internet access must be in compliance with the EH&S standards and the safety checklists.

   d. The employee must sign and submit the CalOptima Teleworking Agreement, along with all other required documentation to HR within the required period of time.

2. A Teleworker will not hold face-to-face business meetings with providers, Members, or professional colleagues at the Home Office.

3. CalOptima may send agents of the organization to assist with equipment set-up in the Home Office.

   a. CalOptima will provide advanced notice of any delivery.

   b. The Teleworker must allow access to the Home Office at the designated day and time.

4. CalOptima will provide a predefined basic set of equipment as required for the Teleworker to perform his or her work duties.

5. All equipment that is provided initially for use at the telework site will be documented in the Telework Equipment Release Agreement.

   a. The Information Systems (IS) Department will maintain a list of CalOptima's equipment and software that is located in the Home Office Locations of Teleworkers.

6. If additional equipment or supplies are required related to Telework, the Teleworker must obtain prior approval for any additional costs.

   a. CalOptima will provide standard office supplies (i.e., pens, paper, and pencils).

   b. CalOptima shall not reimburse out-of-pocket expenses for supplies normally available at the Central Worksite.

7. Prior to beginning the telework program, a Teleworker will provide documentation of the workspace, in the form of current photograph, and must submit such documentation to the EH &S and HR departments.

8. Teleworkers are advised to consult with an insurance agent and/or tax consultant for information regarding their home office site. Individual tax implications, auto and ~~homeowners~~homeowners' insurance, and incidental residential utility costs are the responsibility of the Teleworker.

N. Teleworker Performance Management

1. The manager and Teleworker will develop and agree upon any relevant goals and performance guidelines, as well as the frequency of performance discussions.

2. The manager of the Teleworker shall:

   a. Monitor the Teleworker's productivity and performance consistently and as business needs require.

   b. Provide timely and specific feedback to the Teleworker on a regular basis.

   c. Plan for and use multiple channels to keep the Teleworker informed and up-to-date about departmental and CalOptima activities.

   d. Remove a Teleworker from the program if the employee does not or continues to not meet the set performance standards.

O. Program Reporting and Evaluation

1. Teleworkers ~~-~~agree to monthly reporting and analyses, at a minimum, relating to his or her performance in order to evaluate the effectiveness of the Teleworker and telework program at CalOptima.

2. Each manager of one or more Teleworkers shall be required to provide documentation of goals, performance standards and outcomes for the Teleworkers to HR upon request.

P. Liability

1. A Teleworker is responsible for ensuring the safety of his or her Remote Work Location or alternative work environment.

~~I.A. Liability~~

~~1. A Teleworker is responsible for ensuring the safety of his or her Remote Work Location or alternative work environment.~~

2. A Teleworker will agree to a safety inspection and photographic documentation of the ~~Teleworker~~ Telework Remote Work Location site to comply with workers' compensation liabilities, as well as comply with all items in the ~~Telework Home Inspection Checklist.~~EH&S safety checklists~~.~~.

3. Because liability may arise from hazards in the Remote Work Location that might cause serious harm or injury, CalOptima reserves the right to periodically inspect the Teleworker's Remote Work Location workspace. CalOptima will precede any such inspection by advanced notice and will schedule an appointment.

4. All ergonomic issues must be reported to the ~~Environmental Health and Safety (~~EH&S~~)~~ department. It is the responsibility of a Teleworker to notify EH&S early of any potential ergonomic issues in the home office workspace in the Remote Work Location.

~~3.~~1. ~~It is the responsibility of a Teleworker to notify EH&S early of any potential ergonomic issues in the home office workspace in the Remote Work Location.~~

~~4.~~1. ~~Because liability may arise from hazards in the Remote Work Location that might cause serious harm or injury, CalOptima reserves the right to periodically inspect the Teleworker's Remote Work Location workspace. CalOptima will precede any such inspection by advanced notice and will schedule an appointment.~~

5. CalOptima is not liable for any incident or accident that occurs outside of normal job ~~-~~related activities or hours.

6. In the event of a job-related incident or accident during telework hours, a Teleworker must immediately report the incident to his or her manager. ~~In the event of a job-related incident or accident during telework hours, a Teleworker must immediately report the incident to his or her manager.~~

~~6.~~a. A Teleworker, manager, and CalOptima must follow the policies regarding the reporting of injuries for employees injured while at work.

7. CalOptima is not responsible for any injuries to family members, visitors, and others in a Teleworker's Remote Work Location workspace.

8. CalOptima is not responsible for any loss or damage to:

   a. A Teleworker's property;

   b. Personal property owned by a Teleworker or any of the Teleworker's family members; or

   c. Property of others in the custody of a Teleworker.

9. A Teleworker is responsible for contacting his or her insurance agent and a tax consultant and consulting local ordinances for information regarding Remote Work Location workplaces.

~~J.~~Q. Compliance: ~~-~~ Handling ~~Protected Health Information (~~PHI~~)~~ from a Remote Work Location

1. The same precautions governing the treatment of PHI at the Central Worksite shall apply to the Remote Work Location.

~~2. A Teleworker shall protect all documents that contain Member PHI from the view or access by unauthorized persons during transport to and from the Central Office through the use of:~~

~~a. Binders; or~~

~~b.~~a. ~~Folders or other protective cover.~~

2. A Teleworker shall not leave documents including, but not limited to~~:~~ (electronic and/or hard copies): assessment forms, prior authorization, or other data collection forms unattended in areas accessible by unauthorized persons.

~~3.~~a. If PHI is being accessed by the Teleworker, when the Teleworker leaves the Remote Work Location or workspace, all paper PHI shall be stowed in a locked drawer designated for such storage. The Teleworker shall remain in possession of the key.

3. A Teleworker shall protect all documents that contain Member PHI from the view or access by unauthorized persons during transport to and from the Central Worksite through the use of:

   a. Binders; or

   b. Folders or other protective cover.

4. Upon their disposal, a Teleworker shall shred all PHI documents or files. A Teleworker shall transport PHI documents that are taken to the Remote Work Location and ready for destruction back to the Central Worksite for shredding.

5. A Teleworker shall immediately report any ~~breaches of~~ security incidents or compromised PHI to the Office of Compliance, in accordance with CalOptima ~~policy~~Policy HH.~~3020~~3020 : Reporting ~~a Breach~~and Providing Notice of ~~Data~~ Security~~, Intrusion,~~ Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of ~~Protected Health Information~~PHI/PI and contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.

~~K.~~R. Use of ~~PC~~Computer from Remote Work Location

1. CalOptima will provide a Teleworker with a CalOptima personal computer (PC) or, with the ~~permission~~approval of ~~HR, Compliance and Chief Security Officer~~IS Infrastructure Management in certain circumstances, a laptop computer (laptop), and grant access to the CalOptima network.

~~1.~~2. A Teleworker shall adhere to the following information security procedures:

a. Maintain the confidentiality of his or her user sign-on identification code and password;

b. Keep the PC or laptop secure at all times;

c. Log off the VPN network when the PC or laptop will be left inactive or unattended~~:~~, including but not limited to, during breaks, lunch periods, and at the end of the workday;

d. Ensure that passwords or operating instructions are not stored with the computer~~.~~; and

e. Ensure that any issues with CalOptima equipment or systems are referred to the Help Desk for assistance, and that no unauthorized persons, or organizations, provide technical support for any CalOptima equipment or systems.

~~2.~~3. A Teleworker shall report any security ~~breaches~~incidents to the CalOptima Help Desk including, but not limited to:

a. Loss of a PC or laptop;

b. Software irregularities indicating possible virus infection; and~~/or~~

c. Access by unauthorized persons.

4. Failure to comply with the requirements listed above will result in the termination of the employee's telework arrangement and may also include disciplinary action up to and including termination of employment.

5. In the event of security or PHI incidents, Teleworkers are required to cooperate in internal investigations, outside investigators, law enforcement, and/or criminal and/or civil prosecution, when applicable.

~~L.~~S. Use of electronic mail with PHI

1. Internal e-mail: E-mail sent within the secure virtual private network (VPN) CalOptima system may contain PHI that is limited to the use and disclosure of the minimum necessary data to complete the required message.

2. External e-mail: E-mail that is sent external to CalOptima via the open internet shall not contain PHI unless the e-mail is encrypted using the ~~Ironport system~~required encryption system and the recipient is authorized to receive it.

~~M.~~T. ~~-~~Use of printer from Remote Work Location

1. Teleworkers are not allowed to print anything work related to a home printer. All printing should be done at the Central Worksite when the Teleworker comes into the ~~office.~~ Central Worksite On rare circumstances, HR, the Compliance Officer, and the Chief Security Officer may make an exception to allow for a Teleworker to receive a printer for use at home, but only if the employee is not dealing with any PHI.

~~N. Telework Site/Remote Work Location~~

~~1. A Teleworker will maintain a designated workspace inside the Teleworker's residence that is clean, safe, and free from distractions. Ideally, this workspace will be a separate room that is designated as a home office. A Teleworker must have a designated workspace that consists of a desk that has at least four (4) linear feet of work space, four (4) feet of clearance for a desk chair, internet access, adequate access to power outlets, and is reasonably free of distractions.~~

~~2. A Teleworker will not hold face to face business meetings with providers, Members, or professional colleagues at the Remote Work Location.~~

~~3.1.~~ ~~Teleworkers are advised to consult with an insurance agent and/or tax consultant for information regarding their home office site. Individual tax implications, auto and homeowners insurance, and incidental residential utility costs are the responsibility of the Teleworker.~~

~~O.~~A. ~~Teleworker Performance Management~~

~~1. Depending on the job responsibilities and manager discretion, a work diary may be used to manage performance. A work diary is a document that the Teleworker completes and tracks what is being accomplished during the course of the week. A work diary can be especially useful for positions where traditional work metrics are not relevant or practical.~~

~~2. The manager and Teleworker will develop and agree upon any other relevant guidelines, as well as the frequency of performance discussions.~~

~~P. Establishing a Remote Work Location (Home Office)~~

~~1. CalOptima will supply a Teleworker Home Inspection Checklist which covers equipment, furniture, and services for the home office. Before initiating telework, it is the responsibility of a Teleworker to complete the Teleworker Home Inspection Checklist and determine the suitability of the space and equipment for teleworking. A Teleworker shall complete the following within one (1) week of starting a Telework schedule:~~

~~a. Part 2 of the Home Inspection Checklist;~~

~~b. The Telework Equipment Release Agreement; and~~

~~c. EH &S Telework Training.~~

~~2. CalOptima will provide a Teleworker with the following:~~

~~a. Ergonomic Chair;~~

~~b. Computer (PC);~~

~~c. Office supplies from Central Worksite;~~

~~d. Keyboard and mouse;~~

~~e. Monitor(s) for the Remote Work Location (depending on job category); and~~

~~f. Special ergonomic equipment, if required~~

~~3. The~~ Teleworker will provide the following:

a. Home office location (as described in Section 10 of this policy) in compliance with the Teleworker Home Inspection Checklist;

b. A work desk, which must be forty-eight (48) inches in width that provides adequate space for a PC, monitor(s), keyboard, mouse, and other work necessities;

c. Internet through a DSL/Cable line with a transfer speed of at least 4.5 MB per second and a minimum upload speed of 1MB/sec; and

d. A locking drawer or cabinet for PHI, if necessary.

~~4.a.~~ CalOptima management must authorize any additional costs related to telework prior to purchase. CalOptima will provide standard office supplies (i.e., pens, paper, and pencils). Teleworkers need to obtain supplies while at the Central Worksite. CalOptima shall not reimburse out-of-pocket expenses for supplies normally available at the Central Worksite.

~~5.~~ CalOptima may send agents of the organization to assist with equipment set-up in the Remote Work Location.

~~6.~~ Prior to beginning the telework program, a Teleworker will consent to visual documentation of the workspace, in the form of a photograph, and shall submit it to the EH & S and HR departments.

~~7.~~ CalOptima's Facilities and Information Systems (IS) Departments will maintain a central inventory of CalOptima's equipment and software located in the Remote Work Locations of Teleworkers. CalOptima shall document all equipment that is provided for use at the telework site in the CalOptima Telework Agreement.

~~Q.~~U. Security of CalOptima Assets

~~1.~~ CalOptima shall document assets installed in a Teleworker's home office in the CalOptima Telework Agreement.

1. ~~Teleworkers~~ The Teleworker must take reasonable precautions to secure and prevent damage to ~~CalOptima's~~ equipment~~.~~ provided and delivered to the Remote Location Worksite.

2. CalOptima's equipment must only be used by the Teleworker and may not be used by other ~~family members~~guests or individuals for personal use.

~~2.~~3. If property of CalOptima is stolen or damaged in a Teleworker's home, CalOptima will repair or replace the property at CalOptima's expense, provided there is no contributory negligence on the part of the Teleworker.

~~3.~~4. Upon termination of employment or the telework arrangement, voluntary or otherwise, the employee shall return all CalOptima property to CalOptima.

~~4.~~5. CalOptima may pursue recovery from a Teleworker for CalOptima property that is:

a. Not returned at the conclusion of employment; or

b. Deliberately, or through negligence, damaged, destroyed, or lost while in the Teleworker's control.

~~R. Inspection~~

~~1.~~6. In case of injury, theft, loss, or liability related to telework, a Teleworker must allow agents of the organization to investigate and/or inspect the telework site. CalOptima shall provide reasonable notice of inspection and/or investigation to the Teleworker.

~~S. Training~~

V. ~~**Understanding the policies and procedures of telework is an important determinant of success in the telework program.. All**~~ Travel Reimbursement

1. CalOptima will not reimburse mileage for Teleworkers ~~will complete mandatory telework training to obtain final approval for telework deployment. Managers shall receive telework training as necessary.~~

~~T. Working from~~ **who come into the Central Worksite**

1. ~~At~~ from a ~~future date, work spaces at the Central~~local Remote Worksite ~~may change based on the number of Teleworkers and the amount of time they are teleworking. Changes may include the creation of community work stations or the sharing of cubicle spaces.~~ Location.

~~U.~~A. ~~Travel Reimbursement~~

2. CalOptima will reimburse mileage ~~for days that Teleworkers are~~when a Teleworker is required by management to drive into the Central Worksite only if the employee is required to travel two hundred fifty (250) or more miles one-way. ~~Otherwise, CalOptima will not reimburse mileage for Teleworkers who come into the Central Worksite~~

3. For off-site visits from the Teleworker's home, CalOptima shall base reimbursement for use of privately owned vehicles on actual mileage, to the nearest mile, less the number of miles required to drive from the Teleworker's residence to the Central Worksite, and back again, on a single day and in accordance with CalOptima GA.5004: Travel Policy.

4. Reimbursement shall be made at the mileage rate currently in effect for CalOptima, and in accordance with CalOptima GA.5004: Travel Policy. Different requirements for travel may apply to out-of-state Teleworkers, in which they should receive prior approval from their department executive before such travel arrangements are made.

~~1.~~

~~V.A. Program Reporting and Evaluation~~

~~1. A Teleworker will agree to monthly reporting and analyses relating to his or her performance in order to evaluate the effectiveness of the telework program at CalOptima.~~

~~W. Non-exempt Employees~~

~~1. A Non-exempt employee will be required to complete their timecard electronically, consistent with employees at the Central Worksite.~~

~~2.1.~~ ~~Meal periods and breaks for a Teleworker will be consistent with those at the Central Worksite.~~

~~X.~~W. Other Remote Work arrangements

1. In certain cases, arrangements other than those defined in this policy may be negotiated between CalOptima management, ~~**Human Resources**~~HR, and the Teleworker. All policy deviations must be approved by HR and ~~**shall be reviewed with**~~ the Teleworker's executive.

X. Failure to comply with the requirements of this Policy or follow CalOptima's policies, rules and procedures may result in: termination of the employee's telework arrangement and/or disciplinary action, up to and including termination of the employee. Certain violations of this Policy, other applicable CalOptima policies, and/or state and federal laws may also result in criminal or civil prosecution, where applicable.

~~IV.~~III. PROCEDURE

Not Applicable

~~V.~~IV. ATTACHMENTS

A. CalOptima Telework Agreement
B. ~~Telework Equipment Release~~CalOptima Occasional Off-site Work Agreement
~~B.~~
~~C. Teleworker Home Inspection Checklist Part 1 and Part 2~~

~~VI.~~V. REFERENCES

A. CalOptima Policy GA.8000: Glossary of Terms
B. CalOptima Employee Handbook

C. CalOptima Policy GA.5004: Travel Policy
D. CalOptima Policy GA.8020: 9/80 Work Schedule
E. CalOptima Policy HH.~~3020:~~3020 : Reporting ~~a Breach~~and Providing Notice of ~~Data~~ Security~~,~~ ~~Intrusion,~~ Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of ~~Protected Health Information~~PHI/PI

~~VII.~~VI. REGULATORY AGENCY APPROVALS

~~Not Applicable~~None to Date

~~VIII.~~VII. BOARD ACTIONS

A. 02/01/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 12/03/15: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 05/01/14: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 06/06/13: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 03/01/12: Regular Meeting of the CalOptima Board of Directors

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

Version	~~Version~~ Date	Policy Number	Policy Title	Line(s) of Business
~~Original Date~~Effective	06/06/2013	GA.8044	Telework Program	Administrative
~~Revision Date 1~~Revised	02/06/2014	GA.8044	Telework Program	Administrative
~~Revision Date 2~~Revised	12/03/2015	GA.8044	Telework Program	Administrative
Revised	02/01/2018	GA.8044	Telework Program	Administrative

IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
Central Worksite	CalOptima's -primary physical location of business applicable to the employee, which is either CalOptima's administration building at 505 City Parkway West or the PACE building.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Home Office	A -designated workspace within the Teleworker' residence.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Remote Work Location	The Employee's Home Office or designated pre-approved work location.
Teleworker	An employee who meets CalOptima's Teleworker eligibility criteria and is approved to routinely work their regularly scheduled work hours from a Remote Work Location, unless business needs require otherwise.

Policy #:	GA.8044
Title:	**Telework Program**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader _____

Effective Date:	03/01/12
Last Review Date:	02/01/18
Last Revised Date:	02/01/18

I. PURPOSE

This policy describes guidelines for a work structure that: 1) permits an employee to perform their work from a Remote Work Location, unless business needs require otherwise; 2) increases quality of life for employees; 3) reduces operation and overhead costs; 4) supports recruitment and retention of skilled employees; and 5) promotes a culture of managing by results.

II. POLICY

A. Telework is a workplace arrangement in which an eligible employee works his or her entire work schedule away from the Central Worksite at a Remote Work Location, unless business needs require otherwise.

1. A partial teleworking arrangement is not allowed. A Teleworker may not elect to routinely work a portion of his or her scheduled days at the Central Worksite and the remainder from the Remote Work Location.

B. Telework is not a universal employee benefit or entitlement, but rather, an alternative method of meeting the work needs of the organization through a flexible work structure. Department managers, at their discretion, may discontinue an individual's, group's, or department's participation in the telework program based on business needs.

C. Telework is voluntary unless specifically stated as a condition of employment and may be terminated at any time by either the Teleworker or CalOptima, with or without cause.

D. The total number of employees in telework positions at any point in time may equal but not exceed the maximum number telework positions as directed by the CalOptima Board of Directors.

E. Telework positions may be identified as follows:

1. Human Resources (HR) may designate a position as a telework position if it is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework.

2. HR may reserve a number of telework positions for use in granting reasonable work accommodations, for employees transitioning back to work after a qualifying leave of absence, or for other exigencies, which would require the approval of the Executive Director of HR.

3. A department leader may designate one (1) or more positions as suitable for teleworking if the duties and responsibilities of the position can be performed remotely at the same or higher level of productivity and quality compared to working at the Central Worksite.

F. Remote Work exception to the Telework policy: When special circumstances require it, an employee's manager has the discretion to allow an employee, to work from a Remote Work Location on an occasional basis.

1. Occasional is defined as rare, infrequent and not regularly scheduled for brief periods (usually a day or part of a day); with no specific or implied expectation from an employee that he or she will be allowed to work from a Remote Work Location routinely. This is not considered or counted as a telework position.

2. All employees who occasionally work from a Remote Work Location must abide by the same requirements as employees who telework, including, but not limited to, the applicable conditions set forth in this policy concerning terms of employment, work schedule and accessibility, dependent care, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI, establishing a Remote Work Location, security of CalOptima assets, inspection, etc.

3. Furthermore, for departments which permit employees to work from a Remote Work Location, to be eligible to work occasionally from a Remote Work Location, the employee must execute the CalOptima Occasional Off-site Work Agreement and submit the signed document to the Human Resources Department prior to being permitted to work from a Remote Work Location.

G. Terms of Employment

1. The conditions of employment, such as employee salary, benefits and employer-sponsored insurance coverage, will remain the same for an employee designated as a Teleworker as for non-telework employee.

2. CalOptima's policies, rules and practices are applicable to a Teleworker's Remote Work Location, including, but not limited to, confidentiality, internal communications, communications with the public, public records requests, employee rights and responsibilities, facilities and equipment management, financial management, information resource management, purchasing of property and services, unlawful harassment, drug and alcohol, and safety.

3. Telework will be voluntary unless specifically stated as a condition of employment.

4. Other than those additional duties and obligations expressly imposed on a Teleworker under this policy, the duties, obligations, responsibilities and conditions of a Teleworker's employment with CalOptima shall remain unchanged.

H. Teleworker Selection

1. The employee's department manager, with final review and evaluation by HR, shall consider and ensure that the selected employee and their work responsibilities meet the following conditions:

a. The nature of the work and job responsibilities can be performed effectively away from the Central Worksite.

b. The nature of resources and tools necessary for an employee's work assignments and job responsibilities can be accessed from the employee's Home Office location while ensuring confidentiality where necessary and compliance with all applicable laws, including, but not limited to, Health Insurance Portability and Accountability Act (HIPAA) regulations.

c. The nature of the work and the employee's job responsibilities do not require daily face-to-face contact with other employees or supervisors, and/or the employee and/or the employee's work does not require supervision that can only be accomplished at the Central Worksite.

d. The nature of the work is not dependent on accessing equipment, materials, files, etc., that are only available in the Central Worksite.

2. To be eligible for telework, the following considerations will be evaluated:

a. Employee must be in good standing, with no prior disciplinary action in the last year or on a Performance Improvement Plan, and may be scheduled for full-time or part-time and/or may be exempt or non-exempt (hourly).

b. Based on business considerations and management discretion, supervisors and managers may be approved for telework only if their entire team teleworks.

c. If supervisors and managers have staff that does not telework and/or are not eligible for telework, they must be present in the office to supervise their non-telework staff.

d. Telework is not available for Senior Manager level positions and above, unless the position is classified as a difficult to recruit and/or retain position, and the position is appropriate for telework as determined by the Executive Director of Human Resources, with the approval of the Chief Operating Officer.

3. To participate in the telework program, an employee must meet additional eligibility and selection criteria established by CalOptima, including the suitability of performing the requirements of the job from a Remote Work Location and the ability of the employee to meet performance expectations in a work environment away from the Central Worksite.

4. To be eligible to work from a Remote Work Location the employee must obtain approval from the employee's supervisor/manager and director prior to submitting the request to HR. Employees are required to sign and submit the CalOptima Telework Agreement, along with all other required documentation, to the HR Department prior to being deployed.

I. Termination of Telework Arrangement

1. A Teleworker may elect at any time to move from working at a Remote Work Location to working at the Central Worksite, contingent on space availability.

a. The Teleworker must notify and discuss the change with his or her manager and receive approval.

b. The Teleworker's manager will notify HR of the request to terminate the telework arrangement.

2. A Teleworker's manager may change or end the teleworking arrangement at any time based on business needs, performance or productivity concerns, or changes in the Teleworker's eligibility to telework.

    a. Requests to end the telework arrangement must go through the manager of the Teleworker and be approved by HR.

3. As needed, the Teleworker's manager, in collaboration with HR, may evaluate changes to a Teleworker's job responsibilities and determine if continued participation in the telework program or return to the Central Worksite is appropriate.

J. Work Schedule and Accessibility

1. A Teleworker's schedule of work hours, including breaks, overtime, and deviations from regular work hours, should be approved by the Teleworker's manager.

    a. A manager shall take into consideration the overall impact of a Teleworker assignment to the department's service delivery, employee productivity, or the progress of individual or team assignments.

    b. A manager shall also take into consideration the overall impact of the Teleworker's total time outside of the Central Worksite. Considerations include, but are not limited to: meetings, consultations, presentations and conferences.

    c. CalOptima shall also give consideration to the overall effect of a Teleworker's and co-workers' schedules in maintaining adequate manager supervision and communication.

2. The number of hours normally scheduled to work by an employee shall not change because of telework.

3. Employees will not be eligible to participate in both the telework program and the 9/80 Work Schedule during the same period. Employees eligible for both may only request one alternative at a time.

4. Before working overtime, a non-exempt (hourly) Teleworker must receive his or her manager's written approval in advance.

5. An exempt Teleworker who plans to deviate from the Teleworker's regular work hours, including working beyond normal working hours and making up time, shall obtain his or her supervisor's approval in advance, where feasible.

6. Teleworkers will be required to complete their timecard electronically, consistent with employees at the Central Worksite.

7. Meal periods and breaks for a Teleworker will be consistent with those at the Central Worksite.

8. The Teleworker's manager should ensure that the Teleworker's schedule shall allow adequate time at the Central Worksite for meetings, access to facilities and supplies, and communication with other employees, providers or members.

9. When visiting the Central Worksite, a Teleworker will notify their direct supervisor or alternate of their presence in office building, including their physical location and tentative length of stay.

10. A Teleworker will attend job-related meetings, training sessions, and conferences, as requested by the manager. In addition, management may request a Teleworker to attend "short notice" meetings or to come into the Central Worksite for other CalOptima business related purposes. A Teleworker's manager will use telephone conference calling whenever possible as an alternative to requesting attendance at short notice meetings.

11. During telework hours, a Teleworker must be reachable via telephone, facsimile, office communicator, and/or e-mail during agreed-upon work hours or specific core hours of accessibility. The manager and Teleworker will agree on how to handle telephone messages, including the feasibility of call forwarding and frequency of checking telephone messages.

12. If the Central Worksite is closed due to an emergency or inclement weather, a Teleworker's manager will contact the Teleworker as soon as possible. A Teleworker may continue to work at the Remote Work Location. If there is an emergency at the Remote Work Location such as a power outage, a Teleworker will notify his or her manager as soon as possible. CalOptima may assign the Teleworker to the Central Worksite.

K. Dependent Care

1. A Teleworker will **not** act as a primary caregiver for dependent(s) during the agreed upon telework hours. Dependents may be present in the home during telework hours if care for the dependent will not require the Teleworker's attention. A Teleworker must make dependent care arrangements to permit concentration on performing work duties and responsibilities to the same extent as if he or she were performing work at the Central Worksite.

L. Deployment Preparation

1. All Teleworkers will complete mandatory pre-deployment documentation and telework orientation prior to final approval for telework deployment. Understanding the policies and procedures of telework is an important determinant of success in the telework program. Teleworkers may be required to complete additional educational or informational programs as deemed needed.

M. Telework Site/ Home Office

1. A Teleworker must maintain a suitable and secure designated workspace inside the Teleworker's residence that is clean, safe, and free from distractions.

   a. A Teleworker must set up a designated workspace as required by standards set by Environmental Health and Safety (EH&S) prior to beginning the Telework assignment.

   b. Preferably, this workspace will be a separate room that is designated as a home office.

   c. The home office location and specified workstation and internet access must be in compliance with the EH&S standards and the safety checklists.

d. The employee must sign and submit the CalOptima Teleworking Agreement, along with all other required documentation to HR within the required period of time.

2. A Teleworker will not hold face-to-face business meetings with providers, Members, or professional colleagues at the Home Office.

3. CalOptima may send agents of the organization to assist with equipment set-up in the Home Office.

   a. CalOptima will provide advanced notice of any delivery.

   b. The Teleworker must allow access to the Home Office at the designated day and time.

4. CalOptima will provide a predefined basic set of equipment as required for the Teleworker to perform his or her work duties.

5. All equipment that is provided initially for use at the telework site will be documented in the Telework Equipment Release Agreement.

   a. The Information Systems (IS) Department will maintain a list of CalOptima's equipment and software that is located in the Home Office Locations of Teleworkers.

6. If additional equipment or supplies are required related to Telework, the Teleworker must obtain prior approval for any additional costs.

   a. CalOptima will provide standard office supplies (i.e., pens, paper, and pencils).

   b. CalOptima shall not reimburse out-of-pocket expenses for supplies normally available at the Central Worksite.

7. Prior to beginning the telework program, a Teleworker will provide documentation of the workspace, in the form of current photograph, and must submit such documentation to the EH &S and HR departments.

8. Teleworkers are advised to consult with an insurance agent and/or tax consultant for information regarding their home office site. Individual tax implications, auto and homeowners' insurance, and incidental residential utility costs are the responsibility of the Teleworker.

N. Teleworker Performance Management

1. The manager and Teleworker will develop and agree upon any relevant goals and performance guidelines, as well as the frequency of performance discussions.

2. The manager of the Teleworker shall:

   a. Monitor the Teleworker's productivity and performance consistently and as business needs require.

   b. Provide timely and specific feedback to the Teleworker on a regular basis.

c. Plan for and use multiple channels to keep the Teleworker informed and up-to-date about departmental and CalOptima activities.

d. Remove a Teleworker from the program if the employee does not or continues to not meet the set performance standards.

O. Program Reporting and Evaluation

1. Teleworkers agree to monthly reporting and analyses, at a minimum, relating to his or her performance in order to evaluate the effectiveness of the Teleworker and telework program at CalOptima.

2. Each manager of one or more Teleworkers shall be required to provide documentation of goals, performance standards and outcomes for the Teleworkers to HR upon request.

P. Liability

1. A Teleworker is responsible for ensuring the safety of his or her Remote Work Location or alternative work environment.

2. A Teleworker will agree to a safety inspection and photographic documentation of the Telework Remote Work Location site to comply with workers' compensation liabilities, as well as comply with all items in the EH&S safety checklists.

3. Because liability may arise from hazards in the Remote Work Location that might cause serious harm or injury, CalOptima reserves the right to periodically inspect the Teleworker's Remote Work Location workspace. CalOptima will precede any such inspection by advanced notice and will schedule an appointment.

4. All ergonomic issues must be reported to the EH&S department. It is the responsibility of a Teleworker to notify EH&S early of any potential ergonomic issues in the home office workspace in the Remote Work Location.

5. CalOptima is not liable for any incident or accident that occurs outside of normal job-related activities or hours.

6. In the event of a job-related incident or accident during telework hours, a Teleworker must immediately report the incident to his or her manager.

a. A Teleworker, manager, and CalOptima must follow the policies regarding the reporting of injuries for employees injured while at work.

7. CalOptima is not responsible for any injuries to family members, visitors, and others in a Teleworker's Remote Work Location workspace.

8. CalOptima is not responsible for any loss or damage to:

a. A Teleworker's property;

b. Personal property owned by a Teleworker or any of the Teleworker's family members; or

c. Property of others in the custody of a Teleworker.

9. A Teleworker is responsible for contacting his or her insurance agent and a tax consultant and consulting local ordinances for information regarding Remote Work Location workplaces.

Q. Compliance: Handling PHI from a Remote Work Location

1. The same precautions governing the treatment of PHI at the Central Worksite shall apply to the Remote Work Location.

2. A Teleworker shall not leave documents including, but not limited to (electronic and/or hard copies): assessment forms, prior authorization, or other data collection forms unattended in areas accessible by unauthorized persons.

a. If PHI is being accessed by the Teleworker, when the Teleworker leaves the Remote Work Location or workspace, all paper PHI shall be stowed in a locked drawer designated for such storage. The Teleworker shall remain in possession of the key.

3. A Teleworker shall protect all documents that contain Member PHI from the view or access by unauthorized persons during transport to and from the Central Worksite through the use of:

a. Binders; or

b. Folders or other protective cover.

4. Upon their disposal, a Teleworker shall shred all PHI documents or files. A Teleworker shall transport PHI documents that are taken to the Remote Work Location and ready for destruction back to the Central Worksite for shredding.

5. A Teleworker shall immediately report any security incidents or compromised PHI to the Office of Compliance, in accordance with CalOptima Policy HH.3020 : Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI and contractual requirements, applicable federal and state statutes and regulations, and CalOptima policies.

R. Use of Computer from Remote Work Location

1. CalOptima will provide a Teleworker with a CalOptima personal computer (PC) or, with the approval of IS Infrastructure Management in certain circumstances, a laptop computer (laptop), and grant access to the CalOptima network.

2. A Teleworker shall adhere to the following information security procedures:

a. Maintain the confidentiality of his or her user sign-on identification code and password;

b. Keep the PC or laptop secure at all times;

c. Log off the VPN network when the PC or laptop will be left inactive or unattended, including but not limited to, during breaks, lunch periods, and at the end of the workday;

d. Ensure that passwords or operating instructions are not stored with the computer; and

e. Ensure that any issues with CalOptima equipment or systems are referred to the Help Desk for assistance, and that no unauthorized persons, or organizations, provide technical support for any CalOptima equipment or systems.

3. A Teleworker shall report any security incidents to the CalOptima Help Desk including, but not limited to:

a. Loss of a PC or laptop;

b. Software irregularities indicating possible virus infection; and

c. Access by unauthorized persons.

4. Failure to comply with the requirements listed above will result in the termination of the employee's telework arrangement and may also include disciplinary action up to and including termination of employment.

5. In the event of security or PHI incidents, Teleworkers are required to cooperate in internal investigations, outside investigators, law enforcement, and/or criminal and/or civil prosecution, when applicable.

S. Use of electronic mail with PHI

1. Internal e-mail: E-mail sent within the secure virtual private network (VPN) CalOptima system may contain PHI that is limited to the use and disclosure of the minimum necessary data to complete the required message.

2. External e-mail: E-mail that is sent external to CalOptima via the open internet shall not contain PHI unless the e-mail is encrypted using the required encryption system and the recipient is authorized to receive it.

T. Use of printer from Remote Work Location

1. Teleworkers are not allowed to print anything work related to a home printer. All printing should be done at the Central Worksite when the Teleworker comes into the Central Worksite On rare circumstances, HR, the Compliance Officer, and the Chief Security Officer may make an exception to allow for a Teleworker to receive a printer for use at home, but only if the employee is not dealing with any PHI.

U. Security of CalOptima Assets

1. The Teleworker must take reasonable precautions to secure and prevent damage to equipment provided and delivered to the Remote Location Worksite.

2. CalOptima's equipment must only be used by the Teleworker and may not be used by other guests or individuals for personal use.

3. If property of CalOptima is stolen or damaged in a Teleworker's home, CalOptima will repair or replace the property at CalOptima's expense, provided there is no contributory negligence on the part of the Teleworker.

4. Upon termination of employment or the telework arrangement, voluntary or otherwise, the employee shall return all CalOptima property to CalOptima.

5. CalOptima may pursue recovery from a Teleworker for CalOptima property that is:

   a. Not returned at the conclusion of employment; or

   b. Deliberately, or through negligence, damaged, destroyed, or lost while in the Teleworker's control.

6. In case of injury, theft, loss, or liability related to telework, a Teleworker must allow agents of the organization to investigate and/or inspect the telework site. CalOptima shall provide reasonable notice of inspection and/or investigation to the Teleworker.

V. Travel Reimbursement

1. CalOptima will not reimburse mileage for Teleworkers who come into **the Central Worksite** from a local Remote Worksite Location.

2. CalOptima will reimburse mileage when a Teleworker is required by management to drive into the Central Worksite only if the employee is required to travel two hundred fifty (250) or more miles one-way.

3. For off-site visits from the Teleworker's home, CalOptima shall base reimbursement for use of privately owned vehicles on actual mileage, to the nearest mile, less the number of miles required to drive from the Teleworker's residence to the Central Worksite, and back again, on a single day and in accordance with CalOptima GA.5004: Travel Policy.

4. Reimbursement shall be made at the mileage rate currently in effect for CalOptima, and in accordance with CalOptima GA.5004: Travel Policy. Different requirements for travel may apply to out-of-state Teleworkers, in which they should receive prior approval from their department executive before such travel arrangements are made.

W. Other Remote Work arrangements

1. In certain cases, arrangements other than those defined in this policy may be negotiated between CalOptima management, HR, and the Teleworker. All policy deviations must be approved by HR and the Teleworker's executive.

X. Failure to comply with the requirements of this Policy or follow CalOptima's policies, rules and procedures may result in: termination of the employee's telework arrangement and/or disciplinary action, up to and including termination of the employee. Certain violations of this Policy, other

applicable CalOptima policies, and/or state and federal laws may also result in criminal or civil prosecution, where applicable.

III. PROCEDURE

Not Applicable

IV. ATTACHMENTS

A. CalOptima Telework Agreement
B. CalOptima Occasional Off-site Work Agreement

V. REFERENCES

A. CalOptima Policy GA.8000: Glossary of Terms
B. CalOptima Employee Handbook
C. CalOptima Policy GA.5004: Travel Policy
D. CalOptima Policy GA.8020: 9/80 Work Schedule
E. CalOptima Policy HH.3020 : Reporting and Providing Notice of Security Incidents, Breaches of Unsecured PHI/PI or other Unauthorized Use or Disclosure of PHI/PI

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 02/01/18: 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. 06/06/13: Regular Meeting of the CalOptima Board of Directors
E. 03/01/12: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	06/06/2013	GA.8044	Telework Program	Administrative
Revised	02/06/2014	GA.8044	Telework Program	Administrative
Revised	12/03/2015	GA.8044	Telework Program	Administrative
Revised	02/01/2018	GA.8044	Telework Program	Administrative

IX. GLOSSARY

Term	Definition
9/80 Work Schedule	The 9/80 alternate work schedule consists of eight (8) business days of nine (9) hours per day and one (1) business day of eight (8) hours, for a total of eighty (80) hours during two (2) consecutive workweeks. The eight (8) hour work day must be on the same day of the week as the employee's regularly scheduled day off. Therefore, under the 9/80 work schedule, one calendar week will consist of forty-four (44) hours (four (4) nine (9) hour days and one (1) eight (8) hour day) and the alternating calendar week will consist of thirty-six (36) hours (four (4) nine (9) hour days and one (1) day off). However, each workweek will only consist of forty (40) hours, in accordance with the 9/80 Federal Labor Standards Act (FLSA) Workweek.
Central Worksite	CalOptima's primary physical location of business applicable to the employee, which is either CalOptima's administration building at 505 City Parkway West or the PACE building.
Health Insurance Portability and Accountability Act (HIPAA)	The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA require the Secretary of the U.S. Department of Health and Human Services (HHS) to publicize standards for the electronic exchange, privacy and security of health information, and as subsequently amended.
Home Office	A designated workspace within the Teleworker' residence.
Protected Health Information (PHI)	Has the meaning given such term in Section 160.103 of Title 45, Code of Federal Regulations. Individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. This information identifies the individual or there is reasonable basis to believe the information can be used to identify the individual. The information was created or received by CalOptima or Business Associates and relates to: 1. The past, present, or future physical or mental health or condition of a Member; 2. The provision of health care to a Member; or 3. Past, present, or future Payment for the provision of health care to a Member.
Remote Work Location	The Employee's Home Office or designated pre-approved work location.
Teleworker	An employee who meets CalOptima's Teleworker eligibility criteria and is approved to routinely work their regularly scheduled work hours from a Remote Work Location, unless business needs require otherwise.

CalOptima Teleworking Agreement

Name	
Title:	
Department:	
Supervisor/Manager:	

Telework is a workplace arrangement in which eligible

Teleworker Name: _____

Address: _____ Apt _____

City: _____ Zip code: _____

Day time phone number: (_____) _____ – _____

This agreement, CalOptima employees work their entire work schedule away from the central worksite at a remote work Location, unless business needs require otherwise. **Telework is not a universal employee benefit or entitlement**, but an alternative method of meeting the work needs of the organization through an innovative and flexible work structure.

I, _____ ("Employee") and CalOptima. mutually agree that the Employee
Print Name
will begin a Teleworking work arrangement effective ____/____/_____, is between _____ and CalOptima. The parties, intendingon _____
pursuant to be legally bound, agree as follows:

Scope of this Agreement (the "Agreement"). Date

1. The employee agrees **Participation:** Employee recognizes that teleworking is voluntary and may be reassessed, modified, and may be terminated, by either the employee or CalOptima, with or without notice or cause.

Other than those duties and obligations expressly imposed on the employee under this agreement, the duties, obligations, responsibilities and conditions of Employee's employment with CalOptima remain unchanged. The employee's salary and benefits shall remain unchanged.

The terms "remote work location" or "remote workplace" shall mean the employee's residence. The term

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"central worksite" shall mean CalOptima's customary work address.

2. ~~Summary~~Description of the Remote Work Location:

a. Employee's regular workplace is at CalOptima in Orange, California. CalOptima and Employee agree that Employee is permitted to work from the following remote work location:

Employee's residence at _____
Address City State Zip

Phone number: _____
Work Home Cell

b. Employee's work schedule will be ~~is permitted to work at the remote work location on the following days and times~~:

_____
Days of week Times

c. Employee understands and agrees that Employee is expected to work the schedule and hours and in the location specified above. Deviations from Employee's scheduled hours must be discussed with Employee's supervisor and recorded.

3. **Salary and Benefits**: Employee understands and agrees that this teleworking work arrangement does not affect the Employee's salary or benefits.

Application

~~Telework is a workplace arrangement in which eligible employees work at least part time away from the primary workplace. **Telework is not a universal employee benefit or entitlement**, but an alternative method of meeting the work needs of the organization through an innovative and flexible work structure.~~

4. ~~As part~~ **of** ~~this Agreement, the teleworker must read and agree to the terms in the~~ **CalOptima Policies, Procedures and Rules:**

a. E Employee agrees to abide by the terms and requirements of the Telework Program policy and all other applicable CalOptima policies ~~mployee understands and agrees that this telework work arrangement is subject to CalOptima's Telework Program policy. The policy includes information about:, as modified from time to time.~~

~~1. The purpose of the telework program~~
~~2. Terms of employment~~
~~3. Termination of telework arrangement~~
~~4. Teleworker selection~~
~~5. Work schedule and accessibility~~
~~6. Dependent care~~
~~7. Liability~~
~~8. Compliance handling protected health information (PHI) form a remote work location~~
~~9. Use of PC from remote location~~
~~10. Use of electronic mail with PHI~~

b. ~~Use of printer from~~ Employee understands and agrees that the telework work arrangement is not intended to supersede or override CalOptima's policies, procedures, rules, or standards of conduct and the Employee agrees to adhere to all applicable CalOptima policies, procedures, rules, and standards of conduct.

5. **Technological Capabilities:** Employee understands and agrees that the Employee is expected to maintain an appropriate level of connectivity and technological capability as required by CalOptima.

a. In particular, employee is required to:

1) Provide access to an adequate number of grounded power outlets near their work desk and the home internet equipment.

2) Provide or purchase a surge protector to guard against damage to equipment

3) Provide or purchase *cable internet connection with a minimum transfer speed of 4.5 Mbps download and 1 Mbps upload.

*Note: A wired connection is required. Wireless connection is not ~~permitted~~recommended.

Note: CalOptima's Information Systems (IS) department does not provide support for any home wireless setup or equipment and requires that there be a wired internet connection from the home internet modem/router to CalOptima's computer equipment.

~~1.~~b. CalOptima will provide equipment as required to be used for work purposes at the remote work location. The equipment may include:

~~1. Telework site/remote work location~~
~~2. Teleworker performance management~~

1) ~~Establishing~~Computer
2) Monitor(s)
3) Speaker Bar
4) Phone headset & enabler
5) Keyboard & Mouse
6) VGA Cable
7) Other equipment as deemed necessary to support the Employee's daily work

~~2.~~6. **Safety and Security:** Employee understands and agrees that the Employee is expected to maintain an appropriate safe and secure remote work ~~location (home office)~~space within their residence. To enhance Employee well-being and efficiency, the Employee will apply ergonomically appropriate practices in their daily work. The Employee will:

~~1. Security of CalOptima assets~~
~~2. Inspection~~
~~3. Training~~
~~4. Working from the central work site~~
~~5. Travel reimbursement~~
~~6. Program reporting and evaluation~~
~~7. Non-exempt employees~~
~~8. Other arrangements~~

~~**Unique Circumstances**~~

~~10. Does this position deal with any PHI documents? ☐ Yes ☐ No~~

a. ~~If yes, by initialing here, I agree that I have~~Provide or purchase a desk meeting CalOptima requirements, i.e., at least four (4) linear feet in width and at least 36" of clear leg room space that provides adequate space for a PC or laptop, monitor(s), keyboard, mouse, and other work necessities; to perform all of the assigned duties.

b. The work desk will be placed within 6 feet of the home internet equipment.

~~a.~~c. *Provide or purchase storage with a locked drawer to ~~stow any PHI~~ use to secure Protected Health Information (PHI) related documents when ~~I am~~ not working or when ~~I leave~~leaving the remote work location or workspace.

~~Employee Initials~~

~~2. Participants and managers may agree to a continuation of the 9/80 work schedule while teleworking. By checking the box below, the teleworker, immediate supervisor, and department head all agree to allow the participant to engage in a 9/80 schedule while teleworking~~

~~☐ Check box if Direct Supervisor, Department Head, and teleworker agree to 9/80 schedule~~

*Maybe optional if daily work does not deal with PHI or related materials

d. Provide or purchase a first aid kit and a 2A10BC fire extinguisher meeting CalOptima requirements.

e. Provide or purchase a smoke detector to be placed near the work area.

f. Provide or purchase adequate lights/lighting adequate for reading and completing work.

~~3.~~ **Exceptions**: The space below is for documenting any circumstances unique to this teleworking situation. "Unique circumstances" include any deviations from the above guidelines that are agreed upon by the teleworker, supervisor, and the ~~telework coordinator~~Telework Program Coordinator in Human Resources.~~–~~

Confirmation of Agreement

This Agreement is the entire agreement with respect to the subject-matter addressed herein. This Agreement takes precedence over any prior discussions Employee has had with any CalOptima personnel with respect to the topics addressed in this Agreement.

I understand that this agreement does not create a contract for employment and does not otherwise change the terms and conditions of my at-will employment that apply to employees at CalOptima. I understand that at any time, with or without notice, CalOptima may terminate the

~~4. ☐ I wish to decline participation as a teleworker. Please indicate reason below:~~

~~Sig~~

teleworking agreement and/or my employment, with or without notice, and with o~~ur~~ without cause.

I affirm by my signature below that I have read, understand and agree to comply with all of the work rules and policies described in this agreement and Telework Program Policy. I further agree with the duties, responsibilities and conditions for ~~telecommuting~~telework at a remote work site as set forth ~~in this document~~by my supervisor, including the condition that I am expected to accomplish the job tasks in accordance with the agreed upon schedule and performance standards.~~-~~

~~I understand that this agreement does not create a contract for employment and does not otherwise change the terms and conditions of employment that apply to employees at CalOptima. I understand that at any time, with or without notice, CalOptima may terminate the telecommuting agreement.~~

Teleworker:

CalOptima Teleworking Agreement

Print Name Signature ~~of Teleworker~~ Date

~~Signature of~~ **Immediate Supervisor** ~~:~~

Print Name Signature Date

~~Signature of~~ **Department Head** ~~:~~

Print Name Signature Date

~~Signature of Telework Coordinator (HR)~~ ~~Date~~

Teleworker Work Schedule

Complete and sign the agreed upon work schedule. If the telework schedule will vary by week, check the box marked flexible and outline how the schedule will vary.

Day	Hours	Location: Remote Work Location (RWL) or Central worksite (C)
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		

☐ Flexible – schedule will vary week to week. Please outline below how the schedule will vary.

Comments:

Signature of Teleworker Date

Signature of Immediate Supervisor Date

~~SUBMIT FORM TO HR WITHIN 48 HOURS~~

CalOptima Teleworking Agreement

1
2

HR Only

Date Received: _____

Accepted: ☐ Yes ☐ No

CalOptima Teleworking Agreement

Name	
Title:	
Department:	
Supervisor/Manager:	

Telework is a workplace arrangement in which eligible CalOptima employees work their entire work schedule away from the central worksite at a remote work Location, unless business needs require otherwise. **Telework is not a universal employee benefit or entitlement**, but an alternative method of meeting the work needs of the organization through an innovative and flexible work structure.

I,_ _____, ("Employee")_and CalOptima. mutually agree that the Employee
Print Name
will begin a Teleworking work arrangement effective on _____ pursuant to this
Date
Agreement (the "Agreement").

1. **Participation:** Employee recognizes that teleworking is voluntary and may be reassessed, modified, and may be terminated, by either the employee or CalOptima, with or without notice or cause.

   Other than those duties and obligations expressly imposed on the employee under this agreement, the duties, obligations, responsibilities and conditions of Employee's employment with CalOptima remain unchanged. The employee's salary and benefits shall remain unchanged.

   The terms "remote work location" or "remote workplace" shall mean the employee's residence. The term "central worksite" shall mean CalOptima's customary work address.

2. **Description of the Remote Work Location:**

   a. Employee's regular workplace is at CalOptima in Orange, California. CalOptima and Employee agree that Employee is permitted to work from the following remote work location:

      Employee's residence at _____
      Address City State Zip

      Phone number: _____ _____ _____
      Work Home Cell

   b. Employee's work schedule will be:

      _____
      Days of week Times

Back to Agenda

c. Employee understands and agrees that Employee is expected to work the schedule and hours and in the location specified above. Deviations from Employee's scheduled hours must be discussed with Employee's supervisor and recorded.

3. **Salary and Benefits**: Employee understands and agrees that this teleworking work arrangement does not affect the Employee's salary or benefits.

Application

4. **of CalOptima Policies, Procedures and Rules:**

a. E Employee agrees to abide by the terms and requirements of the Telework Program policy and all other applicable CalOptima policies e.

b. Employee understands and agrees that the telework work arrangement is not intended to supersede or override CalOptima's policies, procedures, rules, or standards of conduct and the Employee agrees to adhere to all applicable CalOptima policies, procedures, rules, and standards of conduct.

5. **Technological Capabilities:** Employee understands and agrees that the Employee is expected to maintain an appropriate level of connectivity and technological capability as required by CalOptima.

a. In particular, employee is required to:

1) Provide access to an adequate number of grounded power outlets near their work desk and the home internet equipment.

2) Provide or purchase a surge protector to guard against damage to equipment

3) Provide or purchase *cable internet connection with a minimum transfer speed of 4.5 Mbps download and 1 Mbps upload.

*Note: A wired connection is required. Wireless connection is not recommended.

Note: CalOptima's Information Systems (IS) department does not provide support for any home wireless setup or equipment and requires that there be a wired internet connection from the home internet modem/router to CalOptima's computer equipment.

b. CalOptima will provide equipment as required to be used for work purposes at the remote work location. The equipment may include:

1) Computer
2) Monitor(s)
3) Speaker Bar
4) Phone headset & enabler
5) Keyboard & Mouse
6) VGA Cable
7) Other equipment as deemed necessary to support the Employee's daily work

6. **Safety and Security:** Employee understands and agrees that the Employee is expected to maintain an appropriate safe and secure remote work space within their residence. To enhance Employee well-being and efficiency, the Employee will apply ergonomically appropriate practices in their daily work. The Employee will:

a. Provide or purchase a desk meeting CalOptima requirements, i.e., at least four (4) linear feet in width and at least 36" of clear leg room space that provides adequate space for a PC or laptop, monitor(s), keyboard, mouse, and other work necessities; to perform all of the assigned duties.

b. The work desk will be placed within 6 feet of the home internet equipment.

c. *Provide or purchase storage with a locked drawer to use to secure Protected Health Information (PHI) related documents when not working or when leaving the remote work location or workspace.

*Maybe optional if daily work does not deal with PHI or related materials

d. Provide or purchase a first aid kit and a 2A10BC fire extinguisher meeting CalOptima requirements.

e. Provide or purchase a smoke detector to be placed near the work area.

f. Provide or purchase adequate lights/lighting adequate for reading and completing work.

Exceptions: The space below is for documenting any circumstances unique to this teleworking situation. "Unique circumstances" include any deviations from the above guidelines that are agreed upon by the teleworker, supervisor, and the Telework Program Coordinator in Human Resources.

Confirmation of Agreement

This Agreement is the entire agreement with respect to the subject-matter addressed herein. This Agreement takes precedence over any prior discussions Employee has had with any CalOptima personnel with respect to the topics addressed in this Agreement.

I understand that this agreement does not create a contract for employment and does not otherwise change the terms and conditions of my at-will employment that apply to employees at CalOptima. I understand that at any time, with or without notice, CalOptima may terminate the teleworking agreement and/or my employment, with or without notice, and with or without cause.

I affirm by my signature below that I have read, understand and agree to comply with all of the work rules and policies described in this agreement and Telework Program Policy. I further agree with the duties, responsibilities and conditions for telework at a remote work site as set forth by my supervisor, including the condition that I am expected to accomplish the job tasks in accordance with the agreed upon schedule and performance standards.

Teleworker:

Print Name	Signature	Date

Immediate Supervisor:

Print Name	Signature	Date

Department Head:

Print Name	Signature	Date

HR Only

Date Received: _____

Accepted: ☐ Yes ☐ No _____

CalOptima Occasional Off-Site Work Agreement

Name:	
Title:	
Department:	
Supervisor/Manager:	

CalOptima supports alternative work arrangements. One arrangement is an opportunity, when appropriate, for an employee to occasionally work off-site, away from the CalOptima central worksite. This is not a universal employee benefit or entitlement, but rather a voluntary alternative method of meeting the work needs of the organization through a flexible work structure.

I _____, ("Employee") and CalOptima, mutually agree that the
Print Name

Employee is eligible to work at a Remote Work Location, occasionally, commencing on _____ pursuant to this Occasional Off-site
Date

Work Agreement (the "Agreement"). This arrangement is defined in CalOptima Policy, GA.8044: Telework Program. It states that, "When special circumstances require it, an employee's manager has the discretion to allow an employee to work from a Remote Work Location on an occasional basis."

"Occasional" is defined as rare, infrequent and not regularly scheduled for brief periods (usually a day or part of a day); with no specific or implied expectation from an employee that he or she will be allowed to work from a Remote Work Location routinely. This is not considered or counted as a telework position. This privilege is voluntary and may be terminated at any time by the employee or manager.

Participation:

Employee recognizes that occasional off-site work is voluntary and at the Employee's discretion. The occasional off-site work arrangement may be reassessed, modified and/or terminated by either the employee or CalOptima, with or without notice or cause.

Other than those duties and obligations expressly imposed on the employee under this Agreement, the duties obligations, responsibilities and conditions of Employee's employment with CalOptima remain unchanged. The employee's salary and benefits shall remain unchanged.

Definitions:

a. The terms and definitions in this Agreement shall have the same meaning as the terms and definitions contained in CalOptima Policy GA.8044: Telework Program.

Application of CalOptima Policies, Procedures and Rules:

a. Employee agrees to abide by the terms and requirements of CalOptima Policy GA.8044: Telework Program and all other applicable CalOptima policies, including, but not limited to, liability, compliance, use of personal computer from the Remote Work Location, use of electronic mail with PHI, security of CalOptima assets, etc.
b. Employee understands and agrees that the occasional off-site work arrangement is not intended to supersede or override CalOptima's policies, procedures, rules or standards of conduct and the Employee agrees to adhere to all applicable CalOptima policies, procedures, rules and standards of conduct.

Technological Capabilities: When using CalOptima devices, the Employee understands and agrees that the Employee is expected to maintain an appropriate level of connectivity and technological capability as required by CalOptima.

Safety and Security: Employee understands and agrees that the Employee is expected to maintain an appropriate safe and secure Remote Work Location when working off-site. In the event employee is not working from a Home Office location, any alternative Remote Work Location must be pre-approved by Employee's supervisor.

Confirmation of Agreement:

This Agreement is the entire agreement with respect to the subject-matter addressed herein. This Agreement takes precedence over any prior discussions Employee has had with any CalOptima personnel with respect to the topics addressed in this Agreement.

I understand that this Agreement does not create a contract for employment and does not otherwise change the terms and conditions of my at-will employment that apply to employees at CalOptima. I understand that at any time, with or without notice, CalOptima may terminate the occasional off-site work agreement or occasional off-site work arrangement and/or my employment, with or without notice, and with or without cause. I understand that any violation of CalOptima's policies and procedures or any violations of state or federal law while working off-site may result in disciplinary action, up to and including termination, and/or civil or criminal prosecution.

I affirm by my signature below that I have read, understand and agree to comply with all of the work rules and policies described in this Agreement and Telework Program Policy. I further agree with the duties, responsibilities and conditions for occasional off-site work as set forth by my supervisor, including the condition that I am expected to accomplish the job tasks in accordance with the agreed upon schedule and performance standards.

Employee:

_____	_____	_____
Print Name	Signature	Date

Immediate Supervisor:

Print Name	Signature	Date

RECEIVED BY HUMAN RESOURCES:

Print Name	Signature	Date

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:	02/01/18
	~~11/02/17~~
	02/01/18

I. PURPOSE

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

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

II. POLICY

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

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

2. Identification of position titles for every employee position;

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

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

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

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

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

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

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

III. PROCEDURE

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

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

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of ~~11/02/17~~02/01/18)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 02/01/18: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 11/02/17: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 09/07/17: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 08/03/17: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 06/01/17: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 05/04/17: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 03/02/17: Regular Meeting of the CalOptima Board of Directors
~~G.~~H. 12/01/16: Regular Meeting of the CalOptima Board of Directors
~~H.~~I. 11/03/16: Regular Meeting of the CalOptima Board of Directors
~~I.~~J. 10/06/16: Regular Meeting of the CalOptima Board of Directors
~~J.~~K. 09/01/16: Regular Meeting of the CalOptima Board of Directors
~~K.~~L. 08/04/16: Regular Meeting of the CalOptima Board of Directors
~~L.~~M. 06/02/16: Regular Meeting of the CalOptima Board of Directors

~~M.~~N. 03/03/16: Regular Meeting of the CalOptima Board of Directors
~~N.~~O. 12/03/15: Regular Meeting of the CalOptima Board of Directors
~~O.~~P. 10/01/15: Regular Meeting of the CalOptima Board of Directors
~~P.~~Q. 06/04/15: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule	Administrative
Revised	06/04/2015	GA.8058	Salary Schedule	Administrative
Revised	10/01/2015	GA.8058	Salary Schedule	Administrative
Revised	12/03/2015	GA.8058	Salary Schedule	Administrative
Revised	03/03/2016	GA.8058	Salary Schedule	Administrative
Revised	06/02/2016	GA.8058	Salary Schedule	Administrative
Revised	08/04/2016	GA.8058	Salary Schedule	Administrative
Revised	09/01/2016	GA.8058	Salary Schedule	Administrative
Revised	10/06/2016	GA.8058	Salary Schedule	Administrative
Revised	11/03/2016	GA.8058	Salary Schedule	Administrative
Revised	12/01/2016	GA.8058	Salary Schedule	Administrative
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
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	02/01/18
Last Revised Date:	02/01/18

I. PURPOSE

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

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

II. POLICY

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

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

2. Identification of position titles for every employee position;

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

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

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

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

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

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

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

III. PROCEDURE

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

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

C. HR shall review the salary schedule and provide recommendations to maintain the competitiveness of the salary schedule to market pay levels.

D. Any adjustments to the salary schedule requires that the Executive Director of HR make a recommendation to the CEO for approval, with the CEO taking the recommendation to the CalOptima Board of Directors for final approval. No changes to the salary schedule, or CEO compensation, shall be effective unless and until approved by the CalOptima Board of Directors.

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of 02/01/18)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

A. 02/01/18: Regular Meeting of the CalOptima Board of Directors
B. 11/02/17: Regular Meeting of the CalOptima Board of Directors
C. 09/07/17: Regular Meeting of the CalOptima Board of Directors
D. 08/03/17: Regular Meeting of the CalOptima Board of Directors
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O. 12/03/15: Regular Meeting of the CalOptima Board of Directors
P. 10/01/15: Regular Meeting of the CalOptima Board of Directors

Q. 06/04/15: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule	Administrative
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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
Revised	02/01/2018	GA.8058	Salary Schedule	Administrative

IX. GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised February 1, 2018
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	

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	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	

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* 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	

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HR Assistant	I	181	$37,128	$46,384	$55,640	
HR Business Partner	M	584	$62,400	$81,120	$99,840	
HR Compensation Specialist Sr	N	TBD	$71,760	$93,184	$114,712	New Position
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	

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	Manager Integration Government Liaison	N	455	$71,760	$93,184	$114,712	
	Manager Long Term Support Services	O	200	$82,576	$107,328	$131,976	
	Manager Marketing & Enrollment (PACE)	O	414	$82,576	$107,328	$131,976	
	Manager Medical Data Management	O	519	$82,576	$107,328	$131,976	
	Manager Medi-Cal Program Operations	N	483	$71,760	$93,184	$114,712	
	Manager Member Liaison Program	N	354	$71,760	$93,184	$114,712	
	Manager Member Outreach & Education	N	616	$71,760	$93,184	$114,712	
	Manager Member Outreach Education & Provider Relations	O	576	$82,576	$107,328	$131,976	
	Manager MSSP	O	393	$82,576	$107,328	$131,976	
	Manager OneCare Clinical	O	359	$82,576	$107,328	$131,976	
	Manager OneCare Customer Service	N	429	$71,760	$93,184	$114,712	
	Manager OneCare Regulatory	N	197	$71,760	$93,184	$114,712	
	Manager OneCare Sales	O	248	$82,576	$107,328	$131,976	
	Manager Outreach & Enrollment	N	477	$71,760	$93,184	$114,712	
	Manager PACE Center	O	432	$82,576	$107,328	$131,976	
	Manager Process Excellence	O	622	$82,576	$107,328	$131,976	
	Manager Program Implementation	O	488	$82,576	$107,328	$131,976	
	Manager Project Management	O	532	$82,576	$107,328	$131,976	
	Manager Provider Data Management Services	N	TBD	$71,760	$93,184	$114,712	
	Manager Provider Network	O	191	$82,576	$107,328	$131,976	
	Manager Provider Relations	N	171	$71,760	$93,184	$114,712	
	Manager Provider Services	O	TBD	$82,576	$107,328	$131,976	
	Manager Purchasing	N	275	$71,760	$93,184	$114,712	
	Manager QI Initiatives	N	433	$71,760	$93,184	$114,712	
	Manager Quality Analytics	O	617	$82,576	$107,328	$131,976	
	Manager Quality Improvement	O	104	$82,576	$107,328	$131,976	
	Manager Regulatory Affairs and Compliance	O	626	$82,576	$107,328	$131,976	
	Manager Reporting & Financial Compliance	O	572	$82,576	$107,328	$131,976	
	Manager Strategic Development	O	603	$82,576	$107,328	$131,976	
	Manager Strategic Operations	N	446	$71,760	$93,184	$114,712	
	Manager Systems Development	P	515	$95,264	$128,752	$162,032	
	Manager Utilization Management	O	250	$82,576	$107,328	$131,976	
	Marketing and Outreach Specialist	J	496	$40,976	$53,352	$65,624	
	Medical Assistant	H	535	$33,696	$42,224	$50,648	
	Medical Authorization Asst	H	11	$33,696	$42,224	$50,648	
	Medical Case Manager	N	72	$71,760	$93,184	$114,712	
	Medical Case Manager (LVN)	L	444	$54,288	$70,512	$86,736	
*	Medical Director	S	306	$164,736	$222,352	$280,072	
	Medical Records & Health Plan Assistant	G	548	$30,576	$38,272	$45,968	
	Medical Records Clerk	E	523	$25,272	$31,720	$37,960	
	Medical Services Case Manager	K	54	$47,112	$61,360	$75,504	
	Member Liaison Specialist	I	353	$37,128	$46,384	$55,640	
	MMS Program Coordinator	K	360	$47,112	$61,360	$75,504	
	Nurse Practitioner (PACE)	P	635	$95,264	$128,752	$162,032	
	Occupational Therapist	N	531	$71,760	$93,184	$114,712	
	Occupational Therapist Assistant	M	623	$62,400	$81,120	$99,840	
	Office Clerk	C	335	$21,008	$26,208	$31,408	
	OneCare Operations Manager	O	461	$82,576	$107,328	$131,976	
	OneCare Partner - Sales	K	230	$47,112	$61,360	$75,504	
	OneCare Partner - Sales (Lead)	K	537	$47,112	$61,360	$75,504	
	OneCare Partner - Service	I	231	$37,128	$46,384	$55,640	
	OneCare Partner (Inside Sales)	J	371	$40,976	$53,352	$65,624	
	Outreach Specialist	I	218	$37,128	$46,384	$55,640	
	Paralegal/Legal Secretary	K	376	$47,112	$61,360	$75,504	
	Payroll Specialist	J	554	$40,976	$53,352	$65,624	
	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	

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	Pharmacy Resident	K	379	$47,112	$61,360	$75,504	
	Pharmacy Services Specialist	I	23	$37,128	$46,384	$55,640	
	Pharmacy Services Specialist Int	J	35	$40,976	$53,352	$65,624	
	Pharmacy Services Specialist Sr	K	507	$47,112	$61,360	$75,504	
	Physical Therapist	N	530	$71,760	$93,184	$114,712	
	Physical Therapist Assistant	M	624	$62,400	$81,120	$99,840	
	Policy Advisor Sr	O	580	$82,576	$107,328	$131,976	
	Privacy Manager	N	536	$71,760	$93,184	$114,712	
	Privacy Officer	P	648	$95,264	$128,752	$162,032	
	Process Excellence Manager	O	529	$82,576	$107,328	$131,976	
	Program Assistant	I	24	$37,128	$46,384	$55,640	
	Program Coordinator	I	284	$37,128	$46,384	$55,640	
	Program Development Analyst Sr	M	492	$62,400	$81,120	$99,840	
	Program Manager	M	421	$62,400	$81,120	$99,840	
	Program Manager Sr	O	594	$82,576	$107,328	$131,976	
	Program Specialist	J	36	$40,976	$53,352	$65,624	
	Program Specialist Int	K	61	$47,112	$61,360	$75,504	
	Program Specialist Sr	L	508	$54,288	$70,512	$86,736	
	Program/Policy Analyst	K	56	$47,112	$61,360	$75,504	
	Program/Policy Analyst Sr	M	85	$62,400	$81,120	$99,840	
	Programmer	L	43	$54,288	$70,512	$86,736	
	Programmer Int	N	74	$71,760	$93,184	$114,712	
	Programmer Sr	O	80	$82,576	$107,328	$131,976	
	Project Manager	M	81	$62,400	$81,120	$99,840	
	Project Manager - Lead	M	467	$62,400	$81,120	$99,840	
	Project Manager Sr	O	105	$82,576	$107,328	$131,976	
	Project Specialist	K	291	$47,112	$61,360	$75,504	
	Project Specialist Sr	L	503	$54,288	$70,512	$86,736	
	Projects Analyst	K	254	$47,112	$61,360	$75,504	
	Provider Enrollment Data Coordinator	I	12	$37,128	$46,384	$55,640	
	Provider Enrollment Data Coordinator Sr	J	586	$40,976	$53,352	$65,624	
	Provider Enrollment Manager	K	190	$47,112	$61,360	$75,504	
	Provider Network Rep Sr	L	391	$54,288	$70,512	$86,736	
	Provider Network Specialist	K	44	$47,112	$61,360	$75,504	
	Provider Network Specialist Sr	L	595	$54,288	$70,512	$86,736	
	Provider Office Education Manager	L	300	$54,288	$70,512	$86,736	
	Provider Relations Rep	K	205	$47,112	$61,360	$75,504	
	Provider Relations Rep Sr	L	285	$54,288	$70,512	$86,736	
	Publications Coordinator	J	293	$40,976	$53,352	$65,624	
	QA Analyst	L	486	$54,288	$70,512	$86,736	
	QA Analyst Sr	N	380	$71,760	$93,184	$114,712	
	QI Nurse Specialist	N	82	$71,760	$93,184	$114,712	
	QI Nurse Specialist (LVN)	M	445	$62,400	$81,120	$99,840	
	Receptionist	F	140	$27,872	$34,840	$41,808	
	Recreational Therapist	L	487	$54,288	$70,512	$86,736	
	Recruiter	L	406	$54,288	$70,512	$86,736	
	Recruiter Sr	M	497	$62,400	$81,120	$99,840	
	Registered Dietitian	L	57	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Analyst	K	628	$47,112	$61,360	$75,504	
	Regulatory Affairs and Compliance Analyst Sr	L	629	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Lead	M	630	$62,400	$81,120	$99,840	
	RN (PACE)	N	480	$71,760	$93,184	$114,712	
	Security Analyst Int	N	534	$71,760	$93,184	$114,712	
	Security Analyst Sr	O	474	$82,576	$107,328	$131,976	
	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	

CalOptima - Annual Base Salary Schedule - Revised February 1, 2018
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Sr Manager Financial Analysis	P	TBD	$95,264	$128,752	$162,032	New Position
Sr Manager Human Resources	P	649	$95,264	$128,752	$162,032	
Sr Manager Information Services	Q	650	$114,400	$154,440	$194,480	
Sr Manager Government Affairs	O	451	$82,576	$107,328	$131,976	
Sr Manager Provider Network	O	651	$82,576	$107,328	$131,976	
Staff Attorney	P	195	$95,264	$128,752	$162,032	
Supervisor Accounting	M	434	$62,400	$81,120	$99,840	
Supervisor Audit and Oversight	N	618	$71,760	$93,184	$114,712	
Supervisor Behavioral Health	N	TBD	$71,760	$93,184	$114,712	
Supervisor Budgeting	M	466	$62,400	$81,120	$99,840	
Supervisor Case Management	N	86	$71,760	$93,184	$114,712	
Supervisor Claims	K	219	$47,112	$61,360	$75,504	
Supervisor Coding Initiatives	M	502	$62,400	$81,120	$99,840	
Supervisor Customer Service	K	34	$47,112	$61,360	$75,504	
Supervisor Data Entry	K	192	$47,112	$61,360	$75,504	
Supervisor Day Center (PACE)	K	619	$47,112	$61,360	$75,504	
Supervisor Dietary Services (PACE)	M	643	$62,400	$81,120	$99,840	
Supervisor Disease Management	N	644	$71,760	$93,184	$114,712	
Supervisor Encounters	L	253	$54,288	$70,512	$86,736	
Supervisor Facilities	L	162	$54,288	$70,512	$86,736	
Supervisor Finance	N	419	$71,760	$93,184	$114,712	
Supervisor Grievance and Appeals	M	620	$62,400	$81,120	$99,840	
Supervisor Health Education	M	381	$62,400	$81,120	$99,840	
Supervisor Information Services	N	457	$71,760	$93,184	$114,712	
Supervisor Long Term Support Services	N	587	$71,760	$93,184	$114,712	
Supervisor MSSP	N	348	$71,760	$93,184	$114,712	
Supervisor OneCare Customer Service	K	408	$47,112	$61,360	$75,504	
Supervisor Payroll	M	517	$62,400	$81,120	$99,840	
Supervisor Pharmacist	P	610	$95,264	$128,752	$162,032	
Supervisor Provider Enrollment	K	439	$47,112	$61,360	$75,504	
Supervisor Provider Relations	M	652	$62,400	$81,120	$99,840	
Supervisor Quality Analytics	M	609	$62,400	$81,120	$99,840	
Supervisor Quality Improvement	N	600	$71,760	$93,184	$114,712	
Supervisor Regulatory Affairs and Compliance	N	627	$71,760	$93,184	$114,712	
Supervisor Social Work (PACE)	L	636	$54,288	$70,512	$86,736	
Supervisor Systems Development	O	456	$82,576	$107,328	$131,976	
Supervisor Therapy Services (PACE)	N	645	$71,760	$93,184	$114,712	
Supervisor Utilization Management	N	637	$71,760	$93,184	$114,712	
Systems Manager	N	512	$71,760	$93,184	$114,712	
Systems Network Administrator Int	M	63	$62,400	$81,120	$99,840	
Systems Network Administrator Sr	N	89	$71,760	$93,184	$114,712	
Systems Operations Analyst	J	32	$40,976	$53,352	$65,624	
Systems Operations Analyst Int	K	45	$47,112	$61,360	$75,504	
Technical Analyst Int	L	64	$54,288	$70,512	$86,736	
Technical Analyst Sr	M	75	$62,400	$81,120	$99,840	
Technical Writer	L	247	$54,288	$70,512	$86,736	
Technical Writer Sr	M	470	$62,400	$81,120	$99,840	
Therapy Aide	J	521	$40,976	$53,352	$65,624	
Training Administrator	L	621	$54,288	$70,512	$86,736	
Training Program Coordinator	K	471	$47,112	$61,360	$75,504	
Translation Specialist	G	241	$30,576	$38,272	$45,968	
Web Architect	O	366	$82,576	$107,328	$131,976	

* These positions are identified for the purposes of CalOptima Policy GA. 8042: Supplemental Compensation as Director level and above positions for which eligible employees may qualify for Employer-Paid Member Contribution.

** 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.

CalOptima - Annual Base Salary Schedule - Revised February 1, 2018
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval

Text in red indicates new changes to the salary schedule proposed for Board approval.

Summary of Changes to Salary Schedule

For February 2018 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
HR Compensation Specialist Sr	N/A	N	This new position is responsible for providing expertise in administering CalOptima's base pay, incentive and merit compensation programs, including job evaluations, salary planning and administration, market analysis and benchmarking, and plays an integral role in ensuring that pay practices are equitable and competitive within established benchmarks so that CalOptima can effectively attract and retain qualified employees.	N/A	February 2018
Sr Manager Financial Analysis	N/A	P	This new position is responsible for analyzing and evaluating the fiscal impact of provider contracts, new programs, and strategic initiatives. It will also be responsible for development of the annual medical cost budget and assessing medical utilization and unit cost trends. In addition, the position will be charged with managing a new unit created to monitor and analyze the Medicare Risk Adjustment process.	N/A	February 2018

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

4. Consider Authorizing Contracting with or Amending Contracts with Community Health Centers Associated with St. Joseph Health to Serve as the Primary Care Provider for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

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

Recommended Action

Subject to approval by the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) of the Board-authorized waiver request, authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into contracts, or amend contracts with Community Health Centers associated with St. Joseph Health to serve as primary care providers for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE), as part of implementation of said waiver.

Background/Discussion

At its December 7, 2017 meeting, the Board authorized contracts/contract amendments with Community Based Physicians (CBPs), except those associated with St. Joseph Health, to serve as primary care providers for Participants enrolled with PACE. St. Joseph Health-affiliated CBPs were carved out of the December 7th recommended action to ensure that a minimum quorum of the Board was available to consider the item. Staff now requests authority to contract with community health centers (clinics) associated with St. Joseph Health, as applicable, to serve as primary care providers for Participants enrolled in PACE.

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

In many cases, potential PACE-eligible participants wish to keep their existing primary care provider due to geographic considerations, as well as cultural and linguistic competencies. Allowing CalOptima PACE to contract with CBPs will allow CalOptima to enroll PACE participants who wish to access the PACE model of care, while maintaining their existing relationship with their primary care physician – often in their neighborhood and language.

On September 7, 2017, the CalOptima Board of Directors authorized staff to submit a waiver request to the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) to allow CBPs to serve as primary care providers to participants in the PACE program. The waiver has been submitted and CalOptima is waiting for a response.

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If the waiver is approved, staff will contract with, or amend existing contracts with St. Joseph Health Clinics, in accordance with current contracting and rate strategies used for other CalOptima contracted Medicare PCPs PACE participants will be able to access care from contracted CBPs where a PACE physician would typically be needed. If the waiver is approved, it is intended that CalOptima would implement the waiver as approved.

Fiscal Impact

The Fiscal Year 2017-18 CalOptima Operating Budget, approved by the Board on June 1, 2017, includes projected total expenses of $730,000 for PACE primary care physician services, some portion of which may be expended as payment for PCP services provided to CalOptima PACE participants by community health centers associated with St. Joseph Health. The recommended action to enter into or amend contracts with St. Joseph Health-affiliated community health centers to serve as primary care providers for PACE participants is budget neutral. The average costs per visit for CBP services are projected to be less than the costs for current center-based physician services.

Rationale for Recommendation

Implementation of the requested waiver, if approved, would provide greater flexibility for CalOptima's PACE center to contract with community clinics, thereby increasing access to participants to receive care in their neighborhood and their language, while also potentially eliminating a barrier to enrollment in PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 7, 2017, Consider Authorizing Contracting with or Amending Contracts with 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)
    a. Board Action dated September 7, 2017, 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)

/s/ Michael Schrader — *1/25/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Contracting with or Amending Contracts with 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)

Contact

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

Recommended Action

Subject to approval by the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) of Board-authorized waiver request, authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into contracts, or amend contracts with Community Based Physicians (CBPs), except those associated with St. Joseph Health System, to serve as primary care providers for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE), as part of implementation of said waiver.

Rev. 12/7/2017

Background/Discussion

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

In many cases, potential PACE-eligible participants wish to keep their existing primary care physician due to geographic considerations, as well as cultural and linguistic competencies. Allowing CalOptima PACE to contract with community-based physicians will allow CalOptima to enroll PACE participants who wish to access the PACE model of care, while maintaining their existing relationship with their primary care physician – often in their neighborhood and language.

On September 7, 2017, the CalOptima Board of Directors authorized staff to submit a waiver request to the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) to allow CBPs to serve as primary care providers to participants in the PACE program. The waiver has been submitted and CalOptima is waiting for a response.

If the waiver is approved, staff will contract with, or amend existing contracts with qualified primary care providers, in accordance with current contracting and rate strategies used for other CalOptima contracted Medicare primary care physicians. PACE participants will be able to access care from contracted CBPs where a PACE physician would typically be needed. If the waiver is approved, it is intended that CalOptima would implement the waiver as approved.

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Fiscal Impact

The Fiscal Year 2017-18 CalOptima Operating Budget, approved by the Board on June 1, 2017, includes projected expenses of $730,000 for PACE primary care physician services. The recommended action to enter into or amend contracts with CBPs to serve as primary care providers for PACE participants is budget neutral. The average cost per visit for CBP services are projected to be less than the costs for current center-based physician services.

Rationale for Recommendation

Implementation of the requested waiver, if approved, would provide greater flexibility for CalOptima's PACE center to contract with community-based primary care physicians, increasing access to participants to receive care in their neighborhood and their language, while also potentially eliminating a barrier to enrollment in PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Board Action dated September 7, 2017, 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)

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

11/30/2017 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

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)

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer to file a waiver request for CalOptima's Program of All-Inclusive Care for the Elderly (PACE) for Section 903 of the Benefits Improvement and Protection Act (BIPA) of 2000, to the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) in order to allow Community Based Physicians (CBP) to serve as the primary care provider, in collaboration with the PACE interdisciplinary team; and
2. ~~Authorize the 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.~~ *Continued to future Board meeting.*

Rev. 9/7/17

Background/Discussion

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

In many cases, potential PACE-eligible participants wish to keep their existing primary care physician due to geographic considerations, as well as cultural and linguistic competencies. Notably, CalOptima PACE currently serves participants who speak 22 different languages, highlighting the diverse Orange County community. Participants may travel up to 15 miles or up to one hour in a vehicle to see their primary care physician. Allowing CalOptima PACE to contract with community-based physicians will allow CalOptima to enroll PACE participants who wish to access the PACE model of care, while maintaining their existing relationship with their primary care physician – in their neighborhood and language.

Section 903 of BIPA allows for specific modifications or waivers of certain regulatory provision to meet the needs of PACE organizations. As such, CalOptima PACE is requesting for a waiver of the regulatory sections listed below from Title 42: Public Health,§460 – PACE, in order to allow a CBP to serve as the primary care provider on the interdisciplinary team:

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- § 460.102(a) *Basic requirement.* A PACE organization must meet the following requirements: (1) Establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each participant.

- § 460.102(d)(3) The members of the interdisciplinary team must serve primarily PACE participants.

This waiver request is to allow CBPs to serve as a primary care provider, as set forth in the PACE regulation, by providing primary care services in their respective clinic settings while also serving non-PACE participants.

Filing of a 903 BIPA Waiver application will not add to PACE expenditures. In fact, it will likely remove a primary barrier to enrollment by allowing participant access to primary care outside of PACE center-based physicians, likely resulting in increased enrollment growth.

If the waiver is approved, then staff would seek to contract with appropriate qualified primary care providers, in accordance with the current contracting and rate strategies used for other CalOptima-contracted Medicare primary care physicians (e.g., CalOptima Care Network PCPs for OneCare/OneCare Connect).

Fiscal Impact
The Fiscal Year 2017-18 CalOptima Operating Budget, approved by the Board on June 1, 2017, included projected expenses of approximately $730,000 for PACE primary care physician services. The recommended action to file a waiver request to allow CBPs to serve as the primary care providers for PACE participants is budget neutral. Staff anticipates CBPs will provide services where a PACE physician would typically be needed, and that the average cost per visit for CBP services will be less than the current PACE Center-based physician services

Rationale for Recommendation
This waiver would provide greater flexibility for PACE centers to contract with community-based primary care physicians, increasing access to participants to receive care in their neighborhood and their language, while also potentially eliminating a barrier to enrollment in PACE.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

5. Consider Authorizing Contracting with or Amending Contracts with Community Based Physicians Associated with St. Joseph Health, Excluding St. Joseph Health-Affiliated Community Health Centers, for Primary Care Physicians Services for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

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

Recommended Action

Subject to approval by the Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS) of the Board-authorized waiver request, authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into contracts, or amend contracts with Community Based Physicians (CBPs) associated with St. Joseph Health, excluding St. Joseph Health affiliated clinics, to serve as primary care physicians for participants enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE), as part of implementation of said waiver.

Background/Discussion

At its December 7, 2017 meeting, the Board authorized contracts/contract amendments with CBPs, except those associated with St. Joseph Health, to serve as primary care physicians (PCPs) for Participants enrolled with PACE. St. Joseph Health-affiliated providers were carved out of the December 7th recommended action to ensure that a minimum quorum of the Board was available to consider the item. Staff now requests authority to contract with CBPs associated with St. Joseph Health, excluding St Joseph affiliated clinics, to serve as PCPs for Participants enrolled in PACE.

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

In many cases, potential PACE-eligible participants wish to keep their existing PCPs due to geographic considerations, as well as cultural and linguistic competencies. Allowing CalOptima PACE to contract with CBPs will allow CalOptima to enroll PACE participants who wish to access the PACE model of care, while maintaining their existing relationship with their primary care physician – often in their neighborhood and language.

On September 7, 2017, the CalOptima Board of Directors authorized staff to submit a waiver request to the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid

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Services (CMS) to allow CBPs to serve as primary care providers to participants in the PACE program. The waiver has been submitted and CalOptima is waiting for a response.

If the waiver is approved, staff will contract with, or amend existing contracts with St. Joseph Health System CBPs in accordance with current contracting and rate strategies used for other CalOptima contracted Medicare PCPs. PACE participants will be able to access care from contracted CBPs where a PACE physician would typically be needed. If the waiver is approved, it is intended that CalOptima would implement the waiver as approved.

Fiscal Impact

The Fiscal Year 2017-18 CalOptima Operating Budget, approved by the Board on June 1, 2017, includes projected total expenses of $730,000 for PACE primary care physician services, some portion of which may be expended as payment for PCP services provided to CalOptima PACE participants by physicians associated with St. Joseph Health. The recommended action to enter into or amend contracts with St. Joseph Health -affiliated physicians, excluding St. Joseph-affiliated community health centers, to serve as primary care providers for PACE participants is expected to be budget neutral. The average costs per visit for CBP services are projected to be less than the costs for current center-based physician services.

Rationale for Recommendation

Implementation of the requested waiver, if approved, would provide greater flexibility for CalOptima's PACE center to contract with community-based primary care physicians, increasing access for participants to receive care in their neighborhood and their language, while also potentially eliminating a barrier to enrollment in PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Action dated December 7, 2017, Consider Authorizing Contracting with or Amending Contracts with 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)
    a. Board Action dated September 7, 2017, 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)

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

9. Consider Authorizing Contracting with or Amending Contracts with 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)

Contact

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

Recommended Action

Subject to approval by the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) of Board-authorized waiver request, authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into contracts, or amend contracts with Community Based Physicians (CBPs), except those associated with St. Joseph Health System, to serve as primary care providers for Participants Enrolled in the CalOptima Program of All-Inclusive Care for the Elderly (PACE), as part of implementation of said waiver.

Rev. 12/7/2017

Background/Discussion

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

In many cases, potential PACE-eligible participants wish to keep their existing primary care physician due to geographic considerations, as well as cultural and linguistic competencies. Allowing CalOptima PACE to contract with community-based physicians will allow CalOptima to enroll PACE participants who wish to access the PACE model of care, while maintaining their existing relationship with their primary care physician – often in their neighborhood and language.

On September 7, 2017, the CalOptima Board of Directors authorized staff to submit a waiver request to the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) to allow CBPs to serve as primary care providers to participants in the PACE program. The waiver has been submitted and CalOptima is waiting for a response.

If the waiver is approved, staff will contract with, or amend existing contracts with qualified primary care providers, in accordance with current contracting and rate strategies used for other CalOptima contracted Medicare primary care physicians. PACE participants will be able to access care from contracted CBPs where a PACE physician would typically be needed. If the waiver is approved, it is intended that CalOptima would implement the waiver as approved.

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Fiscal Impact

The Fiscal Year 2017-18 CalOptima Operating Budget, approved by the Board on June 1, 2017, includes projected expenses of $730,000 for PACE primary care physician services. The recommended action to enter into or amend contracts with CBPs to serve as primary care providers for PACE participants is budget neutral. The average cost per visit for CBP services are projected to be less than the costs for current center-based physician services.

Rationale for Recommendation

Implementation of the requested waiver, if approved, would provide greater flexibility for CalOptima's PACE center to contract with community-based primary care physicians, increasing access to participants to receive care in their neighborhood and their language, while also potentially eliminating a barrier to enrollment in PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Board Action dated September 7, 2017, 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)

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

11/30/2017 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

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)

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer to file a waiver request for CalOptima's Program of All-Inclusive Care for the Elderly (PACE) for Section 903 of the Benefits Improvement and Protection Act (BIPA) of 2000, to the Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS) in order to allow Community Based Physicians (CBP) to serve as the primary care provider, in collaboration with the PACE interdisciplinary team; and
2. ~~Authorize the 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.~~ *Continued to future Board meeting.*

Rev. 9/7/17

Background/Discussion

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

In many cases, potential PACE-eligible participants wish to keep their existing primary care physician due to geographic considerations, as well as cultural and linguistic competencies. Notably, CalOptima PACE currently serves participants who speak 22 different languages, highlighting the diverse Orange County community. Participants may travel up to 15 miles or up to one hour in a vehicle to see their primary care physician. Allowing CalOptima PACE to contract with community-based physicians will allow CalOptima to enroll PACE participants who wish to access the PACE model of care, while maintaining their existing relationship with their primary care physician – in their neighborhood and language.

Section 903 of BIPA allows for specific modifications or waivers of certain regulatory provision to meet the needs of PACE organizations. As such, CalOptima PACE is requesting for a waiver of the regulatory sections listed below from Title 42: Public Health,§460 – PACE, in order to allow a CBP to serve as the primary care provider on the interdisciplinary team:

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- § 460.102(a) *Basic requirement.* A PACE organization must meet the following requirements: (1) Establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each participant.

- § 460.102(d)(3) The members of the interdisciplinary team must serve primarily PACE participants.

This waiver request is to allow CBPs to serve as a primary care provider, as set forth in the PACE regulation, by providing primary care services in their respective clinic settings while also serving non-PACE participants.

Filing of a 903 BIPA Waiver application will not add to PACE expenditures. In fact, it will likely remove a primary barrier to enrollment by allowing participant access to primary care outside of PACE center-based physicians, likely resulting in increased enrollment growth.

If the waiver is approved, then staff would seek to contract with appropriate qualified primary care providers, in accordance with the current contracting and rate strategies used for other CalOptima-contracted Medicare primary care physicians (e.g., CalOptima Care Network PCPs for OneCare/OneCare Connect).

Fiscal Impact
The Fiscal Year 2017-18 CalOptima Operating Budget, approved by the Board on June 1, 2017, included projected expenses of approximately $730,000 for PACE primary care physician services. The recommended action to file a waiver request to allow CBPs to serve as the primary care providers for PACE participants is budget neutral. Staff anticipates CBPs will provide services where a PACE physician would typically be needed, and that the average cost per visit for CBP services will be less than the current PACE Center-based physician services

Rationale for Recommendation
This waiver would provide greater flexibility for PACE centers to contract with community-based primary care physicians, increasing access to participants to receive care in their neighborhood and their language, while also potentially eliminating a barrier to enrollment in PACE.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *8/31/2017*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

6. Consider Authorizing Rate Methodology for Contracted Ambulatory Surgery Centers (ASCs) for Medi-Cal Services; Consider Ratifying Existing ASC Contracts and Authorizing Contracts with Additional ASCs Based on Proposed Methodology

Contact

Greg Hamblin, Chief Financial Officer, (714) 246-8400
Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO) to implement a rate methodology for Ambulatory Surgery Centers (ASCs) for outpatient Medi-Cal services based on Medicare ASC rates;
2. Ratify contracts with ASCs based on Medicare rates for Medi-Cal services; and
3. Authorize the CEO, with the assistance of legal counsel, to enter into contracts and/or amendments with ASCs meeting Medi-Cal enrollment requirements for surgery services based on the proposed methodology.

Background/Discussion

Prior to the development of Ambulatory Surgery Centers (ASC), surgeries were performed at facilities on an inpatient basis. Patients sometimes faced delays in obtaining elective services and often spent multiple days in an inpatient setting. Physicians also faced scheduling challenges, limited operating room availability and slow operating room turnover times. As the practice of medicine has progressed, however, many procedures previously performed on an inpatient basis are now safely and effectively performed in an outpatient setting. In fact, many procedures such as cataract correction, colonoscopies and minor orthopedic procedures, are now performed almost exclusively in outpatient settings. As the demand for outpatient surgery capacity has grown, CalOptima has contracted with a number of ASCs to ensure that members have access to these services in quality and cost-effective settings.

While these changes in practice patterns have occurred, Medi-Cal payment methodology and rates have remained relatively stable, with some ASC operators indicating that Medi-Cal rates for ASCs are not reflective of the surgery centers' cost of doing business, causing a number of ASCs to be unwilling to accept Medi-Cal rates. ASC compensation under Medi-Cal is equivalent to approximately 40% of the Medicare rates depending on the procedure.

To gain access to medically necessary services at ASCs in 2012, CalOptima staff entered into nearly 800 Letters of Agreement (LOAs) using Medicare payment methodology and rates believed to be consistent with community standards. The number of LOAs was so large because LOAs typically are specific to a single member and cover a single procedure or course of treatment. To streamline this process and avoid the need for individual LOA negotiations for each needed procedure, staff subsequently entered into contracts with a number of ASCs (based on the Medicare rates). This led to a significant drop in the number of LOAs entered with ASCs (just 63 in 2016) as well as a corresponding drop in the delays associated with individual LOA negotiation as the member awaits services.

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Management anticipates that until Medi-Cal updates its payment methodology for services provided at ASCs, access to outpatient surgical services at ASCs will remain an ongoing issue. To address that concern in the meantime, staff recommends that the Board ratify existing ASC contracts negotiated based on Medicare rates, and authorize contracts with additional ASCs in accordance with the Medicare payment methodology, at rates consistent with community standards and within existing budgetary parameters, to facilitate access to these surgical centers.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2017-18 Operating Budget approved by the Board on June 1, 2017, includes projected medical expenses for outpatient surgery services. Assuming utilization remains consistent with budgeted levels, the total medical expenses to implement a rate methodology for ASCs that is consistent with community standards for outpatient surgery services for the remainder of FY 2017-18 (i.e., March 1, 2018, through June 30, 2018) is $332,000. The annual projected expense is $997,000. Staff included an expense trend within the operating budget that management believes should be sufficient to fund the projected increase from the recommended actions. Management plans to include updated expenses related to outpatient surgery rates in future operating budgets.

Rationale for Recommendation

Access to out-patient surgery for Medi-Cal members is becoming more difficult to coordinate because CalOptima currently has contracts with a limited number of outpatient surgery centers. CalOptima has been unable to expand the ASC surgery network based on the Medi-Cal payment methodology. Staff seeks ratification of existing ASC contracts based on the Medicare methodology, and authority to enter into additional contracts with ASCs at rates consistent with community standard Medicare Rates to ASCs to ensure adequate access to care for CalOptima members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

Board Action dated June 5, 2007, Authorize the Chief Executive Officer to Negotiate Rates for Certain Fee-for-Service Contracts for Health Care Services

/s/ Michael Schrader — *1/25/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken June 5, 2007
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. B. Authorize the Chief Executive Officer to Negotiate Rates for Certain Fee-for-Service Contracts for Health Care Services

Contact

Gregory Buchert, M.D., MPH, Chief Operating Officer, (714) 246-8400

Recommended Action

Authorize the CalOptima Chief Executive Officer (CEO) or his designee, to negotiate rates for certain fee-for-service (FFS) contracts within budget and rate guidelines and regulatory requirements.

Background

CalOptima has implemented several different contracting models for health care services for its lines of business. The CalOptima Direct (COD) network includes fee-for-service hospital contracts as well as some limited ancillary services contracts (e.g., wheelchairs). The CalOptima OneCare program includes physician shared risk contracts and other contracted hospitals and ancillary providers. At present the delivery system for the Medi-Cal and Healthy Families programs is primarily through capitated health networks. CalOptima needs to be able to negotiate best pricing for physicians, hospitals, ancillary and other services as well as secure access to services. In order to do so, CalOptima seeks authority to enter into negotiated fee-for-service contracts.

Discussion

CalOptima is building a contracted provider network to support the medical needs of all of our members in each of our product lines that is both budget based and medically appropriate. The building of this network is required to have a full scope, qualified provider panel for all of our members and to be able to effectively manage the health care needs for our diverse population including the very young, the very old, and the medically fragile and vulnerable.

CalOptima requires a network of credentialed, quality providers to support our members' medical needs. CalOptima needs to contract with providers using appropriate fee schedules and will base the payment on the product line and current product line rates, but there will be periodic needs to deviate from these rates for issues of access and availability. The fee-for-service agreements will create a provider network both within Orange County and outside of the County, as needed, to support the covered services.

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The following guidelines will apply to negotiated fee-for-service contracts:

- When appropriate to access best pricing or access to services, CalOptima may enter into negotiated fee-for service contracts for identified items and services.
- CalOptima will continue to use standard medical service agreements based on product lines and provider types, with assistance of legal counsel, but may negotiate reimbursement terms.
- Negotiated fee-for-service contracts will not be sought for services to members where CalOptima has subcapitated financial risk for the items and/or services to a provider (e.g., Medi-Cal PHC contracts, Medi-Cal and Medicare shared risk contracts), but CalOptima will encourage contracted parties to extend the same terms, rates and conditions to its subcapitated entities.
- Rates will be negotiated within the guidelines below. Any rate in excess of 150% of the fee schedule will require approval from the CEO or designee.

Rate Summary:

Situation	Payment Rate
Routine services including ancillary services	Contract with rates at or below the fee schedule
Difficult to access services meeting predetermined access criteria	Contract with the minimally mutually agreeable rates < 150% of the fee schedule
Rare, one time situations where provider is unwilling to contract at available rates	One time Letter of Agreement for a specified service for a specific patient

Fiscal Impact

The recommended action to negotiate rates for fee-for-service contracts for certain health care services will use approved contract boilerplate agreements and budget based payment schedules. These costs have been included in budget projections for 2008.

Rationale for Recommendation

CalOptima must be responsive and adaptive to opportunities to secure ancillary items and services based on best pricing and to secure access to providers where such access may be limited. While the goal is to contract as many providers as possible within the standard fee schedules, it is necessary to have the contracting flexibility in these situations.

Concurrence

Procopio, Cory, Hargreaves & Savitch LLP

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Attachments
None

/s/ Richard Chambers *5/31/2007*
Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Consider Authorizing Amendment to Contract with Liberty Dental Plan of California, Inc. for Dental Services Provided to OneCare and OneCare Connect Members

Contact

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

Recommended Action

Authorize the Chief Executive Officer (CEO), or his designee, with the assistance of legal counsel, to enter into an amendment to the Liberty Dental Plan of California, Inc., (Liberty) contract to increase rates for supplemental dental benefits available to OneCare and OneCare Connect Members for the 2018 benefit year as summarized below.

Background/Discussion

At its July 10, 2008 meeting, the CalOptima Board of Directors approved the addition of supplemental dental benefits for the 2009 OneCare program and authorized the CEO to enter into a dental services provider contract. While Denti-Cal provides primary dental coverage for OneCare and OneCare Connect members, the Denti-Cal Program's coverage is limited, and some Medi-Cal recipients have expressed concern with the Denti-Cal Program and with the limited size of its provider network. This network is limited largely due to the refusal of many dentists to participate because of what are perceived as low reimbursement rates. As such, the Board approved a more comprehensive dental package that included supplemental dental benefits.

The vendor providing these benefits was selected through an Request for Proposal (RFP) process sent out in June 2008 for a January 1, 2009 effective date. The vendor selected was Liberty. The contract with Liberty for supplemental dental benefits for OneCare expired December 31, 2014, and supplemental dental benefits were not made available through the OneCare program in calendar year 2015. However, at the Board's April 2, 2015 and December 3, 2015 meetings, it authorized contracting with Liberty for supplemental dental benefits for OneCare Connect members, and the contract was amended effective January 1, 2016 to add back dental services for OneCare members. Beyond December 31, 2016, the Liberty contract included two one-year extension options, each exercisable at CalOptima's sole discretion. The first option was exercised to bring the expiration date to December 31, 2017, and at the Board's December 7, 2017 meeting, it ratified the second extension, moving the expiration date to December 31, 2018.

Dental services administered through Liberty have ensured that OneCare and OneCare Connect members have timely access to a comprehensive, contracted network of quality primary and specialty Denti-Cal providers and in so doing, improving their overall health status.

Although Denti-Cal has restored some of the dental benefits that were cut in 2009 for the 2018 benefit year, CalOptima has already submitted its proposal to the Centers for Medicare & Medicaid Services (CMS) for certain supplement dental benefits for calendar 2018 and is required to ensure that these services are made available to OneCare and OneCare Connect members.

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There has been an increase in utilization of dental care services by OneCare and OneCare Connect members since early 2016, which staff correlates to Members becoming more knowledgeable about the supplemental benefits available to them. Based on this higher level of utilization, the cost for delivering these benefits is estimated to have increased by over 40% over the last year.

CalOptima pays Liberty on a capitated, per member per months basis. The capitation paid to Liberty covers both administrative services and claims costs. Based on the increased demand for services referenced above, staff recommends increasing the capitation rates to compensate Liberty for the increased utilization. Liberty has indicated that, without a rate increase, it would be unable to continue providing the services under the previously-agreed upon terms and submitted a notice of contract termination; however, Liberty rescinded its notice of termination, and committed to continue providing services if the rates are increased; it also indicated its commitment to curing any outstanding deficiencies. Based on these issues, staff has reviewed the utilization data and recommends a capitation rate increase effective February 1, 2018. The proposed increase would better align reimbursement with utilization levels and with Liberty's administrative responsibilities. Because the utilization data supports the recommended rate increase, staff recommends amending Liberty's contract to increase reimbursement rather than conducting a Request for Proposal (RFP) process that would potentially be disruptive to member care and would nonetheless be expected to result in pricing in line with what is being proposed.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2017-18 Operating Budget approved by the Board on June 1, 2017, includes approximately $1.4 million for OneCare and OneCare Connect dental service expenses that were consistent with forecasted enrollment.

Based on the proposed February 1, 2018 effective date, the recommended action to increase rates for supplemental dental benefits for OneCare and OneCare Connect members for the 2018 benefit (calendar) year is projected to increase medical expenses by $850,000. The net fiscal impact for the February 1, 2018 through June 30, 2018 period is estimated at $386,000.

Staff plans to include updated medical expenses for OneCare and OneCare Connect dental services for the period of July 1, 2018, through December 31, 2018, in the CalOptima FY 2018-19 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends Board approval of this action to ensure that OneCare and OneCare Connect members continue to have access to the supplemental dental services for benefit year 2018. For benefit year 2019 and beyond, CalOptima staff will examine the reinstatement of the Denti-Cal benefits and whether access to quality dentists is available through Denti-Cal and make further recommendations to the Board regarding the continuation of supplemental dental benefits.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Board Action dated September 7, 2017, Consider Actions Related to OneCare Connect Enrollment and Deemed Eligibility; Consider Amendments to Related Contracts and Policies
    a. Attachment - Board Action dated December 3, 2015, Authorize Contract Amendments with Liberty Dental for a Supplemental Dental Benefit for OneCare; Extend the Supplemental Dental Benefit for OneCare Connect; and Authorize Deemed Eligibility for Members Receiving Denti-Cal
2. Board Action dated November 3, 2016, Consider Authorizing Extension of Amendment of Contract with Liberty Dental Plan of California, Inc., for Dental Services Provided to OneCare Members for the 2017 Calendar Year
    a. Attachment – Board Action dated December 3, 2015, Authorize Contract Amendments with Liberty Dental for a Supplemental Dental Benefit for OneCare; Extend the Supplemental Dental Benefit for OneCare Connect; and Authorize Deemed Eligibility for Members Receiving Denti-Cal
    b. Attachment – Board Action dated April 2, 2015, Authorize Modifications to Member Assignment Process for the OneCare Connect Program; Authorize Supplemental Dental Benefit for the OneCare Connect Program, as well as Funding and Contracting with a Vendor as Necessary to Implement
    c. Attachment – Board Action dated August 6, 2015, Authorize Actions Related to OneCare Connect Enrollment
3. Board Action dated July 10, 2008, Approve 2009 OneCare Dental Benefit and Authorize the CalOptima Chief Executive Officer to Enter into a Dental Services Provider Contract

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Michelle Laughlin, Executive Director, Provider Network Operations, (714) 246-8400

Recommended Actions

1. Ratify 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 (DHCS);
2. Authorize the Chief Executive Officer (CEO), 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. Direct the CEO to amend OneCare Connect Policy CMC.4004, Member Disenrollment to implement said deeming period and operational updates.

Background

On June 15, 2015, DHCS, in conjunction with the Centers for Medicare & Medicaid Services (CMS), issued guidance encouraging Cal MediConnect (CMC) plans to offer an optional one or two-month period of deemed continued eligibility due to loss of Medi-Cal eligibility. For members who lose OCC eligibility due to loss of Medi-Cal eligibility, health plans including CalOptima were given the option of offering a one or two-month period of deemed continued eligibility. Based on this optional guidance, on August 6, 2015, the CalOptima Board of Directors authorized a one-month deeming period for OCC members. The one-month deeming period was implemented on November 1, 2015. Based on the addition of this one-month deeming period, the CalOptima Board authorized an amendment to the Liberty Dental contract on December 3, 2015, to continue to provide dental services during the one-month deeming period.

In April 2016, DHCS announced it was exploring the possibility of extending deeming for CMC as part of a larger discussion related to CMC program sustainability. Staff is not aware of DHCS making any further mention of extending deeming during 2016. During a CEO meeting in January 2017 and an all managed care plan call in February 2017, DHCS announced the requirement to extend deeming to two-months effective January 2017. Plans, including CalOptima, asked for written guidance on several occasions. Further, CalOptima staff communicated to the DHCS/CMS Contract Management Team that deeming for OCC was originally presented by CalOptima as an optional election of none, one, or two-months. Staff additionally advised the DHCS/CMS Contract Management Team that, as a result of the August 2015 CalOptima Board action approving one-month deeming, any change would require CalOptima Board approval. On May 18, 2017, DHCS issued updated written guidance

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requiring CMC plans to offer two-months of deemed eligibility effective October 2016. This requirement communicated to plans as a directive from DHCS.

Discussion

Members enrolled in OCC must have both Medicare (Parts A and B) and Medi-Cal. Since November 1, 2015, CalOptima provided one-month deeming eligibility to OCC members who lose their Medi-Cal eligibility. The deeming period applies to OCC members who no longer qualify for OCC due to loss of Medi-Cal eligibility or change of circumstance impacting Medi-Cal eligibility. For example, a Member may lose Medi-Cal eligibility as a result of late submission of annual Medi-Cal redetermination documentation, delays in redetermination processing, a report of having an out of county residence, or other health coverage information. In some instances, the situation is quickly remediated either by submission of required redetermination documentation or correcting erroneous records, and Medi-Cal eligibility is reinstated. Without a deeming period, these members who regain eligibility, along with the majority who do not regain eligibility during the deeming period, would be disenrolled from OCC and cannot be automatically enrolled back to the plan. Instead, these members would have to voluntarily re-enroll with OCC to continue coverage.

The DHCS identifies and notifies CalOptima of those members eligible for deemed eligibility. Once OCC members are identified by the DHCS as eligible for deeming, CalOptima sends regulatory notices to affected members informing them of their deemed eligible status. CalOptima Customer Service Representatives also conduct telephonic outreach to members to provide additional information regarding deeming status and make referrals to available community resources. OCC members requiring additional assistance are referred to DHCS or the OCC Ombudsman, Legal Aid Society of Orange County. The Legal Aid Society of Orange County, with the member's permission, will provide assistance to help the member regain Medi-Cal eligibility.

In addition to monitoring deeming status of OCC members who regain eligibility after one month, CalOptima staff also monitors members who would have regained eligibility after two-months and reports this information to the OCC Member Advisory Committee. Approximately 2,900 members were identified by the DHCS as eligible for deeming from November 2015 to May 2017. These members would have had the potential to regain eligibility by July 1, 2017, if two-month deeming was in place. Approximately 900 of these members, or 32%, regained eligibility with OCC during the one-month deeming period. Roughly 2,000, or 68%, of the members did not. Based on historical information, 93 of the remaining 2,000 members would have regained eligibility in the second month. This would have resulted in an overall 35% of members reinstating during the two-month deeming period. CalOptima would have covered the remaining 65% for an additional month without receiving reimbursement from the State. In other words, staff estimates that extending the deeming period for an additional month increases the number of members who regain eligibility by 3%.

On May 18, 2017, DHCS issued updated written guidance requiring CMC plans to offer two-months of deeming effective October 2016. It is anticipated that more members will regain Medi-Cal eligibility if the deeming period is extended to two months. Subsequently, DHCS reiterated that two-month deeming is a regulatory requirement and must be implemented immediately. As a result, CalOptima implemented two-month deeming effective September 1, 2017. During the extended two-

month deeming period, CalOptima will continue providing all OCC benefits to deemed-eligible Members, including dental services through Liberty Dental, as required. CalOptima will continue to receive member premium payments for Medicare; however, Medi-Cal capitation payments will be suspended during this time. Medi-Cal capitation payments from DHCS will be retroactively paid for the deeming months if the Member regains Medi-Cal eligibility during the deeming period. However, if the Member does not regain Medi-Cal eligibility during the deeming period, as is expected to be the case for roughly two-thirds of those deemed eligible, then DHCS is expected to process the OCC disenrollment, and CalOptima is not reimbursed for any Medi-Cal expenses incurred on behalf of the Member during the two-month deeming period.

All regulatory notice requirements to Members will be followed for this process. OCC policy CMC.4004: Member Disenrollment will be modified to include DHCS required revisions related to member deeming and other operational requirements. Consistent with existing policy, CalOptima will, on an ad hoc basis, with member request, retroactively reinstate members in deeming for June through August 2017, who would have remained enrolled in the plan had two-month deeming been in place at the time of their OCC disenrollment. Additionally, CalOptima staff will amend, with the assistance of Legal Counsel, the Liberty Dental contract to extend the Denti-Cal benefit during the second deeming month. Based on follow-up discussions with DHCS during August 2017, staff does not anticipate any adverse regulatory action based on the proposed effective date.

Fiscal Impact

The recommended action to authorize a two-month deeming period for OCC members who no longer meet CMC eligibility requirements due to loss of Medi-Cal eligibility with CalOptima, as determined by DHCS, has been incorporated into the medical expense in the FY 2017-18 Consolidated Operating Budget, approved by the Board on June 1, 2017. The projected total annual cost for two months of deeming (month one and month two) is approximately $2,000,000. The projected cost for the additional second month of deeming from September 1, 2017, through June 30, 2018, including any retroactive reinstatements for June through August 2017, is approximately $800,000 based on historical deeming experience and associated cure rates forecasted forward. Management will include updated medical expenses in future operating budgets.

Rationale for Recommendation

In order to comply with the DHCS requirements for OCC enrollment and to minimize disruption of services to Members while their eligibility status is being updated, CalOptima staff proposes the actions as noted above.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

1. Board Action dated December 3, 2015, Authorize Contract Amendments with Liberty Dental for a Supplemental Dental Benefit for OneCare; Extend the Supplemental Dental Benefit for OneCare Connect; and Authorize Deemed Eligibility for Members Receiving Denti-Cal
    a. Attachment - Board Action dated August 6, 2015, Authorize Actions Related to OneCare Connect Enrollment
2. Coordinated Care Initiative (CCI) Deeming Process for Cal MediConnect Plan Guidance
3. OneCare Connect Policy CMC.4004, Member Disenrollment (redline and clean copies)

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

12. Authorize Contract Amendments with Liberty Dental for a Supplemental Dental Benefit for OneCare; Extend the Supplemental Dental Benefit for OneCare Connect; and Authorize Deemed Eligibility for Members Receiving Denti-Cal

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into contract amendments with Liberty Dental for supplemental dental benefits for:
    a. OneCare from January 1, 2016 through December 31, 2016, with two additional one year extension options, each exercisable at CalOptima's sole discretion
    b. OneCare Connect from January 1, 2016 through December 31, 2017; and
2. Authorize one month of deemed eligibility for OneCare Connect members receiving Denti-Cal services provided by Liberty Dental.

Background/ Discussion

In actions taken on April 2, 2015, the CalOptima Board of Directors authorized a supplemental dental benefit for the OneCare Connect program as well as funding and contracting with Liberty Dental. Voluntary enrollment into OneCare Connect has increased based on the additional supplemental dental benefits being offered by CalOptima in the program. The supplemental dental benefit provides services not covered by the Denti-Cal benefit. Staff believes the supplemental dental benefit has increased member retention in the program.

In order to keep the benefits similar to OneCare Connect, OneCare added the same supplemental dental benefit to the 2016 Centers for Medicare &Medicaid Services (CMS) approved OneCare bid.

At its August 6, 2015 meeting, the CalOptima Board of Directors authorized a one month deeming period for OneCare Connect Members who no longer met Cal MediConnect eligibility requirements due to loss of Medi-Cal eligibility with CalOptima. This benefit was added to mitigate breaks in coverage and maintain continuity of care for members. Management proposes a similar one month deeming period for Denti-Cal benefits for OneCare Connect members. Should a member fail to regain eligibility for the Medi-Cal program during the one month period of deemed eligibility, CalOptima would be financially responsible for the cost of the month of deemed eligibility. Based on the proposed action, eligibility for the one month of deemed dental benefits through Liberty Dental would be available through December 31, 2017 for OneCare Connect members.

Fiscal Impact

Based on the forecasted OneCare enrollment for Fiscal Year (FY) 2015-16, the fiscal impact of the recommended action to issue a contract amendment for the supplemental dental benefit for the OneCare Program from January 1, 2016, through June 30, 2016, is approximately $55,000. Costs associated with the recommended action were incorporated into Calendar Year 2016 OneCare capitation rate. Funding

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for the recommended action for the period July 1, 2016 through December 31, 2016, will be included in the FY 2016-17 CalOptima Consolidated Operating Budget.

Based on the forecasted OneCare Connect enrollment for FY 2015-16, the fiscal impact of the recommended action to issue a contract amendment for supplemental dental benefit for the OneCare Connect Program from January 1, 2016 through June 30, 2016, is approximately $445,000. This is a budgeted item under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015. Funding for the recommended action for the period July 1, 2016 through December 31, 2017, will be budgeted in subsequent operating budgets.

Projected expenses related to the provision of the deeming benefit are approximately $3,500 per month.

Rationale for Recommendation

CalOptima staff recommends supplemental dental services to OneCare Connect members to strengthen the programs ability to minimize pre-enrollment opt out, maximize post enrollment retention and strong provider participation in the program. OneCare members will continue to have the same CMS approved supplemental benefit as OneCare Connect members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Previous Board actions referenced in this Report Item:

- August 6, 2015, Agenda Item VIII. J., Authorize Actions Related to OneCare Connect Enrollment
- April 2, 2015, Agenda Item VIII. B., Authorize Modifications to Member Assignment Process for the OneCare Connect Program; Authorize Supplemental Dental Benefit for the OneCare Connect Program, as well as Funding and Contracting with a Vendor as Necessary to Implement

/s/ Michael Schrader *11/25/2015*

Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. B. Authorize Modifications to Member Assignment Process for the OneCare Connect Program; Authorize Supplemental Dental Benefit for the OneCare Connect Program, as well as Funding and Contracting with a Vendor as Necessary to Implement

Contact

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

Recommended Actions

1. Authorize modifications to the Board approved OneCare Connect (Cal MediConnect) Program member enrollment process to allow for enrollment by Long Term Care (LTC) Facility, subject to approval by the Department of Health Care Services (DHCS); and
2. Authorize the Chief Executive Officer (CEO) to contract with dental benefits administrator to provide a supplemental benefit to the Medi-Cal dental benefit subject to approval by the DHCS and the Centers for Medicare & Medicaid Services (CMS), and upon the successful negotiation of contract terms with Liberty Dental from July 1, 2015 to December 31, 2015.

Background

In actions taken on January 3, 2013, February 7, 2013 and December 5, 2013, the Board authorized the CEO to develop a provider delivery system for implementation of the Duals Demonstration, a program for beneficiaries eligible for Medi-Cal and Medicare or "Duals", also known as Cal MediConnect Program and branded by CalOptima as OneCare Connect.

On December 5, 2013 the Board approved the Member enrollment process in order to ensure a seamless passive enrollment of OneCare Connect members who will be allowed the opportunity to make a voluntary choice to disenroll (opt-out). The enrollment process, previously approved, is based on the DHCS requirements to passively enroll eligible members on their birthday month. Approximately 3,900 members in Orange County are expected to be eligible for passive enrollment monthly.

The Cal MediConnect program launched state wide on April 1, 2014 and has been implemented in six counties. Passive enrollment start dates have been staggered throughout the state and the opt-out rates have varied by county with an overall statewide average of 49%. Concerned about the high opt-out rate, CalOptima staff has developed strategies to mitigate opt-out. The member strategies include increasing member outreach efforts and outreach to our community stakeholders informed as they are considered our member's "trusted advisors". Provider strategies, as approved by your Board, include increased provider participation through the implementation of the Community Network and increasing primary care and specialist reimbursement from 80% to 100% of Medicare fee-for-service. Based on the experience of the other Cal MediConnect plans, staff proposes two additional strategies related to the member enrollment process and dental services.

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Discussion

As CalOptima prepares to launch the Cal MediConnect or OneCare Connect program, CalOptima staff has explored strategies intended to reduce the pre-enrollment opt-out and strengthening retention of members who are passively enrolled in the program. The strategies CalOptima staff considered are both from the member and provider perspective so as to ensure that both stakeholder groups are motivated to remain in OneCare Connect.

Long Term Care Facility Based Enrollment. From the member impact perspective, CalOptima is proposing to modify the previously approved passive enrollment strategy for individuals who are residing in Long-Term Care (LTC) Facilities. Among the approximately 80,000 Dual eligible individuals in Orange County, approximately 3,500 reside in 56 LTC facilities. These 3,500 individuals are among the most vulnerable members, have complex health care needs, and would greatly benefit from increased integration and coordination of care, which will be available with OneCare Connect. For this reason, CalOptima staff is proposing that it would be a better approach to passively enroll these Duals by LTC facility rather than by birth month based on DHCS approval and on a mutually agreed upon schedule with DHCS. This would allow CalOptima to communicate one-on-one with members and their families regarding care options available to them through OneCare Connect. CalOptima staff would also be able to personally educate providers and coordinate member care. Providing the opportunity to work closely with the LTC facilities, to educate and answer questions and provide the additional care coordination component will help improve the OneCare Connect retention rate.

Dental Benefit. Another proposal to improve the retention rate is by providing supplemental dental services not covered by Medi-Cal to CalOptima OneCare Connect members. While OneCare Connect members are eligible for Denti-Cal, in certain situations, access remains an issue. Management believes that improving access to dental services facilitates a positive member experience, thereby motivating members to stay in OneCare Connect. The CalOptima OneCare program previously offered a supplemental dental benefit that was very popular in attracting Duals to enroll in OneCare. Based on member input, CalOptima staff views the availability of dental services as a key component of a successful OneCare Connect program. Subject to approval by both DHCS and the Centers for Medicare & Medicaid Services (CMS), CalOptima management proposes to utilize funding from the DHCS for the Medi-Cal component of the Cal MediConnect capitation payment to implement this option.

If approved, staff recommends contracting with Liberty Dental Plan to administer and coordinate the proposed supplemental dental benefits for OneCare Connect members on a per member per month (PMPM) payment basis. Liberty Dental has been the dental benefit administrator that administered the OneCare benefit on behalf of CalOptima. Management believes that Liberty Dental Plan is the only potential subcontractor qualified to provide the appropriate supplement to the Medi-Cal benefit. Liberty Dental Plan will ensure timely access to a comprehensive, contracted network of primary and specialty Denti-Cal providers. Unlike in Denti-Cal where certain members may face delays or difficulty in accessing care, the proposed benefit would allow OneCare Connect members to have an

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assigned primary care dentist through which to obtain dental services to guarantee a straightforward and seamless path to dental coverage. Through this arrangement, CalOptima intends to:

- Increase CMC members' awareness of the dental benefit through education and outreach;
- Improve utilization of preventive dental services;
- Improve coordination between dental and physical health care providers;
- Provide limited supplemental benefits not covered under Denti-Cal; and
- Improve access to dental providers.

Both the LTC member enrollment and dental strategies require Board and regulator approval. Staff will return to the Board for additional authority, as necessary, to implement these and potentially other retention strategies.

Fiscal Impact

The recommended action to execute a contract with Liberty Dental Plan to provide supplemental dental benefits will have a total fiscal impact between $1.7 million and $2.0 million at capitation rates from $7.00 per member per month (PMPM) to $8.00 PMPM for Fiscal Year 2015-16. Under this capitated arrangement, Liberty Dental Plan will assume full risk for dental services, and will coordinate dental benefits with Denti-Cal. As such, the capitation payment will cover supplemental dental benefits only, including enhanced access to their dental network, with no additional payments made to Liberty Dental Plan. Denti-Cal will remain the primary payor and provider of dental services to OneCare Connect members.

Rationale for Recommendation

CalOptima staff recommends these actions to strengthen the OneCare Connect program's ability to minimize pre enrollment opt-out, maximize post enrollment retention and strong provider participation in the OneCare Connect program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *3/27/2015*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
VIII. J. Authorize Actions Related to OneCare Connect Enrollment

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions
1. Authorize implementation of transition plan of OneCare members to OneCare Connect effective January 1, 2016;
2. Authorize a one-month deeming period effective no sooner than September 1, 2015 for OneCare Connect members who no longer meet Cal MediConnect eligibility requirements due to loss of Medi-Cal eligibility with CalOptima;
3. Authorize enhancement of the delivery model for OneCare Connect members who reside in a long-term care facility that is exclusive to CalOptima Direct, subject to approval by the Department of Health Care Services and the Centers for Medicare & Medicaid Services; and
4. Authorize updates to policies as necessary for implementation.

Background
On December 5, 2013, the CalOptima Board of Directors authorized execution of the Three-Way Agreement between the California Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS) and CalOptima for implementation of Cal MediConnect (CMC), branded CalOptima OneCare Connect Plan (Medicare-Medicaid Plan) (OCC) in Orange County. OCC is a managed care plan that combines Medicare and Medi-Cal, including long-term services and supports (such as In-Home Supportive Services, Multipurpose Senior Services Program, Community-Based Adult Services, and long-term care). Both the DHCS and CMS have continued to issue guidance regarding the implementation of CMC. Two topics of recent regulatory discussion include the enrollment of Medicare Dual-Eligible Special Needs Plans (D-SNPs) and a period of deemed continued eligibility for CMC. Additionally, CalOptima is involved in ongoing communications with CMS and DHCS regarding initiatives specific to members residing in long-term care facilities.

Enrollment into D-SNPs
DHCS issued guidance through an All Plan Letter *(APL) 14-014: Enrollment Requirements for Dual-Eligible Special Needs Plan in Alameda and Orange Counties,* which delineates D-SNP enrollment criteria once CMC is implemented in a county. Specific to CalOptima, the APL states that if a D-SNP is also a CMC plan, the following will apply: "No earlier than January 1, 2016, DHCS will crosswalk all Duals who are eligible for CMC into the corresponding CMC plan once CMC is implemented in Orange County. These Duals will not be permitted to re-enroll in the CMC D-SNP; and the CMC D-SNP may serve any existing or new beneficiaries who are not eligible for CMC (Excluded Beneficiaries) only."

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Based on this guidance, CalOptima is required to transition its OCC-eligible OneCare Members into OCC effective January 1, 2016. OneCare can no longer enroll Members eligible for CMC. However, OneCare can continue to enroll dual eligible Members not eligible for CMC into the OneCare plan. These include, for example, Members under 21 years of age, Members receiving services through Regional Center or Members participating in Section 1115(c) waiver programs, such as Assisted Living, In Home Operations, and Nursing Facility/Acute Hospital Waivers. During this transition to OCC, Members are subject to the same noticing requirements as apply to Members being passively enrolled into OCC, and CalOptima staff is in the process of obtain approval of modifications to the existing notice templates so that they can be used in conjunction with this transition.

Deeming Process for CMC

Current OCC policy provides that Members, who lose Medi-Cal eligibility, as determined by the State, are disenrolled from the plan. DHCS, in compliance with CMS policy, issued guidance on June 15, 2015 encouraging plans such as CalOptima to offer an optional one or two-month period of deemed continued eligibility in the Medicare-Medi-Cal Plan (MMP) due to loss of Medi-Cal eligibility. For OCC members who lose eligibility with the plan due to 1) loss of Medi-Cal eligibility or 2) change of circumstance impacting eligibility (such as a change in Medi-Cal eligibility aid code or a move out of the service area), DHCS will allow plans to choose to provide a one or two month period of deemed continued eligibility. Deeming guidance became effective July 1, 2015.

Long-Term Care

CalOptima has been responsible for the Medi-Cal long-term care benefit since January 1996. The Medi-Cal long-term care benefit includes room and board for Members who are no longer able to live safely at home or in the community, require round-the-clock custodial care prescribed by a physician, and meet DHCS level of care requirements. These members receive medical, social, and personal care services in a nursing facility. Only care in sub-acute, skilled nursing facilities and intermediate care facilities apply; assisted living and board and care facilities are not eligible.

Traditionally, for Dual eligible members, physician and hospital services are provided through the Medicare fee-for-service program, a Medicare Advantage Plan, or a Special-Needs Plan. CalOptima has managed and paid for long-term care services for these members directly and has not delegated this responsibility. Through OCC, Dual eligible members can now receive all of their services through one coordinated plan.

Since 2009, CalOptima Medi-Cal members in long-term care have received physician, hospital, and long-term care services through the CalOptima Direct network, which includes the CalOptima Community Network. OCC now affords CalOptima the opportunity to provide the full scope of services covered under both Medicare and Medi-Cal through the CalOptima Community Network.

Discussion

Enrollment into D-SNPs

As indicated, effective January 1, 2016, CalOptima is required to transition eligible OneCare Members into OCC. CalOptima intends to make the transition as seamless as possible for Members

and ensure that disruption is kept to a minimum. For this reason, staff intends to assign the Member to the same OneCare primary care provider (PCP) and health network, unless otherwise requested by Member. If the PCP participates in a different OCC health network at the time of transition, the Member will be assigned to the same PCP and the PCP's new health network. This is in alignment with the DHCS March 27, 2015 Dual Plan Letter (DPL) 15-003 requirements for continuity of care which states "if the MMP contracts with delegated entities, the MMP must assign the beneficiary to a delegated entity that has the beneficiary's preferred PCP in its network."

If the member's OneCare PCP does not participate in the same OCC health network but does participate in two or more OCC health networks or none, the Member will be assigned according to the OCC auto-assignment policy initially approved during the December 2013 Board meeting and amended in May 2015, unless otherwise requested by Member.

CalOptima will modify its OCC policies related to primary care selection, network assignment, and member notification to the extent necessary to reflect the above.

Deeming Process for CMC

DHCS issued guidance allowing CMC plans to offer up to two months of deeming eligibility due to loss of Medi-Cal eligibility. The deeming period would apply to OCC members who no longer qualify for OCC due to loss of Medi-Cal eligibility or change of circumstance impacting Medi-Cal eligibility. Plans already participating in CMC have reported that many members who have been involuntarily disenrolled from CMC due to loss of Medi-Cal eligibility regain their Medi-Cal eligibility within one to two months after disenrollment.

For example, a Member may lose Medi-Cal eligibility as a result of late submission of annual Medi-Cal redetermination documentation, delays in redetermination processing, a report of having an out of county residence, or other health coverage information. In many instances, the situation is quickly remediated either by submission of required redetermination documentation or correcting erroneous records, and Medi-Cal eligibility is reinstated. Without a deeming period, these members will be disenrolled from OCC and cannot be automatically enrolled back to the plan. Instead, these members would have to voluntarily re-enroll with OCC to continue coverage.

In order to mitigate breaks in coverage and maintain continuity of care for members, staff proposes to allow a one-month deeming period for OCC Members. A one month deeming period is recommended at this time to limit CalOptima's financial exposure. Based on the proposed action, during the deeming period, CalOptima would continue providing OCC benefits to the Member. CalOptima will continue to receive member premium payments from Medicare; however, Medi-Cal capitation payments will be suspended during this time. Medi-Cal capitation payments from DHCS will be retroactively paid for the deeming month if the member regains Medi-Cal eligibility. However, if the Member does not regain Medi-Cal eligibility during the deeming period, the member would be disenrolled from OCC at the end of the deeming period month, and CalOptima would not be reimbursed for Medi-Cal expenses incurred on behalf of this member during the one-month period.

All regulatory notice requirements to Members will be followed for this process. While DHCS permits plans to implement deeming effective July 1, 2015, due to the time required for regulatory

approval of member materials, CalOptima staff proposes to implement the one month deeming process no earlier than September 1, 2015. As proposed, deeming will continue through the duration of the CMC, currently authorized by the DHCS and CMS through December 31, 2017.

CalOptima will modify its OCC policies related to member enrollment and disenrollment, to the extent necessary to implement the above.

Long-Term Care

On April 2, 2015, the CalOptima Board of Directors authorized staff to modify the OCC enrollment process to allow for enrollment by long-term care facility. Regulatory approval was received in July 2015 and the enrollment of members by facility will begin in November 2015. In order to enhance the care for OCC members residing in a long-term care facility, staff proposes to implement a delivery model specific for these members. By enhancing the delivery model, staff expects to:

- Improve coordination of Medicare and Medi-Cal services, consistent with the goals of Cal MediConnect
- Improve member, family and facility satisfaction
- Promote member enrollment in OCC
- Utilize emergency department (ED) and inpatient resources appropriately with subsequent reduction in ED visits, hospital admissions, days and readmissions rates
- Adhere to regulatory requirements for OCC
- Improve communication and discuss expectations with member, facility, providers, and family
- Measure and report benefits of integrated care

A key component of this delivery model is to contract with providers who provide services in skilled nursing and long-term care facilities. These providers are referred to as skilled nursing facility (SNF) physicians. Because these members permanently reside in the facility, it is important for the members' care to be rendered by physicians who go directly to the facility to provide services on a regular and frequent basis in order to identify and treat acute or deteriorating conditions. These physicians will also be available around-the-clock to provide urgent care services at the facility in order to avoid unnecessary emergency department admissions. As such, new contracts requiring the SNF physician to provide around-the-clock care and minimum thresholds of visits in addition to traditional primary care services will be developed. These contracts will be offered exclusively through CalOptima Direct to individual providers and physician groups and may be based on fee-for-service or capitated with a risk sharing agreement.

The other key component of enhancing the deliver model is to designate the managed CalOptima Community Network, a part of CalOptima Direct, as the assigned network for OCC members residing in a long-term care facility, similar to CalOptima's current policy for Medi-Cal members. The CalOptima Community Network is designed to provide physician, hospital, and long-term care services to all Medi-Cal members residing in a long-term care facility. For Dual eligible members, while physician and hospital services are provided through the Medicare fee-for-service program, a Medicare Advantage Plan, or a Special-Needs Plan, CalOptima has always managed and paid for long-term care services for these members directly. Assigning OCC members to CalOptima

Community Network, therefore, promotes continuity with their CalOptima Medi-Cal network. Additionally, this allows a single entity to be responsible for the members entire covered services.

Subject to approval by both the DHCS and CMS, CalOptima will modify and/or develop OCC policies related to health network selection, primary care selection, auto-assignment, and services provided to a member residing in a long-term care facility to the extent necessary to reflect the above.

Fiscal Impact
The recommended actions are budget neutral. Transition of OneCare members into OneCare Connect, expenses due to deeming, and direct costs related to the reimbursement to long-term care facilities are accounted for in the FY16 budget.

Rationale for Recommendation
In order to comply with the DHCS guidelines for OCC enrollment and to maintain maximum membership and minimize disruption of member's health care services, CalOptima staff proposes to implement the above recommended actions.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

07/31/2015 — **Date**

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Title	**Cal MediConnect (CMC) Deeming Process for California**
Purpose	The purpose of this document is to describe the approach to implementing the deeming process in California.
Date	**04/14/15.** First release to Plans. **05/12/15.** Updated based on plan comments/questions submitted on 4/20. **06/09/15**. Updated based on plan questions from version sent on 5/12/15. **08/17/15:** Updated to align with new deeming Health Care Plan (HCP) status codes effective 9/1/15. **5/12/2017:** Updated to align with deeming period of two months for all HCP's
Exhibits*	**Exhibit 22** – Deemed Continued Eligibility due to Loss of Medicaid Eligibility (for use with HCP Status = 41 **– no change to exhibit**). **Exhibit 30a** – Deemed Continued Eligibility Due to Member no Longer Eligible for Cal MediConnect (for use with HCP Status = 61 **– no change to exhibit**). **Appendix 5** – CA-Specific Enrollment/Disenrollment Guidance *CMS released Exhibits 22 and 30a via HPMS on 6/10/15. Updates to Appendix 5 will be published separately by CMS and posted to the CMS website.

Deeming Policy Effective 10/1/2016: For individuals that lose CMC eligibility due to: 1) loss of Medi-Cal eligibility, or 2) a change in circumstance impacting CMC eligibility (such as a change in Medi-Cal eligibility aid code or move out of the service area), the CMC plan will provide a two- month period of deemed continued eligibility. CMC plans must comply with requirements specified in Section 40.2.3.2 of the Medi-Care Medi-Caid Plan (MMP) Enrollment and Disenrollment Guidance and Appendix 5 – California specific requirements as updated by the Department of Health Care Services (DHCS). Updates to AEVS messaging effective 9/1/15:

- ➔ **HCP Status '41'** – New AEVS message: "Subscriber limited to services covered by health plan:_____"
- ➔ **HCP status '61' –** Current AEVS message used for active HCP Status code. Includes plan name and Medi-Cal eligibility information.

I Operational Requirements

A. Start Deeming Period for Beneficiary

1. For plans in the two-month deeming period, plans will be informed of the start of the deeming period through a new HCP Status Code specific on the month-end 834 enrollment file.

   DHCS maintains an internal system table that identifies the deeming period for each plan. The elected deeming period will remain in effect throughout the Demonstration. Any changes to the deeming period should be requested through the Contract Management Team Operational (CMTO).

The deeming period starts on the first day of the month following the month the CMC plan is notified of a change identified by the HCP Status code from an active enrollment to a Hold status (HCP Status = 41 or 61) through the month-end 834 enrollment file. The HCP Status Code is located in Loop 2300 REF HD04 in the 834 enrollment file.

Hold HCP Status Code Descriptions:

HCP Status = '41' – HCP Hold Due to Loss of Medi-Cal Eligibility.
HCP Status = '61' – HCP Hold due to Loss of State-Specific Eligibility for Cal MediConnect.

Plans must send the appropriate notice (Exhibit 22 or 30a) to beneficiary within 10 calendar days of learning of the change in the HCP Status code in the month-end 834 enrollment file:

- Exhibit 22 – use for HCP status = '41'
- Exhibit 30a – use for HCP status = '61'

Example of key activities/dates when beneficiary goes into a deeming period:

a. Plan receives January month-end 834 enrollment file No Later Than (NLT) 1/28/17. HCP status = '41' or '61'.
b. Deeming period starts 2/1/17.
c. Plan mails Exhibit 22 or Exhibit 30a to beneficiary NLT 2/8/17 (10 calendar days after receipt of month-end 834 enrollment file).
d. Two month deeming period ends 3/31/17.

Note: Changes to the member's HCP status are reported in the month-end 834 enrollment file according to the DHCS published schedule maintained on the DHCS Website under APL 14-018:
http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-018.pdf.

2. DHCS will not send a disenrollment transaction to IFOX/CMS or MEDs for beneficiaries in the deeming period.
3. Medicare capitation payments will continue during the deeming period. Medi-Cal capitation payments will be suspended during the deeming period.

B. CMC Eligibility is not Reinstated

1. If the member does not regain CMC eligibility during the deeming period, the member will be disenrolled from the CMC effective the last day of the deeming period.
2. DHCS will send the CMC disenrollment transaction to IFOX/CMS and update MEDS no later than three business days following the last day of the deeming period.
3. For the non-County Organized Health System (COHS) plans, DHCS will send the disenrollment letter to the beneficiary (Exhibit 21) no later than three business days no later than three business days following the end of the deeming period. The COHS plans will send Exhibit 21 to beneficiaries within the same required timeframe.

Example of key dates when beneficiary is not reinstated prior to the end of the deeming period:

1. **Beneficiary has two-month deeming: 2/1/17 through 3/31/17.**
   a. March month-end 834 enrollment file (available NLT 3/28/17) shows beneficiary HCP status = '41' or '61' (no change)
   b. DHCS sends IFOX/CMS disenrollment transaction NLT 3/31/17.
   c. DHCS sends disenrollment letter (Exhibit 21) NLT 4/5/17.
   d. Plan receives disenrollment DTRR NLT 4/6/17.
   e. Member is defaulted into CMC affiliated Medi-Cal Managed Care plan with HCP status '05' or '59'.
   f. CMS will enroll member in Original Medicare and a Medicare drug plan. Beneficiaries can access LI NET for Part D prescriptions during any coverage gap.

C. CMC Eligibility is Reinstated

1. If the member regains CMC eligibility prior to the end of the deeming period, the member's HCP status will change to '51' (Enrollment activated from HCP hold- Supplemental capitation paid at the end of the month).

2. Medi-Cal capitation payments will be retroactively paid for the full two months of the deeming period.

II Beneficiary Communications and Noticing

1. As required in the CMC Enrollment / Disenrollment guidance, the CMC must send Exhibit 22 or Exhibit 30a to the beneficiary within 10 calendar days of learning of the loss of CMC eligibility (through the HCP Status code 41 or 61) on the month-end 834 enrollment file.

   - Exhibit 22 is sent for HCP status = 41
   - Exhibit 30a is sent for HCP status = 61

2. In addition to sending Exhibit 22 or Exhibit 30a, plans may contact the beneficiary directly to inform them about their change in status and encourage them to contact their county eligibility worker. Plans may warm transfer calls to the county offices as well.
3. Communication to beneficiaries from counties regarding their Medi-Cal eligibility will not change as a result of this process.

~~Policy #: CMC.4004~~
~~Title: **Member Disenrollment**~~
~~Department: Customer Service~~
~~Section: Not Applicable~~

~~CEO Approval: Michael Schrader~~

~~Effective Date: 07/01/15~~
~~Last Review Date: 07/01/16~~
~~Last Revised Date: 07/01/16~~

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CEO Approval: Michael Schrader

Effective Date: 07/01/15
Last Review Date: 09/07/17
Last Revised Date: 09/07/17

I. PURPOSE

This policy describes procedures for disenrolling a Member from the OneCare Connect program.

II. POLICY

A. Except as provided in this policy, OneCare Connect may not request or encourage any Member to disenroll from OneCare Connect.

1. CalOptima may not request disenrollment due to adverse changes in a Member's health status, a Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs.

B. A Member may voluntarily disenroll from OneCare Connect in any month and for any reason, in accordance with this policy.

C. CalOptima shall involuntarily disenroll a Member from OneCare Connect if:

1. The Member's change in residence ~~(including incarceration)~~ makes the Member ineligible to participate in OneCare Connect;

2. The Member loses entitlement to either Medicare Part A or Part B;

3. The Member loses entitlement to services under Medi-Cal or Medi-Cal eligibility changes (e.g., to a non-eligible aid code or adding Share of Cost (SOC) when not residing in a LTC facility or receiving In-Home Support Services (IHSS) or Multi Senior Services Program (MSSP);

4. The Member loses a state-specific eligibility qualification for OneCare Connect;

5. The Member is incarcerated;

6. The Member is not lawfully present in the United States;

~~6.~~7. The Member dies;

~~7.~~8. The Contract is terminated or CalOptima reduces its Service Area ~~to exclude~~such that the Member~~;~~ is no longer within the Service Area;

~~8.~~9. The individual materially misrepresents information to OneCare Connect regarding reimbursement for third party coverage; or

~~9.~~10. The individual has comprehensive health insurance other than Medicare or Medi-Cal.

D. ~~OneCare Connect~~CalOptima may request approval from the State and CMS ~~-~~to involuntarily disenroll a Member from ~~CalOptima~~ OneCare Connect, if the Member:

1. Engages in disruptive behavior; or

2. Provides fraudulent information on the Enrollment Form ~~or permits Abuse of the Member's OneCare Connect identification (ID) card.~~; or

3. Permits Abuse of the Member's OneCare Connect identification (ID) card.

E. CalOptima shall retain all OneCare Connect disenrollment ~~requests~~request for ~~the current Contract~~a period ~~and~~of ten (10) ~~prior periods.~~ years from the end of the contract period in which the request was made.

III. PROCEDURE

A. Voluntary Disenrollment

1. A Member may request to disenroll from OneCare Connect by:

a. Enrolling in another Medicare health or Part D plan, including a PACE organization;

b. Enrolling in another Medicare Medicaid Plan (MMP);

c. Calling 1-800-MEDICARE (1-800-633-4227); or

d. Giving or faxing a signed written disenrollment notice to ~~OneCare Connect~~CalOptima, or to the State.

2. If a Member verbally requests disenrollment from OneCare Connect, the CalOptima staff member receiving such request must instruct the Member to make the request in one (1) of the ways described above.

3. If a Member is unable to sign the written request to disenroll from OneCare Connect, an Authorized Representative shall sign the request. If an Authorized Representative signs the disenrollment request, the Authorized Representative shall attest that they have such authority to make the request and that proof of the authority is available upon request by CalOptima or CMS. If CalOptima has reason to believe that an individual making an Election on behalf of a Member may not be authorized under State law to do so, CalOptima shall contact CMS, in accordance with the Medicare Managed Care Manual.

4. The Member, or Authorized Representative, shall write the date they signed the disenrollment request on the disenrollment request. If the Member or Authorized Representative fails to include the date on the disenrollment request, OneCare Connect's mailroom shall stamp the date of receipt of the disenrollment request, and such date shall serve as the signature date.

5. If the Member, or Authorized Representative, fails to include a signature on the disenrollment request, CalOptima may verbally verify with the Member or Authorized Representative the request to disenroll. CalOptima shall document the verbal verification to complete the disenrollment request and shall retain such documentation in its records.

6. If CalOptima requests additional information to be submitted for the disenrollment request, CalOptima shall explain to the Member or Authorized Representative that the additional information must be received by the end of the calendar month in which the request to disenroll was received, or within twenty-one (21) calendar days after receipt of the disenrollment request for a disenrollment request to be considered complete (whichever is later). If CalOptima does not receive additional information within the allowable timeframe, CalOptima shall not disenroll the Member.

7. Notice Requirements

   a. If a Member requests disenrollment through CalOptima, CalOptima shall mail the Member *Exhibit 14, Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request ~~form~~ from Member* within ten (10) calendar days after receipt of the disenrollment request. The acknowledgement of disenrollment letter shall include an explanation of the effective date of the disenrollment. The notice shall also inform the disenrolling Member that it may take up to forty-five (45) calendar days for the Medicare computer records to be updated, and advise the Member ~~ask any providers to hold their Original Medicare~~to inform his or ~~Medi-Cal claims for up to one (1) month so that Medicare~~her provider the Member was just disenrolled from OneCare Connect and ~~Medi-Cal computer records can~~there may be ~~updated to show that the person is no longer enrolled in~~a short delay with updating the ~~plan so that claims are processed for payment and not denied.~~ Member's records.

   b. If a Member requests disenrollment through an entity other than CalOptima, as specified in this policy, CMS will notify CalOptima in the Daily Transaction Reply Report (DTRR). If CalOptima learns of the voluntary disenrollment from the DTRR (as opposed to a written request from the Member), CalOptima shall input the disenrollment in the OneCare Connect eligibility system and mail *Exhibit 16, Model Notice to Confirm Voluntary Disenrollment Following Receipt of Transaction Reply Report (TRR)* to the Member within ten (10) calendar days after the availability of the information on the DTRR from CMS.

8. Processing Request for Disenrollment

   a. The CalOptima mailroom shall stamp the date of receipt of a disenrollment request received from a Member, or Member's Authorized Representative, upon receipt of that request.

   b. CalOptima shall submit a disenrollment transaction to CMS within seven (7) calendar days after the date of receipt of a disenrollment request.

   ~~c. Members eligible for passive enrollment who Opt-Out shall be processed, in accordance with CalOptima Policy CMC.4006: Passive Enrollment, as follows:~~

~~i. For Members making a verbal request to Opt-Out, OneCare Connect shall ask the Member if they want to Opt-Out of future Passive Enrollments and document the Member's response.~~

~~ii. If the Member indicates they want to Opt-Out of future Passive Enrollments, CalOptima OneCare Connect shall submit the disenrollment transaction code, TC 51, to CMS showing an MMO Opt-Out Flag data element as "Y" = Opted out of Passive Enrollment in position 202.~~

~~iii. Such individual may enroll in a MMP in the future by submitting a voluntary enrollment request.~~

9. If a Member requests voluntary disenrollment from OneCare Connect, such disenrollment shall be effective on the first (1st) calendar day of the month after the month CalOptima receives a completed disenrollment request, unless otherwise stated in writing for a future date.

10. CalOptima may deny a voluntary request for disenrollment only when:

    a. The request was made by someone other than the Member, and that individual is not the Member's Authorized Representative, as described in this policy; or

    b. The request was incomplete, and the required information is not provided within the required ~~timeframe~~time frame.

11. If CalOptima receives a disenrollment request that OneCare Connect is required to deny, CalOptima shall mail *Exhibit 17, Model Notice for Denial of Disenrollment* to the Member within ten (10) calendar days after the receipt of the request and shall include the reason for the denial.

B. Involuntary Disenrollment

1. If CalOptima involuntarily disenrolls a Member for causes specified in this policy, CalOptima shall provide the Member with a disenrollment letter ~~prior to submitting the disenrollment transaction to CMS that:~~that:

    a. Advises the Member that CalOptima plans to disenroll the Member, and the reason for such disenrollment; and

    b. Explains the Member's right to file a Grievance, in accordance with CalOptima Policy CMC.9002: Member Grievance Process, except if the Contract is terminating as specified in this policy.

C. Involuntary Disenrollment for Change in Residence

1. CalOptima shall initiate disenrollment when a Member's permanent residence is confirmed outside of the Service Area or when a Member's ~~temporary~~ absence from the OneCare Connect Service Area exceeds ~~one (1) month~~six (6) consecutive months.

2. ~~OneCare Connect~~CalOptima may receive notice of a change in a Member's residence from DHCS, the Member, the Member's Authorized Representative, a DTRR from CMS, or other source.

a. DHCS ~~shall~~ will notify CalOptima of a potential move out of area with an HCP status code ~~59/~~61 in the monthly 834 eligibility file:

i. Within ten (10) calendar days of receiving HCP status code ~~59/~~61 CalOptima shall mail *Exhibit 30a,~~ Model Notice for Deemed~~ Continued Eligibility due to Change in Medicaid Eligibility or Potential Move Out-of-Area* to the Member.

ii. A period of ~~one (1) calendar month~~two (2) months of deemed continued eligibility begins the first day of the calendar month following the month CalOptima receives the code ~~59/~~61.

iii. CalOptima shall make a minimum of three (3) telephonic attempts during the deemed continued eligibility period to inform the member of his/her eligibility status and provide the necessary resources so the member can attempt to regain eligibility.

~~iii.~~ If the month-end 834 enrollment file received by CalOptima at the end of the period of deemed continued eligibility shows no change in the Member's HCP Status code ~~59/61, CalOptima shall disenroll the Member effective at the end of the period of deemed continued eligibility.~~

~~iv. No later than three (3) business days following the last day of the deeming period~~61, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status*~~.~~ no later than three (3) business days following the last day of the deeming period.~~.~~

iv. ~~.~~

v. Within three (3) business days following the ~~disenrollment effective date, CalOptima shall~~end of the period of deemed continued eligibility, DHCS will submit a disenrollment transaction to CMS, effective the ~~last~~first (1st) day of the calendar month from the end of the period of deemed continued eligibility.

vi. This section does not apply if CalOptima has confirmed the out-of-area move and will process the disenrollment as otherwise set forth in this policy.

b. If CalOptima is notified of a potential out-of-area change in residence through a source other than DHCS, the Member, or the Member's Authorized Representative, ~~OneCare Connect~~CalOptima shall not assume the move is permanent and shall not disenroll the Member until the Member, or Member's Authorized Representative, confirms the out-of-area move, or until six (6) consecutive months have elapsed following the date CalOptima OneCare Connect receives information regarding the Member's potential address change ~~or,~~ whichever is sooner.

i. ~~OneCare Connect~~CalOptima shall, within ten (10) calendar days of receipt of such notice, send the Member *Exhibit 30, a Notice to Research Potential Out of Area Status and Address Verification Form* to verify the change in address and whether it is temporary, or permanent.

ii. The Member shall have six (6) calendar months following the date of the notice to respond.

iii. If, at the end of the sixth (6th) calendar month, there is no response to Exhibit 30, and CalOptima has not received an HCP Status Code ~~59/~~61 from DHCS, ~~OneCare Connect~~CalOptima shall document this information in its records and forward the request to disenroll ~~the Member at the end of six (6) calendar months following the date Exhibit 30 was mailed.~~ to DHCS..

iv. Within the first ten (10) calendar days of the sixth (6th) calendar month following discovery of a potential out-of-area residence, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice of Disenrollment due to Loss of Medicaid Status or Other State-Specific Eligibility Status, or Out-of-Area Status.*

v. Within three (3) business days following the disenrollment effective date, ~~CalOptima shall~~DHCS will submit a disenrollment transaction to CMS, effective the ~~last~~first (1st) day of the calendar month following the end ~~-~~of the sixth (6th) month.

c. CalOptima shall accept verbal, or written, confirmation from the Member, or Member's Authorized Representative, of an address change.

i. If the confirmation indicates the permanent address is outside of the Service Area. CalOptima shall document this information in its records and ~~disenroll the Member effective the last day of the calendar month in which confirmation was received.~~forward the request to disenroll to DHCS. CalOptima shall mail *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* within ten (10) calendar days of the date the out-of-area address was confirmed.

d. ~~CalOptima shall~~DHCS will submit a disenrollment transaction to CMS, effective the ~~last~~first (1st) day of the calendar month ~~in which~~following the date ~~-~~CalOptima received the confirmation.

i. If the confirmation indicates the permanent address is within the OneCare Connect Service Area, CalOptima shall discontinue the disenrollment process.

~~e.~~ If an enrolling Member shows an address within the plan Service Area on the enrollment application, while the CMS or Medi-Cal records show an address outside of the plan Service Area, the Member's enrollment application serves as attestation of their current address.

~~f.~~e. ~~Following such enrollment, CalOptima should receive a Transaction Reply Report (TRR) from CMS listing the Member with Transaction Reply Code (TRC) 016 – Enrollment Accepted, Out of Area accompanied with a TRC 011 – Enrollment Accepted as Submitted. CalOptima shall not initiate the involuntary disenrollment process or attempt to contact the Member to verify their address, in these cases.~~

f. If CalOptima learns of a permanent change in address directly from the Member or Member's Authorized Representative, and that address is outside of the OneCare Connect Service Area, ~~OneCare Connect~~CalOptima shall document this information in its records and forward the request to disenroll ~~the Member and~~to DHCS.

g. CalOptima shall mail *Exhibit 20, Model Notice for Disenrollment Due to Confirmation of Out-of-Area Status (Upon New Address Verification from Member)* to the Member within ten (10) calendar days of receiving the information. ~~Generally, such~~

~~g.~~h. DHCS will submit a disenrollment ~~shall be~~transaction to CMS, effective the first (1st) day of the calendar month after the date the Member begins residing outside of OneCare Connect's Service Area and after the Member, or their Authorized Representative, notifies CalOptima that they have moved and no longer resides in the Service Area.

~~h.~~i. In the case of an individual who provides advance notice of the move, the disenrollment will be effective the first (1st) day of the calendar month following the month in which the individual indicates they will be moving.

~~i.~~j. In the case of incarcerated individuals, where CalOptima receives notification of the out-of-area status via a DTRR, ~~CalOptima shall~~DHCS will disenroll the Member on the first (1st) day of the calendar month following confirmation of current incarceration.

~~j.~~k. A Member who is incarcerated is considered out of the plan's Service Area, even if the correctional facility is located within the Service Area.

~~k.~~l. CalOptima is not required to contact the Member to confirm incarceration, but must still confirm incarceration using public sources such as a federal or state entity or other public records.

~~l.~~m. If CalOptima confirms a Member's current incarceration, but is unable to confirm the start date of the incarceration, ~~CalOptima shall~~DHCS will disenroll the Member prospectively effective the first (1st) of the calendar month following the date on which the current incarceration was confirmed.

~~m.~~n. If CalOptima confirms the Member's start date of the incarceration, ~~CalOptima shall~~DHCS will disenroll the Member effective the first (1st) day of the calendar month following the start date of the incarceration.

~~n.~~o. If the disenrollment effective date is outside of the current calendar month transaction submission timeframe as defined by CMS, ~~CalOptima~~DHCS must submit a retroactive disenrollment request to the Retroactive Processing Contractor (RPC~~,~~), unless the period of incarceration is already completed. If the period of incarceration is already complete, disenrollment is not necessary unless otherwise instructed by CMS.

~~o.~~p. If the Member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the first (1st) day of the calendar month after the move), ~~CalOptima shall~~DHCS will submit this request to CMS or its designated ~~Retroactive Processing Contractor (~~RPC~~)~~ for consideration of retroactive action.

D. Involuntary Disenrollment for Loss of Entitlement to Medicare Part A or Part B

1. Upon notice from CMS, via the ~~TRR~~DTRR, that a Member's entitlement to Medicare Part A or Part B has ended, CalOptima shall ~~involuntarily disenroll the Member from OneCare Connect effective the first (1st) day of the calendar month following the last month of the Member's entitlement to Medicare Part A or Part B, whichever entitlement ends first, or~~update its eligibility systems with the date specified on the ~~TRR~~DTRR from CMS.

2. If a Member loses entitlement to Medicare Part A, CalOptima shall not:

   a. Allow the Member to remain a Member and receive Medicare Part B-only services; or

b. Offer the Member Part A-equivalent services for a premium.

3. If a Member loses entitlement to Medicare Part B, CalOptima shall not allow the Member to remain a Member and receive Medicare Part A-only services.

4. Notice Requirement

a. CalOptima shall mail the Member *Exhibit ~~19/20/21,~~24: Model Notice ~~for Disenrollment due to Loss~~Offer Beneficiary Services, Pending Correction of ~~Medicaid Status, Other State Specific Eligibility Status or Out-of-Area Status~~Erroneous Medicare Part A and/or Part B Termination* informing the Member of disenrollment due to loss of entitlement to Medicare Part A or Part B, within ten (10) calendar days from the date of discovery via the DTRR, so that any erroneous disenrollments can be corrected as soon as possible.

E. Involuntary Disenrollment for Loss of Entitlement to Services under Medi-Cal

1. Effective September 1, 2017, CalOptima shall involuntarily disenroll a Member who loses entitlement to Medi-Cal benefits or has a change in Medi-Cal status or due to loss of State-specific eligibility, following a period of ~~one (1~~two (2) calendar ~~month~~months of deemed continued eligibility.

2. For loss of Medi-Cal Eligibility, DHCS ~~shall notify~~ notifies CalOptima ~~of a loss of Medi-Cal eligibility~~ with an HCP status code ~~05/41~~041 in the monthly 834 eligibility file.

a. Within ten (10) calendar days of receiving HCP status code ~~05/41~~041, CalOptima shall mail the Member *Exhibit 22, Model Notice for Period of Deemed Continued Eligibility due to Loss of Medicaid.*

b. ~~A~~Effective September 1, 2017, a period of ~~one (1~~two (2) calendar ~~month~~months of deemed continued eligibility begins the first (1st) day of the calendar month following the month CalOptima receives the code ~~05/41~~041.

c. CalOptima shall make a minimum of three (3) telephonic attempts during the deemed continued eligibility period to inform the Member of his/her eligibility status and provide the necessary resources so the member can attempt to regain eligibility.

~~c.~~ If the month-end 834 enrollment file received by CalOptima at the end of the deeming month shows no change in the Member's HCP Status code ~~05/41, CalOptima shall disenroll the Member effective at the end of the period of deemed continued eligibility.~~

d. ~~If eligibility is not regained during the period of deemed continued eligibility~~041, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the last day of the deeming period.

e. The notice shall include the disenrollment effective date and the Medicare Special Election Period (SEP) for which the individual is eligible.

i. This section does not apply if CalOptima has confirmed with the Member (or Authorized Representative) that the Member has lost Medi-Cal eligibility and does not intend to reapply or seek redetermination prior to the start of the deeming period.

f. Within three (3) business days following the last day of the deeming period, submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month following the end of the period of deemed continued eligibility.

3. For Loss of Cal MediConnect Eligibility (including a change in circumstance such as a change in Medi-Cal ~~status~~aid code or ~~loss of State-specific eligibility status,~~move out of Service Area), DHCS ~~shall notify~~ notifies CalOptima ~~of a loss of eligibility~~ with an HCP status code ~~59/61~~061 in the monthly 834 eligibility file.

a. Within ten (10) calendar days of receiving HCP status code ~~59/61~~061, CalOptima shall mail the Member *Exhibit 30a, Model Notice for Deemed Eligibility due to Change in Medicaid Eligibility or Potential Move Out-of-Area.*

b. ~~A~~Effective September 1, 2017, a period of ~~one (1~~two (2) calendar ~~month~~months of deemed continued eligibility begins the first day of the calendar month following the month CalOptima receives the code ~~59/61~~061.

c. CalOptima shall make a minimum of three (3) telephonic attempts during the deemed continued eligibility period to inform the Member of his/her eligibility status and provide the necessary resources so the Member can attempt to regain eligibility.

~~c.~~d. If the month-end 834 enrollment file received by CalOptima at the end of the deeming month shows no change in the Member's HCP Status code ~~59/61~~061, CalOptima shall ~~disenroll~~mail the Member ~~effective at~~*Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the ~~end~~last day of the deeming period ~~of deemed continued eligibility~~.

e. The notice shall include the disenrollment effective date and the Medicare SEP for which the individual is eligible.

~~d.~~

~~e.~~f. ~~If eligibility is not regained during the period of deemed continued eligibility, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than~~Within three (3) business days following the last day of the deeming period~~.~~, DHCS will submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month following the end of the period of deemed continued eligibility.

~~f. The notice shall include the disenrollment effective date and the Medicare SEP for which the individual is eligible.~~

g. This section does not apply if CalOptima has confirmed with the Member (or authorized representative) that the Status ~~59/61~~061 code is correct prior to the start of the deeming period.

4. If CalOptima receives information from a source outside of CalOptima, other than DHCS, indicating loss of State-specific qualifications for OneCare Connect, CalOptima shall research to confirm the information.

a. If confirmed, CalOptima shall ~~proceed with~~document this information in its records and forward the ~~involuntary disenrollment process, and~~request to disenroll to DHCS.

~~a.~~b. CalOptima shall mail *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the date Medi-Cal or other State-specific eligibility requirement ended.

c. The notice shall include the disenrollment effective date and the Medicare SEP for which the individual is eligible.

d. DHCS will submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month following the loss of State-specific qualifications.

~~b.~~c. ~~The notice shall include the disenrollment effective date and the Medicare SEP for which the individual is eligible.~~

~~c.~~f. Exception: As stated in the DHCS OneCare Connect and Managed Long Term Services and Supports (MLTSS) Operations Meeting Frequently Asked Questions dated June 3, 2014, CalOptima shall not disenroll a Member from OneCare Connect or MLTSS for unmet Share of Cost (SOC) provided the Member is also participating in IHSS, MSSP or LTC.

~~5. An individual passively enrolled into OneCare Connect who loses eligibility and is subsequently disenrolled, may not again be passively enrolled into OneCare Connect upon regaining Medi-Cal eligibility in the same calendar year. Individuals may be enrolled passively only once in a calendar year.~~

F. Involuntary Disenrollment due to Death

~~1.~~ Upon ~~a Member's~~notice from CMS, via the DTRR, of the Member's death, ~~CMS shall disenroll the Member from OneCare Connect and shall notify~~ CalOptima ~~of such disenrollment in the DTRR.~~

~~Such disenrollment shall be effective the first (1st) day of the calendar month following~~shall update its eligibility systems with the date ~~of death.~~ specified on the DTRR.

~~2.~~1.

~~3.~~2. Within ten (10) calendar days of receipt of notice from CMS of a Member's death, CalOptima shall mail *Exhibit 23, Model Notice to Offer Beneficiary Services, Pending Correction for Erroneous Death Status* ~~-~~addressed to the estate of the Member so that any erroneous disenrollments can be corrected as soon as possible.

~~4.~~3. If CalOptima learns of a Member's death from another reliable source, CalOptima shall reach out to the Member's estate to advise them to notify Social Security and their Medi-Cal eligibility office of the Member's death. The disenrollment process shall not be initiated until notice of disenrollment is received in the CMS DTRR.

G. Involuntary Disenrollment for Termination or Non-renewal of the Contract:

1. CalOptima shall disenroll a Member from OneCare Connect if the Contract is terminated.

2. CalOptima shall notify all Members in writing of the effective date of the termination and shall include a description of alternatives for obtaining benefits under the Medicare program. Members who do not make an election for a Prescription Drug Plan (PDP) or Medicare Advantage-Prescription Drug (MA-PD) plan will be deemed to have elected and will result in a change of enrollment to Original Medicare and auto-enrollment by CMS into a Medicare Prescription Drug Plan, as well as access to the LI NET transitional PDP during any coverage gap.

H. Disenrollment due to Material Misrepresentation of Third Party Reimbursement

1. If a Member intentionally withholds or falsifies information about third-party reimbursement coverage, CMS requires the individual be disenrolled from the plan.

2. OneCare Connect Customer Service shall notify the Office of Compliance of such an event.

3. If the Office of Compliance determines it appropriate, CalOptima shall submit disenrollment for this reason to the Contract ~~Review~~Management Team for approval along with any information regarding the claim of material misrepresentation.

4. ~~If~~Should the request be~~-~~ approved, the disenrollment will be effective the first (1st) day of the calendar month ~~following~~after the month in which the Member is ~~notified~~given a written notice of ~~the~~ disenrollment or as ~~CMS specifies.~~provided by the CMT.

I. Optional Involuntary Disenrollment

1. CalOptima may request approval to disenroll a Member if:

a. The Member engages in disruptive behavior; or

b. The Member provides fraudulent information~~.~~.

2. ~~If CalOptima disenrolls a Member~~Should the disenrollment be approved by CMT for any of the aforementioned optional involuntary disenrollment reasons, ~~CalOptima shall provide the Member with a~~the disenrollment will be effective the first (1st) day of the calendar month after the month in which the Member is given a written notice of disenrollment or as provided by CMT. The disenrollment letter shall:

~~2.~~ Advise the Member that~~:~~

a. ~~Advises the Member that OneCare Connect~~ CalOptima plans to disenroll the Member from OneCare Connect and the reasons for such disenrollment;

b. ~~Provides~~Provide the effective date of disenrollment; and

c. ~~Explains~~Explain the Member's right to a hearing under the State's Grievance procedures, CalOptima Policy CMC.9002: Member Grievance Process.

3. Involuntary Disenrollment for Disruptive Behavior

a. CalOptima may request approval from CMS and DHCS~~-~~, through the CMT, to disenroll a Member if the Member's behavior is disruptive, unruly, abusive, or uncooperative to the

extent that the Member's continued enrollment in CalOptima OneCare Connect seriously impairs CalOptima's or a Contracted Provider's ability to furnish Covered Services to the Member or other Members, provided Member's behavior is determined to be unrelated to an adverse change in the Member's health status, or because of a Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs.

b. CalOptima shall not disenroll a Member from OneCare Connect because the Member:

i. Exercises the option to make treatment decisions with which OneCare Connect disagrees, including the option to receive no treatment or diagnostic testing; or

ii. Chooses not to comply with any treatment regimen developed by OneCare Connect or any Contracted Provider associated with OneCare Connect.

c. CalOptima shall make serious efforts to resolve problems presented by a Member prior to requesting approval from DHCS and CMS to disenroll the Member from OneCare Connect.

i. Such efforts to find a resolution must include providing reasonable accommodations, as determine by ~~the State~~DHCS or CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities;

ii. CalOptima must also inform the individual of their Grievance rights.

d. CalOptima shall provide three (3) notices for disenrollment due to disruptive behavior:

i. ~~—~~Advance notice to a disruptive Member, in writing, that continued disruptive behavior will result in involuntary disenrollment from OneCare Connect.

ii. If such behavior continues, CalOptima shall provide written notice of its intent to request CMS' and DHCS' permission to disenroll the Member from OneCare Connect.

iii. Planned action notice advising that CMS and DHCS have approved the request.

e. CalOptima shall submit documentation of the specific case to DHCS and CMS through the ~~State~~CMT for review~~. If~~, including the ~~State agrees with the request for involuntary disenrollment, the State must submit this~~ documentation ~~to CMS with a recommendation for approval. Such request shall include:~~listed below:

i. A thorough explanation of the reason for the disenrollment request, detailing how the Member's behavior has impacted OneCare Connect's ability to arrange for or provide services to the Member or other Members of the plan;

ii. Member information, including age, diagnosis, mental status, Functional Status, and a description of the Member's social support systems;

iii. ~~A statement~~Statements from the ~~Provider~~Providers describing their experience with the Member;

iv. Documentation of the Member's disruptive behavior;

v. Documentation of CalOptima's efforts to resolve the problem, including efforts to:

a) Provide reasonable accommodations for a Member with a disability, if applicable, in accordance with the Americans with Disabilities Act (ADA);

b) Establish that the Member's behavior is not related to the use or lack of use of medical services; and

c) Establish that the Member's behavior is not related to diminished mental capacity.

vi. A description of any extenuating circumstances as cited under Title 42, Code of Federal Regulations (C.F.R), Section 422.74 (d)(2)(iv);

vii. Copy of notice to the Member of the consequences of continued disruptive behavior;

viii. Copy of notice to the Member of CalOptima OneCare Connect's intent to request the Member's disenrollment; and

ix. Any information provided by the Member~~.~~ (e.g., complaints, statements).

f. ~~Upon~~ The CMT will make a decision within twenty (20) business days after the receipt of ~~approval from the CMS Regional Office with concurrence from~~all information required to complete its review.

~~f.~~ Should the ~~CMS central office, CalOptima shall provide a Planned Action Notice to the Member, in writing, that CMS and the State have~~request be approved, the ~~Member's~~ disenrollment ~~from OneCare Connect.~~

g. ~~CalOptima shall disenroll the Member~~ will be effective the first (1st) day of the calendar month after the month ~~it notifies~~in which CalOptima gives the Member a written notice of the disenrollment, or as provided by CMT.

h. A disenrollment processed under the disruptive behavior provision will always result in a change of enrollment to Original Medicare, and auto-enrollment by CMS into a Medicare Prescription Drug Plan, including to the LI NET traditional PDP during any coverage gap.

i. If the request for involuntary disenrollment for disruptive behavior is approved:

i. CMS and DHCS may require CalOptima to provide reasonable accommodations to the Member in such exceptional circumstances that CMS and DHCS deems necessary.

ii. CalOptima may request that CMS and DHCS consider prohibiting re-enrollment in the MMP. If this is not requested, and the Member is disenrolled due to disruptive behavior, the member may re-enroll into the MMP in the future.

J. Involuntary Disenrollment for Fraud and Abuse

~~a.~~1. CalOptima may request approval from the State and CMS ~~to disenroll~~through the CMT to cancel the enrollment of a Member who knowingly provides on the Enrollment Form fraudulent information that materially affects the determination of a Member's eligibility ~~for enrollment~~to enroll in OneCare Connect.

~~b.~~2. CalOptima may request approval from the State and CMS through the CMT to disenroll a Member who intentionally permits others to use their OneCare Connect identification (ID) card to obtain Covered Services.

~~c.~~3. With such a disenrollment request, CalOptima shall immediately notify the State and CMS so the Health and Human Services (HHS) Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

~~d.~~4. If such disenrollment request is approved by CMS and the State, CalOptima shall notify the Member in writing of the disenrollment and the reason for the disenrollment. Such disenrollment shall be effective the first (1st) day of the calendar month after the month in which CalOptima gives the Member written notice and will result in a change of enrollment to Original Medicare and auto-enrollment by CMS into a Medicare Prescription Drug Plan, as well as access to the LI NET transitional PDP during any coverage gap.

K. Involuntary Disenrollment Due Unlawful Presence Status

1. CalOptima cannot retain a Member if CMS has determined that the Member is not lawfully present in the United States. CMS will notify CalOptima with specific Transaction Reply Code (TRC-) 349 via the Daily Transaction Reply Report (DTRR) that the Member is not lawfully present, and CMS will make the disenrollment effective the first (1st) day of the month following notification by CMS. CMS provides the official status to CalOptima, and CalOptima may not request any documentation of U.S. citizenship or alien status from a Member.

2. Within ten (10) calendar days following the receipt of notification (via DTRR) of the disenrollment due to unlawful presence, CalOptima shall provide a written notice to the Member so that the Member is aware of the loss of coverage in CalOptima and any erroneous disenrollments can be corrected as soon as possible.

~~K.~~L. Reinstatements may be necessary if a disenrollment is not legally valid.

1. CalOptima shall submit a reinstatement request to CMS if:

   a. Disenrollment occurred due to an erroneous death indicator;

   b. Disenrollment occurred due to erroneous loss of Medicare Part A or Part B;

   c. Disenrollment occurred due to an erroneous loss of entitlement of Medi-Cal eligibility or state specific eligibility criteria, as listed in CalOptima Policy CMC.4003: Member Enrollment (Voluntary);

   d. There is evidence that a Member did not intend to disenroll, e.g. if the Member cancelled a new enrollment in another plan; and

   e. Disenrollment occurred due to CalOptima, CMS, or State error.

2. If a Member contacts CalOptima and states that they were disenrolled from OneCare Connect for any of the reasons stated in Section III.E.1 of this policy, except III.E.1.d., and states that they wish to remain a Member, CalOptima shall instruct the Member, in writing within ten (10) calendar days of the Member's contact with CalOptima reporting the erroneous disenrollment, to continue using OneCare Connect Covered Services.

3. CalOptima shall indicate active coverage as of the date CalOptima instructs the Member to continue to use Covered Services.

4. If a Member is disenrolled due to any of the reasons stated in Section III.E.1 of this policy, CalOptima shall submit to CMS a request to reinstate the Member which shall include:

   a. A copy of the TRR from CMS showing the disenrollment;

   b. A copy of the disenrollment letter that CalOptima OneCare Connect sent to the Member;

   c. A copy of any correspondence from the Member disputing the disenrollment;

   d. A copy of the letter to the Member informing them to continue to use CalOptima OneCare Connect services until the issue is resolved, except for III.E.1.d.;

   e. Verification that the disenrollment was erroneous; and

   f. Within ten (10) calendar days of receipt of DTRR confirmation of the Member's reinstatement, CalOptima shall mail *Exhibit 27, Model Acknowledgement of Reinstatement* to the Member.

~~L.~~M. Cancellation of Voluntary Disenrollment

1. CalOptima may cancel a Member's disenrollment only if CalOptima makes the request prior to the effective date of the disenrollment, unless otherwise directed by CMS.

   a. If CalOptima receives a request for cancellation of disenrollment after it transmitted the disenrollment request to CMS, CalOptima shall submit a cancellation of disenrollment to reinstate a Member with no lapse in coverage.

   b. If CalOptima is unable to cancel the disenrollment transaction, CalOptima shall submit the request to cancel the action to the CMS Retroactive Processing Contractor (RPC) in order to cancel the disenrollment.

   c. CalOptima shall submit a transaction to cancel only those disenrollment transactions submitted to CMS.

   d. CalOptima shall mail *Exhibit 18, Model Acknowledgement of Request to Cancel Disenrollment* to the Member within ten (10) calendar days after receipt of a Member's request for cancellation of disenrollment, stating that the cancellation is being processed and the Member may continue using OneCare Connect Covered Services.

2. Within ten (10) calendar days of receipt of confirmation of the Member's reinstatement, CalOptima shall mail the Member *Exhibit 27, Model Acknowledgment of Reinstatement.*

3. If CalOptima receives a Member's request for cancellation of disenrollment after the effective date of disenrollment, and CMS does not allow the reinstatement, CalOptima shall instruct the Member to complete a new Enrollment form and re-enroll with OneCare Connect during an Election Period.

~~M.~~N. Retroactive Disenrollment

1. CMS may grant a retroactive disenrollment if:

   a. An enrollment was never legally valid, e.g. the result of fraudulent enrollment or misleading marketing practices;

   b. A valid request for disenrollment was properly made, but not processed or acted upon (whether due to system, plan or state error);

   c. The reason for the disenrollment is related to a permanent move out of the OneCare Connect Service Area; or

   d. The reason for the disenrollment is due to CalOptima's confirmation of an incarcerated status with a retroactive start date;

2. A Member or CalOptima may submit a request to CMS (or its Designee) for a retroactive disenrollment. CMS will notify DHCS.

3. If CalOptima submits a request for retroactive disenrollment, it shall include a copy or other record of the disenrollment request made by the individual and supporting evidence explaining why the disenrollment request was not processed correctly. CalOptima shall submit retroactive disenrollment requests to the CMS Retroactive Processing Contractor within the timeframe provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor. CMS will notify DHCS.

   a. If the reason is due to plan or state error, CalOptima must include clear information regarding what the plan or state has communicated to the affected individual throughout the period in question, including evidence that the individual was notified prospectively of the disenrollment and relevant information supporting the correction. This should include a copy of the disenrollment request and evidence of notices sent to the individual related to or caused by the error and which demonstrate that retroactive disenrollment is appropriate under the circumstances.

   b. If the reason for disenrollment is due to incarceration status with a retroactive start date, CalOptima must provide written confirmation of the incarceration status, including the start date. Such documentation may include documentation of telephonic communications.

IV. ATTACHMENTS~~/EXHIBITS~~

A. Exhibit 14~~–~~:Model Notice to Acknowledge Receipt of Voluntary Disenrollment from the Member
~~❖~~B. Exhibit 16:~~–~~Model Notice to Confirm Voluntary Disenrollment ~~from the Member and~~ Following Receipt of Transaction Reply Report (TRR) ~~(H8016_MM1013)~~
~~❖~~C. Exhibit 17:~~–~~Model Notice for Denial of Disenrollment ~~(H8016_MM1014)~~
~~❖~~D. Exhibit 18:~~–~~Model Acknowledgement of Request to Cancel Disenrollment ~~(H8016_MM1015)~~
E. Exhibit 19 ~~&~~:Model Notice for Disenrollment due to Out-of-Area Status (No Response to Request for Address Verification)
F. Exhibit 20~~&~~:Model Notice for Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member)
~~❖~~G. Exhibit 21:~~–~~Model Notice for Disenrollment due to Loss of Medicaid Status or Other State-Specific Eligibility Status ~~or Out-of-Area Status~~ - Notification of Involuntary Disenrollment ~~(H8016_MM1018)~~

H. Exhibit 22:Model Notice for Period of Deemed Continued Eligibility due to Loss of Medicaid
I. Exhibit 23 ~~&24 & 25: ~~:Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status~~, or~~
J. Exhibit 24:Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A~~/~~ and/or Part B Termination~~,~~
~~❖~~K. Exhibit 25:Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to State or Plan Error ~~(H8016_MM1019)~~
~~❖~~L. Exhibit 27: Model Acknowledgement of Reinstatement ~~(H8016_MM1023)~~
~~❖~~M. Exhibit 30: Model Notice to Research Potential Out of Area Status – Address Verification Form included ~~(H8016_MM1026)~~
~~❖~~N. Exhibit 30a: ~~MMP~~ Model Notice of Disenrollment following period of Deemed continued Eligibility due to change in Medicaid Eligibility or Potential Move out of Area ~~(H8016_1058)~~

V. REFERENCES

~~A.~~ CalOptima Policy CMC.~~1001: Glossary of Terms~~
~~B.~~A. ~~CalOptima Policy CMC.4006: Passive~~4003: Member Enrollment (Voluntary)
~~C.~~B. CalOptima Policy CMC.9002: Member Grievance Process
~~D.~~C. CalOptima Three-W~~w~~ay Contract with the ~~California Department of Health Care Services (DHCS) and the~~ Centers for Medicaid and Medicare Services (CMS) and the Department of Health Care Services (DHCS) for ~~OneCare Connect~~Cal MediConnect
D. Medicare–Medicaid Plan (MMP) Deeming Process for California, DHCS issued June 15, 2015
E. Medicare–Medicaid Plan (MMP) Enrollment and Disenrollment Guidance ~~Updated June 14, 2013~~(R~~r~~evised 9/2/2016)
F. OneCare Connect & Managed Long Term Services and Supports (MLTSS) Operations Meeting FAQ, June 3, 2014
~~G. MMP Deeming Process for California, DHCS issued June 15, 2015~~
~~H.~~G. Title 42, Code of Federal Regulations (C.F.R~~),~~.), §§422.66(b) and 422.74

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

~~None to Date~~

09/07/2017: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	07/01/2015	CMC.4004	Member Disenrollment	OneCare Connect
Revised	07/01/2016	CMC.4004	Member Disenrollment	OneCare Connect
Revised	09/07/2017	CMC.4004	Member Disenrollment	OneCare Connect

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Authorized Representative	For the purpose of this policy, an Authorized Representative is the same as Legal Representative. Centers for Medicare & Medicaid Services (CMS) defines Authorized/Legal Representative as an individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the state in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request, e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity.
Contract	The contract between United States Department of Health & Human Services Centers for Medicare & Medicaid Services, California Department of Health Care Services and Orange County Health Authority
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disenrollment	For the purposes of this policy, disenrollments are actions taken by the Member or plan after the effective date of enrollment. ~~Voluntary disenrollments may be accompanied by a request to Opt-Out of future Passive Enrollment requests for the OneCare Connect program.~~
Election	Enrollment in, or voluntary disenrollment from, a Medicare Advantage (MA) plan or Original Medicare.
Election Period	The time during which an eligible individual may elect a Medicare Advantage (MA) plan or Original Medicare. The type of Election period determines the effective date of MA coverage as well as the types of enrollment requests allowed.
Functional Status	An individuals' ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being.
Grievance	Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action
In-Home Supportive Services (IHSS)	A program that provides in-home care for people who cannot remain in their own homes without assistance.
Member	An enrollee-beneficiary of the CalOptima OneCare Connect program.
Multi-Purpose Senior Services Program (MSSP)	A California-specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 or older with

Term	Definition
	disabilities as an alternative to nursing facility placement.
~~Opt-Out~~	~~An individual's declination of Passive Enrollment received by CalOptima OneCare Connect prior to the Passive Enrollment effective date.~~
Original Medicare	The traditional Medicare Fee-for-Service program.
~~Passive Enrollment~~	~~An enrollment process through which an eligible individual is enrolled by DHCS into a Contractor's plan following a minimum 90-day advance notification that includes the opportunity for the Enrollee to choose another plan or Opt-Out prior to the effective date.~~
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.
Share of Cost (SOC)	The amount, set by Medi-Cal based on the Member's income, that the Member must contribute to the cost of their health care each month before Medi-Cal will pay.
Service Area	Orange County, California, and ten (10) air miles of any portion of Orange County, California.
Special Election Period	Election Period provided to individuals in situations where; 1. The individual has made a change in residence outside of the service area or continuation area or has experienced another change in circumstances as determined by Centers for Medicare & Medicaid Services (CMS) (other than termination for non-payment of premiums or disruptive behavior) that causes the individual to no longer be eligible to elect the Medicare Advantage plan; 2. CMS or the organization has terminated the Medicare Advantage organization's contract for the Medicare Advantage plan in the area in which the individual resides, or the organization has notified the individual of the impending termination of the plan or the impending discontinuation of the plan in the area in which the individual resides; 3. The individual demonstrates that the Medicare Advantage organization offering the Medicare Advantage plan substantially violated a material provision of its contract under Medicare Advantage in relation to the individual, or the Medicare Advantage organization (or its agent) materially misrepresented the plan when marketing the plan; 4. The individual is entitled to Medicare Part A and Part B and receives any type of assistance from Medi-Cal; or 5. The individual meets such other exceptional conditions as CMS may provide.

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Policy #:	CMC.4004
Title:	**Member Disenrollment**
Department:	Customer Service
Section:	Not Applicable
CEO Approval:	Michael Schrader _____
Effective Date:	07/01/15
Last Review Date:	09/07/17
Last Revised Date:	09/07/17

I. PURPOSE

This policy describes procedures for disenrolling a Member from the OneCare Connect program.

II. POLICY

A. Except as provided in this policy, OneCare Connect may not request or encourage any Member to disenroll from OneCare Connect.

1. CalOptima may not request disenrollment due to adverse changes in a Member's health status, a Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs.

B. A Member may voluntarily disenroll from OneCare Connect in any month and for any reason, in accordance with this policy.

C. CalOptima shall involuntarily disenroll a Member from OneCare Connect if:

1. The Member's change in residence makes the Member ineligible to participate in OneCare Connect;

2. The Member loses entitlement to either Medicare Part A or Part B;

3. The Member loses entitlement to services under Medi-Cal or Medi-Cal eligibility changes (e.g., to a non-eligible aid code or adding Share of Cost (SOC) when not residing in a LTC facility or receiving In-Home Support Services (IHSS) or Multi Senior Services Program (MSSP);

4. The Member loses a state-specific eligibility qualification for OneCare Connect;

5. The Member is incarcerated;

6. The Member is not lawfully present in the United States;

7. The Member dies;

8. The Contract is terminated or CalOptima reduces its Service Area such that the Member is no longer within the Service Area;

9. The individual materially misrepresents information to OneCare Connect regarding reimbursement for third party coverage; or

10. The individual has comprehensive health insurance other than Medicare or Medi-Cal.

D. CalOptima may request approval from the State and CMS to involuntarily disenroll a Member from OneCare Connect, if the Member:

1. Engages in disruptive behavior; or

2. Provides fraudulent information on the Enrollment Form; or

3. Permits Abuse of the Member's OneCare Connect identification (ID) card.

E. CalOptima shall retain all OneCare Connect disenrollment request for a period of ten (10) years from the end of the contract period in which the request was made.

III. PROCEDURE

A. Voluntary Disenrollment

1. A Member may request to disenroll from OneCare Connect by:

a. Enrolling in another Medicare health or Part D plan, including a PACE organization;

b. Enrolling in another Medicare Medicaid Plan (MMP);

c. Calling 1-800-MEDICARE (1-800-633-4227); or

d. Giving or faxing a signed written disenrollment notice to CalOptima, or to the State.

2. If a Member verbally requests disenrollment from OneCare Connect, the CalOptima staff member receiving such request must instruct the Member to make the request in one (1) of the ways described above.

3. If a Member is unable to sign the written request to disenroll from OneCare Connect, an Authorized Representative shall sign the request. If an Authorized Representative signs the disenrollment request, the Authorized Representative shall attest that they have such authority to make the request and that proof of the authority is available upon request by CalOptima or CMS. If CalOptima has reason to believe that an individual making an Election on behalf of a Member may not be authorized under State law to do so, CalOptima shall contact CMS, in accordance with the Medicare Managed Care Manual.

4. The Member, or Authorized Representative, shall write the date they signed the disenrollment request on the disenrollment request. If the Member or Authorized Representative fails to include the date on the disenrollment request, OneCare Connect's mailroom shall stamp the date of receipt of the disenrollment request, and such date shall serve as the signature date.

5. If the Member, or Authorized Representative, fails to include a signature on the disenrollment request, CalOptima may verbally verify with the Member or Authorized Representative the request to disenroll. CalOptima shall document the verbal verification to complete the disenrollment request and shall retain such documentation in its records.

6. If CalOptima requests additional information to be submitted for the disenrollment request, CalOptima shall explain to the Member or Authorized Representative that the additional information must be received by the end of the calendar month in which the request to disenroll was received, or within twenty-one (21) calendar days after receipt of the disenrollment request

for a disenrollment request to be considered complete (whichever is later). If CalOptima does not receive additional information within the allowable timeframe, CalOptima shall not disenroll the Member.

7. Notice Requirements

   a. If a Member requests disenrollment through CalOptima, CalOptima shall mail the Member *Exhibit 14, Model Notice to Acknowledge Receipt of Voluntary Disenrollment Request from Member* within ten (10) calendar days after receipt of the disenrollment request. The acknowledgement of disenrollment letter shall include an explanation of the effective date of the disenrollment. The notice shall also inform the disenrolling Member that it may take up to forty-five (45) calendar days for the Medicare computer records to be updated, and advise the Member to inform his or her provider the Member was just disenrolled from OneCare Connect and there may be a short delay with updating the Member's records.

   b. If a Member requests disenrollment through an entity other than CalOptima, as specified in this policy, CMS will notify CalOptima in the Daily Transaction Reply Report (DTRR). If CalOptima learns of the voluntary disenrollment from the DTRR (as opposed to a written request from the Member), CalOptima shall input the disenrollment in the OneCare Connect eligibility system and mail *Exhibit 16, Model Notice to Confirm Voluntary Disenrollment Following Receipt of Transaction Reply Report (TRR)* to the Member within ten (10) calendar days after the availability of the information on the DTRR from CMS.

8. Processing Request for Disenrollment

   a. The CalOptima mailroom shall stamp the date of receipt of a disenrollment request received from a Member, or Member's Authorized Representative, upon receipt of that request.

   b. CalOptima shall submit a disenrollment transaction to CMS within seven (7) calendar days after the date of receipt of a disenrollment request.

9. If a Member requests voluntary disenrollment from OneCare Connect, such disenrollment shall be effective on the first (1st) calendar day of the month after the month CalOptima receives a completed disenrollment request, unless otherwise stated in writing for a future date.

10. CalOptima may deny a voluntary request for disenrollment only when:

    a. The request was made by someone other than the Member, and that individual is not the Member's Authorized Representative, as described in this policy; or

    b. The request was incomplete, and the required information is not provided within the required time frame.

11. If CalOptima receives a disenrollment request that OneCare Connect is required to deny, CalOptima shall mail *Exhibit 17, Model Notice for Denial of Disenrollment* to the Member within ten (10) calendar days after the receipt of the request and shall include the reason for the denial.

B. Involuntary Disenrollment

1. If CalOptima involuntarily disenrolls a Member for causes specified in this policy, CalOptima shall provide the Member with a disenrollment letter that:

a. Advises the Member that CalOptima plans to disenroll the Member, and the reason for such disenrollment; and

b. Explains the Member's right to file a Grievance, in accordance with CalOptima Policy CMC.9002: Member Grievance Process, except if the Contract is terminating as specified in this policy.

C. Involuntary Disenrollment for Change in Residence

1. CalOptima shall initiate disenrollment when a Member's permanent residence is confirmed outside of the Service Area or when a Member's absence from the OneCare Connect Service Area exceeds six (6) consecutive months.

2. CalOptima may receive notice of a change in a Member's residence from DHCS, the Member, the Member's Authorized Representative, a DTRR from CMS, or other source.

a. DHCS will notify CalOptima of a potential move out of area with an HCP status code 61 in the monthly 834 eligibility file:

i. Within ten (10) calendar days of receiving HCP status code 61 CalOptima shall mail *Exhibit 30a, Model Notice for Deemed Continued Eligibility due to Change in Medicaid Eligibility or Potential Move Out-of-Area* to the Member.

ii. A period of two (2) months of deemed continued eligibility begins the first day of the calendar month following the month CalOptima receives the code 61.

iii. CalOptima shall make a minimum of three (3) telephonic attempts during the deemed continued eligibility period to inform the member of his/her eligibility status and provide the necessary resources so the member can attempt to regain eligibility.

iv. If the month-end 834 enrollment file received by CalOptima at the end of the period of deemed continued eligibility shows no change in the Member's HCP Status code 61, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the last day of the deeming period.

v. Within three (3) business days following the end of the period of deemed continued eligibility, DHCS will submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month from the end of the period of deemed continued eligibility.

vi. This section does not apply if CalOptima has confirmed the out-of-area move and will process the disenrollment as otherwise set forth in this policy.

b. If CalOptima is notified of a potential out-of-area change in residence through a source other than DHCS, the Member, or the Member's Authorized Representative, CalOptima shall not assume the move is permanent and shall not disenroll the Member until the Member, or Member's Authorized Representative, confirms the out-of-area move, or until six (6) consecutive months have elapsed following the date CalOptima OneCare Connect receives information regarding the Member's potential address change, whichever is sooner.

i. CalOptima shall, within ten (10) calendar days of receipt of such notice, send the Member *Exhibit 30, a Notice to Research Potential Out of Area Status and Address Verification Form* to verify the change in address and whether it is temporary, or permanent.

ii. The Member shall have six (6) calendar months following the date of the notice to respond.

iii. If, at the end of the sixth (6^{th}) calendar month, there is no response to Exhibit 30, and CalOptima has not received an HCP Status Code 61 from DHCS, CalOptima shall document this information in its records and forward the request to disenroll to DHCS..

iv. Within the first ten (10) calendar days of the sixth (6^{th}) calendar month following discovery of a potential out-of-area residence, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice of Disenrollment due to Loss of Medicaid Status or Other State-Specific Eligibility Status, or Out-of-Area Status.*

v. Within three (3) business days following the disenrollment effective date, DHCS will submit a disenrollment transaction to CMS, effective the first (1^{st}) day of the calendar month following the end of the sixth (6^{th}) month.

c. CalOptima shall accept verbal, or written, confirmation from the Member, or Member's Authorized Representative, of an address change.

i. If the confirmation indicates the permanent address is outside of the Service Area. CalOptima shall document this information in its records and forward the request to disenroll to DHCS. CalOptima shall mail *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* within ten (10) calendar days of the date the out-of-area address was confirmed.

d. DHCS will submit a disenrollment transaction to CMS, effective the first (1^{st}) day of the calendar month following the date CalOptima received the confirmation.

i. If the confirmation indicates the permanent address is within the OneCare Connect Service Area, CalOptima shall discontinue the disenrollment process.

e. If an enrolling Member shows an address within the plan Service Area on the enrollment application, while the CMS or Medi-Cal records show an address outside of the plan Service Area, the Member's enrollment application serves as attestation of their current address.

f. If CalOptima learns of a permanent change in address directly from the Member or Member's Authorized Representative, and that address is outside of the OneCare Connect Service Area, CalOptima shall document this information in its records and forward the request to disenroll to DHCS.

g. CalOptima shall mail *Exhibit 20, Model Notice for Disenrollment Due to Confirmation of Out-of-Area Status (Upon New Address Verification from Member)* to the Member within ten (10) calendar days of receiving the information.

h. DHCS will submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month after the date the Member begins residing outside of OneCare Connect's Service Area and after the Member, or their Authorized Representative, notifies CalOptima that they have moved and no longer resides in the Service Area.

i. In the case of an individual who provides advance notice of the move, the disenrollment will be effective the first (1st) day of the calendar month following the month in which the individual indicates they will be moving.

j. In the case of incarcerated individuals, where CalOptima receives notification of the out-of-area status via a DTRR, DHCS will disenroll the Member on the first (1st) day of the calendar month following confirmation of current incarceration.

k. A Member who is incarcerated is considered out of the plan's Service Area, even if the correctional facility is located within the Service Area.

l. CalOptima is not required to contact the Member to confirm incarceration, but must still confirm incarceration using public sources such as a federal or state entity or other public records.

m. If CalOptima confirms a Member's current incarceration, but is unable to confirm the start date of the incarceration, DHCS will disenroll the Member prospectively effective the first (1st) of the calendar month following the date on which the current incarceration was confirmed.

n. If CalOptima confirms the Member's start date of the incarceration, DHCS will disenroll the Member effective the first (1st) day of the calendar month following the start date of the incarceration.

o. If the disenrollment effective date is outside of the current calendar month transaction submission timeframe as defined by CMS, DHCS must submit a retroactive disenrollment request to the Retroactive Processing Contractor (RPC), unless the period of incarceration is already completed. If the period of incarceration is already complete, disenrollment is not necessary unless otherwise instructed by CMS.

p. If the Member establishes that a permanent move occurred retroactively and requests retroactive disenrollment (not earlier than the first (1st) day of the calendar month after the move), DHCS will submit this request to CMS or its designated RPC for consideration of retroactive action.

D. Involuntary Disenrollment for Loss of Entitlement to Medicare Part A or Part B

1. Upon notice from CMS, via the DTRR, that a Member's entitlement to Medicare Part A or Part B has ended, CalOptima shall update its eligibility systems with the date specified on the DTRR from CMS.

2. If a Member loses entitlement to Medicare Part A, CalOptima shall not:

a. Allow the Member to remain a Member and receive Medicare Part B-only services; or

b. Offer the Member Part A-equivalent services for a premium.

3. If a Member loses entitlement to Medicare Part B, CalOptima shall not allow the Member to remain a Member and receive Medicare Part A-only services.

4. Notice Requirement

   a. CalOptima shall mail the Member *Exhibit 24: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination* informing the Member of disenrollment due to loss of entitlement to Medicare Part A or Part B, within ten (10) calendar days from the date of discovery via the DTRR, so that any erroneous disenrollments can be corrected as soon as possible.

E. Involuntary Disenrollment for Loss of Entitlement to Services under Medi-Cal

1. Effective September 1, 2017, CalOptima shall involuntarily disenroll a Member who loses entitlement to Medi-Cal benefits or has a change in Medi-Cal status or due to loss of State-specific eligibility, following a period of two (2) calendar months of deemed continued eligibility.

2. For loss of Medi-Cal Eligibility, DHCS notifies CalOptima with an HCP status code 041 in the monthly 834 eligibility file.

   a. Within ten (10) calendar days of receiving HCP status code 041, CalOptima shall mail the Member *Exhibit 22, Model Notice for Period of Deemed Continued Eligibility due to Loss of Medicaid.*

   b. Effective September 1, 2017, a period of two (2) calendar months of deemed continued eligibility begins the first (1st) day of the calendar month following the month CalOptima receives the code 041.

   c. CalOptima shall make a minimum of three (3) telephonic attempts during the deemed continued eligibility period to inform the Member of his/her eligibility status and provide the necessary resources so the member can attempt to regain eligibility.

   d. If the month-end 834 enrollment file received by CalOptima at the end of the deeming month shows no change in the Member's HCP Status code 041, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the last day of the deeming period.

   e. The notice shall include the disenrollment effective date and the Medicare Special Election Period (SEP) for which the individual is eligible.

      i. This section does not apply if CalOptima has confirmed with the Member (or Authorized Representative) that the Member has lost Medi-Cal eligibility and does not intend to reapply or seek redetermination prior to the start of the deeming period.

   f. Within three (3) business days following the last day of the deeming period, submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month following the end of the period of deemed continued eligibility.

3. For Loss of Cal MediConnect Eligibility (including a change in circumstance such as a change in Medi-Cal aid code or move out of Service Area), DHCS notifies CalOptima with an HCP status code 061 in the monthly 834 eligibility file.

a. Within ten (10) calendar days of receiving HCP status code 061, CalOptima shall mail the Member *Exhibit 30a, Model Notice for Deemed Eligibility due to Change in Medicaid Eligibility or Potential Move Out-of-Area.*

b. Effective September 1, 2017, a period of two (2) calendar months of deemed continued eligibility begins the first day of the calendar month following the month CalOptima receives the code 061.

c. CalOptima shall make a minimum of three (3) telephonic attempts during the deemed continued eligibility period to inform the Member of his/her eligibility status and provide the necessary resources so the Member can attempt to regain eligibility.

d. If the month-end 834 enrollment file received by CalOptima at the end of the deeming month shows no change in the Member's HCP Status code 061, CalOptima shall mail the Member *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the last day of the deeming period.

e. The notice shall include the disenrollment effective date and the Medicare SEP for which the individual is eligible.

f. Within three (3) business days following the last day of the deeming period, DHCS will submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month following the end of the period of deemed continued eligibility.

g. This section does not apply if CalOptima has confirmed with the Member (or authorized representative) that the Status 061 code is correct prior to the start of the deeming period.

4. If CalOptima receives information from a source outside of CalOptima, other than DHCS, indicating loss of State-specific qualifications for OneCare Connect, CalOptima shall research to confirm the information.

a. If confirmed, CalOptima shall document this information in its records and forward the request to disenroll to DHCS.

b. CalOptima shall mail *Exhibit 19/20/21, Model Notice for Disenrollment due to Loss of Medicaid Status, or Other State Specific Eligibility Status or Out-of-Area Status* no later than three (3) business days following the date Medi-Cal or other State-specific eligibility requirement ended.

c. The notice shall include the disenrollment effective date and the Medicare SEP for which the individual is eligible.

d. DHCS will submit a disenrollment transaction to CMS, effective the first (1st) day of the calendar month following the loss of State-specific qualifications.

e. Exception: As stated in the DHCS OneCare Connect and Managed Long Term Services and Supports (MLTSS) Operations Meeting Frequently Asked Questions dated June 3, 2014, CalOptima shall not disenroll a Member from OneCare Connect or MLTSS for unmet Share of Cost (SOC) provided the Member is also participating in IHSS, MSSP or LTC.

F. Involuntary Disenrollment due to Death

1. Upon notice from CMS, via the DTRR, of the Member's death, CalOptima shall update its eligibility systems with the date specified on the DTRR.

2. Within ten (10) calendar days of receipt of notice from CMS of a Member's death, CalOptima shall mail *Exhibit 23, Model Notice to Offer Beneficiary Services, Pending Correction for Erroneous Death Status* addressed to the estate of the Member so that any erroneous disenrollments can be corrected as soon as possible.

3. If CalOptima learns of a Member's death from another reliable source, CalOptima shall reach out to the Member's estate to advise them to notify Social Security and their Medi-Cal eligibility office of the Member's death. The disenrollment process shall not be initiated until notice of disenrollment is received in the CMS DTRR.

G. Involuntary Disenrollment for Termination or Non-renewal of the Contract:

1. CalOptima shall disenroll a Member from OneCare Connect if the Contract is terminated.

2. CalOptima shall notify all Members in writing of the effective date of the termination and shall include a description of alternatives for obtaining benefits under the Medicare program. Members who do not make an election for a Prescription Drug Plan (PDP) or Medicare Advantage-Prescription Drug (MA-PD) plan will be deemed to have elected and will result in a change of enrollment to Original Medicare and auto-enrollment by CMS into a Medicare Prescription Drug Plan, as well as access to the LI NET transitional PDP during any coverage gap.

H. Disenrollment due to Material Misrepresentation of Third Party Reimbursement

1. If a Member intentionally withholds or falsifies information about third-party reimbursement coverage, CMS requires the individual be disenrolled from the plan.

2. OneCare Connect Customer Service shall notify the Office of Compliance of such an event.

3. If the Office of Compliance determines it appropriate, CalOptima shall submit disenrollment for this reason to the Contract Management Team for approval along with any information regarding the claim of material misrepresentation.

4. Should the request be approved, the disenrollment will be effective the first (1st) day of the calendar month after the month in which the Member is given a written notice of disenrollment or as provided by the CMT.

I. Optional Involuntary Disenrollment

1. CalOptima may request approval to disenroll a Member if:

   a. The Member engages in disruptive behavior; or

   b. The Member provides fraudulent information.

2. Should the disenrollment be approved by CMT for any of the aforementioned optional involuntary disenrollment reasons, the disenrollment will be effective the first (1st) day of the

calendar month after the month in which the Member is given a written notice of disenrollment or as provided by CMT. The disenrollment letter shall:

a. Advise the Member that CalOptima plans to disenroll the Member from OneCare Connect and the reasons for such disenrollment;

b. Provide the effective date of disenrollment; and

c. Explain the Member's right to a hearing under the State's Grievance procedures, CalOptima Policy CMC.9002: Member Grievance Process.

3. Involuntary Disenrollment for Disruptive Behavior

a. CalOptima may request approval from CMS and DHCS, through the CMT, to disenroll a Member if the Member's behavior is disruptive, unruly, abusive, or uncooperative to the extent that the Member's continued enrollment in CalOptima OneCare Connect seriously impairs CalOptima's or a Contracted Provider's ability to furnish Covered Services to the Member or other Members, provided Member's behavior is determined to be unrelated to an adverse change in the Member's health status, or because of a Member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs.

b. CalOptima shall not disenroll a Member from OneCare Connect because the Member:

i. Exercises the option to make treatment decisions with which OneCare Connect disagrees, including the option to receive no treatment or diagnostic testing; or

ii. Chooses not to comply with any treatment regimen developed by OneCare Connect or any Contracted Provider associated with OneCare Connect.

c. CalOptima shall make serious efforts to resolve problems presented by a Member prior to requesting approval from DHCS and CMS to disenroll the Member from OneCare Connect.

i. Such efforts to find a resolution must include providing reasonable accommodations, as determine by DHCS or CMS, for individuals with mental or cognitive conditions, including mental illness and developmental disabilities;

ii. CalOptima must also inform the individual of their Grievance rights.

d. CalOptima shall provide three (3) notices for disenrollment due to disruptive behavior:

i. Advance notice to a disruptive Member, in writing, that continued disruptive behavior will result in involuntary disenrollment from OneCare Connect.

ii. If such behavior continues, CalOptima shall provide written notice of its intent to request CMS' and DHCS' permission to disenroll the Member from OneCare Connect.

iii. Planned action notice advising that CMS and DHCS have approved the request.

e. CalOptima shall submit documentation of the specific case to DHCS and CMS through the CMT for review, including the documentation listed below:

i. A thorough explanation of the reason for the disenrollment request, detailing how the Member's behavior has impacted OneCare Connect's ability to arrange for or provide services to the Member or other Members of the plan;

ii. Member information, including age, diagnosis, mental status, Functional Status, and a description of the Member's social support systems;

iii. Statements from the Providers describing their experience with the Member;

iv. Documentation of the Member's disruptive behavior;

v. Documentation of CalOptima's efforts to resolve the problem, including efforts to:

a) Provide reasonable accommodations for a Member with a disability, if applicable, in accordance with the Americans with Disabilities Act (ADA);

b) Establish that the Member's behavior is not related to the use or lack of use of medical services; and

c) Establish that the Member's behavior is not related to diminished mental capacity.

vi. A description of any extenuating circumstances as cited under Title 42, Code of Federal Regulations (C.F.R), Section 422.74 (d)(2)(iv);

vii. Copy of notice to the Member of the consequences of continued disruptive behavior;

viii. Copy of notice to the Member of CalOptima OneCare Connect's intent to request the Member's disenrollment; and

ix. Any information provided by the Member (e.g., complaints, statements).

f. The CMT will make a decision within twenty (20) business days after the receipt of all information required to complete its review.

g. Should the request be approved, the disenrollment will be effective the first (1st) day of the calendar month after the month in which CalOptima gives the Member a written notice of the disenrollment, or as provided by CMT.

h. A disenrollment processed under the disruptive behavior provision will always result in a change of enrollment to Original Medicare, and auto-enrollment by CMS into a Medicare Prescription Drug Plan, including to the LI NET traditional PDP during any coverage gap.

i. If the request for involuntary disenrollment for disruptive behavior is approved:

i. CMS and DHCS may require CalOptima to provide reasonable accommodations to the Member in such exceptional circumstances that CMS and DHCS deems necessary.

ii. CalOptima may request that CMS and DHCS consider prohibiting re-enrollment in the MMP. If this is not requested, and the Member is disenrolled due to disruptive behavior, the member may re-enroll into the MMP in the future.

J. Involuntary Disenrollment for Fraud and Abuse

1. CalOptima may request approval from the State and CMS through the CMT to cancel the enrollment of a Member who knowingly provides on the Enrollment Form fraudulent information that materially affects the determination of a Member's eligibility to enroll in OneCare Connect.

2. CalOptima may request approval from the State and CMS through the CMT to disenroll a Member who intentionally permits others to use their OneCare Connect identification (ID) card to obtain Covered Services.

3. With such a disenrollment request, CalOptima shall immediately notify the State and CMS so the Health and Human Services (HHS) Office of the Inspector General may initiate an investigation of the alleged fraud and/or abuse.

4. If such disenrollment request is approved by CMS and the State, CalOptima shall notify the Member in writing of the disenrollment and the reason for the disenrollment. Such disenrollment shall be effective the first (1st) day of the calendar month after the month in which CalOptima gives the Member written notice and will result in a change of enrollment to Original Medicare and auto-enrollment by CMS into a Medicare Prescription Drug Plan, as well as access to the LI NET transitional PDP during any coverage gap.

K. Involuntary Disenrollment Due Unlawful Presence Status

1. CalOptima cannot retain a Member if CMS has determined that the Member is not lawfully present in the United States. CMS will notify CalOptima with specific Transaction Reply Code (TRC) 349 via the Daily Transaction Reply Report (DTRR) that the Member is not lawfully present, and CMS will make the disenrollment effective the first (1st) day of the month following notification by CMS. CMS provides the official status to CalOptima, and CalOptima may not request any documentation of U.S. citizenship or alien status from a Member.

2. Within ten (10) calendar days following the receipt of notification (via DTRR) of the disenrollment due to unlawful presence, CalOptima shall provide a written notice to the Member so that the Member is aware of the loss of coverage in CalOptima and any erroneous disenrollments can be corrected as soon as possible.

L. Reinstatements may be necessary if a disenrollment is not legally valid.

1. CalOptima shall submit a reinstatement request to CMS if:

   a. Disenrollment occurred due to an erroneous death indicator;

   b. Disenrollment occurred due to erroneous loss of Medicare Part A or Part B;

   c. Disenrollment occurred due to an erroneous loss of entitlement of Medi-Cal eligibility or state specific eligibility criteria, as listed in CalOptima Policy CMC.4003: Member Enrollment (Voluntary);

   d. There is evidence that a Member did not intend to disenroll, e.g. if the Member cancelled a new enrollment in another plan; and

   e. Disenrollment occurred due to CalOptima, CMS, or State error.

2. If a Member contacts CalOptima and states that they were disenrolled from OneCare Connect for any of the reasons stated in Section III.E.1 of this policy, except III.E.1.d., and states that they wish to remain a Member, CalOptima shall instruct the Member, in writing within ten (10) calendar days of the Member's contact with CalOptima reporting the erroneous disenrollment, to continue using OneCare Connect Covered Services.

3. CalOptima shall indicate active coverage as of the date CalOptima instructs the Member to continue to use Covered Services.

4. If a Member is disenrolled due to any of the reasons stated in Section III.E.1 of this policy, CalOptima shall submit to CMS a request to reinstate the Member which shall include:

   a. A copy of the TRR from CMS showing the disenrollment;

   b. A copy of the disenrollment letter that CalOptima OneCare Connect sent to the Member;

   c. A copy of any correspondence from the Member disputing the disenrollment;

   d. A copy of the letter to the Member informing them to continue to use CalOptima OneCare Connect services until the issue is resolved, except for III.E.1.d.;

   e. Verification that the disenrollment was erroneous; and

   f. Within ten (10) calendar days of receipt of DTRR confirmation of the Member's reinstatement, CalOptima shall mail *Exhibit 27, Model Acknowledgement of Reinstatement* to the Member.

M. Cancellation of Voluntary Disenrollment

1. CalOptima may cancel a Member's disenrollment only if CalOptima makes the request prior to the effective date of the disenrollment, unless otherwise directed by CMS.

   a. If CalOptima receives a request for cancellation of disenrollment after it transmitted the disenrollment request to CMS, CalOptima shall submit a cancellation of disenrollment to reinstate a Member with no lapse in coverage.

   b. If CalOptima is unable to cancel the disenrollment transaction, CalOptima shall submit the request to cancel the action to the CMS Retroactive Processing Contractor (RPC) in order to cancel the disenrollment.

   c. CalOptima shall submit a transaction to cancel only those disenrollment transactions submitted to CMS.

   d. CalOptima shall mail *Exhibit 18, Model Acknowledgement of Request to Cancel Disenrollment* to the Member within ten (10) calendar days after receipt of a Member's request for cancellation of disenrollment, stating that the cancellation is being processed and the Member may continue using OneCare Connect Covered Services.

2. Within ten (10) calendar days of receipt of confirmation of the Member's reinstatement, CalOptima shall mail the Member *Exhibit 27, Model Acknowledgment of Reinstatement*.

3. If CalOptima receives a Member's request for cancellation of disenrollment after the effective date of disenrollment, and CMS does not allow the reinstatement, CalOptima shall instruct the Member to complete a new Enrollment form and re-enroll with OneCare Connect during an Election Period.

N. Retroactive Disenrollment

1. CMS may grant a retroactive disenrollment if:

   a. An enrollment was never legally valid, e.g. the result of fraudulent enrollment or misleading marketing practices;

   b. A valid request for disenrollment was properly made, but not processed or acted upon (whether due to system, plan or state error);

   c. The reason for the disenrollment is related to a permanent move out of the OneCare Connect Service Area; or

   d. The reason for the disenrollment is due to CalOptima's confirmation of an incarcerated status with a retroactive start date;

2. A Member or CalOptima may submit a request to CMS (or its Designee) for a retroactive disenrollment. CMS will notify DHCS.

3. If CalOptima submits a request for retroactive disenrollment, it shall include a copy or other record of the disenrollment request made by the individual and supporting evidence explaining why the disenrollment request was not processed correctly. CalOptima shall submit retroactive disenrollment requests to the CMS Retroactive Processing Contractor within the timeframe provided in the Standard Operating Procedures for the CMS Retroactive Processing Contractor. CMS will notify DHCS.

   a. If the reason is due to plan or state error, CalOptima must include clear information regarding what the plan or state has communicated to the affected individual throughout the period in question, including evidence that the individual was notified prospectively of the disenrollment and relevant information supporting the correction. This should include a copy of the disenrollment request and evidence of notices sent to the individual related to or caused by the error and which demonstrate that retroactive disenrollment is appropriate under the circumstances.

   b. If the reason for disenrollment is due to incarceration status with a retroactive start date, CalOptima must provide written confirmation of the incarceration status, including the start date. Such documentation may include documentation of telephonic communications.

IV. ATTACHMENTS

A. Exhibit 14:Model Notice to Acknowledge Receipt of Voluntary Disenrollment from the Member
B. Exhibit 16:Model Notice to Confirm Voluntary Disenrollment Following Receipt of Transaction Reply Report (TRR)
C. Exhibit 17:Model Notice for Denial of Disenrollment
D. Exhibit 18:Model Acknowledgement of Request to Cancel Disenrollment
E. Exhibit 19:Model Notice for Disenrollment due to Out-of-Area Status (No Response to Request for Address Verification)

F. Exhibit 20:Model Notice for Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member)
G. Exhibit 21:Model Notice for Disenrollment due to Loss of Medicaid Status or Other State-Specific Eligibility Status - Notification of Involuntary Disenrollment
H. Exhibit 22:Model Notice for Period of Deemed Continued Eligibility due to Loss of Medicaid
I. Exhibit 23:Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Death Status
J. Exhibit 24:Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination
K. Exhibit 25:Model Notice to Offer Reinstatement of Beneficiary Services, Pending Correction of Disenrollment Status Due to State or Plan Error
L. Exhibit 27: Model Acknowledgement of Reinstatement
M. Exhibit 30: Model Notice to Research Potential Out of Area Status – Address Verification Form included
N. Exhibit 30a:Model Notice of Disenrollment following period of Deemed continued Eligibility due to change in Medicaid Eligibility or Potential Move out of Area

V. REFERENCES

A. CalOptima Policy CMC.4003: Member Enrollment (Voluntary)
B. CalOptima Policy CMC.9002: Member Grievance Process
C. CalOptima Three-Way Contract with the Centers for Medicaid and Medicare Services (CMS) and the Department of Health Care Services (DHCS) for Cal MediConnect
D. Medicare–Medicaid Plan (MMP) Deeming Process for California, DHCS issued June 15, 2015
E. Medicare–Medicaid Plan (MMP) Enrollment and Disenrollment Guidance (Revised 9/2/2016)
F. OneCare Connect & Managed Long Term Services and Supports (MLTSS) Operations Meeting FAQ, June 3, 2014
G. Title 42, Code of Federal Regulations (C.F.R.), §§422.66(b) and 422.74

VI. REGULATORY AGENCY APPROVALS

None to Date

VII. BOARD ACTIONS

09/07/2017: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title	Line(s) of Business
Effective	07/01/2015	CMC.4004	Member Disenrollment	OneCare Connect
Revised	07/01/2016	CMC.4004	Member Disenrollment	OneCare Connect
Revised	09/07/2017	CMC.4004	Member Disenrollment	OneCare Connect

IX. GLOSSARY

Term	Definition
Abuse	Actions that may, directly or indirectly, result in: unnecessary costs to a CalOptima Program, improper payment, payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment. Abuse cannot be differentiated categorically from fraud, because the distinction between "fraud" and "abuse" depends on specific facts and circumstances, intent and prior knowledge, and available evidence, among other factors.
Authorized Representative	For the purpose of this policy, an Authorized Representative is the same as Legal Representative. Centers for Medicare & Medicaid Services (CMS) defines Authorized/Legal Representative as an individual who is the legal representative or otherwise legally able to act on behalf of an enrollee, as the law of the state in which the beneficiary resides may allow, in order to execute an enrollment or disenrollment request, e.g., court appointed legal guardians, persons having durable power of attorney for health care decisions, or individuals authorized to make health care decisions under state surrogate consent laws, provided they have the authority to act for the beneficiary in this capacity.
Contract	The contract between United States Department of Health & Human Services Centers for Medicare & Medicaid Services, California Department of Health Care Services and Orange County Health Authority
Designee	A person selected or designated to carry out a duty or role. The assigned designee is required to be in management or hold the appropriate qualifications or certifications related to the duty or role.
Disenrollment	For the purposes of this policy, disenrollments are actions taken by the Member or plan after the effective date of enrollment.
Election	Enrollment in, or voluntary disenrollment from, a Medicare Advantage (MA) plan or Original Medicare.
Election Period	The time during which an eligible individual may elect a Medicare Advantage (MA) plan or Original Medicare. The type of Election period determines the effective date of MA coverage as well as the types of enrollment requests allowed.
Functional Status	An individuals' ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being.
Grievance	Any Complaint, other than one involving an Organization Determination, expressing dissatisfaction with any aspect of CalOptima's, a Health Network's, or a Provider's operations, activities, or behavior, regardless of any request for remedial action
In-Home Supportive Services (IHSS)	A program that provides in-home care for people who cannot remain in their own homes without assistance.
Member	An enrollee-beneficiary of the CalOptima OneCare Connect program.
Multi-Purpose Senior Services Program (MSSP)	A California-specific program, the 1915(c) Home and Community-Based Services Waiver that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals who are 65 or older with disabilities as an alternative to nursing facility placement.
Original Medicare	The traditional Medicare Fee-for-Service program.

Term	Definition
Provider	A physician, pharmacist, nurse, nurse mid-wife, nurse practitioner, medical technician, physician assistant, hospital, laboratory, health maintenance organization, Health Network, Physician Medical Group, or other person or institution who furnishes Covered Services.
Share of Cost (SOC)	The amount, set by Medi-Cal based on the Member's income, that the Member must contribute to the cost of their health care each month before Medi-Cal will pay.
Service Area	Orange County, California, and ten (10) air miles of any portion of Orange County, California.
Special Election Period	Election Period provided to individuals in situations where; 1. The individual has made a change in residence outside of the service area or continuation area or has experienced another change in circumstances as determined by Centers for Medicare & Medicaid Services (CMS) (other than termination for non-payment of premiums or disruptive behavior) that causes the individual to no longer be eligible to elect the Medicare Advantage plan; 2. CMS or the organization has terminated the Medicare Advantage organization's contract for the Medicare Advantage plan in the area in which the individual resides, or the organization has notified the individual of the impending termination of the plan or the impending discontinuation of the plan in the area in which the individual resides; 3. The individual demonstrates that the Medicare Advantage organization offering the Medicare Advantage plan substantially violated a material provision of its contract under Medicare Advantage in relation to the individual, or the Medicare Advantage organization (or its agent) materially misrepresented the plan when marketing the plan; 4. The individual is entitled to Medicare Part A and Part B and receives any type of assistance from Medi-Cal; or 5. The individual meets such other exceptional conditions as CMS may provide.

1

<Date>

<Name>
<Address>
<City>, <State> <ZIP>

<Name>:

We got your request to disenroll from OneCare Connect Cal MediConnect (Medicare-Medicaid Plan).

You'll be disenrolled from OneCare Connect on <**date**>. OneCare Connect will not pay for your Medi-Cal and Medicare health services and prescription drugs after <**date**>.

You'll be covered by Original Medicare starting <date>.

You'll get your Medicare health services through Original Medicare starting <date> if you don't enroll in a Medicare health plan. When you see a provider through Original Medicare, you should use your red, white, and blue Medicare card to get health care services.

If you have questions about Medicare plans in your area, visit www.Medicare.gov, or call toll-free number 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

IMPORTANT: You need to choose a Medicare Prescription Drug Plan. When OneCare Connect services end on <date>, OneCare Connect prescription drug coverage ends too. You can enroll in a Medicare Advantage plan that includes prescription drug coverage or a Medicare Prescription Drug Plan.

- If you don't select a new prescription drug plan, Medicare will enroll you in one.
- If you don't want to join a Medicare prescription drug plan, you must call 1-800- MEDICARE.
- If you need help comparing prescription drug plans or would like to discuss other enrollment choices, you can speak with a California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222, 8:00am to 4:00pm, 5 days a week.
- If you don't want California to enroll you in another Medicare-Medicaid Plan in the future, you must call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. If you have questions or would like to join a Medicare

Advantage or Medicare prescription drug plans, visit www.Medicare.gov, or call toll-free number 1- 800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You must choose a Medi-Cal health plan to get your Medi-Cal benefits.

You will continue to receive your Medi-Cal services, including Long Term Services and Supports (LTSS) that help with on-going personal care needs through CalOptima.

Your health coverage change will become effective soon.

It may take up to 45 days for your records to be updated. If your providers need to send claims, tell them that you just left OneCare Connect and there may be a short delay in updating your records.

Who should I call if I have questions about OneCare Connect?

If you have questions, call OneCare Connect Customer Service 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect. You can also call OneCare Connect Customer Service at 1-855-705-8823.

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823. TTY users should call 1-800-735-2929. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week. For complaints, difficulty accessing care or other similar issues call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week.

If you have questions about Medicare or Medi-Cal?

- If you have questions about Medicare, visit www.Medicare.gov, or call toll free 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1- 877-486-2048.
- If you have questions about Medi-Cal call 1-800-281-9799, Monday - Friday 7:00 am - 5:00 pm.

For more information, visit www.caloptima.org/onecareconnect. **If you have questions**, call OneCare Connect at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

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Para más información, visite www.caloptima.org/onecareconnect. **Si tiene preguntas,** llame a OneCare Connect al 1-855-705-8823, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TTY deben llamar al 1-800-735-2929. Esta llamada es gratuita. Puede obtener esta información gratis en otros idiomas y formatos, como en letra grande, braille y audio.

Để biết thêm chi tiết, xin vào thăm trang mạng www.caloptima.org/onecareconnect. **Nếu quý vị có thắc mắc,** hãy gọi OneCare Connect ở số 1-855-705-8823, 24 giờ một ngày, 7 ngày một tuần. Thành viên sử dụng máy TTY nên gọi ở số 1-800-735-2929. Cuộc gọi này là miễn phí. Quý vị có thể nhận thông tin này miễn phí bằng những ngôn ngữ và hình thức khác, như chữ in khổ lớn, chữ nổi Braille, và đĩa thu âm.

자세한 정보는 웹사이트 www.caloptima.org/onecareconnect 를 방문하십시오. **질문이 있으시면**, OneCare Connect 번호 1-855-705-8823 으로 주 7 일 24 시간 전화하십시오. TTY 사용자는 1-800-735-2929 로 전화하십시오. 통화는 무료입니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실수 있습니다.

برای اطلاعات بیشتر، به سایت www.caloptima.org/onecareconnect **لطفاً اگر پرسشی دارید،** مراجعه نمایید. تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در 7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

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Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

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توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

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ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم

1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

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«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

You're OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) coverage is ending. You'll no longer be in OneCare Connect as of «Term_date».

If you think there was a mistake:
If you didn't ask to leave OneCare Connect and want to stay in OneCare Connect, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929.

Who should I call if I have questions about OneCare Connect?

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect. You can also call OneCare Connect Customer Service at 1-855-705-8823.

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week. For complaints, difficulty accessing care or other similar issues call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week.

For more information, visit www.caloptima.org/onecareconnect**. If you have questions,** call OneCare Connect at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

H8016_MM17_62 Approved (11/21/16)

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Para más información, visite www.caloptima.org/onecareconnect. **Si tiene preguntas,** llame a OneCare Connect al 1-855-705-8823, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TTY deben llamar al 1-800-735-2929. Esta llamada es gratuita. Puede obtener esta información gratis en otros idiomas y formatos, como en letra grande, braille y audio.

Để biết thêm chi tiết, xin vào thăm trang mạng www.caloptima.org/onecareconnect. **Nếu quý vị có thắc mắc,** hãy gọi OneCare Connect ở số 1-855-705-8823, 24 giờ một ngày, 7 ngày một tuần. Thành viên sử dụng máy TTY nên gọi ở số 1-800-735-2929. Cuộc gọi này là miễn phí. Quý vị có thể nhận thông tin này miễn phí bằng những ngôn ngữ và hình thức khác, như chữ in khổ lớn, chữ nổi Braille, và đĩa thu âm.

자세한 정보는 웹사이트 www.caloptima.org/onecareconnect 를 방문하십시오. **질문이 있으시면**, OneCare Connect 번호 1-855-705-8823 으로 주 7 일 24 시간 전화하십시오. TTY 사용자는 1-800-735-2929 로 전화하십시오. 통화는 무료입니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실수 있습니다.

برای اطلاعات بیشتر، به سایت www.caloptima.org/onecareconnect **لطفاً اگر پرسشی دارید،** مراجعه نمایید. تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در 7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

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«Date»

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«First1» «Last2»:

You've asked to be disenrolled from OneCare Connect Cal MediConnect (Medicare-Medicaid Plan). We can't process your request to disenroll from OneCare Connect because:

[You didn't send us the information we needed by «Due_Date_for_Requested_Info».

Or

The request was made by someone other than you and that person isn't your authorized representative.]

If you think we made a mistake or you have questions:

- If you have any questions about the information in this notice, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. The call is free. TTY users should call 1-800-735-2929.
- For questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week.
- For complaints, difficulty accessing care or other similar issues you can call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week for more questions about the enrollment.
- For information on your Medicare coverage, visit www.Medicare.gov, or call toll-free number1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

For more information, visit www.caloptima.org/onecareconnect. **If you have questions**, call OneCare Connect at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

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«First1» «Last2»:

You're enrolled in OneCare Connect Cal MediConnect (Medicare-Medicaid Plan).
We've got your request to cancel your disenrollment from OneCare Connect. You'll continue to get your health and prescription drug services through OneCare Connect. Keep using OneCare Connect primary care providers for your health care services and a network pharmacy for your drugs.

IMPORTANT: You need to cancel other Medicare or prescription drug plan coverage before it starts.
If you've recently applied to join a Medicare health or prescription drug plan, but you want to remain in OneCare Connect, you must call the other plan and tell them to stop processing your application.

Who should I call if I have questions about OneCare Connect?
If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect. You can also call OneCare Connect Customer Service at 1-855-705-8823.

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week. For complaints, difficulty accessing care or other similar issues call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week.

For information on your Medicare coverage, visit www.Medicare.gov , or call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-

877-486-2048.

For more information, visit www.caloptima.org/onecareconnect**. If you have questions,** call OneCare Connect at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Para más información, visite www.caloptima.org/onecareconnect. **Si tiene preguntas,** llame a OneCare Connect al 1-855-705-8823, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TTY deben llamar al 1-800-735-2929. Esta llamada es gratuita. Puede obtener esta información gratis en otros idiomas y formatos, como en letra grande, braille y audio.

Để biết thêm chi tiết, xin vào thăm trang mạng www.caloptima.org/onecareconnect. **Nếu quý vị có thắc mắc,** hãy gọi OneCare Connect ở số 1-855-705-8823, 24 giờ một ngày, 7 ngày một tuần. Thành viên sử dụng máy TTY nên gọi ở số 1-800-735-2929. Cuộc gọi này là miễn phí. Quý vị có thể nhận thông tin này miễn phí bằng những ngôn ngữ và hình thức khác, như chữ in khổ lớn, chữ nổi Braille, và đĩa thu âm.

자세한 정보는 웹사이트 www.caloptima.org/onecareconnect 를 방문하십시오. **질문이 있으시면**, OneCare Connect 번호 1-855-705-8823 으로 주 7 일 24 시간 전화하십시오. TTY 사용자는 1-800-735-2929 로 전화하십시오. 통화는 무료입니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실수 있습니다.

برای اطلاعات بیشترwww.caloptima.org/onecareconnect **لطفاً اگر پرسشی دارید**، به سایت مراجعه نمایید. تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

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Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-855-705-8823** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم

1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল্য কৰনঃ যিদ আপিন বাংলা, কথা বলেত পাের্ন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল ে আছ। ের্ফান কৰন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

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Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

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«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

IMPORTANT: Your health care & prescription drug coverage will change on «Effective_date».

On «Date_Notice_Sent», you were sent a notice asking if you moved out of the OneCare Connect service area. Because you didn't reply, you've been disenrolled from OneCare Connect on «Term_date». This means that beginning «Effective_date», OneCare Connect will no longer cover any health care services or prescription drugs you get.

To be a member of OneCare Connect, you must live in the OneCare Connect service area and can only temporarily leave the service area for up to 6 months in a row. This is because OneCare Connect is providing coverage to you as part of Cal-Medi Connect Program. The Cal-Medi Connect Program is not offered nationwide. This program is only offered through OneCare Connect in certain services areas within your State

You'll be covered by Original Medicare starting «Effective_date».

- You'll get your Medicare health care services through Original Medicare starting «Effective_date» if you don't enroll in a Medicare health plan. When you see a provider through Original Medicare, you should use your red, white, and blue Medicare card to get health care services.
- You have the option to enroll in another Medicare health plan. If you have questions about Medicare plans in your area, visit www.Medicare.gov, or call toll-free number 1- 800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You may need to choose a new Medicaid plan.
You will continue to receive your Medi-Cal benefits through CalOptima. If you moved to a different State, you'll need to apply for Medicaid in that State.

Your prescription drug coverage has also changed.
Your drug coverage through OneCare Connect ended on «Term_date». If you want prescription drug coverage, you need to join a Medicare Prescription Drug Plan or a Medicare Advantage plan with prescription drug coverage. If you don't choose a Medicare drug plan, Medicare will choose one for you.

You can join a new Medicare plan.
If you don't want health coverage through Original Medicare, you can join a new plan that serves the area where you now live. Call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week for information about plans that serve your area. TTY users should call 1-877-486-2048.

What to do if you disagree with your disenrollment from OneCare Connect.
If you don't agree with your disenrollment in OneCare Connect, you can file a grievance asking us to reconsider our decision. Please call OneCare Connect Customer Service at 1-855-705-8823. TTY users should call 1-800-735-2929 for information about how to file a grievance.

Who should I call if I have questions about OneCare Connect?
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مراجعه نمایید. **اگر پرسشی دارید،** لطفاً www.caloptima.org/onecareconnect **برای اطلاعات بیشتر،** به سایت تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در 7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929 کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

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Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

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If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week. For complaints, difficulty accessing care or other similar issues call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week.

For information on your Medicare coverage, visit www.Medicare.gov , or call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

For more information, visit www.caloptima.org/onecareconnect**. If you have questions,** call OneCare Connect at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-

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800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Para más información, visite www.caloptima.org/onecareconnect. **Si tiene preguntas,** llame a OneCare Connect al 1-855-705-8823, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TTY deben llamar al 1-800-735-2929. Esta llamada es gratuita. Puede obtener esta información gratis en otros idiomas y formatos, como en letra grande, braille y audio.

Để biết thêm chi tiết, xin vào thăm trang mạng www.caloptima.org/onecareconnect. **Nếu quý vị có thắc mắc,** hãy gọi OneCare Connect ở số 1-855-705-8823, 24 giờ một ngày, 7 ngày một tuần. Thành viên sử dụng máy TTY nên gọi ở số 1-800-735-2929. Cuộc gọi này là miễn phí. Quý vị có thể nhận thông tin này miễn phí bằng những ngôn ngữ và hình thức khác, như chữ in khổ lớn, chữ nổi Braille, và đĩa thu âm.

자세한 정보는 웹사이트 www.caloptima.org/onecareconnect 를 방문하십시오. **질문이 있으시면**, OneCare Connect 번호 1-855-705-8823 으로 주 7 일 24 시간 전화하십시오. TTY 사용자는 1-800-735-2929 로 전화하십시오. 통화는 무료입니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실수 있습니다.

مراجعه نمایید. **اگر پرسشی دارید،** لطفاً www.caloptima.org/onecareconnect **برای اطلاعات بیشتر،** به سایت تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در 7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929 کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

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Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

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Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

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Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم

1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল্য কৱনঃ যিদ আপিন বাংলা, কথা বলেত পাের্ন, তাহেল িনঃখৱচায় ভাষা সহায়তা পিৱেষবা উপল ত্মোছ। ের্ফান কৱন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

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[Exhibit 20: Model Notice for Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member)]

<Date>

<Name>
<Address>
<City>, <State> <ZIP>

<Name>:

IMPORTANT: Your health care & prescription drug coverage has changed.
Thank you for telling us your new address. Your permanent address is outside the OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) area. To stay a member of OneCare Connect, you must live in the OneCare Connect service area, but you can temporarily leave the service area for up to 6 months in a row. This is because OneCare Connect is providing coverage to you as part of Cal-Medi Connect Program. The Cal-Medi Connect Program is not offered nationwide. This program is only offered through OneCare Connect in certain services areas within your State. You will no longer be a member of OneCare Connect as of <**disenrollment effective date**>. Because you've been disenrolled, OneCare Connect won't cover any health care services or prescription drugs you get after <**effective date**>.

You'll be covered by Original Medicare starting <effective date>.

- You'll get your Medicare health care services through Original Medicare starting <**effective date**> if you don't enroll in a Medicare health plan. When you see a provider through Original Medicare, you should use your red, white, and blue Medicare card to get health care services.
- You have the option to enroll in another Medicare health plan. If you have questions about Medicare plans in your area, visit www.Medicare.gov, or call toll-free number 1- 800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You may need to choose a new Medicaid plan.
You will continue to receive your Medi-Cal benefits through CalOptima. If you moved to a different State, you'll need to apply for Medicaid in that State.

Your prescription drug coverage has also changed.
Your drug coverage through OneCare Connect ended on <**effective date**>. If you want prescription drug coverage, you need to join a Medicare Prescription Drug Plan or a Medicare

Advantage plan with prescription drug coverage. If you don't choose a Medicare drug plan, Medicare will choose one for you.

You can join a new Medicare plan.
If you don't want health coverage through Original Medicare, you can join a new plan that serves the area where you now live. Call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week for information about plans that serve your area. TTY users should call 1-877-486-2048.

What to do if you disagree with your disenrollment from OneCare Connect.
If you don't agree with your disenrollment in OneCare Connect, you can file a grievance asking us to reconsider our decision. Please call OneCare Connect Customer Service at 1-855-705-8823. TTY users should call 1-800-735-2929 for information about how to file a grievance.

If you've moved, you must also tell Social Security & Medi-Cal your new address.
If you've moved, call Social Security at 1-800-772-1213 (Monday to Friday 7am – 7pm) and tell them your new address. TTY users should call 1-800-325-0778. The call is free. You can also change your address and phone number by going to my Social Security account at: https://www.ssa.gov/myaccount/. You can also OneCare Connect Customer Service at 1-855-705-8823. TTY users should call 1-877-486-2048.

Call Medi-Cal at 800-772-1213 to tell them your new address and to find out your choices for getting Medicaid benefits. If you've already called Social Security and Medicaid and told them your new address, you don't need to call again.

Who should I call if I have questions about OneCare Connect?
If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect. You can also call OneCare Connect Customer Service at 1-855-705-8823.

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week. For complaints, difficulty accessing care or other similar issues call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week.

For information on your Medicare coverage, visit www.Medicare.gov , or call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate

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on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-855-705-8823** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

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Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم

1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

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Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পারেন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল আেছ। েফান করন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

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«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

Your health & prescription drug coverage is changing.
[Insert if individual lost Medicaid status: Your OneCare Connect health and prescription drug coverage will end on «Term_date» because you no longer qualify for Medi-Cal. OneCare Connect can cover your health and prescription drug benefits only if you're eligible for both Medicare and Medi-Cal.]

[Insert if individual lost State-specific status: Your OneCare Connect health and prescription drug coverage will end on «Term_date» because you no longer qualify to be enrolled OneCare Connect. OneCare Connect can cover your health and prescription drug benefits only if you're eligible for both Medicare and Medi-Cal and meet state-specific eligibility criteria.]

You'll be in Original Medicare and have a Medicare Prescription Drug Plan.

- When your OneCare Connect services end on «Term_date», OneCare Connect prescription drug coverage ends too. Medicare will enroll you in Original Medicare and in a Medicare Prescription Drug Plan.
- If you need help comparing prescription drug plans or would like to discuss other enrollment choices, you can speak with a your California Health Insurance Counseling & Advocacy Program (HICAP) counselor at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week.
- If you have questions or don't want Medicare to enroll you in a drug plan, you must call toll-free number 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- **If you need to fill any covered prescriptions before your new Medicare Prescription Drug Plan coverage starts**, call Medicare's Limited Income NET program (also called LINET) at 1-800-783-1307, Monday through Friday, 5:00 a.m. to 8:00 p.m. PST. TTY users should call 1-877-801-0369. The call is free. You can also visit www.humana.com/pharmacists.

What to do if you want stay in OneCare Connect.

OneCare Connect can only cover your health services until «Term_date». If you think you might still qualify for Medi-Cal, please call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. This call is free. If you have questions about how to re-apply for Medi-Cal call 1-800-281-9799, Monday - Friday 7:00 am - 5:00 pm.

You can join another Medicare plan if you don't get your Medicaid back.

- Because you no longer qualify for Medi-Cal and you're no longer eligible for OneCare Connect after «Term_date» due to you losing your Medicaid, you have up to 2 months after «Term_date» to join a Medicare health plan or Medicare prescription drug plan.
- Your new Medicare coverage will begin the 1st of the following month after you enrolled in a new Medicare health plan or Prescription Drug plan. If you don't take any action, OneCare Connect will continue to cover your Medicare benefits until «Term_date».
- You can only make changes to your Medicare Prescription Drug Plan or Medicare health plan coverage during Open Enrollment. Open Enrollment happens every year from October 15 through December 7.
- There are exceptions to when you can make changes. You can leave a plan at other times during the year if:
  - You move out of the plan's service area,
  - You want to join a plan in your area with a 5-star rating, or
  - You qualify for Extra Help paying for prescription drug coverage. If you are getting Extra Help with your prescription drug costs, you may join or leave a plan at any time. If your Extra Help ends, you can still make a change for two months after you find out that you are not getting Extra Help.

Who should I call if I have questions about OneCare Connect?
If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect. You can also call OneCare Connect Customer Service at 1-855-705-8823.

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توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

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(الهاتف النصي/خط الاتصال لضعاف السمع **1-855-705-8823**) (**1-800-735-2929**: TTY

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

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«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

Important Information – Keep This Notice for Your Records

«First1» «Last2»:

You no longer qualify for OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan).
OneCare Connect, your Cal MediConnect plan, can no longer cover your health and prescription drug benefits because you are no longer eligible for Medi-Cal.

Even though you're no longer eligible for Medi-Cal, you may keep getting your benefits from OneCare Connect until «Term_Date». To stay a member of OneCare Connect, you must qualify for Medi-Cal again by «Term_Date».

If you believe you are still eligible for Medi-Cal, you must contact your county social worker at 1-800-281-9799 immediately.

How long will I have coverage?
OneCare Connect will keep covering your Medicare-Medi-Cal plan benefits until «Term_Date». You have until «Term_Date» to again qualify for Medi-Cal.

Which services will not be covered?
Cal MediConnect does not cover dental services offered by the Denti-Cal program and Mental Health Services offered by the county. These are Medi-Cal benefits covered outside of the Cal MediConnect program. Because you are no longer eligible for Medi-Cal, you may not be eligible for Denti-Cal or County Mental Health Services. To verify coverage of these benefits please contact your county social worker at 1-800-281-9799.

When will my coverage end?

If you don't qualify for Medi-Cal by «Term_Date», you'll be disenrolled from OneCare Connect and you'll get coverage through Original Medicare and a Medicare Prescription Drug Plan starting «Effective_Date».

What do I do if my coverage ends?
If you're disenrolled from OneCare Connect, Medicare will enroll you in Original Medicare and a Medicare Prescription Drug Plan. You don't need to do anything for this to happen. If you don't want Medicare to enroll you in a drug plan or if you have questions, call 1-800-MEDICARE(1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-2048 if you use TTY.

You can also contact OneCare Connect to find out about other Medicare health or Prescription Drug Plans that they offer based on your Medicare or Medi-Cal eligibility. Please call OneCare Connect's Customer Service for more information at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users should call 1-800-735-2929..

Can I join another Medicare plan?
Yes. Because you no longer qualify for Medi-Cal and are no longer eligible for OneCare Connect after «Term_Date», you have a special opportunity to join a Medicare health or Prescription Drug Plan. This opportunity begins now and ends when you enroll in a different plan or on «M_2Mos_after_term_date», whichever is earlier. If you choose this option, your new Medicare health or drug coverage will begin the 1st day of the following month after you enroll in the new plan.

After «M_2Mos_after_term_date»**, you can only make changes to your Medicare coverage during certain times of the year.** From October 15 through December 7 each year, you can enroll in a new Medicare health or Prescription Drug Plan for coverage starting January 1 of the following year.

Can I join another Medicare plan at some other time?
Yes. You can leave a plan and join a new one at other times during the year for special reasons, including:

- You move out of the plan's service area.
- You want to join a plan with a 5-star rating in your area.
- You qualify for Extra Help paying for prescription drug coverage. If you're getting Extra Help with your drug costs, you may join or leave a plan at any time. If your Extra Help ends, you can still make a change for 2 months after you find out you're no longer getting Extra Help.

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Who should I contact if I have questions?
For questions about OneCare Connect:

- Call OneCare Connect Customer Service at **1-855-705-8823**, 24 hours a day, 7 days a week..
- Call 1-800-735-2929 if you use TTY.
- Visit www.caloptima.org/onecareconnect.

For questions about **Medicare**:

- Call 1-800-633-4227 (1-800-MEDICARE), 24 hours a day, 7 days a week.
- Call 1-877-486-2048 if you use TTY.
- Visit the Medicare home page at http://www.medicare.gov.

For questions about your **Medi-Cal eligibility,** call 1-800-281-9799.

Get free help with Cal MediConnect plan problems and complaints by calling the Cal MediConnect Ombudsman at 1-855-501-3077, Monday to Friday, 9 a.m. to 5 p.m.**. Call 1-855-847-7914 if you use TTY. The call is free.**

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

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Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

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Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم

(**1-800-735-2929**: TTY (الهاتف النصي/خط الاتصال لضعاف السمع **1-855-705-8823**

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Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পারেন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল আেছ। েফান করন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

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[Exhibit 24: Model Notice to Offer Beneficiary Services, Pending Correction of Erroneous Medicare Part A and/or Part B Termination]

<Date>

<Name>
<Address>
<City>, <State> <ZIP>

<Name>:

[IMPORTANT: Your Medicare coverage has been corrected.]
Or
[IMPORTANT: Your Medicare coverage may end. Act now.]

We learned that your Medicare coverage has ended as of <**date**>. You must have Medicare Part A (Hospital Insurance) and Part B (Medical Insurance) to be a member of OneCare Connect.

Social Security and Medicare will correct your record.

Or

To stay in OneCare Connect, do these 2 things no later than <insert the date that is 60 days from date of disenrollment notice>:

1. Call Social Security at 1-800-772-1213 (Monday to Friday 7am – 7pm) to have them fix your records. TTY users should call 1-800-325-0778. Ask Social Security to give you a notice that says they've fixed your records.
2. Send a copy of Social Security's letter to your County Social Services Eligibility Worker.
3. When we get this notice, we'll share this information with Medicare and Medicaid.

Please keep using your OneCare Connect primary care providers for your health care services and your network pharmacy while your record is being corrected by Social Security and Medicare.

If you don't have Medicare Part [**insert "A" and/or "B" as appropriate**], or if you don't send proof that you have Medicare by [**insert date: 60 days from date of disenrollment notice**], you'll have to pay for any health care service and prescription drug coverage you got after <**disenrollment date**>.

If you have any questions about this notice, call Social Security at 1-800-772-1213 (Monday to

Friday 7am – 7pm) to have them fix the error in your records. TTY users should call 1-800-325-0778.

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823. TTY users should call 1-800-735-2929. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week. For complaints, difficulty accessing care or other similar issues, call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week. For more information, visit www.caloptima.org/onecareconnect**.**

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)
Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

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باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

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1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল্য কৃনঃ যিদ আপিন বাংলা, কথা বলেত পাের্ন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল আেছ। ের্ফান কৃন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

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«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

You've been re-enrolled in OneCare Connect as of «Effective_date».

Thank you for letting us know you still want to be a member of OneCare Connect. By mistake, we [**select one based on the circumstance: disenrolled you from or cancelled your enrollment in**] our plan. [**Insert brief summary of the State/plan error that caused the disenrollment.**] We've corrected our records to show that you're still a member of OneCare Connect.

Please keep using your OneCare Connect primary care providers for your health services and network pharmacy for your prescriptions.

Keep using the OneCare Connect plan
Below are instructions on how to access the following items you already got when you were enrolled before:

- List of Covered Drugs (also called a "formulary") *[visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.]*
- Provider and Pharmacy Directory *[visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.]*
- Member Handbook (Evidence of Coverage) *[visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.]*
- Summary of Benefits with the welcome mailing: Summary of Benefits *[visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.]*

Who should I call if I have questions about OneCare Connect?

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect. You can also call OneCare Connect Customer Service at 1-855-705-8823.

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week. For complaints, difficulty accessing care or other similar issues call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week. For more information, visit www.caloptima.org/onecareconnect.

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Farsi:

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توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

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«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

The state has enrolled you back in OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) as of «Effective_date».
There will be no break in your health services and prescription drug coverage. You should keep using OneCare Connect primary care providers for your health care services and network pharmacy for your prescription drugs.

Keep using the OneCare Connect Member ID Card that you currently have.

Below are instructions on how to access the following items you already got when you were enrolled before:

- List of Covered Drugs (also called a "formulary"): visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.
- Provider and Pharmacy Directory: visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.
- Member Handbook (Evidence of Coverage: visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.
- Summary of Benefits with the welcome mailing: Summary of Benefits: visit www.caloptima.org/onecareconnect or call OneCare Connect toll free at 1-855-705-8823.

Who should I call if I have questions about OneCare Connect?
If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. You can visit www.caloptima.org/onecareconnect.

If you have questions, call OneCare Connect at 1-855-705-8823. TTY users should call 1-800-735-292. For general questions about other enrollment choices, you can also call your

California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 8:00am to 4:00pm, 5 days a week.. For complaints, difficulty accessing care or other similar issues you can call your California Ombudsman at 1-855-501-3077, 9:00am to 5:00pm, 5 days a week.

For more information, visit www.caloptima.org/onecareconnect. **If you have questions**, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Para más información, visite www.caloptima.org/onecareconnect. **Si tiene preguntas,** llame a OneCare Connect al 1-855-705-8823, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TTY deben llamar al 1-800-735-2929. Esta llamada es gratuita. Puede obtener esta información gratis en otros idiomas y formatos, como en letra grande, braille y audio.

Để biết thêm chi tiết, xin vào thăm trang mạng www.caloptima.org/onecareconnect. **Nếu quý vị có thắc mắc,** hãy gọi OneCare Connect ở số 1-855-705-8823, 24 giờ một ngày, 7 ngày một tuần. Thành viên sử dụng máy TTY nên gọi ở số 1-800-735-2929. Cuộc gọi này là miễn phí. Quý vị có thể nhận thông tin này miễn phí bằng những ngôn ngữ và hình thức khác, như chữ in khổ lớn, chữ nổi Braille, và đĩa thu âm.

자세한 정보는 웹사이트 www.caloptima.org/onecareconnect 를 방문하십시오. **질문이 있으시면**, OneCare Connect 번호 1-855-705-8823 으로 주 7 일 24 시간 전화하십시오. TTY 사용자는 1-800-735-2929 로 전화하십시오. 통화는 무료입니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실수 있습니다.

برای اطلاعات بیشتر، به سایت www.caloptima.org/onecareconnect لطفاً **اگر پرسشی دارید**، مراجعه نمایید. تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. OneCare Connect complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance

services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-855-705-8823** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:
ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم
1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল□য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পা◌েরন, তাহেল ি◌নঃখরচায় ভাষা সহায়তা পিরেষবা উপল□ আেছ। ◌েফান করন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

«First1» «Last2»:

IMPORTANT: We need your address.

If you don't contact us to verify your address, you will be disenrolled from OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) effective «DER_eff_date». This means that you will no longer be able to get health services or prescription drug coverage through OneCare Connect as of «DER_eff_date».

If you've moved, you may no longer live in OneCare Connect's service area. Please provide your new address by «M_1_day_prior»**.**

- **How to provide your address**
  Call **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users should call 1-800-735-2929. The call is free.
- Fill out the "Address Verification Form" and return it in the enclosed envelope or by fax.

Your permanent address must be inside OneCare Connect's service area.

You can be away from OneCare Connect's service area for up to 6 months in a row and still stay a member of OneCare Connect. If you move and your new address is outside the service area, or if you leave the area for more than 6 months in a row, you'll be disenrolled from OneCare Connect's health services and prescription drug coverage. If you're disenrolled, you may be able to join a plan that serves the area where you now live.

You must also tell Social Security about your address change.

If you've moved and haven't told Social Security your new address, call toll-free number 1-800-772-1213 (Monday to Friday 7am – 7pm). TTY users should call 1-800-325-0778. The call is free. You can also change your address and phone number by going to my Social Security account at: https://www.ssa.gov/myaccount/

Who should I call if I have questions about OneCare Connect?

If you have questions, you can visit www.caloptima.org/onecareconnect or call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929.

If you have questions, call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929.. For general questions about other enrollment choices, you can also call your California Health Insurance Counseling & Advocacy Program (HICAP) at 1-800-434-0222 or 1-714-560-0424, 24 hours a day, 7 days a week. For complaints, difficulty accessing care or other similar issues you can contact your California Ombudsman at 1-855-501-3077, 24 hours a day, 7 days a week

For more information, visit www.caloptima.org/onecareconnect. **If you have questions,** call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week. TTY users should call 1-800-735-2929. The call is free. You can get this information for free in other languages and formats, like large print, braille, and audio.

Para más información, visite www.caloptima.org/onecareconnect. **Si tiene preguntas,** llame a OneCare Connect al 1-855-705-8823, las 24 horas al día, los 7 días de la semana. Usuarios de la línea TTY deben llamar al 1-800-735-2929. Esta llamada es gratuita. Puede obtener esta información gratis en otros idiomas y formatos, como en letra grande, braille y audio.

Để biết thêm chi tiết, xin vào thăm trang mạng www.caloptima.org/onecareconnect. **Nếu quý vị có thắc mắc,** hãy gọi OneCare Connect ở số 1-855-705-8823, 24 giờ một ngày, 7 ngày một tuần. Thành viên sử dụng máy TTY nên gọi ở số 1-800-735-2929. Cuộc gọi này là miễn phí. Quý vị có thể nhận thông tin này miễn phí bằng những ngôn ngữ và hình thức khác, như chữ in khổ lớn, chữ nổi Braille, và đĩa thu âm.

자세한 정보는 웹사이트 www.caloptima.org/onecareconnect 를 방문하십시오. **질문이 있으시면**, OneCare Connect 번호 1-855-705-8823 으로 주 7 일 24 시간 전화하십시오. TTY 사용자는 1-800-735-2929 로 전화하십시오. 통화는 무료입니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실수 있습니다.

برای اطلاعات بیشتر، به سایت www.caloptima.org/onecareconnect **لطفاً اگر پرسشی دارید،** مراجعه نمایید. تماس 1-855-705-8823 از طریق شماره OneCare Connect طی 24 ساعت شبانه روز، در 7 روز هفته با تماس بگیرند. این تماس رایگان است. شما می توانید 1-800-735-2929 کاربران TTY می توانند با شماره بگیرید. این اطلاعات را بطور رایگان در فرمهای دیگر، از قبیل چاپ درشت، خط بریل و صوتی دریافت کنید.

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on the basis of race, color, national origin, age, disability, or sex. Please call our Customer Service number at **1-855-705-8823**, 24 hours a day, 7 days a week. TDD/TTY users can call **1-800-735-2929**.

English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)

Vietnamese: CHÚ Ý: Nếu bạn nói T

iếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

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Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.

باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

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Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:

ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم

1-855-705-8823 (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**)

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল্য কৃরনঃ যিদ আপিন বাংলা, কথা বলেত পাের্রন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল ত্মোছ। ের্ফান কৃরন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

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Address Verification Form

What is your permanent address?

Provide the permanent address where you live. This can't be a P.O. box.

Address

City State Zip Code

County Phone

What is your temporary address?

(You may skip this section if you're living at your permanent address.)
Provide your temporary address. This can't be a P.O. box.

Address

City State Zip Code

County Phone

When did you begin living at this address?
When do you think you'll go back to your permanent address?

Where you would like to get your mail?

Address

City State Zip Code

Send us the form in one of two ways:

1. Mail your completed form to OneCare Connect 505 City Parkway West, Orange, CA 92868.
2. Fax your completed form to 714-246-8580.

For more information, visit www.caloptima.org/onecareconnect. **If you have questions**, call OneCare Connect at 1-855-705-8823, 24 hours a day, 7 days a week. The call is free.

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«Date»

«First» «Last»
«Address»
«City», «St» «Zip»

Important Information – Keep This Notice for Your Records

«First1» «Last2»:

You no longer qualify for OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan).
OneCare Connect, your Cal MediConnect plan, can no longer cover your health and prescription drug benefits because you are no longer eligible. This may be for one of the following reasons:

1. Your Medi-Cal eligibility status has changed; or

2. We got information that you may have moved out of OneCare Connect's service area.

If you believe you are still eligible for Cal MediConnect, you must contact your Orange County Social Services Agency at 1-800-281-9799 (Monday through Friday, 8 a.m. to 5 p.m.) immediately. TDD/TTY users can call 1-800-735-2929.

Even though you're no longer eligible for Cal MediConnect, you may keep getting your benefits from OneCare Connect until **«Term_date».** To stay a member of OneCare Connect, you must qualify for Cal MediConnect again by «Term_date».

How long will I have coverage?
OneCare Connect will keep covering your benefits until **«Term_date»**. You have until **«Term_date»** to again qualify for Cal MediConnect.

When will my coverage end?
If you don't qualify for Cal MediConnect by **«Term_date»**, you'll be disenrolled from OneCare Connect and you'll get coverage through Original Medicare and a Medicare Prescription Drug Plan starting **«Effective_date»**.

If you don't contact us to confirm your address or your change in Medi-Cal eligibility status, you will be disenrolled from OneCare Connect effective «Term_date». This means that you will no longer be able to get health services or prescription drug coverage through OneCare Connect as of this date.

If you've moved, you may no longer live in OneCare Connect's service area. Please provide your new address by **«Term_date»** in one of the following ways:

1. Call 1-855-705-8823, 24 hours a day, 7 days a week. TDD/TTY users should call 1-800-735-2929.; or

2. Contact Orange County Social Services Agency at 1-800-281-9799 (Monday through Friday, 8 a.m. to 5 p.m.) immediately. TDD/TTY users can call 1-800-735-2929. immediately.

Your permanent address must be inside OneCare Connect's service area.
The state has indicated that you have moved outside OneCare Connect's service area. You'll be disenrolled from OneCare Connect's health services and prescription drug coverage on **«Term_date»**, unless you call your Orange County Social Services Agency at 1-800-281-9799 (Monday through Friday, 8 a.m. to 5 p.m.) TDD/TTY users can call 1-800-735-2929 to indicate you still live in OneCare Connect's service area. If you have moved, you'll be able to join a plan that serves the area where you now live.

You must also tell Social Security & your Medi-Cal County Eligibility Office about your address change.
If you've moved and haven't told Social Security your new address, call 1-800-772-1213, Monday through Friday from 7:00 a.m. to 7:00 p.m. Call 1-800-325-0778 if you use TTY. Also, call your Medi-Cal County Eligibility Office at 1-800-281-9799 (Monday through Friday, 8 a.m. to 5 p.m.) TDD/TTY users can call 1-800-735-2929 to tell them your new address and to find out your options for getting Medi-Cal benefits.

What do I do if my coverage ends?
If you're disenrolled from OneCare Connect, Medicare will enroll you in Original Medicare and a Medicare Prescription Drug Plan. You don't need to do anything for this to happen. If you don't want Medicare to enroll you in a drug plan or if you have questions, call 1-800-MEDICARE
(1-800-633-4227), 24 hours a day, 7 days a week. Call 1-877-486-2048 if you use TTY.

You can also contact OneCare Connect to find out about other Medicare health or Prescription Drug Plans that they offer based on your Medicare or Medi-Cal eligibility. Please call OneCare

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Connect's Customer Service for more information at 1-855-705-8823, 24 hours a day, 7 days a week. TDD/TTY users should call 1-800-735-2929.

After «M_2_mons_after_term_date», you can only make changes to your Medicare coverage during certain times of the year. From October 15 through December 7 each year, you can enroll in a new Medicare health or Prescription Drug Plan for coverage starting January 1 of the following year.

Can I join another Medicare plan at some other time?
Yes. You can leave a plan and join a new one at other times during the year for special reasons, including:

- You move out of the plan's service area.
- You want to join a plan with a 5-star rating in your area.
- You qualify for Extra Help paying for prescription drug coverage. If you're getting Extra Help with your drug costs, you may join or leave a plan at any time. If your Extra Help ends, you can still make a change for 2 months after you find out you're no longer getting Extra Help.

Who should I contact if I have questions?
For questions about OneCare Connect:

Call OneCare Connect Customer Service at 1-855-705-8823, 24 hours a day, 7 days a week.

- Visit www.caloptima.org/onecareconnect..

For questions about **Medicare**:

- Call 1-800-633-4227 (1-800-MEDICARE), 24 hours a day, 7 days a week.
- Call TTY 1-877-486-2048 if you use TTY.
- Visit the Medicare home page at http://www.medicare.gov.

For questions about your **Medi-Cal eligibility**, call
Orange County Social Services Agency at 1-800-281-9799 (Monday through Friday, 8 a.m. to 5 p.m.) TDD/TTY users can call 1-800-735-2929.

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Get free help with Cal MediConnect plan problems and complaints by calling the Cal MediConnect Ombudsman at 1-855-501-3077. The call is free.

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English: ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-855-705-8823** (TTY: **1-800-735-2929**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-855-705-8823** (TTY: **1-800-735-2929**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-855-705-8823** (TTY: **1-800-735-2929**)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-855-705-8823** (TTY: **1-800-735-2929**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-855-705-8823** (TTY: **1-800-735-2929**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-855-705-8823** (TTY: **1-800-735-2929**)번으로 전화해 주십시오.

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-855-705-8823** (TTY (հեռատիպ)՝ **1-800-735-2929**):

Farsi:

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد.
باشماره **1-855-705-8823** (TTY: **1-800-735-2929**) تماس بگیرید.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-855-705-8823** (телетайп: **1-800-735-2929**).

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Japanese:
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-855-705-8823** (TTY: **1-800-735-2929**)まで、お電話にてご連絡ください。

Arabic:
ملحوظة: إذا كنت تتحدث بلغة أخري غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل علي الرقم (الهاتف النصي/خط الاتصال لضعاف السمع TTY: **1-800-735-2929**) **1-855-705-8823**

Punjabi: ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-855-705-8823** (TTY: **1-800-735-2929**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ল য্ করনঃ যিদ আপিন বাংলা, কথা বলেত পারেন, তাহেল িনঃখরচায় ভাষা সহায়তা পিরেষবা উপল ে আছ। ফান করন **1-855-705-8823**(TTY: **1-800-735-2929**)

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-855-705-8823** (TTY: **1-800-735-2929**).

Hindi: ध्यान दें: यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-855-705-8823** (TTY: **1-800-735-2929**) पर कॉल करें।

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-855-705-8823** (TTY: **1-800-735-2929**).

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken November 3, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Action

Authorize the Chief Executive Officer, with the assistance of legal counsel, to exercise an option to extend the Liberty Dental Plan of California, Inc. contract for OneCare members for calendar year 2017 under the existing terms and conditions.

Background/Discussion

The OneCare program includes a supplemental dental benefit for its members. In actions taken on December 3, 2015 the CalOptima Board of Directors authorized a contract amendment to the Liberty Dental OneCare Connect contract to provide the supplemental dental benefit for OneCare members. The contract period with Liberty Dental for OneCare was granted from January 1, 2016 through December 31, 2016, with two additional one-year extension options, each exercisable at CalOptima's sole discretion.

At its May 2016 meeting, the Board authorized submission of the OneCare Bid for calendar year 2017. The bid has been submitted and was accepted by the Centers for Medicare & Medicaid Services (CMS), and includes the supplemental dental benefit. Staff now seeks authority to exercise an option to extend the contract with Liberty Dental through December 31, 2017.

Fiscal Impact

The CalOptima Fiscal Year (FY) 2016-17 Operating Budget approved by the Board on June 2, 2016 includes OneCare dental service expenses that were consistent with forecasted enrollment. Staff included approximately $100,000 in the FY2016-17 budget for this purpose. Since the rates and terms of the contract will not change, the recommended action to renew the contract with Liberty Dental for dental services from January 1, 2017, through June 30, 2017, is a budgeted item with no additional fiscal impact

Management will include expenses for the period of July 1, 2017, through December 31, 2017, related to the contract renewal in the CalOptima FY 2017-18 Operating Budget.

Rationale for Recommendation

CalOptima staff recommends Board approval of this action to ensure that OneCare members continue to have access to dental services.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
Board Action dated December 3, 2015, Authorize Contract Amendments with Liberty Dental for a Supplemental Dental Benefit for OneCare; Extend the Supplemental Dental Benefit for OneCare Connect; and Authorize Deemed Eligibility for Member Receiving Denti-Cal

/s/ Michael Schrader — *9/28/2016*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

12. Authorize Contract Amendments with Liberty Dental for a Supplemental Dental Benefit for OneCare; Extend the Supplemental Dental Benefit for OneCare Connect; and Authorize Deemed Eligibility for Members Receiving Denti-Cal

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to enter into contract amendments with Liberty Dental for supplemental dental benefits for:
    a. OneCare from January 1, 2016 through December 31, 2016, with two additional one year extension options, each exercisable at CalOptima's sole discretion
    b. OneCare Connect from January 1, 2016 through December 31, 2017; and
2. Authorize one month of deemed eligibility for OneCare Connect members receiving Denti-Cal services provided by Liberty Dental.

Background/ Discussion

In actions taken on April 2, 2015, the CalOptima Board of Directors authorized a supplemental dental benefit for the OneCare Connect program as well as funding and contracting with Liberty Dental. Voluntary enrollment into OneCare Connect has increased based on the additional supplemental dental benefits being offered by CalOptima in the program. The supplemental dental benefit provides services not covered by the Denti-Cal benefit. Staff believes the supplemental dental benefit has increased member retention in the program.

In order to keep the benefits similar to OneCare Connect, OneCare added the same supplemental dental benefit to the 2016 Centers for Medicare &Medicaid Services (CMS) approved OneCare bid.

At its August 6, 2015 meeting, the CalOptima Board of Directors authorized a one month deeming period for OneCare Connect Members who no longer met Cal MediConnect eligibility requirements due to loss of Medi-Cal eligibility with CalOptima. This benefit was added to mitigate breaks in coverage and maintain continuity of care for members. Management proposes a similar one month deeming period for Denti-Cal benefits for OneCare Connect members. Should a member fail to regain eligibility for the Medi-Cal program during the one month period of deemed eligibility, CalOptima would be financially responsible for the cost of the month of deemed eligibility. Based on the proposed action, eligibility for the one month of deemed dental benefits through Liberty Dental would be available through December 31, 2017 for OneCare Connect members.

Fiscal Impact

Based on the forecasted OneCare enrollment for Fiscal Year (FY) 2015-16, the fiscal impact of the recommended action to issue a contract amendment for the supplemental dental benefit for the OneCare Program from January 1, 2016, through June 30, 2016, is approximately $55,000. Costs associated with the recommended action were incorporated into Calendar Year 2016 OneCare capitation rate. Funding

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for the recommended action for the period July 1, 2016 through December 31, 2016, will be included in the FY 2016-17 CalOptima Consolidated Operating Budget.

Based on the forecasted OneCare Connect enrollment for FY 2015-16, the fiscal impact of the recommended action to issue a contract amendment for supplemental dental benefit for the OneCare Connect Program from January 1, 2016 through June 30, 2016, is approximately $445,000. This is a budgeted item under the CalOptima FY 2015-16 Operating Budget approved by the Board on June 4, 2015. Funding for the recommended action for the period July 1, 2016 through December 31, 2017, will be budgeted in subsequent operating budgets.

Projected expenses related to the provision of the deeming benefit are approximately $3,500 per month.

Rationale for Recommendation

CalOptima staff recommends supplemental dental services to OneCare Connect members to strengthen the programs ability to minimize pre-enrollment opt out, maximize post enrollment retention and strong provider participation in the program. OneCare members will continue to have the same CMS approved supplemental benefit as OneCare Connect members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Previous Board actions referenced in this Report Item:

- August 6, 2015, Agenda Item VIII. J., Authorize Actions Related to OneCare Connect Enrollment
- April 2, 2015, Agenda Item VIII. B., Authorize Modifications to Member Assignment Process for the OneCare Connect Program; Authorize Supplemental Dental Benefit for the OneCare Connect Program, as well as Funding and Contracting with a Vendor as Necessary to Implement

/s/ Michael Schrader *11/25/2015*

Authorized Signature **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken April 2, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. B. Authorize Modifications to Member Assignment Process for the OneCare Connect Program; Authorize Supplemental Dental Benefit for the OneCare Connect Program, as well as Funding and Contracting with a Vendor as Necessary to Implement

Contact

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

Recommended Actions

1. Authorize modifications to the Board approved OneCare Connect (Cal MediConnect) Program member enrollment process to allow for enrollment by Long Term Care (LTC) Facility, subject to approval by the Department of Health Care Services (DHCS); and
2. Authorize the Chief Executive Officer (CEO) to contract with dental benefits administrator to provide a supplemental benefit to the Medi-Cal dental benefit subject to approval by the DHCS and the Centers for Medicare & Medicaid Services (CMS), and upon the successful negotiation of contract terms with Liberty Dental from July 1, 2015 to December 31, 2015.

Background

In actions taken on January 3, 2013, February 7, 2013 and December 5, 2013, the Board authorized the CEO to develop a provider delivery system for implementation of the Duals Demonstration, a program for beneficiaries eligible for Medi-Cal and Medicare or "Duals", also known as Cal MediConnect Program and branded by CalOptima as OneCare Connect.

On December 5, 2013 the Board approved the Member enrollment process in order to ensure a seamless passive enrollment of OneCare Connect members who will be allowed the opportunity to make a voluntary choice to disenroll (opt-out). The enrollment process, previously approved, is based on the DHCS requirements to passively enroll eligible members on their birthday month. Approximately 3,900 members in Orange County are expected to be eligible for passive enrollment monthly.

The Cal MediConnect program launched state wide on April 1, 2014 and has been implemented in six counties. Passive enrollment start dates have been staggered throughout the state and the opt-out rates have varied by county with an overall statewide average of 49%. Concerned about the high opt-out rate, CalOptima staff has developed strategies to mitigate opt-out. The member strategies include increasing member outreach efforts and outreach to our community stakeholders informed as they are considered our member's "trusted advisors". Provider strategies, as approved by your Board, include increased provider participation through the implementation of the Community Network and increasing primary care and specialist reimbursement from 80% to 100% of Medicare fee-for-service. Based on the experience of the other Cal MediConnect plans, staff proposes two additional strategies related to the member enrollment process and dental services.

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Discussion

As CalOptima prepares to launch the Cal MediConnect or OneCare Connect program, CalOptima staff has explored strategies intended to reduce the pre-enrollment opt-out and strengthening retention of members who are passively enrolled in the program. The strategies CalOptima staff considered are both from the member and provider perspective so as to ensure that both stakeholder groups are motivated to remain in OneCare Connect.

Long Term Care Facility Based Enrollment. From the member impact perspective, CalOptima is proposing to modify the previously approved passive enrollment strategy for individuals who are residing in Long-Term Care (LTC) Facilities. Among the approximately 80,000 Dual eligible individuals in Orange County, approximately 3,500 reside in 56 LTC facilities. These 3,500 individuals are among the most vulnerable members, have complex health care needs, and would greatly benefit from increased integration and coordination of care, which will be available with OneCare Connect. For this reason, CalOptima staff is proposing that it would be a better approach to passively enroll these Duals by LTC facility rather than by birth month based on DHCS approval and on a mutually agreed upon schedule with DHCS. This would allow CalOptima to communicate one-on-one with members and their families regarding care options available to them through OneCare Connect. CalOptima staff would also be able to personally educate providers and coordinate member care. Providing the opportunity to work closely with the LTC facilities, to educate and answer questions and provide the additional care coordination component will help improve the OneCare Connect retention rate.

Dental Benefit. Another proposal to improve the retention rate is by providing supplemental dental services not covered by Medi-Cal to CalOptima OneCare Connect members. While OneCare Connect members are eligible for Denti-Cal, in certain situations, access remains an issue. Management believes that improving access to dental services facilitates a positive member experience, thereby motivating members to stay in OneCare Connect. The CalOptima OneCare program previously offered a supplemental dental benefit that was very popular in attracting Duals to enroll in OneCare. Based on member input, CalOptima staff views the availability of dental services as a key component of a successful OneCare Connect program. Subject to approval by both DHCS and the Centers for Medicare & Medicaid Services (CMS), CalOptima management proposes to utilize funding from the DHCS for the Medi-Cal component of the Cal MediConnect capitation payment to implement this option.

If approved, staff recommends contracting with Liberty Dental Plan to administer and coordinate the proposed supplemental dental benefits for OneCare Connect members on a per member per month (PMPM) payment basis. Liberty Dental has been the dental benefit administrator that administered the OneCare benefit on behalf of CalOptima. Management believes that Liberty Dental Plan is the only potential subcontractor qualified to provide the appropriate supplement to the Medi-Cal benefit. Liberty Dental Plan will ensure timely access to a comprehensive, contracted network of primary and specialty Denti-Cal providers. Unlike in Denti-Cal where certain members may face delays or difficulty in accessing care, the proposed benefit would allow OneCare Connect members to have an

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assigned primary care dentist through which to obtain dental services to guarantee a straightforward and seamless path to dental coverage. Through this arrangement, CalOptima intends to:

- Increase CMC members' awareness of the dental benefit through education and outreach;
- Improve utilization of preventive dental services;
- Improve coordination between dental and physical health care providers;
- Provide limited supplemental benefits not covered under Denti-Cal; and
- Improve access to dental providers.

Both the LTC member enrollment and dental strategies require Board and regulator approval. Staff will return to the Board for additional authority, as necessary, to implement these and potentially other retention strategies.

Fiscal Impact

The recommended action to execute a contract with Liberty Dental Plan to provide supplemental dental benefits will have a total fiscal impact between $1.7 million and $2.0 million at capitation rates from $7.00 per member per month (PMPM) to $8.00 PMPM for Fiscal Year 2015-16. Under this capitated arrangement, Liberty Dental Plan will assume full risk for dental services, and will coordinate dental benefits with Denti-Cal. As such, the capitation payment will cover supplemental dental benefits only, including enhanced access to their dental network, with no additional payments made to Liberty Dental Plan. Denti-Cal will remain the primary payor and provider of dental services to OneCare Connect members.

Rationale for Recommendation

CalOptima staff recommends these actions to strengthen the OneCare Connect program's ability to minimize pre enrollment opt-out, maximize post enrollment retention and strong provider participation in the OneCare Connect program.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *3/27/2015*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item
VIII. J. Authorize Actions Related to OneCare Connect Enrollment

Contact
Candice Gomez, Executive Director, Program Implementation, (714) 246-8400
Javier Sanchez, Chief Network Officer, (714) 246-8400

Recommended Actions
1. Authorize implementation of transition plan of OneCare members to OneCare Connect effective January 1, 2016;
2. Authorize a one-month deeming period effective no sooner than September 1, 2015 for OneCare Connect members who no longer meet Cal MediConnect eligibility requirements due to loss of Medi-Cal eligibility with CalOptima;
3. Authorize enhancement of the delivery model for OneCare Connect members who reside in a long-term care facility that is exclusive to CalOptima Direct, subject to approval by the Department of Health Care Services and the Centers for Medicare & Medicaid Services; and
4. Authorize updates to policies as necessary for implementation.

Background
On December 5, 2013, the CalOptima Board of Directors authorized execution of the Three-Way Agreement between the California Department of Health Care Services (DHCS), the Centers for Medicare & Medicaid Services (CMS) and CalOptima for implementation of Cal MediConnect (CMC), branded CalOptima OneCare Connect Plan (Medicare-Medicaid Plan) (OCC) in Orange County. OCC is a managed care plan that combines Medicare and Medi-Cal, including long-term services and supports (such as In-Home Supportive Services, Multipurpose Senior Services Program, Community-Based Adult Services, and long-term care). Both the DHCS and CMS have continued to issue guidance regarding the implementation of CMC. Two topics of recent regulatory discussion include the enrollment of Medicare Dual-Eligible Special Needs Plans (D-SNPs) and a period of deemed continued eligibility for CMC. Additionally, CalOptima is involved in ongoing communications with CMS and DHCS regarding initiatives specific to members residing in long-term care facilities.

Enrollment into D-SNPs
DHCS issued guidance through an All Plan Letter *(APL) 14-014: Enrollment Requirements for Dual-Eligible Special Needs Plan in Alameda and Orange Counties,* which delineates D-SNP enrollment criteria once CMC is implemented in a county. Specific to CalOptima, the APL states that if a D-SNP is also a CMC plan, the following will apply: "No earlier than January 1, 2016, DHCS will crosswalk all Duals who are eligible for CMC into the corresponding CMC plan once CMC is implemented in Orange County. These Duals will not be permitted to re-enroll in the CMC D-SNP; and the CMC D-SNP may serve any existing or new beneficiaries who are not eligible for CMC (Excluded Beneficiaries) only."

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Based on this guidance, CalOptima is required to transition its OCC-eligible OneCare Members into OCC effective January 1, 2016. OneCare can no longer enroll Members eligible for CMC. However, OneCare can continue to enroll dual eligible Members not eligible for CMC into the OneCare plan. These include, for example, Members under 21 years of age, Members receiving services through Regional Center or Members participating in Section 1115(c) waiver programs, such as Assisted Living, In Home Operations, and Nursing Facility/Acute Hospital Waivers. During this transition to OCC, Members are subject to the same noticing requirements as apply to Members being passively enrolled into OCC, and CalOptima staff is in the process of obtain approval of modifications to the existing notice templates so that they can be used in conjunction with this transition.

Deeming Process for CMC

Current OCC policy provides that Members, who lose Medi-Cal eligibility, as determined by the State, are disenrolled from the plan. DHCS, in compliance with CMS policy, issued guidance on June 15, 2015 encouraging plans such as CalOptima to offer an optional one or two-month period of deemed continued eligibility in the Medicare-Medi-Cal Plan (MMP) due to loss of Medi-Cal eligibility. For OCC members who lose eligibility with the plan due to 1) loss of Medi-Cal eligibility or 2) change of circumstance impacting eligibility (such as a change in Medi-Cal eligibility aid code or a move out of the service area), DHCS will allow plans to choose to provide a one or two month period of deemed continued eligibility. Deeming guidance became effective July 1, 2015.

Long-Term Care

CalOptima has been responsible for the Medi-Cal long-term care benefit since January 1996. The Medi-Cal long-term care benefit includes room and board for Members who are no longer able to live safely at home or in the community, require round-the-clock custodial care prescribed by a physician, and meet DHCS level of care requirements. These members receive medical, social, and personal care services in a nursing facility. Only care in sub-acute, skilled nursing facilities and intermediate care facilities apply; assisted living and board and care facilities are not eligible.

Traditionally, for Dual eligible members, physician and hospital services are provided through the Medicare fee-for-service program, a Medicare Advantage Plan, or a Special-Needs Plan. CalOptima has managed and paid for long-term care services for these members directly and has not delegated this responsibility. Through OCC, Dual eligible members can now receive all of their services through one coordinated plan.

Since 2009, CalOptima Medi-Cal members in long-term care have received physician, hospital, and long-term care services through the CalOptima Direct network, which includes the CalOptima Community Network. OCC now affords CalOptima the opportunity to provide the full scope of services covered under both Medicare and Medi-Cal through the CalOptima Community Network.

Discussion

Enrollment into D-SNPs

As indicated, effective January 1, 2016, CalOptima is required to transition eligible OneCare Members into OCC. CalOptima intends to make the transition as seamless as possible for Members

and ensure that disruption is kept to a minimum. For this reason, staff intends to assign the Member to the same OneCare primary care provider (PCP) and health network, unless otherwise requested by Member. If the PCP participates in a different OCC health network at the time of transition, the Member will be assigned to the same PCP and the PCP's new health network. This is in alignment with the DHCS March 27, 2015 Dual Plan Letter (DPL) 15-003 requirements for continuity of care which states "if the MMP contracts with delegated entities, the MMP must assign the beneficiary to a delegated entity that has the beneficiary's preferred PCP in its network."

If the member's OneCare PCP does not participate in the same OCC health network but does participate in two or more OCC health networks or none, the Member will be assigned according to the OCC auto-assignment policy initially approved during the December 2013 Board meeting and amended in May 2015, unless otherwise requested by Member.

CalOptima will modify its OCC policies related to primary care selection, network assignment, and member notification to the extent necessary to reflect the above.

Deeming Process for CMC

DHCS issued guidance allowing CMC plans to offer up to two months of deeming eligibility due to loss of Medi-Cal eligibility. The deeming period would apply to OCC members who no longer qualify for OCC due to loss of Medi-Cal eligibility or change of circumstance impacting Medi-Cal eligibility. Plans already participating in CMC have reported that many members who have been involuntarily disenrolled from CMC due to loss of Medi-Cal eligibility regain their Medi-Cal eligibility within one to two months after disenrollment.

For example, a Member may lose Medi-Cal eligibility as a result of late submission of annual Medi-Cal redetermination documentation, delays in redetermination processing, a report of having an out of county residence, or other health coverage information. In many instances, the situation is quickly remediated either by submission of required redetermination documentation or correcting erroneous records, and Medi-Cal eligibility is reinstated. Without a deeming period, these members will be disenrolled from OCC and cannot be automatically enrolled back to the plan. Instead, these members would have to voluntarily re-enroll with OCC to continue coverage.

In order to mitigate breaks in coverage and maintain continuity of care for members, staff proposes to allow a one-month deeming period for OCC Members. A one month deeming period is recommended at this time to limit CalOptima's financial exposure. Based on the proposed action, during the deeming period, CalOptima would continue providing OCC benefits to the Member. CalOptima will continue to receive member premium payments from Medicare; however, Medi-Cal capitation payments will be suspended during this time. Medi-Cal capitation payments from DHCS will be retroactively paid for the deeming month if the member regains Medi-Cal eligibility. However, if the Member does not regain Medi-Cal eligibility during the deeming period, the member would be disenrolled from OCC at the end of the deeming period month, and CalOptima would not be reimbursed for Medi-Cal expenses incurred on behalf of this member during the one-month period.

All regulatory notice requirements to Members will be followed for this process. While DHCS permits plans to implement deeming effective July 1, 2015, due to the time required for regulatory

approval of member materials, CalOptima staff proposes to implement the one month deeming process no earlier than September 1, 2015. As proposed, deeming will continue through the duration of the CMC, currently authorized by the DHCS and CMS through December 31, 2017.

CalOptima will modify its OCC policies related to member enrollment and disenrollment, to the extent necessary to implement the above.

Long-Term Care

On April 2, 2015, the CalOptima Board of Directors authorized staff to modify the OCC enrollment process to allow for enrollment by long-term care facility. Regulatory approval was received in July 2015 and the enrollment of members by facility will begin in November 2015. In order to enhance the care for OCC members residing in a long-term care facility, staff proposes to implement a delivery model specific for these members. By enhancing the delivery model, staff expects to:

- Improve coordination of Medicare and Medi-Cal services, consistent with the goals of Cal MediConnect
- Improve member, family and facility satisfaction
- Promote member enrollment in OCC
- Utilize emergency department (ED) and inpatient resources appropriately with subsequent reduction in ED visits, hospital admissions, days and readmissions rates
- Adhere to regulatory requirements for OCC
- Improve communication and discuss expectations with member, facility, providers, and family
- Measure and report benefits of integrated care

A key component of this delivery model is to contract with providers who provide services in skilled nursing and long-term care facilities. These providers are referred to as skilled nursing facility (SNF) physicians. Because these members permanently reside in the facility, it is important for the members' care to be rendered by physicians who go directly to the facility to provide services on a regular and frequent basis in order to identify and treat acute or deteriorating conditions. These physicians will also be available around-the-clock to provide urgent care services at the facility in order to avoid unnecessary emergency department admissions. As such, new contracts requiring the SNF physician to provide around-the-clock care and minimum thresholds of visits in addition to traditional primary care services will be developed. These contracts will be offered exclusively through CalOptima Direct to individual providers and physician groups and may be based on fee-for-service or capitated with a risk sharing agreement.

The other key component of enhancing the deliver model is to designate the managed CalOptima Community Network, a part of CalOptima Direct, as the assigned network for OCC members residing in a long-term care facility, similar to CalOptima's current policy for Medi-Cal members. The CalOptima Community Network is designed to provide physician, hospital, and long-term care services to all Medi-Cal members residing in a long-term care facility. For Dual eligible members, while physician and hospital services are provided through the Medicare fee-for-service program, a Medicare Advantage Plan, or a Special-Needs Plan, CalOptima has always managed and paid for long-term care services for these members directly. Assigning OCC members to CalOptima

Community Network, therefore, promotes continuity with their CalOptima Medi-Cal network. Additionally, this allows a single entity to be responsible for the members entire covered services.

Subject to approval by both the DHCS and CMS, CalOptima will modify and/or develop OCC policies related to health network selection, primary care selection, auto-assignment, and services provided to a member residing in a long-term care facility to the extent necessary to reflect the above.

Fiscal Impact
The recommended actions are budget neutral. Transition of OneCare members into OneCare Connect, expenses due to deeming, and direct costs related to the reimbursement to long-term care facilities are accounted for in the FY16 budget.

Rationale for Recommendation
In order to comply with the DHCS guidelines for OCC enrollment and to maintain maximum membership and minimize disruption of member's health care services, CalOptima staff proposes to implement the above recommended actions.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

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

07/31/2015 — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken July 10, 2008
Regular Meeting of the CalOptima Board of Directors

Report Item
VI. B. Approve 2009 OneCare Dental Benefit and Authorize the CalOptima Chief Executive Officer (CEO) to Enter into a Dental Services Provider Contract

Contact
Kurt Hubler, Executive Director of OneCare (714) 246-8400.

Recommended Action
A. Approve addition of mandatory supplemental dental benefit package for 2009 OneCare Program; and
B. Authorize the CalOptima CEO to enter into a dental services provider contract for OneCare, with the assistance of legal counsel, which contract will be contingent upon the Centers for Medicare & Medicaid Services (CMS's) approval of a dental benefit in the 2009 bid.

Background
CMS requires Medicare Advantage Plans to submit a benefit package for 2009 to CMS by June 2, 2008. The annual submission of benefits into CMS is part of the Medicare Advantage bid process. As part of CalOptima's OneCare 2009 bid, it was proposed that OneCare offer a dental benefit to all 8,000 OneCare members.

Discussion
The State provides all Medi-Cal recipients in Orange County with dental coverage through Denti-Cal. The Denti-Cal program covers one cleaning per year and additional benefits at no cost. However, feedback received from focus groups, OneCare members, and OneCare Partner sales representatives suggests that Medi-Cal recipients are dissatisfied with the Denti-Cal program. Concerns include limited access to quality dental coverage and the refusal of many dentists to provide a dental service under Denti-Cal because of low reimbursement rates. The perception in the community from the Medi-Cal recipients is that Denti-Cal will only cover tooth extraction beyond the annual cleaning. In light of the current state fiscal crisis, further cuts or elimination of the already limited Denti-Cal program are being considered.

OneCare is proposing to offer a more comprehensive dental package that provides for two annual cleanings and selected fillings, root canals, crowns, caps, dentures and peridontics at no cost to members. This benefit package is designed to offer the most common dental procedures at no cost to members and with adequate reimbursement to dental providers. Other services will be offered at 50% of usual and customary fees. Under the proposed plan, OneCare members will be able to access quality dental providers and thereby improve their

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overall health status. Studies have shown a direct correlation between the level of oral health and the overall health status of an individual.

As proposed, the vendor providing the dental benefit will be selected via the Request for Proposal (RFP) process. An RFP was sent out in June 2008, with responses due in late July. A contract term of three years (January 1, 2009-December 31, 2011) is proposed.

Fiscal Impact
Preliminary estimates from dental health plans estimate that a benefit package as described above will cost approximately $12.00 per member per month (PMPM) under a capitated dental network. Based on their belief in the importance of this benefit, the OneCare medical groups have agreed to amend their OneCare contracts with CalOptima to reflect that they will share in its cost by having the $12 PMPM amount deducted prior to the calculation of the percent of premium contractual split among the medical groups, the shared risk pool, and OneCare.

Rationale for Recommendation
Oral health is a key component of a person's overall health status. The State Denti-Cal program is not fully meeting the needs of the dual eligible population and may be curtailed or eliminated altogether. Offering a dental plan will be an attractive addition to the OneCare benefit package, will better meet the health needs of our members, and strengthen OneCare's competitive position.

Concurrence
Procopio, Cory, Hargreaves & Savitch LLP

Attachments
None

/s/ Richard Chambers — *7/2/2008*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

8. Consider Authorizing Contracts with Alternative Care Settings (ACS) to Support Expansion and Growth of CalOptima Program of All-Inclusive Care for the Elderly (PACE)

Contact

Michelle Laughlin, Executive Director, Network Operations, (714) 246-8400
Richard Helmer, Chief Medical Officer, (714) 246-8400

Recommended Actions

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

1. Enter into contracts with Community Based Adult Services (CBAS) centers to serve as Alternative Care Setting (ACS) sites for CalOptima PACE members; ~~and~~
2. Contract with additional ACS sites on established operational and quality standards and potential PACE participant needs, subject to Board approval; and
3. Staff to report performance metrics back to the Board.

Rev. 2/1/2018

Background

PACE is a managed care service delivery model for the frail elderly that integrates acute, chronic, and long-term care for nursing home certified seniors. The goals of PACE are to prevent unnecessary institutionalization and maintain or improve the functional status of the program's participants. The CalOptima PACE Center provides health services, rehabilitation, care coordination, nutrition, recreation activities, social services, and administrative support all at the same location. CalOptima opened its PACE center on October 1, 2013, and currently serves approximately 238 members at the single location.

At its February 4, 2016 meeting, the Board authorized submission of a service area expansion to the California Department of Health Care Services (DHCS) and the Centers for Medicare & Medicaid Services (CMS), authorized a Request for Proposal (RFP) process for the ACS model for PACE expansion satellite locations to include CBAS centers, and directed staff to perform additional analysis. Subsequently, at its May 4, 2017 meeting, the Board requested that staff first issue a Request for Information (RFI) on alternative care settings. The RFI was released on May 26, 2017. Findings from the RFI, including a market analysis, locations and capabilities of potential ACS sites, were used to develop a RFP, which was released on November 3, 2017. Staff has completed scoring of the proposals and qualified five CBAS centers based on:

- CBAS center currently serving CalOptima members located in or adjacent to the service area
- Operational for a minimum of one year
- Capacity to provide services to a minimum of 15 CalOptima PACE members

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- Fiscal soundness, as evidenced by evaluation of financial statements for three consecutive years, as well as a third-party risk report when available. Metrics evaluated include liquidity, debt ratio, short-term viability, and delinquency.
- Capable of providing six of the seven PACE core services per PACE regulatory requirements and evaluated according to descriptions of the operational, security, financial, compliance and analytics requirements of the RFP.
- In good standing with regulatory agencies, as evidenced by no active corrective action plans or sanctions.
- Capacity to increase access to services based on cultural competency, geographical area or medical condition.

The five CBAS centers that qualified through the RFP process are listed in Attachment 1.

While CalOptima's current service area is limited to north Orange County, the ACS model is expected to be an important step toward increasing access to PACE services throughout Orange County. CalOptima's request for expansion of the service area to include all Orange County Zip Codes is currently under review by CMS, with approval anticipated as soon as July 1, 2018. Four of the five CBAS centers qualified through the RFP are in the current service area, with one in the proposed expanded service area.

Discussion

Using alternative care settings for CalOptima PACE members is expected to increase access to culturally and linguistically competent, specialized services in close geographical proximity to participants' residences. CMS defines an alternative care setting as a facility, other than the participants' primary residence, where PACE participants receive the services listed in section 460.98 of U.S. Code: Title 42 (Public Health and Welfare).

In accordance with section 460.98, an ACS can provide six of the seven core PACE services, with the seventh, primary care, provided by the CalOptima PACE site. ACS sites will provide the following six services:

- Social services
- Restorative therapies, including physical therapy and occupational therapy
- Personal care and supportive services
- Nutritional counseling
- Recreational therapy
- Meals

Interdisciplinary Team assessment and care planning will remain components provided directly by the PACE center. Primary care may be provided by CalOptima PACE or a community-based physician, on an individualized basis. Transportation services will be provided by CalOptima PACE or by ACS sites, based on the ability to fulfill operational and quality standards. The proposed contracts include rates and terms for ACS sites deemed capable of providing transportation services.

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Through the RFP process, staff have developed a program design for CalOptima PACE to utilize ACS, including operational and quality standards required to be designated as an ACS. In the future, ACS sites may potentially be added based on a tool that determines operational and quality standards required to operate as an ACS, allowing CalOptima PACE to respond to access needs in specific areas of the county.

Fiscal Impact

The recommended actions to authorize contracts with CBAS centers to serve as PACE ACS sites are expected to increase enrollment in the PACE program, while maintaining current financial performance. Pro forma projections for Fiscal Year 2018-19 assume a net increase of two members per month related to the addition of the ACS sites. Increasing access to PACE services through the ACS strategy is expected to allow more eligible county residents to participate in the CalOptima PACE program, and may improve operational efficiencies and increase economies of scale. CalOptima will pay contracted ACS sites a per diem rate derived from CalOptima PACE's experience and projected unit costs for day center attendance, which includes six of the seven core PACE services. Given the modest anticipated enrollment increase, Management projects that the medical loss ratio, administrative loss ratio, and net margin will remain consistent with current levels through the fiscal year.

Rationale for Recommendation

Alternative care settings will increase access to care for current PACE members. Specifically, these services are culturally competent and specialized, possibly in more convenient geographical locations to PACE members' residences. In addition, the alternative care setting strategy has been identified as a vehicle for expanding the PACE model of care to all Zip Codes of Orange County. Currently, service area is limited to 60-minute one-way ride radius from the PACE center in Garden Grove. With ACS 'satellite' sites throughout Orange County, eligible CalOptima members will have access to the coordinated quality care provided by CalOptima PACE.

Concurrence

Gary Crockett, Chief Counsel

Attachment

1. RFP-Qualified CBAS Providers
2. PowerPoint Presentation: PACE Alternative Care Setting (ACS) RFP Results

/s/ Michael Schrader *1/25/2018*
Authorized Signature **Date**

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RFP-Qualified CBAS Providers

Center Name	Contract Name	Contract Effective Date	Center Address
Acacia Adult Day Services	Acacia Adult Day Services	7/1/12	11391 Acacia Parkway Garden Grove, CA 92840
Anaheim VIP Adult Day Health Care	Community Seniorserv, Inc., dba Anaheim VIP Adult Day Health Care	7/1/12	1158 North Knollwood Circle Anaheim, CA 92801
Santa Ana/Tustin VIP Adult Day Health Care	Community Seniorserv, Inc., dba Santa Ana/Tustin VIP Adult Day Health Care	7/1/12	1101 South Grand Avenue, Suite L Santa Ana, CA 92705
South County Adult Day Services	Alzheimer's Orange County	7/1/12	24260 El Toro Road Laguna Woods, CA 92637
Sultan Adult Day Health Care Center	Pacific GIS, Inc., dba Sultan Adult Day Health Care Center	7/1/12	125 W. Cerritos Avenue Anaheim, CA 92805

PACE

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PACE Alternative Care Setting (ACS) RFP Results

Board of Directors Meeting

February 1, 2018

Richard Helmer, M.D., Chief Medical Officer

Elizabeth Lee, Director, PACE

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Goal of Implementing ACS

- To expand access to PACE to all eligible Orange County seniors
  - Geographic coverage in current North County service area and future South County service area, anticipated in July 2018

- To ensure PACE supports participants' unique needs
  - Culture competence
  - Language access
  - Health conditions

ACS Background

- Staff progress on Board-approved ACS directives
  - September 2016: Presented financial information to Finance and Audit Committee (FAC)
  - February 2017: Updated FAC with additional financial performance metrics
  - May 2017: Conducted a three-hour PACE Study Session for the full Board, with a presentation by the state regulator and analysis of ACS by National PACE Association
  - May 2017: Issued a Request for Information (RFI) from potential ACS partners
  - August 2017: Distributed a 300-page PACE informational binder to the Board
  - November 2017: Released a Request for Proposal (RFP) for ACS partners

PACE and CBAS Alignment

- PACE and Community-Based Adult Services (CBAS) centers serve similar populations
  - Are nursing home-eligible
  - Have multiple chronic conditions
  - Need help with activities of daily living
- PACE and CBAS centers have an opportunity to better meet participants' preferences and needs
  - Increased convenience and appropriateness for participants
    - Conditions, language and ethnicity, and residence
- PACE and CBAS centers seeking new avenues for growth
  - CBAS centers are a referral source to PACE
  - Partnership provides CBAS centers with stable revenue

CBAS as an ACS

- CBAS centers deliver six of seven core PACE services
  - Social services
  - Restorative therapies
  - Personal care and supportive services
  - Nutritional counseling
  - Recreational therapy
  - Meals

- CalOptima PACE retains responsibility for the seventh core service
  - Primary care

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RFI Background

- CalOptima issued an RFI for ACS sites in May 2017
- Responses were collected, with all Orange County respondents interviewed as of August 2017
- There were a total of 11 respondents, nine located in Orange County
  - Of those nine, eight were licensed CBAS centers

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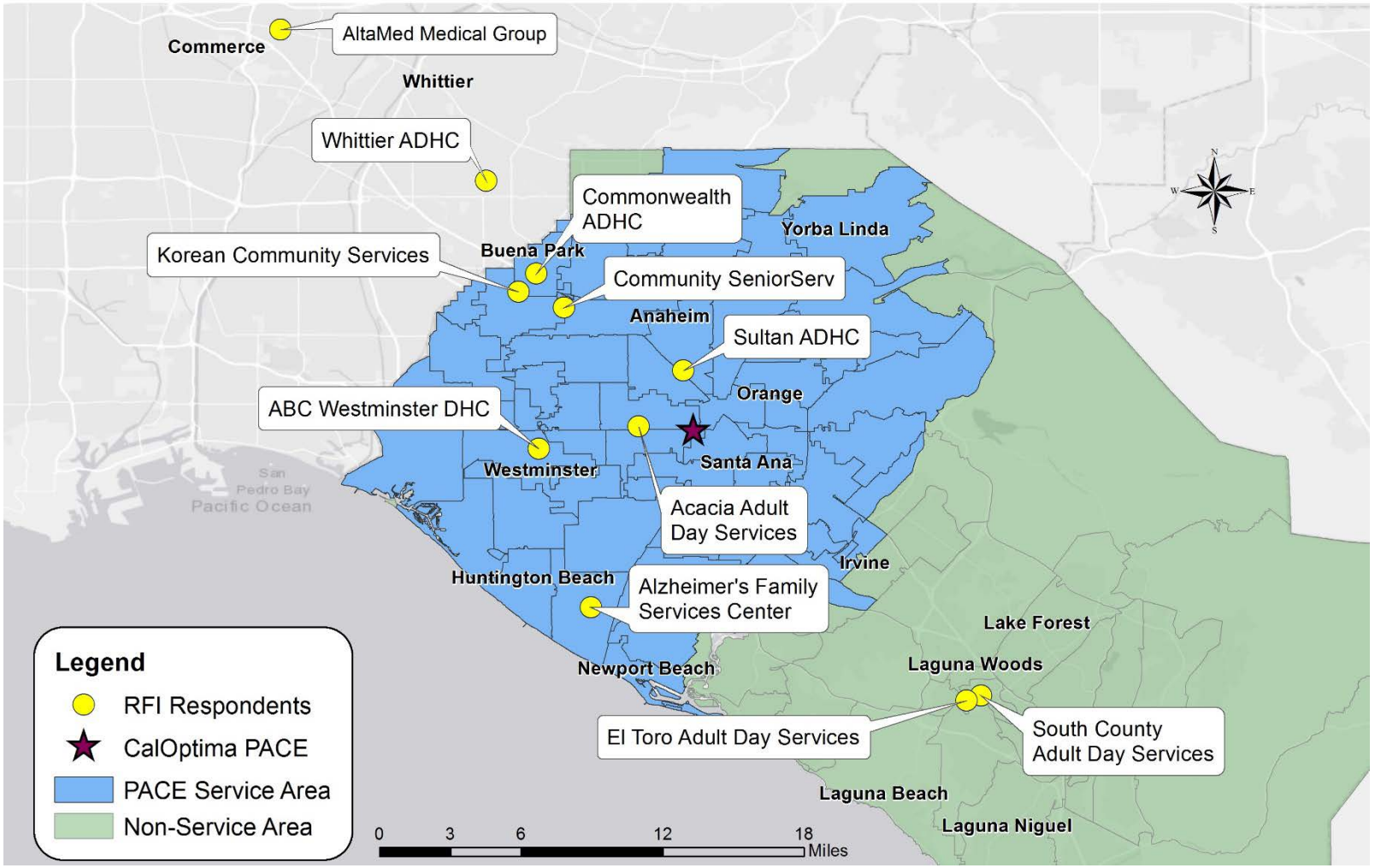
RFI Respondents/PACE Service Area



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RFI Findings

- Interest level provided a solid basis from which to move forward on a countywide RFP
- Respondents seemed to understand the ACS concept and have elements in place to participate
- Information from respondents helped the development of a program design, including operational, quality and capacity standards, for the RFP

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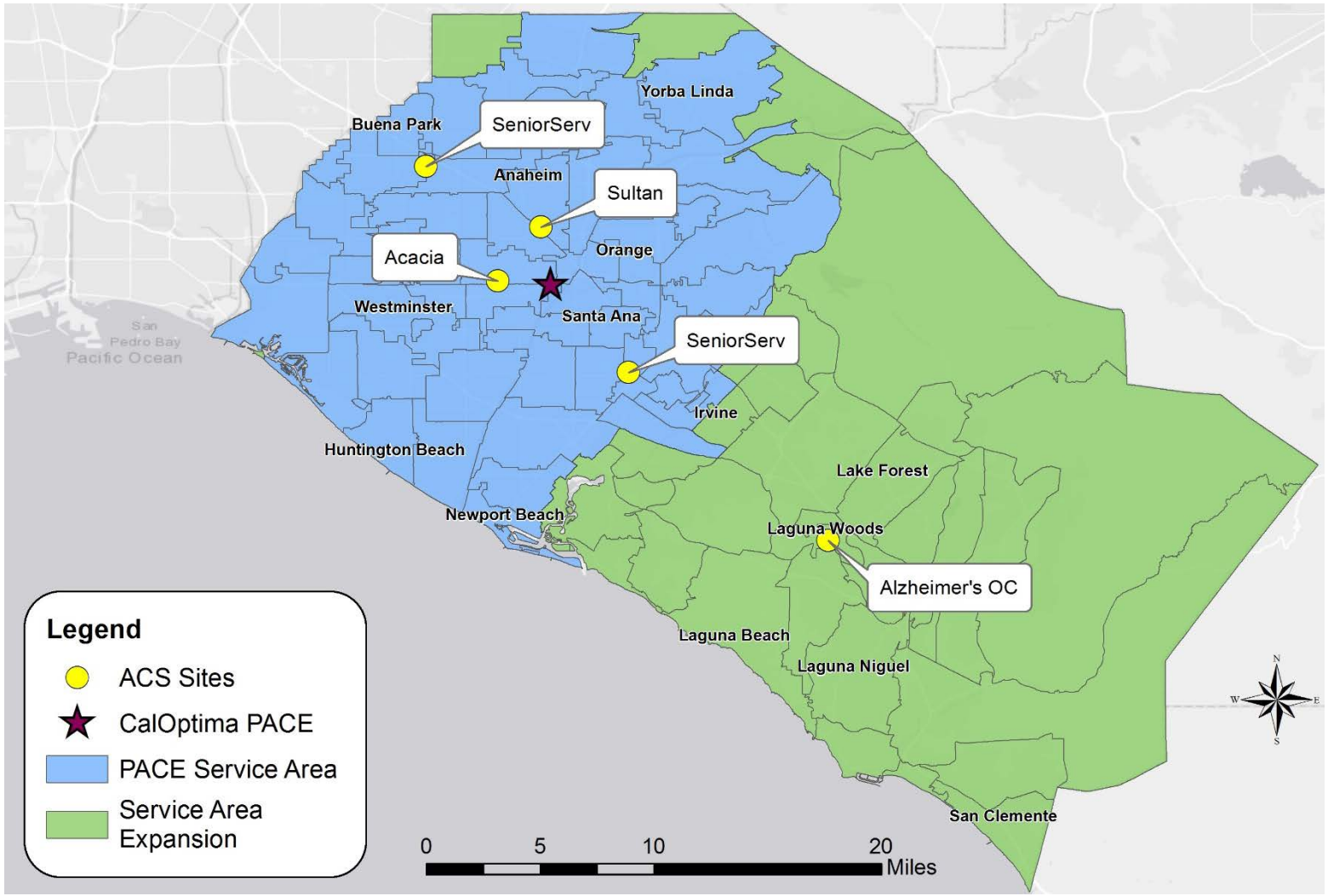
RFP Background

- CalOptima issued an RFP for ACS sites in November 2017
  - RFP included detailed criteria
    - Operational
    - Security
    - Financial
    - Compliance
    - Analytics
  - RFP included a proposed contract amendment, which defined rates and requirements
- There were eight respondents
- Site visits were conducted with respondents meeting the initial criteria
- Five respondents were deemed qualified

Proposed ACS Sites



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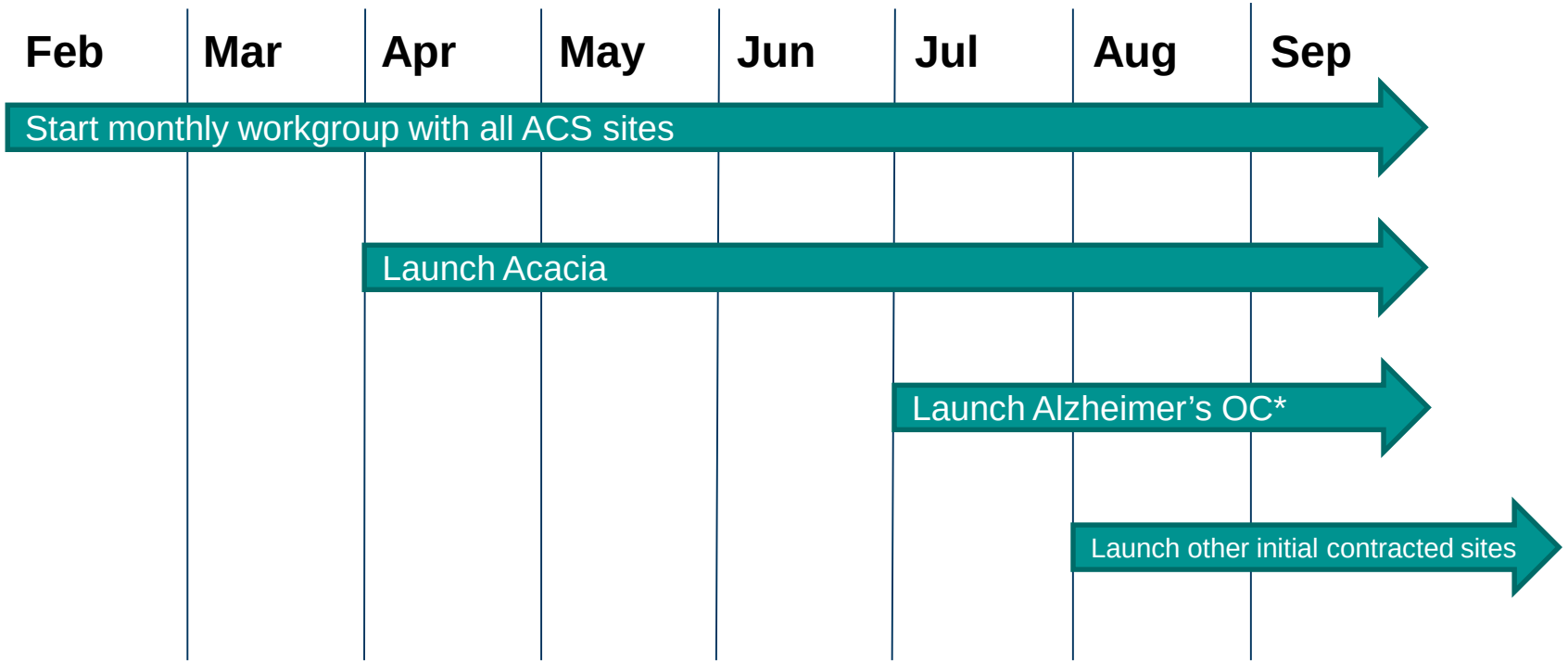
Phased Implementation

- Phased implementation supports use of best practices
- Monthly workgroup fosters collaboration from the start



** Pending CMS approval of service area expansion*

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Additional ACS Sites

- Program design allows for additional ACS sites to be added based on an application process that:
  - Assesses operational and quality standards
  - Considers potential PACE participant needs
  - Supports efficient use of time and resources
  - Accommodates future growth

Staff Recommendation

- Authorize the Chief Executive Officer, with the assistance of legal counsel, to:

  - Enter into contracts with CBAS centers to serve as ACS sites for CalOptima PACE members, and;

  - Contract with additional ACS sites on established operational and quality standards and potential PACE participant needs.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
9. Consider Authorizing Amendment of Existing Contract with Verscend Technologies

Contact
Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Len Rosignoli, Chief Information Officer, (714) 246-8400

Recommended Actions
1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to amend the existing contract with Verscend Technologies to extend the term for the period of March 1, 2018 through ~~June 30, 2019~~ January 31, 2019; and
2. Authorize unbudgeted expenditures of an amount not to exceed $285,822 from existing reserves for the Verscend Technologies contract amendment through June 30, 2018.

Rev. 2/1/2018

Background
CalOptima currently processes (adjudicates) claims related to all lines of business for CalOptima Community Network, Health Network shared risk, and other services that are the financial responsibility of CalOptima. During adjudication, claims are processed through a series of system validation edits prior to payment.

Staff implemented a pre-payment claims review solution, provided by Optum, a vendor selected as part of a Request for Proposal (RFP) process. However, CalOptima has encountered challenges with the effective use of the Optum Claims Editing System (CES) and related processes since implementation as of January 1, 2017. This includes the sophistication of the vendor's support team as well as the regular and required updates to the CES Medi-Cal program claims edits. The Optum support team has limited expertise with Medi-Cal, and this impacts the effectiveness of the CES solution. Therefore, CalOptima staff determined that it needed to engage a third-party vendor with expertise in secondary claims editing to identify the potentially problematic or missing edits and, once identified, to allow for timely and efficient remediation and identification of any prior overpayments or underpayments in order to make timely claims adjustments.

Based on Board action on September 7, 2017, Verscend Technologies was engaged to review all claims (both institutional and professional) for all lines of business from January 1, 2017 through February 28, 2018 in a secondary editor role after initial edits are performed by the Optum CES system. Effective September 13, 2017, Verscend began performing pre-payment claims editing. In addition, Verscend completed a post payment review for all claims processed from January 1, 2017 through September 12, 2017.

Discussion
CalOptima claims staff started receiving daily pre-payment claims edits beginning September 13, 2017 from Verscend. Based on the contract entered into on September 8, 2017, Verscend receives a contingency fee equal to 22% of savings realized from the edits accepted. Management believes this is

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a competitive rate and savings for contingency contracts based on prior experience. Net savings related to the accepted pre-payment claims from Verscend from September 13, 2017 through December 29, 2017 was $769,285 for this 3½ month period after factoring in the contingency fee. Based on these figures, staff projects net claims savings for a full 12-month period at approximately $2.7 million.

As discussed at the Board meeting of September 7, 2017, considering the challenges with the Optum CES product and the temporary nature of the secondary editor arrangement, staff has issued a Request for Proposal (RFP) for a longer term, ideally single solution, for these services. The proposed extension of the existing Verscend contract through the vendor selection and implementation period is expected to provide sufficient time for CalOptima staff to complete the RFP process, the contracting process and, as applicable, implement these services with the selected vendor(s).

For these reasons, and based on the positive savings generated to date, staff recommends extension of the current Verscend contract through June 30, 2019. As indicated, the effectiveness of the Secondary Claims Editing solution has been validated by the savings generated between September and December 2017. During the proposed contract extension period, where possible and practical, staff plans to continue to update the Optum CES product to ensure that we are deriving all possible savings from the CES solution. Of note, CalOptima will pay Optum $888,000 during Fiscal Year (FY) 2017-18 for the final year license fee to use the CES software tool. Also of note, while staff has had preliminary discussions with Verscend about changing the expiration date of the current contract from February 28, 2018 to June 30, 2019, Verscend has also expressed interest in modifying other terms of the agreement. In the event that Verscend is unwilling to extend the contract under the current terms and conditions as proposed, staff plans to include post payment review as part of the Scope of Work in the current RFP cycle, similar to the process followed with respect to the January 1 – September 13, 2017 period.

Fiscal Impact

The recommended action to amend the Verscend Technologies contract to extend the secondary claims editing services is an unbudgeted item. As proposed, an allocation of an amount not to exceed $285,822 from existing reserves will be used to fund this action through June 30, 2018. This estimates the contracted contingency fee of 22% of savings realized from accepted claims edits.

Management will include expenses related to the Verscend Technologies contract extension for July 1, 2018, through June 30, 2019, in the CalOptima FY 2018-19 Operating Budget

Rationale for Recommendation

The above actions are recommended to maintain appropriate levels of validation review prior to final claims adjudication and payment, to identify and adjust and to correct claims edit variances.

Concurrence

Gary Crockett, Chief Counsel

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Attachment

Board Action dated September 7, 2017, 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

/s/ Michael Schrader — *1/25/2018*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken September 7, 2017
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

Sesha Mudunuri, Executive Director, Operations, (714) 246-8400
Len Rosignoli, Chief Information Officer, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), 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. Approve unbudgeted expenditures of up to $788,500 from existing reserves for the Verscend Technologies contract amendment.

Background

CalOptima currently processes (adjudicates) approximately 223,000 claims per month related to all lines of business for CalOptima Community Network, Health Network shared risk, and other services that are the financial responsibility of CalOptima. During adjudication, claims are processed through a series of system validation edits prior to payment. The validation edits are currently conducted directly in CalOptima's core business system, Facets, or through the Optum Claims Edit System (CES) – an integrated solution.

Beginning in 2008, CalOptima contracted with Verscend Technologies (formerly Verisk) for a variety of claims review services, including (a) claims editing; (b) catastrophic forensic claims review; (c) identification of potential fraud, waste, or abuse (FWA) cases. CalOptima continues to contract with Verscend for items (b) and (c) above; however, claims editing services under (a) were migrated to the Optum CES product in December of 2016. This was addressed in the attached COBAR, "Authorize Extension of Contract with Healthcare Insight, a Division of Verisk Health, Inc." during the August 4, 2016 Board meeting. The claims editing scope of work under the Verscend Technologies terminated December 31, 2016.

In 2015, CalOptima staff conducted a Request for Proposal (RFP) process for the purposes of developing more comprehensive claims editing capabilities and incorporating pre-payment claims edits into its core business system, Facets. As a result of the RFP process, the Optum CES product was selected and implemented effective December 27, 2016. The initial term of the Optum contract is from February 19, 2016 through February 18, 2019.

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Discussion

CalOptima has encountered significant challenges with implementation of the Optum CES product over the last eight months, including the sophistication and implementation of Medi-Cal program claims edits. CalOptima staff has reviewed sample claims during this period which suggest that edits have not been properly implemented or are missing, which results in erroneous claims adjudication and/or the need to re-adjudicate previously paid claims. Staff has determined that it needs to engage a third-party vendor with expertise in secondary claims editing in order to identify the potentially problematic or missing edits and, once identified, to allow for timely and efficient remediation and identification of any prior overpayments or underpayments in order to make timely claims adjustments.

In light of the need to expedite this process, staff believes the most cost-effective and expedient option is to re-engage Verscend Technologies to act as the temporary secondary claims editor. This is particularly efficient as Verscend continues to receive CalOptima claims on a daily basis to perform the other current services. The intent would be to re-engage Verscend for a limited time period to review claims from January 1,2017 through February 28, 2018. During that period, Verscend would also recommend implementation of appropriate edits and identify claims that need to be re-processed.

The cost of this engagement is estimated to be a fixed fee of $128,500 for review of previously paid claims through September 11, 2017. As proposed, Verscend would receive 22% of savings realized for claims reviewed between September 11, 2017 and February 28, 2018. During this period, CalOptima staff plans to continue to evaluate the efficiency of the Optum CES product and the most appropriate long-term claims editing solution for CalOptima, and return to the Board with a recommendation in the next several months.

Fiscal Impact

The recommended action to amend the Verscend Technologies Contract to include secondary claims editing services is an unbudgeted item. As proposed, an allocation of up to $788,500 from existing reserves will be used to fund this action. This amount includes $128,500 for services during the period of January 1, 2017 through September 11, 2017, and $660,000 for the period thereafter through February 28, 2018.

Rationale for Recommendation

The above action is recommended to maintain appropriate levels of validation review prior to final claims adjudication and payment, to identify, adjust and recover any incorrect payments previously made and to identify and correct claims edit variances.

Concurrence

Gary Crockett, Chief Counsel

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Attachments

Board Action dated August 4, 2016, Authorize Extension of Contract with Healthcare Insight, a Division of Verisk Health, Inc.

/s/ Michael Schrader — *8/31/2017*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken August 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item
34. Authorize Extension of Contract with Healthcare Insight, a Division of Verisk Health, Inc.

Contact
Ladan Khamseh, Chief Operating Officer, (714)246-8400
Silver Ho, Executive Director, Compliance, (714) 246-8400

Recommended Action
Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to negotiate an amendment to extend the existing Amended and Restated Contract (Contract) with Verisk Health, Inc. (Verisk) through December 31, 2017.

Background
CalOptima currently contracts with Verisk to provide three separate and distinct functions: 1) pre-payment claims clinical edits; 2) forensic claims review; and 3) identification of potential fraud, waste, and abuse (FWA) cases. CalOptima initially contracted with Verisk on October 1, 2008, following a competitive bidding process, to provide professional claims review and FWA reporting services. CalOptima amended the contract, effective September 1, 2010, to include catastrophic claim pre-payment forensic review services and to clarify several other contractual requirements, which amendments were ratified and approved by the Board on July 7, 2011. At that time, the contract was also extended to December 31, 2014 with two, one year extension options. CalOptima has subsequently exercised both of the extension options such that the contract now expires on December 31, 2016.

A summary of the Verisk contracted services is as follows:

1. Pre-Payment Claims Edits: During the pre-payment claims review, Verisk applies the National Correct Coding Initiative (NCCI) standards for Medicare and Medi-Cal outpatient claims as well as other pre-payment clinical claims edits to identify irregular claims billing practices. These edits are conducted in addition to the edits currently embedded in CalOptima's core operating system, Facets. The largest volume of data is processed during the pre-payment claims review.

2. Catastrophic Forensic Claims Review: Verisk provides clinical forensic review of large dollar claims with total billed charges in excess of $100,000 or $50,000 in reimbursement payments per claim. The reviews generally focus on claims that include services paid based on a charge reimbursement methodology. During the clinical forensic review process, charges will not be allowed if determined to be coded/billed inappropriately. The clean portion of the claim is paid and disallowed charges are pended if additional medical justification is required to support the disallowed charges. Verisk conducts a medical record review to verify accuracy of billed charges. The disallowed charges are denied if additional information is not received within the required time limits. CalOptima has final determination on whether to deny charges based on Verisk recommendation. Verisk is reimbursed for the forensic reviews based on a percent of savings realized by CalOptima.

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3. Identification of Potential FWA Cases: Medicare Advantage and Medicaid managed care regulations require that the plan sponsor or managed care organization performs effective monitoring in order to prevent and detect FWA. Verisk analyzes historical and current claims data to identify potential FWA cases. Potential FWA cases are referred to CalOptima's Special Investigations Unit (SIU) for further consideration.

CalOptima contracted with a new pre-payment claims edit vendor, Optum, which was selected through a Request for Proposal (RFP) process. When fully implemented in November 2016, the Optum process will include new clinical editing protocols integrated into Facets; this will eliminate the need for outside vendor review, leading to a more robust and timely clinical edit processing of claims in-house.

Due to the complexity, cost consideration and specialized skill set required for the forensic review of high dollar claims as well as FWA reporting, staff plans to conduct separate RFP processes to consider vendors for these two services currently performed by Verisk.

Discussion

During the past year, CalOptima staff has made efforts to improve efficiencies in identifying inappropriate coding/claims billing practices and potential FWA cases. As such, an RFP was issued for the purposes of developing more comprehensive editing capabilities and incorporating pre-payment claims edits into the core business system, Facets, rather than sending data to an external vendor for review. Implementation efforts with its new vendor, Optum, began in early 2016 with an expected go-live in November 2016. Additionally, dedicated staff with technical experience (clinical as well as hospital coding) will be resourced to oversee this function.

While CalOptima has contracted with Optum to begin pre-payment claim editing in-house as the first step, CalOptima will continue to rely on Verisk for two of its claims review functions—forensic claims review and FWA reporting services—until an RFP process is completed and contract(s) are entered into with appropriate vendor(s). Staff is currently in the process of issuing RFPs for these services.

During the past year, savings of over $2.8 million, after payment of contingency fees, have been realized by CalOptima under this contract based on the forensic review of claims. To ensure best practices and effective management of these functions, staff has evaluated how these services can be best provided. To date, CalOptima has implemented strategies intended to reduce the number of disputes related to high dollar claims while meeting applicable requirements to ensure the appropriate payments, as well as identify and report potential fraud, waste and abuse trending.

CalOptima staff seeks authority to extend the current Verisk contract as it relates to forensic claims review and FWA reporting services through December 31, 2017. Extension of the contract through this period will provide sufficient time for CalOptima staff to conduct the RFPs, complete the contracting process and, as applicable, implement these services with qualified vendors.

Fiscal Impact

Funding for this recommended action is included in the CalOptima FY 2016-17 Operating Budget approved by the Board on June 2, 2016. Management will budget expenses related to the proposed contract extension in the CalOptima FY 2017-18 Operating Budget accordingly.

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Rationale for Recommendation
Staff recommends that the Board authorize an extension and amendment of the Verisk contract through December 2017 to allow sufficient time to complete competitive bidding processes for forensic claims review and FWA reporting services.

Concurrence
Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer

Attachment
July 7, 2011 CalOptima Board Action Agenda Referral, VI. B., Authorize the Chief Executive Officer (CEO) to Execute a Contract with One or More Vendors for Credit Balance Recovery Services; Ratify and Authorize the Chief Executive Officer to Amend an Existing Vendor Claims Contract with HealthCare Insight to Add Catastrophic Claims Post-Payment Review

/s/ Michael Schrader — *07/29/2016*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken July 7, 2011
Regular Meeting of the CalOptima Board of Directors

Report Item

VI. B. Authorize the Chief Executive Officer (CEO) to Execute a Contract with One or More Vendors for Credit Balance Recovery Services; Ratify and Authorize the Chief Executive Officer to Amend an Existing Vendor Claims Contract with HealthCare Insight to Add Catastrophic Claims Post-Payment Review

Contact

Ruth Watson, Executive Director - Operations, (714) 246-8400

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into a three-year contingency-based contract with two separate one-year extension options, with one or more vendors, for the provision of Credit Balance Recovery (CBR) Services; and,

2. Ratify amendment to HealthCare Insight contract for prepayment recovery services to add catastrophic claims post-payment review, and authorize the Chief Executive Officer, with the assistance of legal counsel, to further amend the contract regarding those services.

Background

CalOptima currently processes approximately 1.5 million claims per year for CalOptima Direct and OneCare members, with payments associated with these claims exceeding $660 million dollars annually. Since 2008, as part of CalOptima's program integrity strategy, staff has sought and received Board approval to contract with several vendors to ensure claim payment accuracy. These include the following:

- In 2008, the Board authorized staff to enter into a contract with a vendor to provide coordination of benefits (COB) identification and overpayment recovery services for claims when it is determined that CalOptima is not the primary payer. Under this authority, staff contracted with Health Management Services, which has identified and recovered more than $5 million on behalf of CalOptima using a data mining process.

- In 2008, the Board also authorized staff to contract with a vendor for claims pre-payment code review, fraud, waste, and abuse prevention services. Based on this authority, staff contracted with HealthCare Insight (HCI). CalOptima has recognized pre-payment savings in excess of $3.5 million since the inception of the HCI contract.

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- In 2010, staff received approval to enter into a contract with Socrates to pursue third party liability (TPL) subrogation recovery services for the OneCare and Healthy Families lines of business.

Discussion

Program integrity activities are key to ensuring that public funds are appropriately spent. As indicated, CalOptima has successfully implemented a variety of cost containment initiatives in support of that goal. Medi-Cal's size and diversity make it vulnerable to improper payments that can result from fraud, waste, abuse, or clerical errors. CalOptima staff continues to look for additional program integrity activities that can prevent, detect, and recover improper payments, and has identified two additional programs designed to prevent and/or recover claim overpayments as a result of fraud, waste, abuse or clerical errors.

1) Credit Balance Recovery. Credit balances are improper or excess payments made to a provider. Such payments can occur on patient accounts when the reimbursement received by the provider exceeds the appropriate or expected reimbursement for services rendered, for example, as a result of multiple reimbursements from different payers (by both CalOptima and the primary payer), adjustments to previously-paid claims, computer-generated billing errors, or mis-postings to accounts (e.g., where no refund is due to the patient or payer). Some of the amounts may be considered "overpayments" due to the Medicaid program. When such "credit balances" occur, they appear in the provider's records as a credit on the patient account that is carried forward month to month in the provider's books. Under Federal law, providers are obligated to disclose and refund known overpayments. In addition, having such credit balances on their books distorts the liabilities in a provider's patient accounting system. Providers work with CBR vendors to identify and address credit balances that are the result of billing and/or payment errors made by both hospitals and payers. Credit Balance Recovery Services involve a financial review of the provider's patient accounts; it is not a hospital bill audit. The vendor works collaboratively with the provider's staff to reconcile accounts to resolve the outstanding credit balance and refund the overpayment to the appropriate payor. Implementing CBR services can translate into a $1-$5 per member per year in overpayment recovery opportunity.

   Earlier this year, CalOptima staff issued a Request for Proposal (RFP) soliciting vendors that had a well-established presence in the Credit Balance Recovery arena in Orange County. Staff is currently evaluating RFP responses to identify the vendor or vendors whose service offerings best meet CalOptima's needs. Specific criteria to be included in the vendor contract include an agreed upon approval process to ensure that CalOptima will make the final determination regarding all overpayment recovery activities in compliance with CalOptima's policies and procedures, as well as all applicable regulatory requirements.

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As proposed, vendors for CBR services are paid a percentage of the recovery on a contingency basis after CalOptima recovers credit balances it is owed. While the provider has an independent obligation to reimburse CalOptima for such amounts involving its members, contracting with a CBR vendor is expected to result in greater recoveries.

2) Catastrophic Claim Post-Payment Review. In unique situations such as when services needed by a CalOptima member are not available at a contracted facility, CalOptima staff negotiates with non-contracted facilities. With non-contracted providers, reimbursement for each admission is typically negotiated separately and a Letter of Agreement (LOA) is signed by the facility and CalOptima. The Assist Group (TAG), a strategic partner of HCI, provides pre-payment and post-payment review of large dollar claims to ensure billed services are supported by corresponding medical records. TAG performs a pre-screen review and makes a recommendation on whether a detailed forensic review is warranted. Non-contested charges would be paid at the agreed upon LOA rate, while any contested charges would be reviewed against medical records to determine whether the charges are substantiated. The provider has the right to appeal this determination by submitting additional information to TAG as part of CalOptima's standard Provider Dispute Resolution (PDR) process for first level appeals. If a provider is not satisfied with the outcome of this first level review, it would have the ability to submit a second level appeal through CalOptima's standard processes to CalOptima's Grievance and Appeals Services (GARS) department. Additional payment would be made to the facility if the forensic review, PDR process or GARS process determines that some portion of the contested charges are supported.

As indicated above, CalOptima entered into a contract with HCI for pre-payment claims review in 2008. This contract was amended twice in 2010, first to reflect a change in vendor ownership status, and second to extend the agreement through September 2013 and to incorporate a number of changes to the scope of work, including the addition of post payment forensic review services. Ratification of these changes is now being sought, along with authority to further amend the HCI agreement consistent with regulatory requirements, and to clarify issues including PDR review responsibilities, settling authority, and criteria for vendor reimbursement.

Fiscal Impact

1. CBR Services - As proposed, the contract with the selected vendor will be structured with a negotiated contingency payment scale related to a percentage of savings. It is anticipated that net recovery over the proposed three-year term of the agreement may be as much as $1million.

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2. Catastrophic Claim Post-Payment Review - The HCI contract contains a contingency payment scale related to a percentage of savings. The estimated annual savings/ recoupments from post payment review services could potentially reach $1 million.

Rationale for Recommendation

By contracting with a Credit Balance Recovery vendor, CalOptima will have the ability to identify and recover overpayments due to other insurance coverage, misapplied payments and contractual issues that remain un-reimbursed on a provider's accounts receivables.

Ratifying and further amending the HCI contract for Catastrophic Claim Post-Payment Review better ensures that CalOptima will reimburse facilities for only those charges that are substantiated through a detailed review of large dollar hospital bills.

Successful implementation of these services will enable CalOptima to better meet its obligations to insure program integrity and identify potential instances of fraud, waste and abuse.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Richard Chambers — *7/5/11*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

10. Consider Making an Exception to CalOptima's Supplemental Compensation Policy by Ratifying Employee Overpayments Related to Bilingual Pay

Contact

Lori Shaw, Executive Director Human Resources, (714) 246-8400

Recommended Actions

1. Approve an exception to CalOptima Policy GA.8042: Supplemental Compensation Policy for payments of bilingual pay to employees (and former employees) who continued to receive bilingual pay, but were not eligible for bilingual pay, after policy changes were approved by the Board in December 3, 2015, in an amount not to exceed $60,000; and
2. Make a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose.

Background

Updates to CalOptima Policy GA.8042: Supplemental Compensation (Policy) were approved by the Board of Directors on December 3, 2015. These updates included changes to bilingual pay, including implementation of a two–tiered structure based on the job description requirements and extent of usage, with qualifying employees receiving an extra $60 per pay period if bilingual language skills in a threshold language is "required in job description and used regularly in the performance of job duties," and $40 per pay period if "bilingual language usage is preferred in the job description and used regularly in the performance of an employee's job." At both levels, demonstrated fluency in a threshold language is required. The update also made bilingual pay pensionable for purposes of the California Public Employees Retirement System (CalPERS). Based on these changes to the Policy, bilingual pay was no longer offered to employees who infrequently use their language skills as part of their job responsibilities.

Following the Board's approval of these changes, staff implemented the Policy for new positions and new employees; however, no process was implemented to audit and validate existing employees and job positions to ensure that payments for bilingual language skills aligned with the updated Policy. While general organization-wide communications were provided to all employees, including a Regulatory Affairs and Compliance email notifying all employees of updated policies, several impacted employees were not individually contacted and notified of this change.

At its September 7, 2017, meeting the Board approved additional updates to the Policy, with additional clarification provided regarding bilingual pay eligibility. Following this update, an audit by the Human Resources Department (HR) revealed that the bilingual pay process had not been fully implemented consistent with the Policy. More specifically, the audit identified cases of employees being paid bilingual pay when they were not eligible for such pay because their job description either no longer required it or required it at a level below the Policy's eligibility threshold. The audit also identified

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cases of employees being paid bilingual pay at the lower rate when their job description required payment at the higher rate.

Discussion
When the Policy update was approved at the September 7, 2017 Board of Directors' meeting, no fiscal impact was identified for bilingual pay. However, the HR audit has revealed that the amount of underpayment, or the amount CalOptima owes employees who were not receiving bilingual pay or who were not receiving the correct level of bilingual pay, equates to approximately $30,000. CalOptima has issued payment to employees who were determined at the time of the audit, by their management, to be eligible for bilingual pay. For those employees who were receiving overpayments, the amounts ranged from $60 to $2,800, and total, in aggregate, less than $60,000. While these employees were not eligible for bilingual pay or the level of bilingual pay received based on the December 2015 changes to the policy, they were eligible based on the prior policy and on management input. HR and Payroll are finalizing the actions related to the audit and any payments made from pay periods from January 2016 through pay periods in January 2018. While CalPERS reversal adjustments will be made as appropriate on the under and overpayments in this instance, management recommends not recouping the overpayment amounts due to the unique circumstances related to the implementation of the bilingual pay policy changes.

To avoid such errors going forward, HR plans to implement updated guidelines and a process to ensure that, prior to changes in compensation, and following Board actions affecting compensation, all impacted employees will be notified of the change. It is also the responsibility of each employee to report any and all overpayments received from CalOptima, and CalOptima will work with employees to recoup any overpayments made outside this recommended one-time exception.

Fiscal Impact
There is no Income Statement fiscal impact for FY 2017-18 to authorize an exception to the Policy by allowing employees who were overpaid for bilingual pay to retain such overpayments in an aggregate not to exceed $60,000 because the payments have been included in employees' paychecks, though Net Assets as reported on the Balance Sheet would be lower by this amount.

Rationale for Recommendation
Due to implementation challenges associated with updates to CalOptima's bilingual pay practices, management recommends approval of the recommended actions.

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Policy GA.8042: Supplemental Compensation

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

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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

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

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).

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 February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

11. Receive and File the Member Health Needs Assessment Executive Summary, Consider Authorization of the Allocation of Intergovernmental Transfer (IGT) 5 Funds, and Release Requests for Proposals for Community Grants

Contact

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

Recommended Actions

1. Receive and file the CalOptima Member Health Needs Assessment Executive Summary;
2. Approve allocation of IGT 5 funds for each CalOptima Board-approved priority area; and
3. Authorize the release of Requests for Proposals (RFP) for community grants, with staff returning to the Board with evaluation of proposals and recommendations prior to any awards being granted.

Background/Discussion

CalOptima began participating in the rate range Intergovernmental Transfer (IGT) program for Rate Year 2010-2011 (IGT 1) to secure additional Medicaid program dollars for Orange County. These IGTs have generated funds to support and provide enhanced benefits for existing CalOptima Medi-Cal members.

On April 7, 2016, the CalOptima Board of Directors approved the recommended priority areas for IGT 5 to guide CalOptima's community support. The approved priority areas include:

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

In December 2016, the CalOptima Board of Directors authorized an allocation of funds to complete a comprehensive Member Health Needs Assessment (MHNA) of which results would be used to inform the development of competitive community grants and for the allocation of IGT 5 funds per priority area approved in April 2017. CalOptima worked with the board approved consultant, Harder+Company Community Research to implement the MHNA activities. The MHNA data collection activities were completed in November 2017 with nearly 6,000 surveys returned, 31 face-to-face focus groups coordinated, and more than 20 interviews conducted with key community stakeholders. In addition, the preliminary results of the MHNA and the proposed community grant opportunities were shared and vetted with community and provider partners.

Staff is recommending the following allocation amounts for IGT 5 Board approved priority areas through eight RFPs. Multiple applicants may be selected per grant for an award.

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#	Request for Proposal	Description	Allocated Amount	Priority Area
1.	Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services	Programs that expand/increase direct services to CalOptima members ages 19-64 (adult) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$5 million	Adult Mental Health
2.	Expand Mental Health and Socialization Services for Older Adults	Programs that expand/increase direct services to CalOptima members ages 65+ (older adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$500,000	Adult Mental Health
3.	Expand Access to Mental Health/Developmental Services for Children Ages 0-5	Programs that expand/increase direct services to CalOptima members ages 0-5 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Children's Mental Health
4.	Nutrition Education and Fitness Program for Children and their Families	Programs that provide nutrition education and physical fitness services to CalOptima members ages 0-18 (children) and their families to promote healthy lifestyles, healthy nutrition and exercise	$1 million	Childhood Obesity
5.	Medi-Cal Benefits Education and Outreach	Programs that conduct outreach and provide education to CalOptima members on their Medi-Cal benefits, covered services, how to access services, and who to contact for questions etc.	$500,000	Strengthening the Safety Net

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6.	Expand Access to Primary Care Services and Programs Addressing Social Determinants of Health	Programs that expand/increase direct services to CalOptima members for primary health care by increasing number of staff, extending hours/days of operation and/or providing additional services. Programs should also offer services and/or connections to community resources that focus on the social determinants of health such as distribution or connections to healthy food, housing navigation, education, employment, etc.	$4 million	Strengthening the Safety Net
7.	Expand Access to Adult Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 19-64 (adults) by increasing the number of staff, extending hours/days of operation and/or providing additional services	$1.4 million	Strengthening the Safety Net
8.	Expand Access to Children's Dental Services and Provide Outreach	Programs that expand/increase direct dental services to CalOptima members ages 0-18 (children) by increasing number of staff, extending hours/days of operation and/or providing additional services	$1 million	Strengthening the Safety Net

Staff will return with recommendations of grantees for Board approval on the expenditure of the approximate $14.4 million of IGT 5 funds following the completion of the grant application process. Once grant recipients have been identified, staff, with the assistance of Legal Counsel, will prepare grant documents, as appropriate.

Fiscal Impact

The recommended action to approve the expenditure plan of $14.4 million for IGT 5 has no fiscal impact to CalOptima's operating budget. Expenditure of IGT funds is for restricted, one-time purposes for the benefit of CalOptima Medi-Cal members, and does not commit CalOptima to future budget allocations.

Rationale for Recommendation

As part of CalOptima's vision in working Better. Together, CalOptima, as the community health plan for Orange County, will work with our provider and community partners to address community health needs and gaps and work to improve the availability, access and quality of health care services.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Member Health Needs Assessment PowerPoint Presentation
2. Executive Summary - Member Health Needs Assessment
3. CalOptima Member Survey Data Book

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

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Member Health Needs Assessment

Board of Directors Meeting
February 1, 2018

Cheryl Meronk
Director, Strategic Development

Back to Agenda

Member Health Needs Assessment

A better study offering deeper insight, leading to a healthier future.

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A Better Study

- ➔ More Comprehensive
- ➔ More Engaging
- ➔ More Personal

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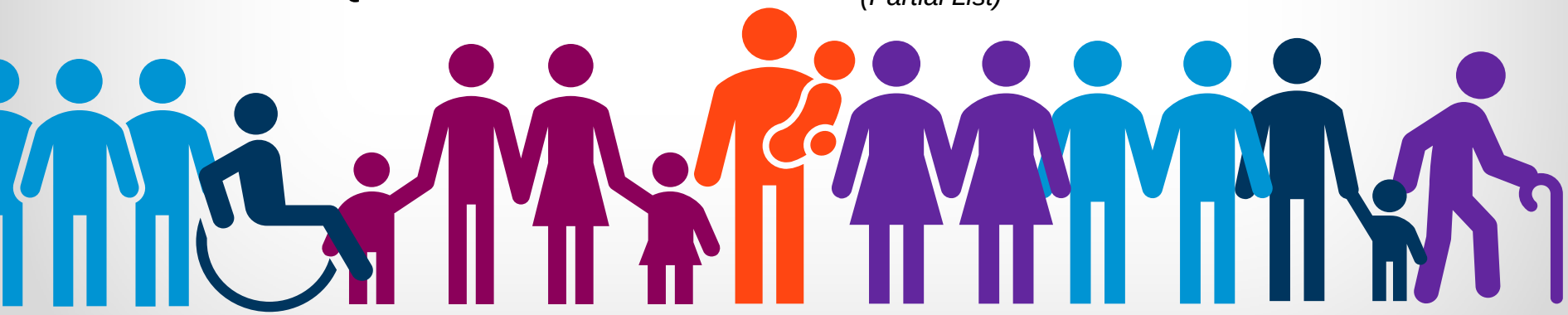
More Comprehensive

- Reached new groups of members whose voices have rarely been heard before
  - Young adults with autism
  - People with disabilities
  - Homeless families with children
  - High school students
  - Working parents
  - New and expectant mothers
  - LGBTQ teens
  - Homeless people in recuperative care
  - Farsi-speaking members of a faith-based group
  - PACE participants
  - Chinese-speaking parents of children with disabilities

(Partial List)



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More Comprehensive (Cont.)

- Gathered responses from all geographic areas of Orange County

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More Comprehensive (Cont.)

- Probed a broader view of members' lives beyond immediate health care needs
  - Hunger
  - Child care
  - Economic stress
  - Housing status
  - Employment status
  - Physical activity
  - Community engagement
  - Family relationships
  - Mental health
  - Personal safety
  - Domestic violence
  - Alcohol and drug consumption

(Partial List)

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More Comprehensive (Cont.)

- Asked more tailored, relevant and targeted questions, in part to elicit data about social determinants of health
  - Have you needed help with housing in the past six months?
  - How often do you care for a family member?
  - How often do you get enough sleep?
  - How many jobs do you have?
  - In the past 12 months, did you have the need to see a mental health specialist?
  - How open are you with your doctor about your sexual orientation?
  - How sensitive are your health care providers in understanding your disability?

(Partial List)

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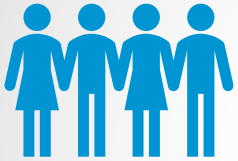
More Engaging: Members



Focus Groups

- 31 face-to-face meetings in the community
- 353 members

Telephone Conversations

- 534 live interviews in members' languages

Mailed Surveys

- Nearly 6,000 surveys returned

Electronic Responses

- More than 250 replied conveniently online

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More Engaging: Member Advocates

- Abrazar Inc.
- Access CA Services
- Alzheimer's OC
- Boys & Girls Club
- The Cambodian Family
- CHOC
- Dayle McIntosh
- La Habra Family Resource Center
- Latino Health Access
- Korean Community Services
- Mercy House
- MOMS Orange County
- OMID
- SeniorServ
- South County Outreach
- State Council on Developmental Disabilities
- Vietnamese Community of OC Inc.

(*Partial List)*

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More Personal

- Met in familiar, comfortable locations at convenient times for our members
  - Apartment complexes
  - Churches
  - Community centers
  - Schools
  - Homeless shelters
  - Recuperative care facilities
  - PACE center
  - Community clinics
  - Restaurant meeting rooms

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More Personal (Cont.)

- We spoke their language
  - English
  - Spanish
  - Vietnamese
  - Korean
  - Farsi
  - Chinese
  - Arabic
  - Cambodian
  - Marshallese
  - American Sign Language

The Voice of the Member

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Offering Deeper Insight

- ➔ Barriers to Care
- ➔ Lack of Awareness About Benefits and Resources
- ➔ Negative Social and Environmental Impacts

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Notable Barriers to Care

- Study revealed that members encounter structural and personal barriers to care
  - Structural
    - It can be challenging to get an appointment to see a doctor
    - It takes too long to get an appointment
    - Doctors do not always speak members' languages
    - Interpreter services are not always readily available
    - Doctors lack understanding of members' cultures
  - Personal
    - Members don't think it is necessary to see the doctor
    - Members have personal beliefs that limit treatment
    - Members are concerned about their immigration status
    - Members are concerned someone would find out they sought mental health care

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Barriers to Care (Cont.)

Examples

52%

Don’t think it is necessary to see the doctor for a checkup

28%

Takes too long to get an appointment

26%

Concerned someone would find out about mental health needs

41%

Didn’t think it is necessary to see a specialist, even when referred

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Notable Lack of Awareness

- Survey revealed a lack of understanding about available benefits and services
  - 25 percent of members who needed to see a mental health specialist did not pursue treatment
  - 38 percent of members had not seen a dentist in more than a year

- Focus group participants commented frequently about having difficulty regarding certain resources
  - Interpreter services
  - Social services needs
  - Transportation

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Lack of Awareness (Cont.)

Examples

40%

Didn’t know who to ask for help with mental health needs

41%

Didn’t see a dentist because of cost (i.e., didn’t know dental care was covered)

25%

Don’t have or know of a dentist

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Negative Social and Environmental Impacts

- Survey revealed significant social and environmental difficulties
  - Lack of well paying jobs and employment opportunities
  - Lack of affordable housing
  - Social isolation due to cultural differences, language barriers or fear of violence
  - Economic insecurity and financial stress
  - Lack of walkable neighborhoods and the high cost of gym programs

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Negative Impacts (Cont.)

Examples

32%

Needed help getting food in the past six months

56%

Accessing other public assistance

43%

Needed help to buy basic necessities

29%

Needed help getting transportation

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Negative Impacts (Cont.)

Stakeholder Perspective

> There's a significant issue with improper nutrition. They may not have enough money or the ability to go to the grocery store to buy the right foods. They get what they can, and that's what they eat.
>
> *—Interviewee*

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Leading to a Healthier Future

- ➔ Funding
- ➔ Requests for Proposal
- ➔ Moving Forward

Back to Agenda

Funding

$14.4 Million

Total Available IGT 5 Funds

- **Member Health Needs Assessment results drive funding allocations**

- **Eight Requests for Proposal (RFPs) to expand access to mental health, dental and other care, and outreach/education services**

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RFP 1

Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $5 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category
Adult Mental Health

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RFP 2

Expand Mental Health and Socialization Services for Older Adults

Funding Amount: $500,000

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not knowing where and who to call for information
- ✓ Limited culturally sensitive information about the stigma regarding mental health

Funding Category
Adult Mental Health

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RFP 3

Expand Access to Mental Health/ Developmental Services for Children 0–5 Years

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Shortage of pediatric mental health professionals
- ✓ Shortage of children's inpatient mental health beds
- ✓ Increase in adolescent depression

Funding Category
Children's Mental Health

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RFP 4

Nutrition Education and Fitness Programs for Children and Their Families

Funding Amount: $1 million

Findings Addressed

- ✓ Healthier food choices can be more expensive, less convenient and less accessible
- ✓ Cultural foods may not be the healthiest options
- ✓ Lack of time and safe places may limit physical activity

Funding Category
Childhood Obesity

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RFP 5

Medi-Cal Benefits Education and Outreach

Funding Amount: $500,000

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits

Funding Category

Supporting the Safety Net

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RFP 6

Expanded Access to Primary Care and Programs Addressing Social Determinants of Health

Funding Amount: $4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Lack of ability to cover basic necessities

Funding Category
Supporting the Safety Net

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RFP 7

Expand Adult Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1.4 million

Findings Addressed

- ✓ Challenging to get an appointment to see a provider
- ✓ Lack of understanding about covered benefits
- ✓ Limited dental providers for adults

Funding Category
Supporting the Safety Net

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RFP 8

Expand Access to Children's Dental Services and Provide Outreach to Promote Awareness of Services

Funding Amount: $1 million

Findings Addressed

- ✓ Lack of understanding about covered benefits
- ✓ Not utilizing covered services
- ✓ Challenging to get an appointment to see a provider

Funding Category
Children's Health

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Moving Forward

- Eight Grant Applications/RFPs
  - Expand access to mental health, dental and other care services
  - Expand access to childhood obesity services regarding nutrition and fitness
  - Support outreach and education regarding social services and covered benefits
- RFPs to be released in March 2018
- Recommended grantees to be presented at June Board meeting

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EXECUTIVE SUMMARY
MEMBER HEALTH NEEDS ASSESSMENT

CalOptima
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In summer and fall 2017, more than 6,000 CalOptima members, service providers and community representatives participated in one of the most extensive and inclusive member health needs assessments (MHNA) undertaken by CalOptima in its 20-plus year history. The MHNA provides data critical to ensuring that CalOptima can continue to address the challenges faced by its members and meet its mission to provide members with access to quality health care services delivered in a cost-effective and compassionate manner.

CalOptima participates in numerous efforts to assess the health of Orange County's residents and create community-driven plans for improving the health of the Medi-Cal population. Some examples are detailed below.

- The 2013 Orange County Health Profile, produced by the Orange County Health Care Agency, highlighted key health indicators as well as other social, economic and environmental indicators that impact health conditions in groups of people based on economics, race, ethnicity, gender, age and geography.
- The 2016 Orange County Community Indicators Report tracked and analyzed Orange County's health and prosperity on a myriad of issues.
- The 2017 Conditions of Children in Orange County Report offered a comprehensive and detailed summary of how children in Orange County fair in the areas of health, economic well-being, educational achievement, and safe homes and communities.
- CalOptima's Group Needs Assessment, conducted every five years with annual updates in between, identifies members' needs, available health education, cultural and linguistic programs, and gaps in services.

When combined, these assessments provide a broad picture of important health information in Orange County. However, they do not focus specifically on Medi-Cal beneficiaries or on ethnic and linguistic minorities within this population, whose health needs are at the core of CalOptima's mission. For this reason, CalOptima undertook this comprehensive MHNA, summarized on the following pages.

By the Numbers

5,815
Surveys

31
Focus Groups

24
Stakeholder Interviews

21
Provider Surveys

10
Languages

Birth–101
Years of Age

Back to Agenda

CalOptima's comprehensive MHNA is an innovative collaboration that builds upon existing data-gathering efforts and takes them a step further. The study was designed to be a more comprehensive assessment, using engaging methods that resulted in a much more personal experience for our members and the community. The MHNA captures the unique and specific needs of Medi-Cal beneficiaries from an array of perspectives, including providers, community leaders and, most importantly, the members themselves. As a result, this in-depth study offers actionable recommendations for consideration by the CalOptima Board of Directors and executive leadership.

The MHNA was designed to help CalOptima identify:

1. Unique needs and challenges of specific ethnic communities, including economic, social and environmental stressors, to improve health outcomes

2. Challenges to health care access and how to collaborate with community-based organizations and providers to address these barriers

3. Member awareness of CalOptima services and resources, and effective strategies to increase awareness as well as disseminate information within target populations

4. Ways to leverage outreach efforts by partnering with community-based organizations on strategic programs

Our Partners

To guide the direction of the study, CalOptima established an MHNA Advisory Committee made up of community-based representatives. The committee then engaged CalOptima staff and Harder+Company Community Research (Harder+Company), in partnership with the Social Science Research Center (SSRC) at California State University, Fullerton. A summary of their qualifications to participate in this extensive effort is below.

Harder+Company was founded in 1986 and works with philanthropic, nonprofit and public-sector clients nationwide to reveal new insights about the nature and impact of clients' work. Harder+Company has a deep commitment to lifting the voices of marginalized and underserved communities — and working across sectors to promote lasting change. In addition, Harder+Company offers extensive experience working with health organizations to plan, evaluate and improve services for vulnerable populations, along with deep experience assisting hospitals, health departments and other health agencies on a variety of efforts, including conducting needs assessments, engaging and gathering meaningful input from community members, and using data for program development and implementation.

SSRC was established in 1987 to provide research services to community organizations and research support to university faculty. The center's primary goal is to assist nonprofit and tax-supported agencies and organizations to answer research questions that will lead to improved service delivery and public policy. The SSRC conducts surveys, evaluation research and other applied research activities to meet its clients' information needs. The center conducts multilingual telephone surveys from its 24-station computer-assisted telephone interviewing lab, as well as web-based, mailed and face-to-face surveys. In the past 10 years, SSRC has successfully completed 200 telephone survey projects using a variety of sample designs in diverse areas of focus, such as health care, public safety, education, workforce development and pregnancy prevention.

harder + co | community research

CALIFORNIA STATE UNIVERSITY FULLERTON

Due to strong partnerships with the community, the 2017 MHNA engaged members who may be hard to reach. We are proud that our efforts included:

- Young adults on the autism spectrum
- People with disabilities
- Homeless families and children
- High school students
- Working parents
- New and expectant mothers
- LGBTQ teens
- Farsi-speaking members of faith-based groups
- PACE participants
- Chinese-speaking parents of children with disabilities

More Comprehensive

To represent CalOptima's nearly 800,000 members, an in-depth analysis was performed to uncover their unique needs and challenges. An oversampling was thoughtfully incorporated in the calculation of responses needed to achieve a true statistical representation of the Orange County Medi-Cal population. For the mailed survey, more than 42,000 members were selected within a specific sampling frame that included language, age range and region.

With the oversampling, the aim was to collect 4,000 responses with targets for each subgroup. The final data collection results were far beyond the goal in every subgroup. More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

The assessment gathered responses from all geographic areas of Orange County, across all age groups and 10 languages. Additionally, the assessment reached new groups of members whose voices have rarely been sought out or heard before, such as young adults with autism, people with disabilities and homeless families with children.

Ultimately, the assessment concentrated on the underlying social determinants of health that have been recognized as factors that impact the health of individuals. The MHNA probed a broader view of members' lives beyond immediate health care needs to explore issues related to:

- ☑ Hunger
- ☑ Child care
- ☑ Economic stress
- ☑ Housing status
- ☑ Employment status
- ☑ Physical activity
- ☑ Community engagement
- ☑ Family relationships
- ☑ Mental health
- ☑ Personal safety
- ☑ Domestic violence
- ☑ Alcohol and drug use

More than 6,000 members, providers and community stakeholders provided information, experiences and insights to the MHNA.

More Engaging

The MHNA used a mixed-methods approach to engage members who generally have been underrepresented in previous assessments as well as community stakeholders who work directly with the Medi-Cal population. The data collection effort was extensive, incorporating both qualitative and quantitative methods and going beyond previous processes in Orange County. The mixed-methods approach consisted of the following:

Member Survey

5,815 members completed an in-depth 50-question survey that was available in each of CalOptima's seven threshold languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic. As described further below, three additional languages that are less common in Orange County were also incorporated to ensure the assessment was comprehensive. Most surveys were completed and returned via mail (86 percent), with 9 percent completed via telephone and 5 percent online. Telephone calls were made to reach members who were homeless or more transient and may not have a permanent address. An online survey was offered for members' convenience.

Provider Survey

An online survey of 20 questions was sent to a broad sample of providers in CalOptima's network to seek insight on the challenges that members face. Providers identified what they perceive as the top problems for Medi-Cal members as well as barriers for these members in accessing health care. There were 21 network or physician medical groups that completed the provider survey.

Focus Groups

31 focus groups were conducted with members in partnership with community-based organizations across Orange County. Focus groups allowed for face-to-face conversations with members in comfortable and familiar environments, which helped to foster organic, open-ended discussions where members felt safe to share their thoughts. The discussions were conducted in CalOptima's seven threshold languages, as well as Cambodian, Marshallese and American Sign Language. Focus group conversations covered numerous key topics, including quality of life, community assets, barriers to accessing care, violence, behavioral health, chronic disease, and health practices, such as healthy eating and active living.

Key Stakeholder Interviews

24 leaders from community-based organizations participated in the interviews. Those chosen for the study have direct interactions with Medi-Cal members or serve as advocates for Orange County's vulnerable population. Interviews focused on key health issues facing Medi-Cal members, the provision of culturally competent services, and the social determinants of health, such as economic and environmental factors.

In the spirit of collaboration, individuals and groups in the community came together in a remarkable way to demonstrate their dedication to CalOptima members. Countless hours were spent planning, engaging and meeting with members. For example, in addition to serving as stakeholder interviewees, many of CalOptima's community partners reached out to members to encourage them to respond to the surveys, and they also hosted and recruited members to focus group meetings. Community organizations were invaluable in helping members feel comfortable with the process and in providing another view into members' lives. The engagement of community partners and member advocates was instrumental in the success of the MHNA.

More Personal

The MHNA aimed to give CalOptima members a more personal experience by hosting focus group conversations in familiar locations at convenient times, often evenings and weekends. These settings were intentionally selected based on members' comfort levels. Focus groups were also held at specific times to ensure that members could have their voices heard without having to miss work, school or other obligations. Focus groups were conducted in 10 languages enabling members to respond in their preferred spoken language.

Focus groups were held at:

- Apartment complexes
- Churches
- Community centers
- Schools
- Homeless shelters
- Recuperative care facilities
- PACE center
- Community clinics
- Restaurant meeting rooms

Methods

With a strong focus on engaging a representative sample of CalOptima members, Harder+Company and SSRC developed the sample frame to capture a breadth of perspectives as well as focus on the specific needs of key populations. Although the purpose of the MHNA was to assess the needs of Medi-Cal members in Orange County overall, Harder+Company and SSRC sought to gain a better understanding of the needs of CalOptima's non-English speakers by purposefully oversampling all seven subgroups. The oversampling of members designated as speaking one of the seven threshold languages ensured that CalOptima and community stakeholders can be 95 percent confident that the true population parameters for any particular subgroup will fall between +/- 5 percent of the observed sample estimate.

At more than 5,800 members, the survey response far exceeded the target number of respondents in the sampling frame. The robust response was due to a comprehensive data collection plan that included communication with members and partners in advance of sending the survey, reminder phone calls and multilingual computer-assisted telephone interviewing for members preferring to respond by phone.

Survey data was entered, monitored and quality checked by SSRC before being exported for analysis by Harder+Company. All variables were screened to determine the amount of missing data, and basic frequencies were initially computed for each question by language, region and age. To adjust for the oversampling built into the sampling frame, comprehensive statistical analysis was then completed applying weights calculated by SSRC. Additional analysis included collapsing of questions, construction of scale scores and cross-tabulations.

Exhibit 1: Distribution of Completed Surveys and CalOptima Population by Language, Region and Age

Language	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
English	658	11.3%	55.5%
Spanish	715	12.3%	28.6%
Vietnamese	981	16.9%	10.3%
Korean	940	16.2%	1.4%
Farsi	743	12.8%	1.1%
Arabic	648	11.1%	0.6%
Chinese	731	12.6%	0.5%
Other	399	6.9%	2.0%

Region	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
Central	2,315	39.8%	51.5%
North	1,947	33.5%	32.4%
South	1,538	26.4%	15.1%
Out of County	15	0.3%	1.0%

Age	Number of Completed Surveys	Percent of Completed Surveys	Percent of CalOptima Members
0–18 years old	1,665	28.6%	41.8%
19–64 years old	2,453	42.2%	47.2%
65 or older	1,697	29.2%	10.9%

KEY FINDINGS

Given the scope and depth of the study, the MHNA revealed many key findings, which will all be included in the final, comprehensive report. This Executive Summary shares five **key findings**, including related **bright spots** and **opportunities**. Bright spots are CalOptima and community-based resources that already serve to support health behaviors and outcomes. CalOptima can nurture, leverage and build upon these assets. **Opportunities** are areas that CalOptima and its partners can strengthen to positively impact the health and well-being of members.

KEY FINDING: SOCIAL DETERMINANTS OF HEATLH

Financial stressors, social isolation and safety concerns impact the overall health and well-being of CalOptima members.

Given that Medi-Cal eligibility is income-based, it is not surprising that many CalOptima members struggle with economic insecurity. In fact, 55.7 percent of members receive some form of public benefits (Exhibit 2). Further, in the past six months, more than one-quarter of members indicated they needed help with food (32.4 percent), housing (24 percent), money to buy things they need (43.1 percent) and transportation (28.8 percent) (Exhibit 3). Economic stress and financial insecurity cause members and their families to make tradeoffs, such as living in more dense and overcrowded housing with limited space for play and exercise, buying cheaper but less healthy food, or not going to the doctor despite wanting to.

Exhibit 2: Percent of members who receive public benefits (n=5,117)

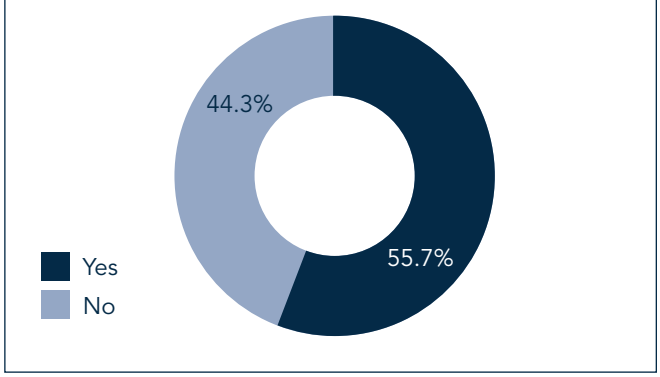
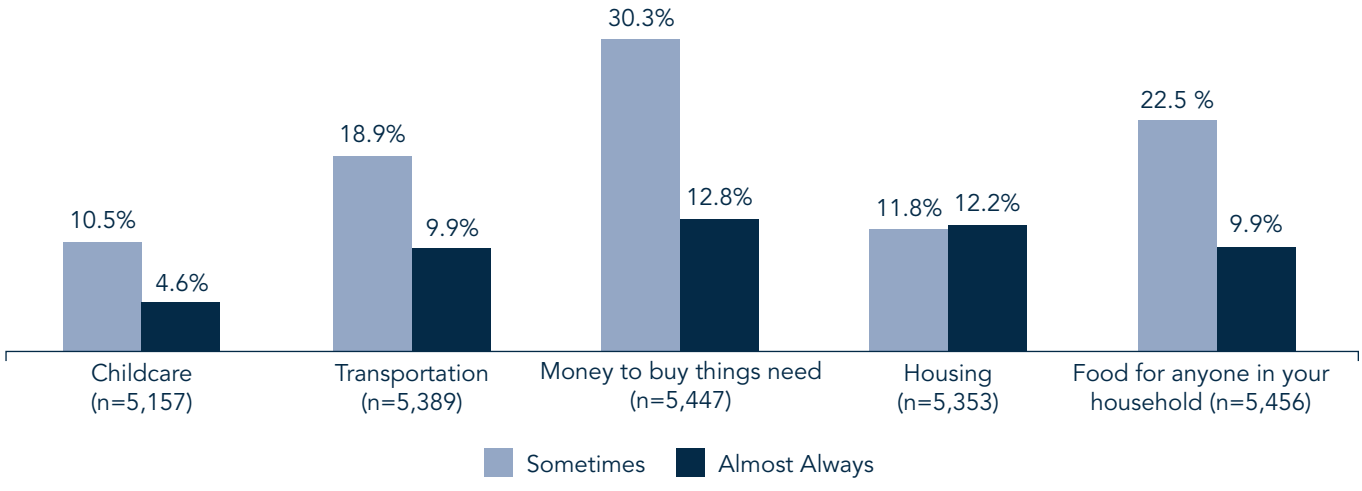
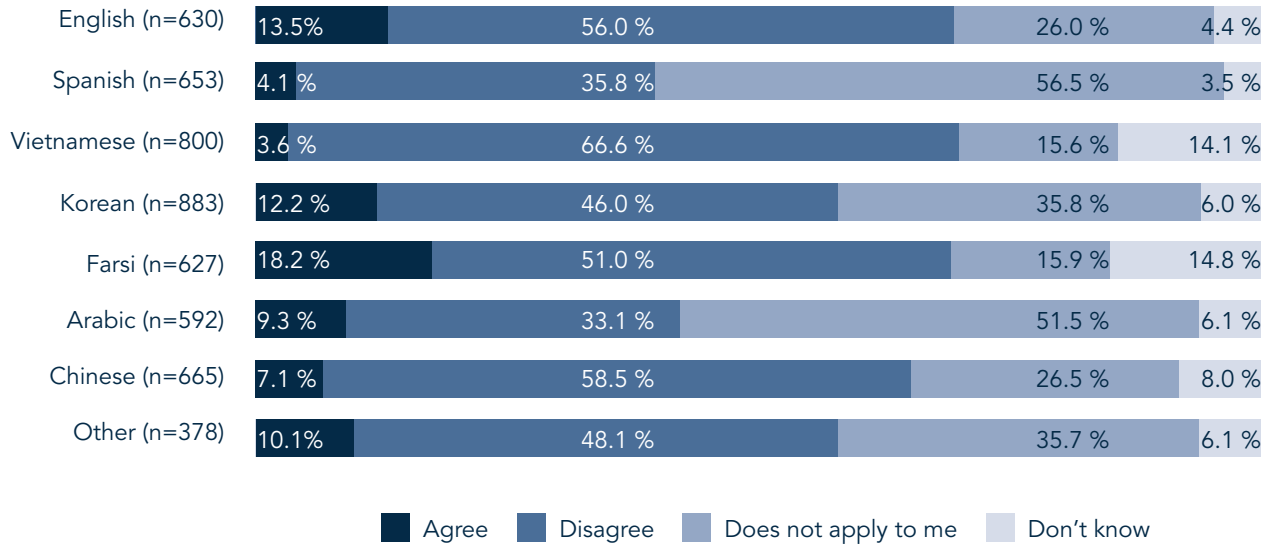


Exhibit 3: Percent of members who needed help with basic needs in the past six months



Social isolation negatively impacts the overall health and well-being of some CalOptima member populations. Social isolation is characterized by a lack of social supports and relationships. It occurs for many reasons, including language barriers, immigration status, age, ability and sexual orientation. In focus groups, members described how feelings of being disconnected from the community can lead to depression, lack of follow-up with health care or service providers, and negative health behaviors. In the survey, 10 percent of all respondents indicated that they felt lonely or isolated. Yet there were higher rates among certain populations, with loneliness and isolation affecting more speakers of English (13.5 percent), Korean (12.2 percent) and Farsi (18.2 percent) (Exhibit 4).

Exhibit 4: Percent of those who reported feeling lonely or isolated by language



Environmental factors also contribute to social isolation and other negative health behaviors, such as lack of physical activity. Focus group participants discussed feeling unsafe in their neighborhoods, which caused them to stay inside or to avoid nearby parks and/or other common spaces.

In addition, lack of affordable housing was a major concern to MHNA respondents, and it resulted in living in overcrowded households, neighborhoods with high crime rates, areas with poor indoor and outdoor air quality, and in the most extreme cases, homelessness.

Bright Spot: CalOptima members care about their health and understand the importance of seeking treatment, eating healthy and being active. However, environmental circumstances, such as financial stress, social isolation and related conditions, make it challenging for members to make their health a priority, not a lack of knowledge or concern.

Opportunity: CalOptima has already taken steps to strengthen the safety net for members by expanding access to primary care services and will be releasing grants to support programs designed to address social determinants of health. The MHNA data reaffirms this strategy and suggests efforts to expand this work would positively impact health outcomes in the long run. CalOptima can ensure that providers and community partners understand the social and economic issues that members face and how to adapt health care services accordingly.

KEY FINDING: MENTAL HEALTH

Lack of knowledge and fear of stigma are key barriers to using mental health services.

About 14 percent of members reported needing mental health services in the past year (Exhibit 5). However, local and national data suggest that the need for mental health services is likely underreported and underrecognized. Among those reporting a need, nearly 25 percent did not see a mental health specialist (Exhibit 6). Members did not seek mental health services for several reasons (Exhibit 7), including not knowing who to call or how to ask for help making an appointment (39.8 percent), not feeling comfortable talking about personal problems (37.5 percent) or concern that someone would find out they had a problem (26.1 percent). These factors, along with data gathered from key stakeholder interviews and focus groups, reflect a fear of stigma associated with seeking mental health services.

Exhibit 5: Percent of members who indicated they needed to see a mental health specialist (n=5,723)

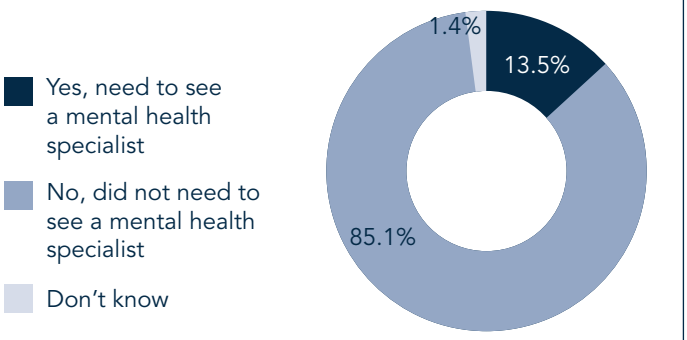
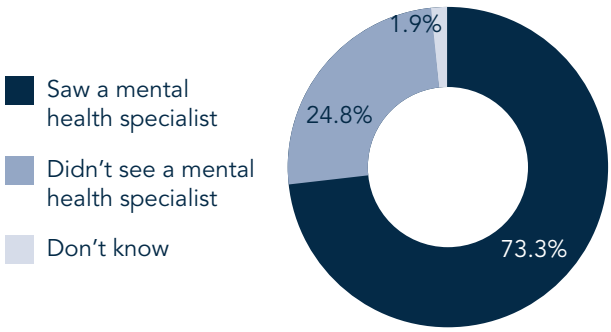
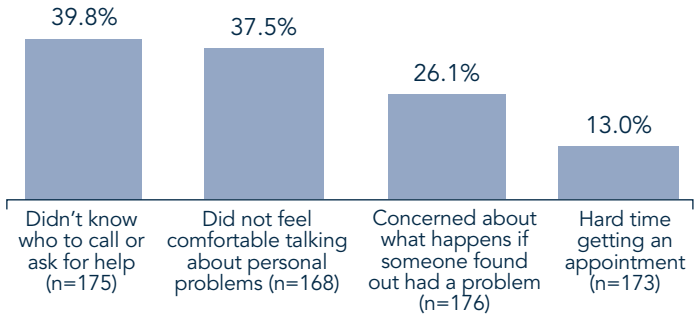


Exhibit 6: Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)



Fear of stigma is more prevalent among certain language groups. For example, Chinese-speaking members were more likely to indicate discomfort talking about personal problems and concern about what others might think if they found out about a mental illness than other language groups, followed by Korean-, Vietnamese- and English-speaking members. Conversations with community members and service providers offered cultural context for these findings as many stakeholders described prevalent feelings of shyness, avoidance and shame around discussing mental health issues, let alone seeking care.

Exhibit 7: Reasons why members (who needed to see a mental health specialist but) didn't get services



Bright Spot: CalOptima provides access to mental health services, which meets a clearly established need. Although members needing mental health services do not always connect with providers, many do not do so because of a lack of knowledge, an issue that can be addressed through strengthened connections with existing systems.

Opportunity: Although mental health services are covered by CalOptima, fear of stigma may prevent members from seeking services. This presents an opportunity for CalOptima to continue to provide culturally relevant education around mental health to improve understanding of available services and to address fear of stigma many people face. Community partners with deep knowledge of specific cultural communities are eager to offer support that would increase the use of mental health services.

KEY FINDING: PRIMARY CARE

Most members are connected to primary care, but barriers can make it challenging to receive timely care.

The majority of CalOptima members indicated that they are connected to at least one primary care doctor (82.6 percent), and most go to a doctor's office (69.2 percent) or clinic/health center (18.1 percent) when they need medical attention (Exhibits 8 and 9). However, navigating the health care system can be challenging, and significant barriers make it difficult for people to seek or follow through with care when needed.

Exhibit 8: Percent who report at least one person as their doctor (n=5,749)

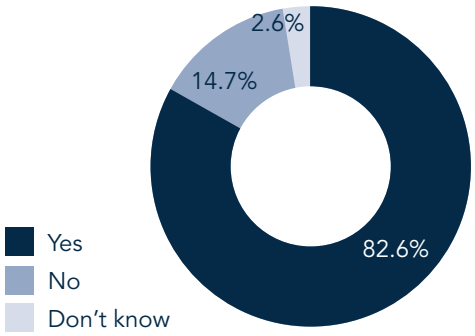
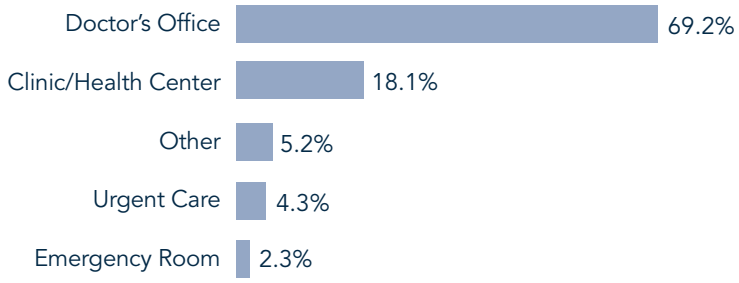


Exhibit 9: Where respondents go to see their doctor (n=5,743)

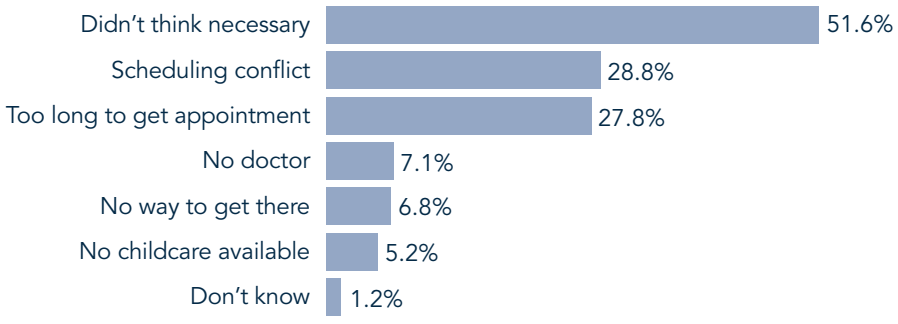


Focus group participants also described frustration at being redirected when they call to make an appointment and challenges finding the right doctor to meet their needs, such as for a child with developmental delays. Additional barriers, such as months-long wait times to get an appointment, limited hours of operation and inefficiency of public transportation, can make it difficult for people to receive care when needed. When asked why they don't make an appointment to see a doctor, 27.8 percent of CalOptima members indicated that it takes too long to get an appointment while 51.6 percent of members did not think it was necessary to make an appointment (Exhibit 10).

Bright Spot: CalOptima members have access to more than 1,500 primary care providers and 6,200 specialists, as well as 14 different health networks. And staff members are dedicated to continually engaging and educating these providers and networks to ensure they are ready to deliver the care needed by members.

Opportunity: The challenge of maintaining a robust provider network never goes away, and CalOptima must carefully monitor members' access to care. The provider community may be ready to embrace innovations that enhance access, such as extended hours, weekend operations or telemedicine visits, to expand the options for members.

Exhibit 10: Reasons why members don't make an appointment to see doctor (n=4,598)[1]



KEY FINDING: PROVIDER ACCESS

Members are culturally diverse and want providers who both speak their language and understand their culture.

CalOptima members hail from around the globe, reflecting the rich diversity of Orange County's population. In total, 40.3 percent of respondents were born outside of the U.S. and 23.6 percent indicated that they don't speak English well (Exhibits 11 and 12). Among non-English speakers, more than 50 percent were born outside of the United States and many are still acculturating to life in the U.S. This presents challenges when finding a well-paying and fulfilling job, safe and affordable housing, and healthy and familiar food. It also affects the ways members interact with the health care system. In fact, those born outside of the U.S. were significantly less likely to have a doctor and more likely to report feeling lonely or isolated.

Exhibit 11: How well members speak English (n=5,549)

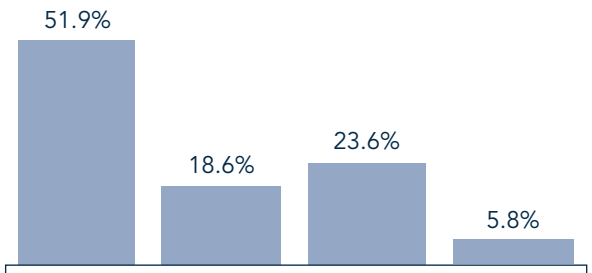
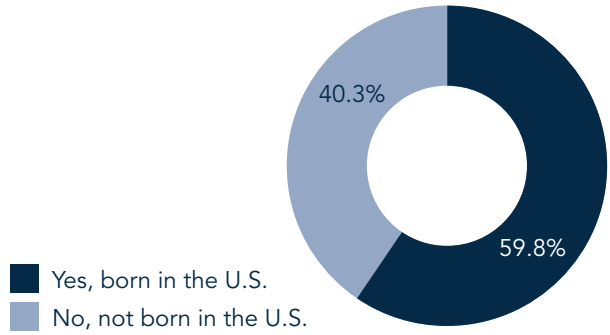


Exhibit 12: Percent of members who were born in the United States (n=5,599)



Further, they report having to adapt to new ways of receiving medical care. Some focus group participants shared that they did not understand why they must wait so long to see a doctor, as it is not this way in their country of origin. Others shared that cultural beliefs and practices made them uncomfortable and often unwilling to see a physician of the opposite gender. In addition, members and key stakeholders indicated that it can be challenging to seek medical care from providers who do not speak members' preferred language, which leads to issues with communication and comfort level. Although many stakeholders highlighted the availability of translation or interpretation services, such services do not always meet members' needs, especially when limited by short appointment times and when sharing sensitive information.

Bright Spot: CalOptima provides services and resources to members in seven languages[2] and can connect members to translation and interpretation services in any language when needed. Members appreciate that CalOptima recognizes the importance of providing care in familiar languages, and they also highly value providers who are sensitive to the cultural norms and practices of their homeland.

Opportunity: CalOptima has an opportunity to build its existing resources and deepen cultural competence of providers and services. CalOptima can engage partners in culturally focused community-based organizations to tailor and implement trainings for providers around specific populations. Trainings can build language and sensitivity skills and increase knowledge in areas such as ethnopharmacology (variations in medication responses in diverse ethnic populations). This can strengthen the workforce and improve member/provider interactions overall.

KEY FINDING: DENTAL CARE

Many members are not accessing dental care and are often unsure about what dental services are covered.

The gap in dental health care is striking and pronounced; 38.2 percent of members indicated they had not seen a dentist within the past 12 months (Exhibit 13). Among those individuals, 41 percent cited cost as the main reason they did not see a dentist (Exhibit 14). Members expressed confusion about dental care benefits available to them via Medi-Cal/Denti-Cal, and they said they would be more likely to seek out a dentist if they knew some of their visits were covered.

Bright Spot: Members in all CalOptima programs are eligible for routine dental care through Denti-Cal, and members in OneCare and OneCare Connect have access to supplemental dental care as well. Better yet, for 2018, California restored additional Denti-Cal benefits, expanding the covered services even further. The challenge is ensuring that members know about these benefits and then actually obtain the services.

Opportunity: To boost the number of members receiving dental care, CalOptima will have to first raise awareness about the availability of services and correct misperceptions that dental care comes at a cost. Further, to remove barriers to care and expand access, the community may embrace the use of alternative providers, such as mobile dental clinics, or the option of co-located dental and medical services.

Exhibit 13: When members last saw a dentist (n=5,685)

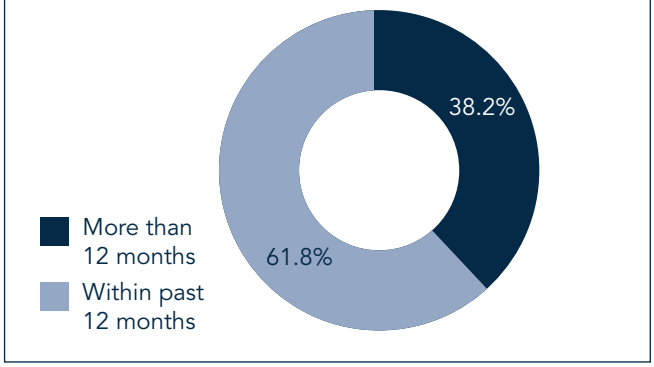
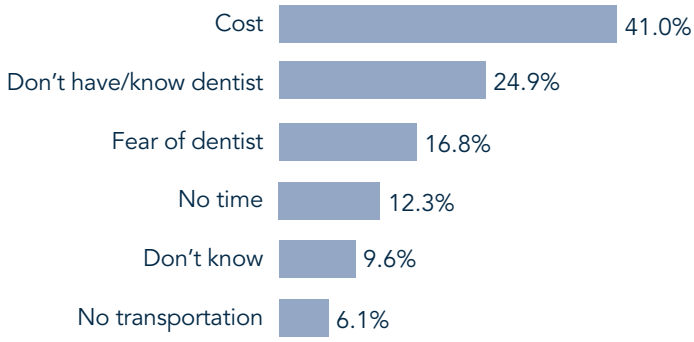


Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)[3][4]



Endnotes

[1] Members could choose multiple answers; thus, the total does not equal 100 percent.

[2] CalOptima provides bilingual staff, interpreter services, health education and enrollment materials in seven languages, including English, Spanish, Vietnamese, Korean, Farsi, Chinese and Arabic.

[3] Members could choose multiple answers; thus, the total does not equal 100 percent.

[4] Only reported those who have not seen a dentist within the past 12 months.

January 2018

CalOptima Member Survey Analysis:

Unweighted Estimates by Language, Region, and Age

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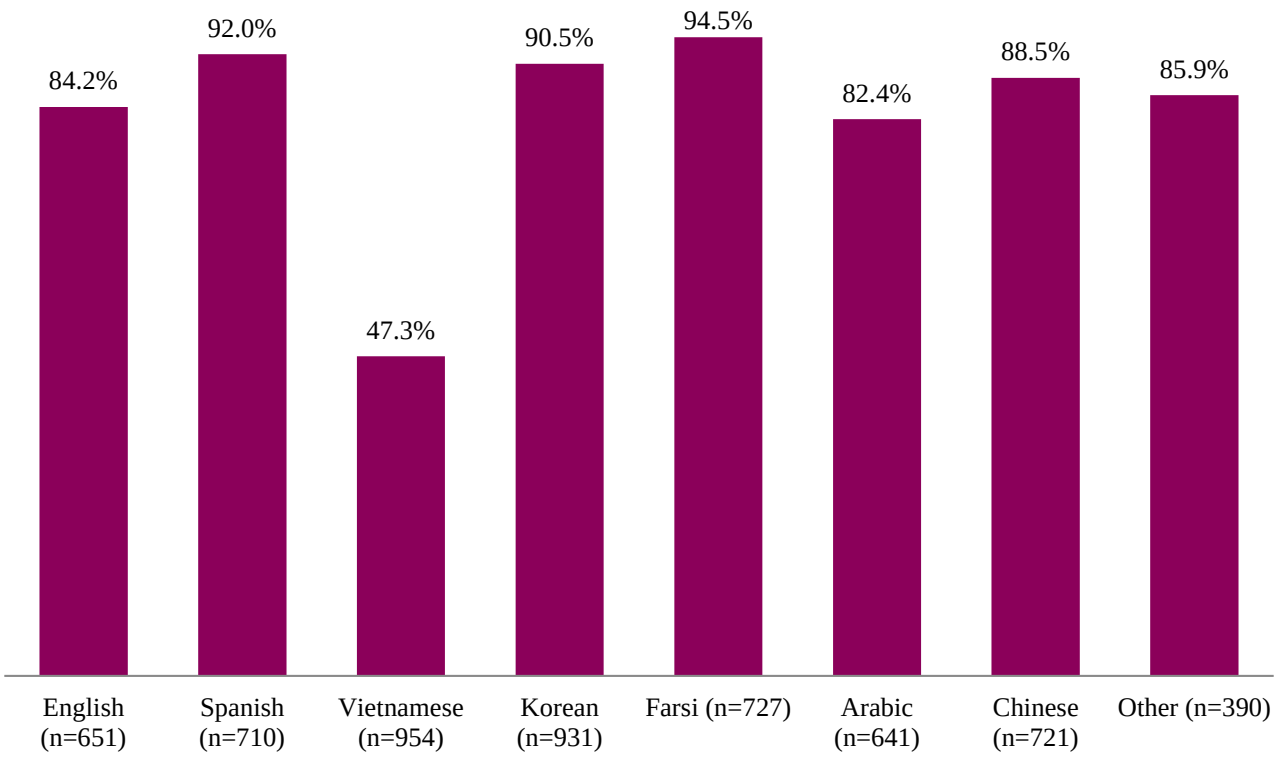
Back to Agenda

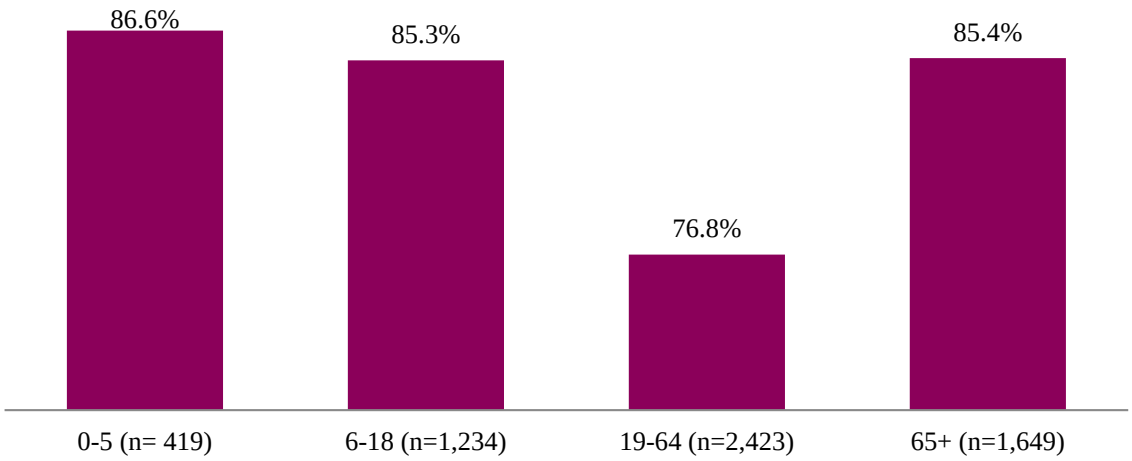
Navigating the Healthcare System

Exhibit 1. Percent who report at least one person as their doctor[1]

CalOptima language:



Age Group:



[1] An issue was identified with the Vietnamese translation of this question. Therefore, results likely misrepresent percentage of Vietnamese members who have a doctor.

CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

Region:

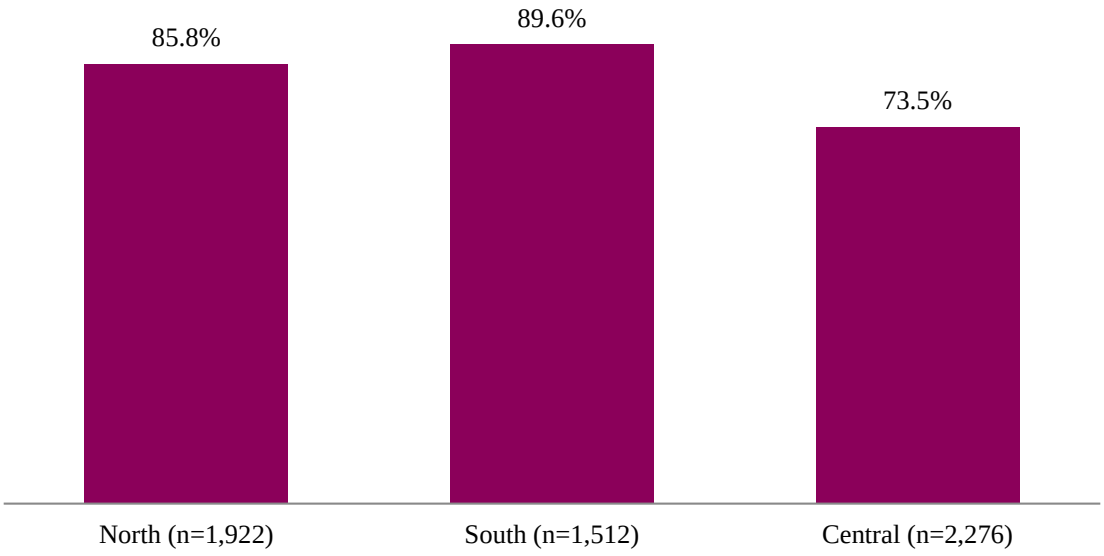


Exhibit 2. Where respondents go to see their doctor

CalOptima language:

CalOptima Language	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
English	71.8%	11.9%	2.0%	6.6%	0.5%	6.4%	0.8%	653
Spanish	59.7%	32.3%	3.4%	1.0%	0.3%	3.1%	0.1%	699
Vietnamese	86.3%	12.0%	0.1%	0.2%	0.0%	1.0%	0.3%	965
Korean	87.8%	4.3%	0.9%	1.1%	0.7%	4.1%	1.2%	938
Farsi	84.0%	6.5%	3.0%	0.8%	0.1%	5.0%	0.5%	737
Arabic	65.3%	15.8%	4.6%	5.4%	0.3%	8.0%	0.5%	625
Chinese	77.2%	11.4%	0.3%	0.8%	0.4%	6.6%	3.3%	727
Other	72.2%	12.6%	1.5%	3.0%	0.0%	9.6%	1.0%	396

Age Category:

CalOptima Age Category	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	68.4%	19.1%	1.9%	2.7%	0.2%	7.2%	0.5%	414
6-18 (Children)	73.0%	16.5%	1.6%	3.0%	0.4%	4.4%	1.0%	1,224
19-64 (Adults/MCE)	73.1%	14.2%	2.6%	2.7%	0.5%	5.5%	1.4%	2,425
65+ (Older Adults)	87.5%	6.8%	0.8%	0.4%	0.1%	4.1%	0.4%	1,677

Region:

CalOptima Region	Doctor's office	Clinic /health center	Emergency room	Urgent Care	Alternative medicine provider /herbalist	Other	Don't Know	n
	%	%	%	%	%	%	%	
North	74.4%	13.8%	1.7%	3.4%	0.4%	5.4%	1.0%	1,920
South	80.4%	7.9%	2.0%	1.4%	0.5%	6.4%	1.4%	1,521
Central	76.8%	15.5%	1.8%	1.4%	0.2%	3.6%	0.6%	2,284

Exhibit 3. Reasons why members go somewhere other than their doctor when they need medical attention

CalOptima language:

CalOptima Language	I don't have a doctor	It is easier for me to get to the emergency room or urgent care than my doctor's office	It's hard to get an appointment with my doctor	Other	Don't know	n
	%	%	%	%	%	
English	7.4%	26.5%	21.4%	40.7%	4.0%	570
Spanish	7.5%	22.2%	20.1%	37.9%	12.4%	523
Vietnamese	3.1%	31.8%	16.8%	46.2%	2.1%	584
Korean	11.5%	22.7%	27.8%	37.6%	0.4%	687
Farsi	3.1%	15.4%	22.7%	58.8%	0.0%	422
Arabic	5.2%	40.6%	25.5%	28.0%	0.7%	554
Chinese	9.1%	26.8%	14.6%	47.9%	1.6%	549
Other	6.0%	24.9%	16.7%	50.8%	1.6%	317

Age Category:

Age Category	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
0-5 (Children)	4.5%	34.4%	25.4%	29.3%	6.5%	355
6-18 (Children)	5.2%	27.7%	24.0%	36.2%	6.9%	986
19-64 (Adults/MCE)	9.2%	26.0%	23.7%	39.9%	1.3%	1,789
65+ (Older Adults)	4.5%	34.4%	25.4%	29.3%	6.5%	1,076

Region:

Region	I don't have a doctor %	It is easier for me to get to the emergency room or urgent care than my doctor's office %	It's hard to get an appointment with my doctor %	Other %	Don't know %	n
North	7.4%	27.1%	25.2%	38.4%	1.9%	1,501
South	6.7%	23.1%	20.5%	47.2%	2.5%	1,052
Central	6.3%	28.9%	17.6%	43.2%	4.0%	1,639

Exhibit 4. When do members make an appointment to see doctor[2]

CalOptima Language:

CalOptima Language	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
English	75.8%	77.2%	51.8%	1.1%	4.2%	650
Spanish	77.7%	76.2%	36.9%	0.8%	4.5%	713
Vietnamese	76.0%	74.7%	39.7%	0.1%	1.7%	973
Korean	81.3%	75.2%	47.4%	0.4%	0.6%	938
Farsi	87.4%	80.0%	65.1%	1.8%	3.7%	736
Arabic	82.5%	40.4%	30.9%	0.5%	1.4%	644
Chinese	80.3%	73.6%	48.6%	1.5%	1.2%	727
Other	70.1%	82.0%	51.1%	1.5%	4.6%	395

Age Category:

Age Category	When Sick %	Check-Up %	Specialist Needed %	Don't Know %	Other %	n
0-5 (Children)	86.4%	76.9%	41.9%	0.7%	1.2%	420
6-18 (Children)	81.8%	73.2%	39.9%	0.5%	2.2%	1,236
19-64 (Adults/MCE)	78.0%	67.9%	47.3%	1.1%	2.3%	2,433
65+ (Older Adults)	77.8%	77.4%	50.0%	0.9%	3.4%	1,687

[2] **Members were allowed to choose multiple answers; thus, the total does not equal 100%.**

Region:

Region	When Sick	Check-Up	Specialist Needed	Don't Know	Other	n
	%	%	%	%	%	
North	78.2%	70.5%	43.6%	0.9%	2.3%	1,938
South	83.3%	75.9%	55.9%	1.3%	2.8%	1,527
Central	77.7%	72.0%	41.8%	0.5%	2.5%	2,296

Exhibit 5. Reasons why members don't make an appointment to see doctor[3]

CalOptima language:

CalOptima Language	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
English	7.8%	6.7%	28.0%	27.6%	5.2%	54.0%	1.8%	554
Spanish	6.3%	6.5%	20.8%	27.4%	5.2%	53.2%	0.8%	504
Vietnamese	2.3.%	7.0%	50.9%	24.8%	4.1%	42.8%	0.0%	725
Korean	11.7%	4.1%	48.4%	39.7%	3.8%	31.5%	0.0%	677
Farsi	5.7%	19.5%	24.9%	45.1%	6.9%	33.3%	0.0%	406
Arabic	2.7%	7.0%	28.2%	42.6%	2.1%	37.1%	0.0%	561
Chinese	7.2%	9.6%	29.8%	24.8%	2.2%	51.0%	0.9%	541
Other	4.1%	8.8%	25.0%	29.1%	1.7%	56.8%	0.0%	296

[3] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Age Category:

Age Category	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%	%	%	
0-5 (Children)	4.6%	6.5%	32.8%	35.9%	10.5%	43.7%	0.0%	323
6-18 (Children)	4.8%	4.5%	38.2%	32.8%	3.9%	43.4%	0.1%	990
19-64 (Adults /MCE)	7.8%	7.4%	36.3%	34.5%	4.2%	39.5%	0.8%	1,933
65+ (Older Adults)	4.5%	13.3%	26.1%	26.9%	1.3%	53.2%	0.3%	1,018

Region:

Region	No Doctor	No way to get there	Scheduling Conflict	Too long to get appointment	No childcare available	Didn't think necessary	Don't Know	n
	%	%	%	%	%			
North	7.6%	7.7%	36.3%	35.0%	3.3%	40.5%	0.3%	1,521
South	6.3%	10.5%	27.5%	35.8%	4.8%	45.7%	0.6%	1,019
Central	4.6%	6.9%	35.9%	28.1%	4.0%	46.1%	0.5%	1,712

Exhibit 6. When do members make an appointment to see a specialist[4]

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
English	76.0%	26.5%	63.5%	638
Spanish	71.9%	30.5%	60.7%	679
Vietnamese	70.3%	24.4%	56.7%	949
Korean	69.1%	27.1%	45.2%	877
Farsi	78.6%	31.4%	55.7%	688
Arabic	68.9%	16.3%	42.5%	631
Chinese	66.0%	35.6%	45.4%	694
Other	79.2%	26.8%	59.9%	384

Age Category:

Age Category	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
0-5 (Children)	71.1%	28.4%	53.8%	394
6-18 (Children)	67.7%	25.7%	52.6%	1,172
19-64 (Adults/MCE)	71.5%	25.2%	54.5%	2,328
65+ (Older Adults)	75.7%	31.3%	51.7%	1,646

[4] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

Region:

CalOptima Language	Doctor gave referral %	Doctor helped schedule the appointment %	Important for health %	n
North	69.3%	27.7%	50.6%	1,857
South	74.3%	28.3%	52.9%	1,453
Central	72.6%	26.6%	55.5%	2,216

Exhibit 7. Reasons why members don't make an appointment to see specialist[5]

CalOptima Language:

CalOptima Language	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
English	19.5%	8.0%	20.4%	27.0%	41.1%	548
Spanish	7.9%	5.5%	12.0%	20.2%	46.4%	560
Vietnamese	11.3%	9.3%	37.8%	30.7%	33.4%	724
Korean	14.2%	12.5%	32.6%	41.5%	27.6%	696
Farsi	13.9%	14.3%	15.2%	37.6%	24.5%	474
Arabic	9.9%	6.9%	21.5%	47.1%	25.6%	577
Chinese	11.9%	14.6%	17.6%	25.4%	42.6%	556
Other	15.6%	12.6%	16.5%	27.2%	39.2%	334

Age Category:

Age Category	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
0-5 (Children)	10.8%	8.1%	22.8%	33.5%	41.0%	334
6-18 (Children)	12.1%	7.9%	27.2%	32.1%	35.9%	1,019
19-64 (Adults/MCE)	13.7%	9.8%	24.9%	35.5%	31.6%	1,953
65+ (Older Adults)	12.6%	13.8%	16.3%	27.6%	37.0%	1,163

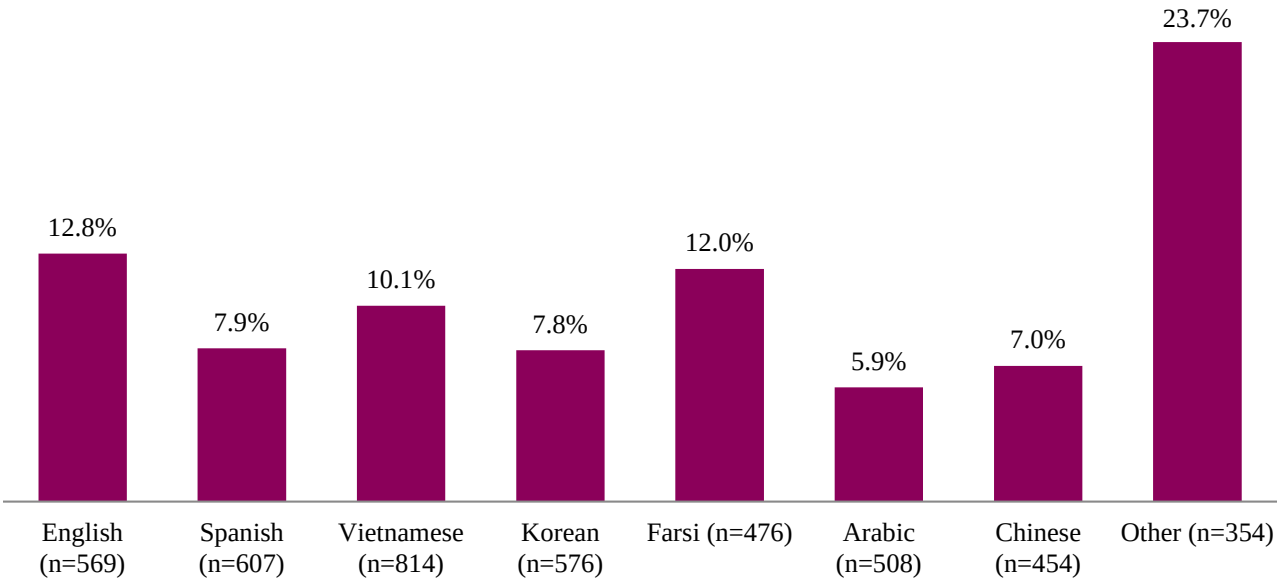
[5]Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Region:

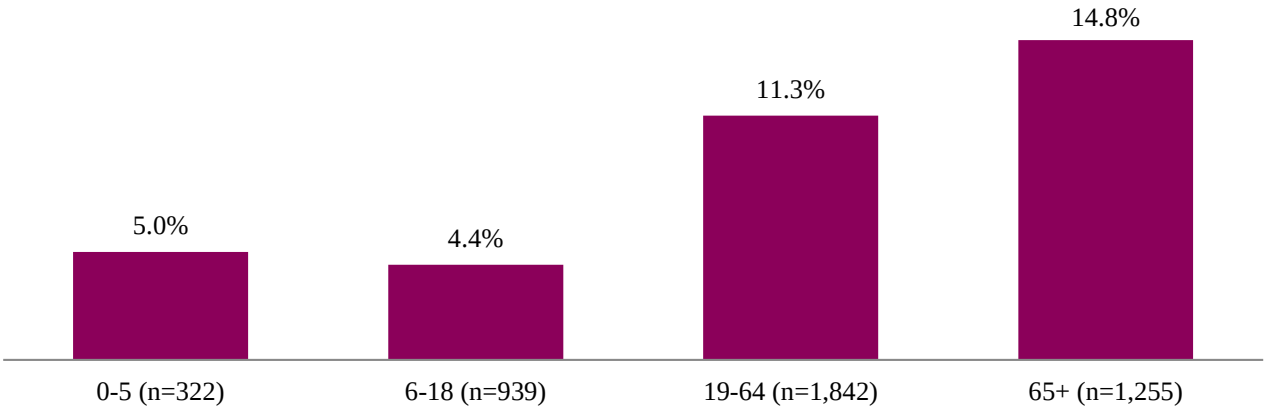
Region	Too far away	No transportation	Appointments not at times that work with schedule	Takes too long to get an appointment	Didn't think needed to go	n
	%	%	%	%	%	
North	14.0%	11.3%	24.8%	35.9%	31.1%	1,567
South	13..6%	11.3%	17.5%	33.6%	35.9%	1,097
Central	11.4%	8.8%	24.9%	28.9%	37.2%	1,792

Exhibit 8. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor

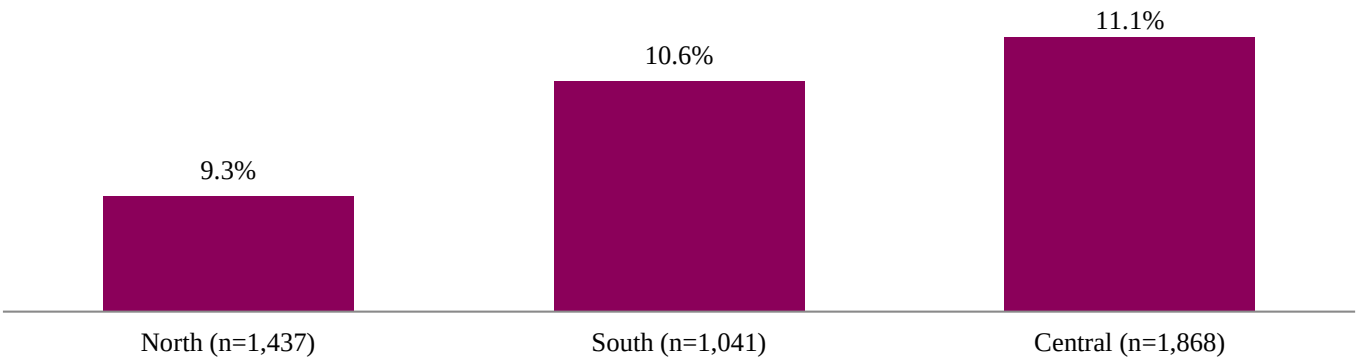
CalOptima language:



Age Category:



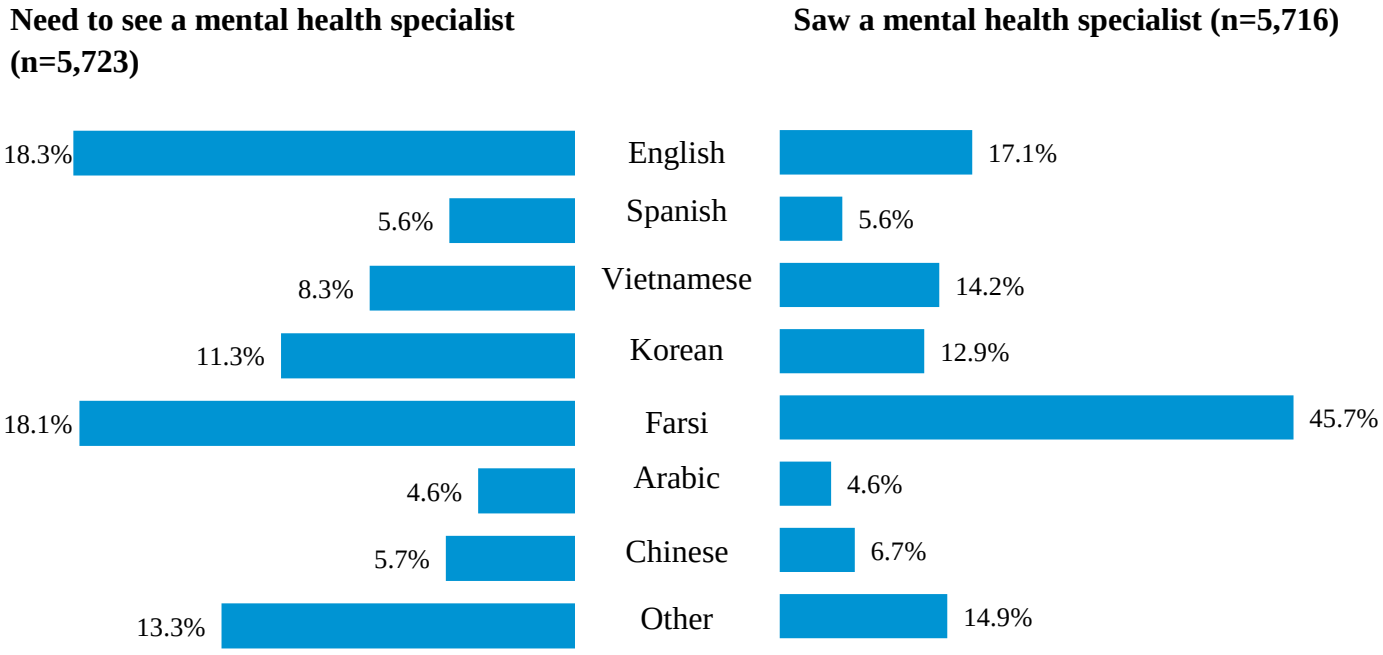
Region:



Social and Emotional Well-Being

Exhibit 9. Members who needed to see compared to those who saw a mental health specialist in the last 12 months[6]

CalOptima Language:

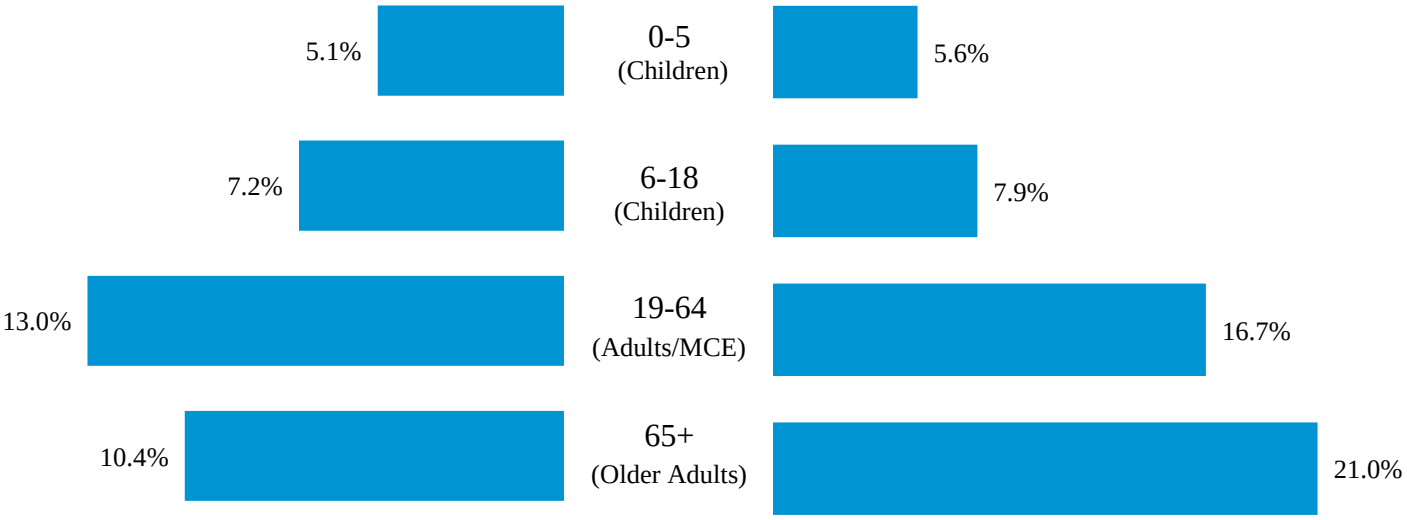


[6] For Farsi speakers, there is likely a translation issue on the survey that accounts for the discrepancy of those who indicated they needed to see a mental health specialist vs. those that actually saw one. This also likely affected the Age and Region graphs on the following page.

Age Category:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)



Region:

Need to see a mental health specialist (n=5,713)

Saw a mental health specialist (n=5,696)

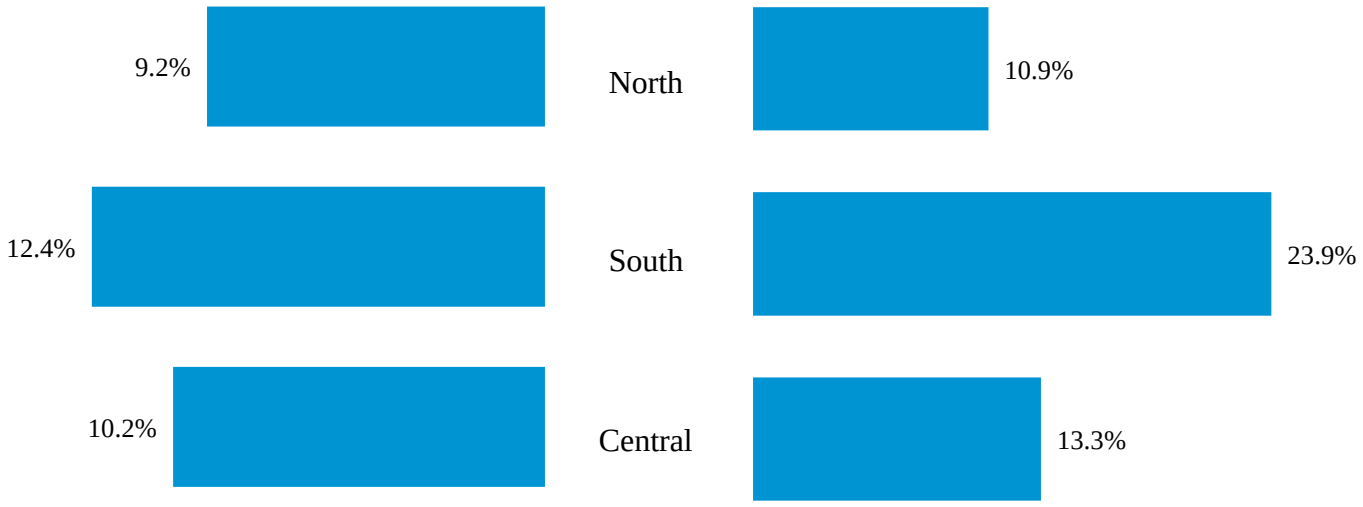
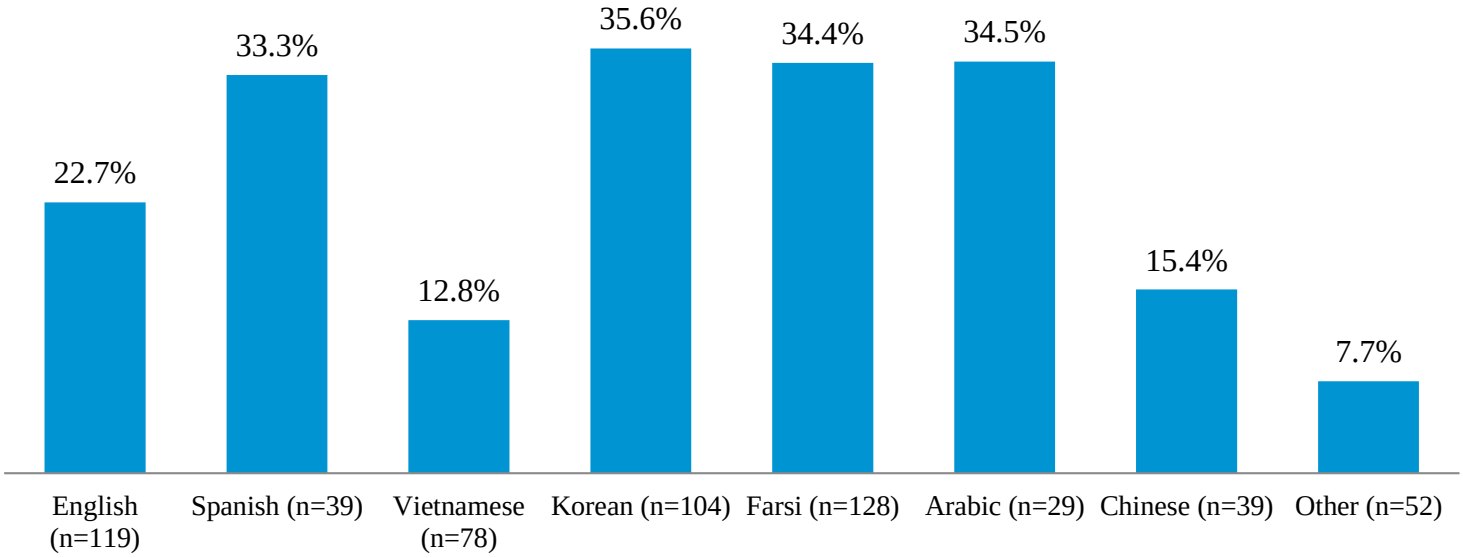
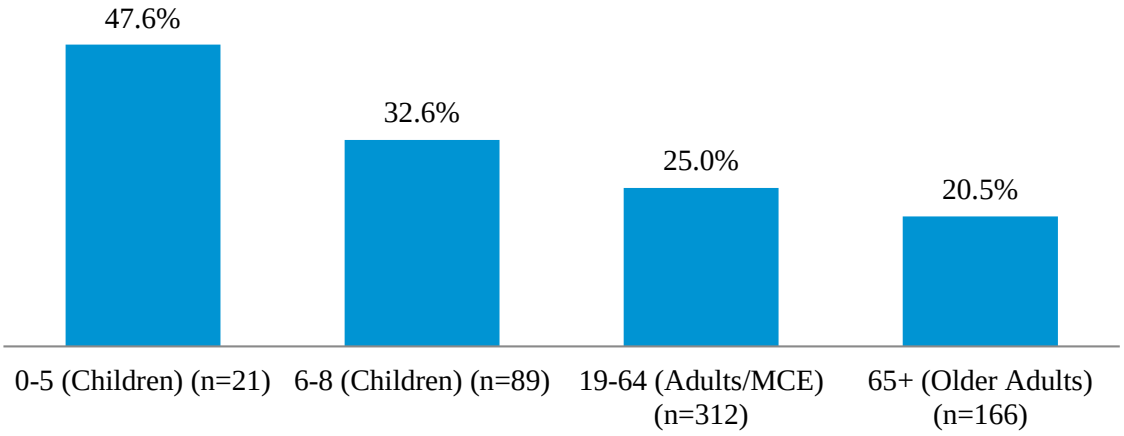


Exhibit 10. Percent of members who needed to see a mental health specialist but didn't see a mental health specialist

CalOptima Language:



Age Category:



Region:

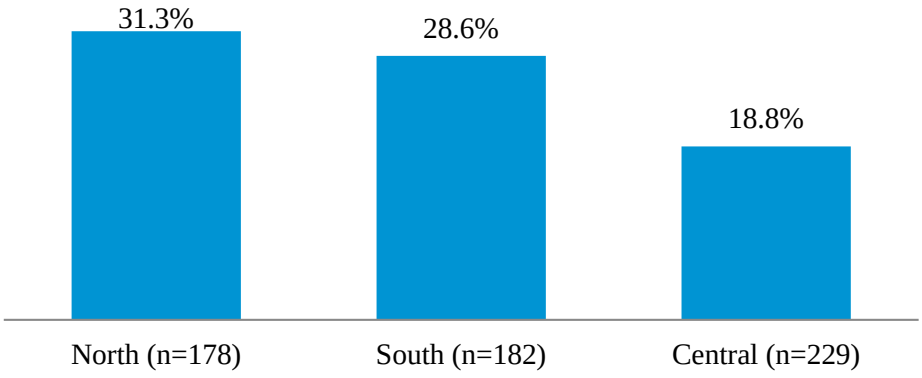
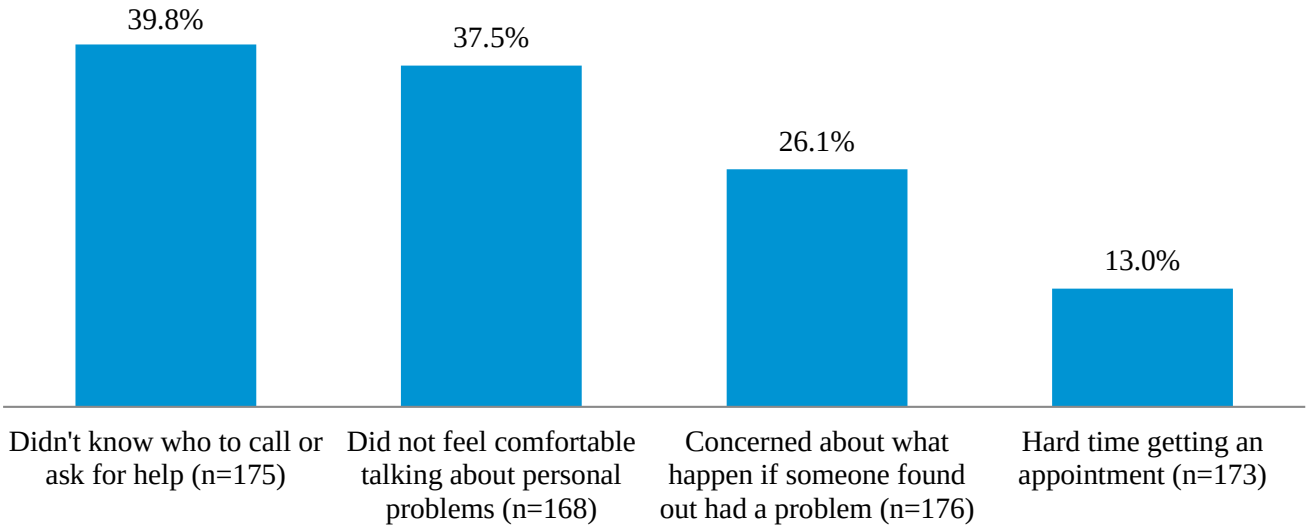


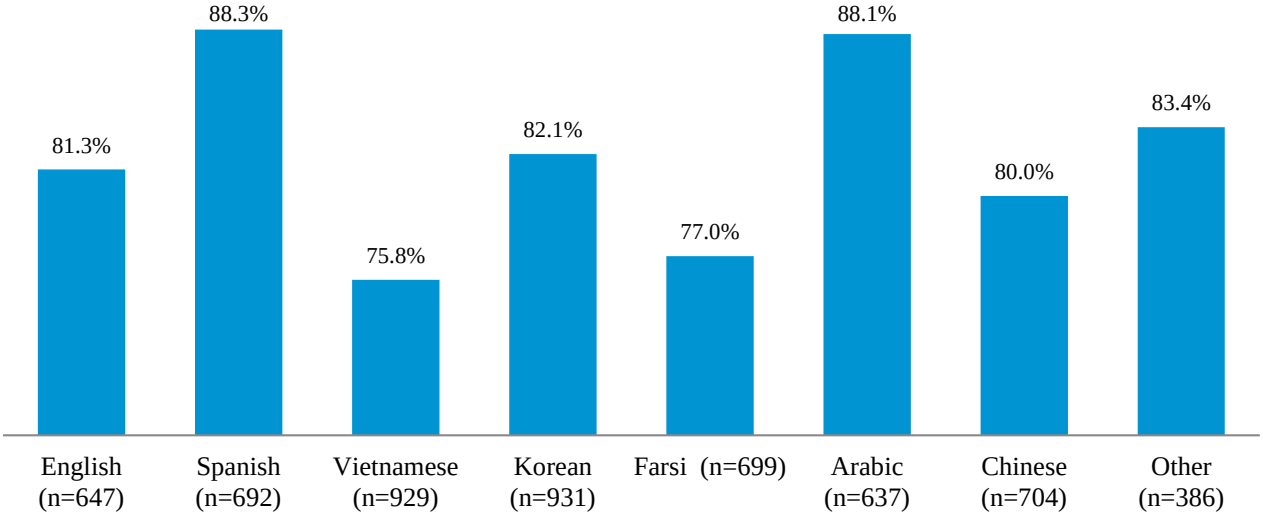
Exhibit 11. Reasons why members didn't see mental health specialist[7]



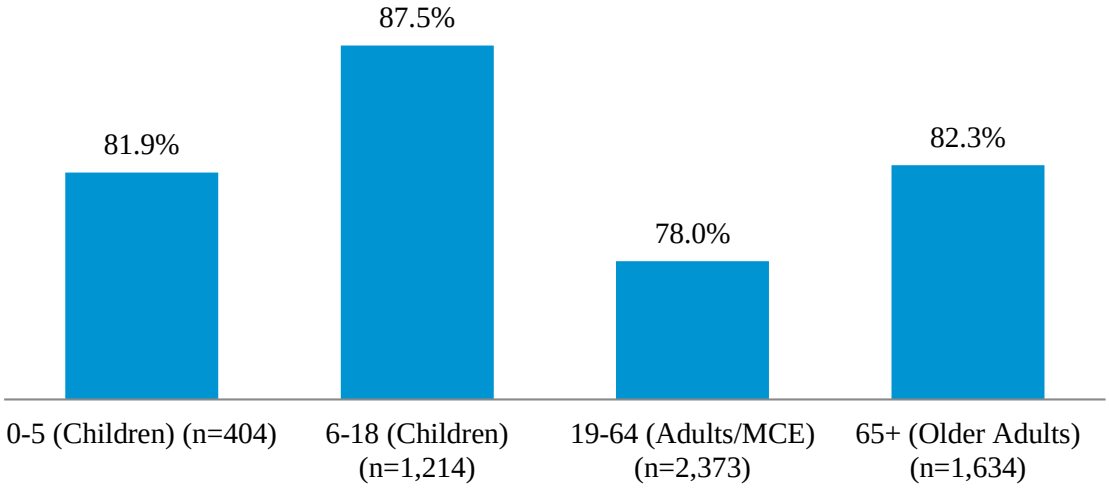
[7] Among those who indicated that they needed to see a mental health specialist but did not see one.

Exhibit 12. Percent of members who can share their worries with family members

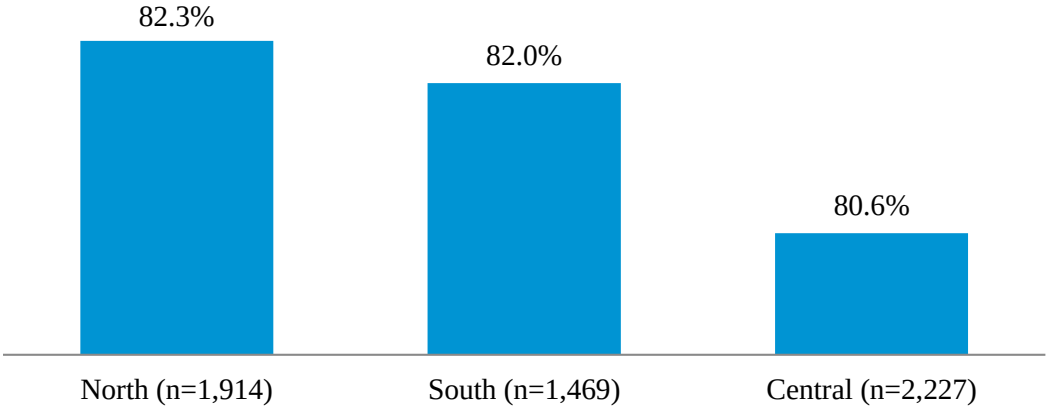
CalOptima language:



Age Category:



Region:

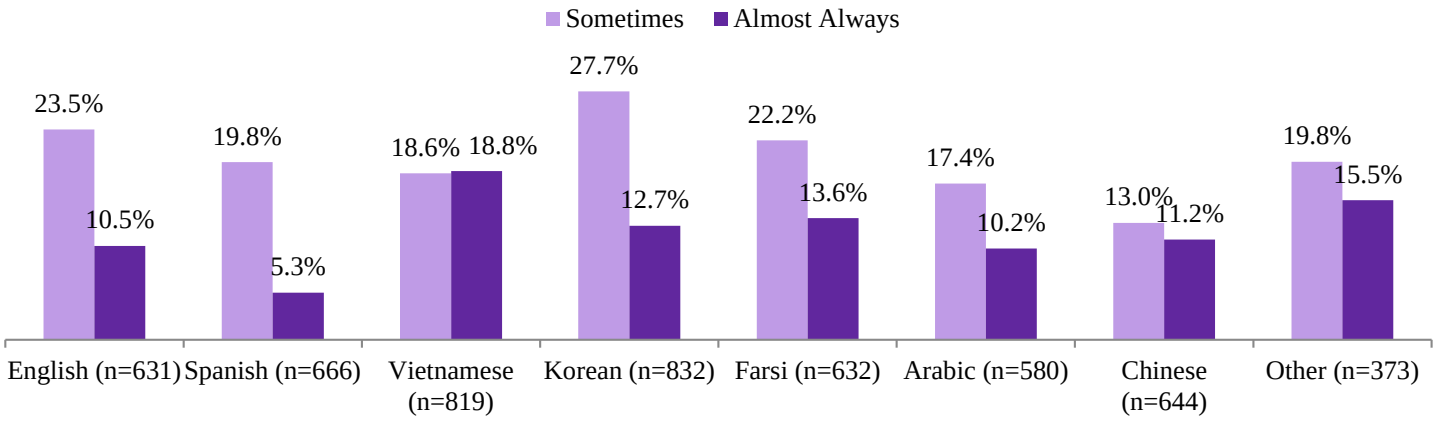


Social Determinants of Health

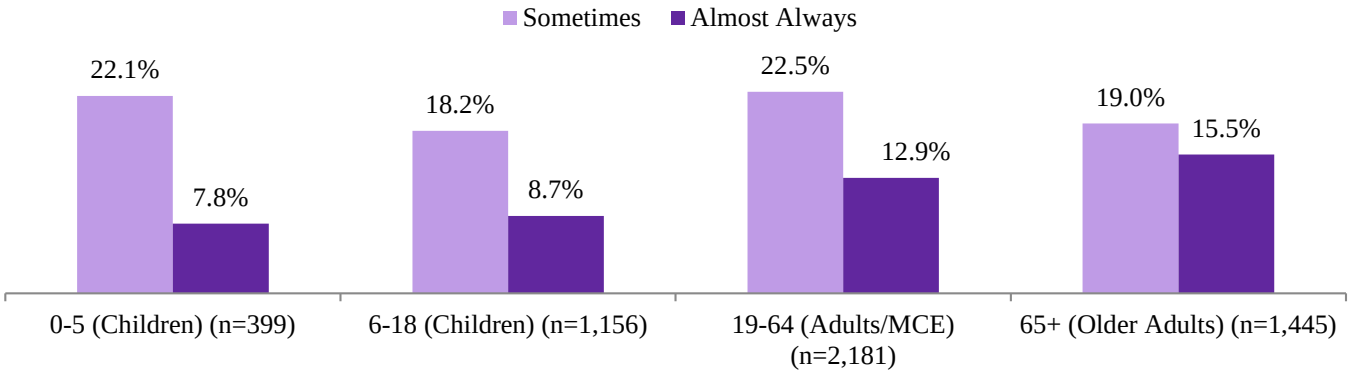
Exhibit 13. Needed help with the following in the past 6 months:

Food for anyone in your household:

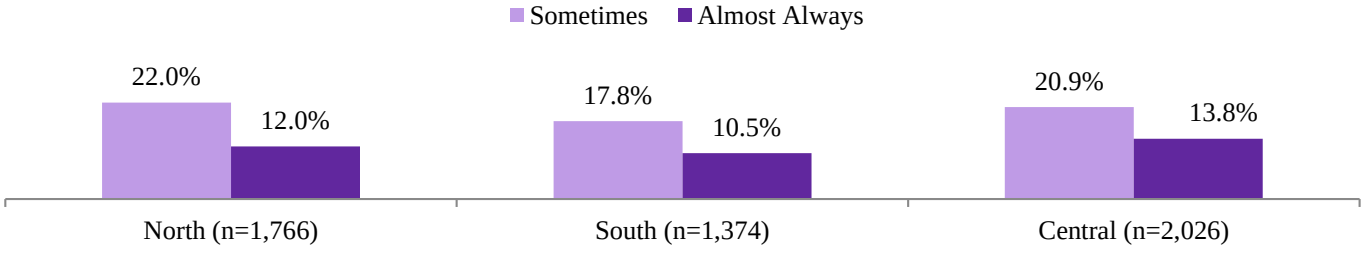
CalOptima language:



Age Category:

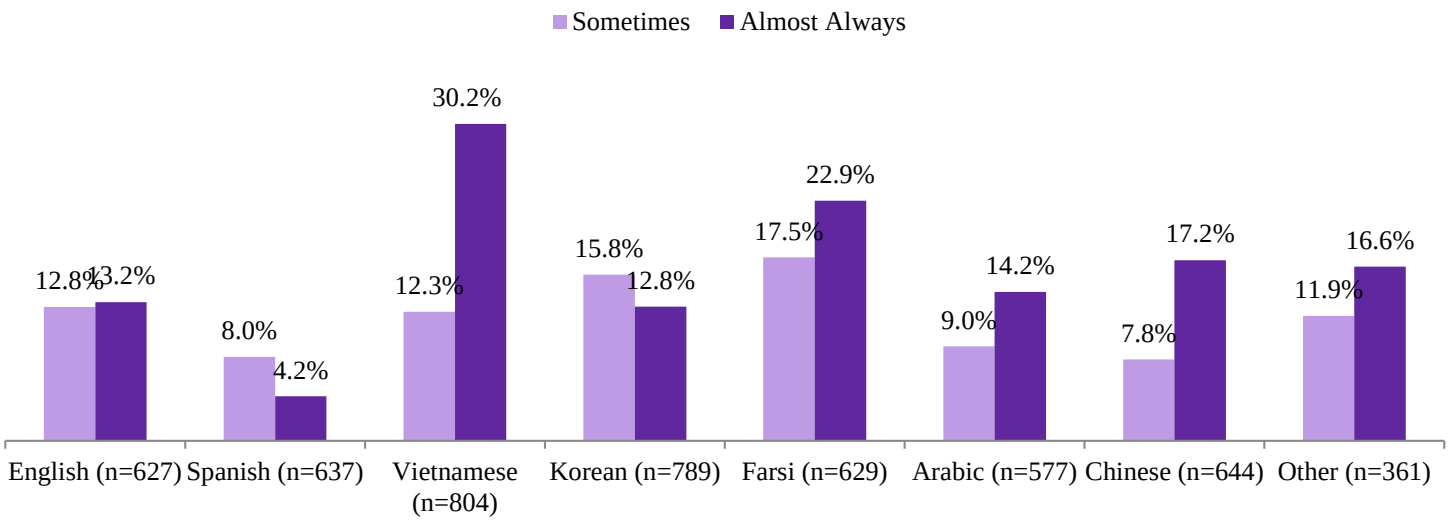


Region:

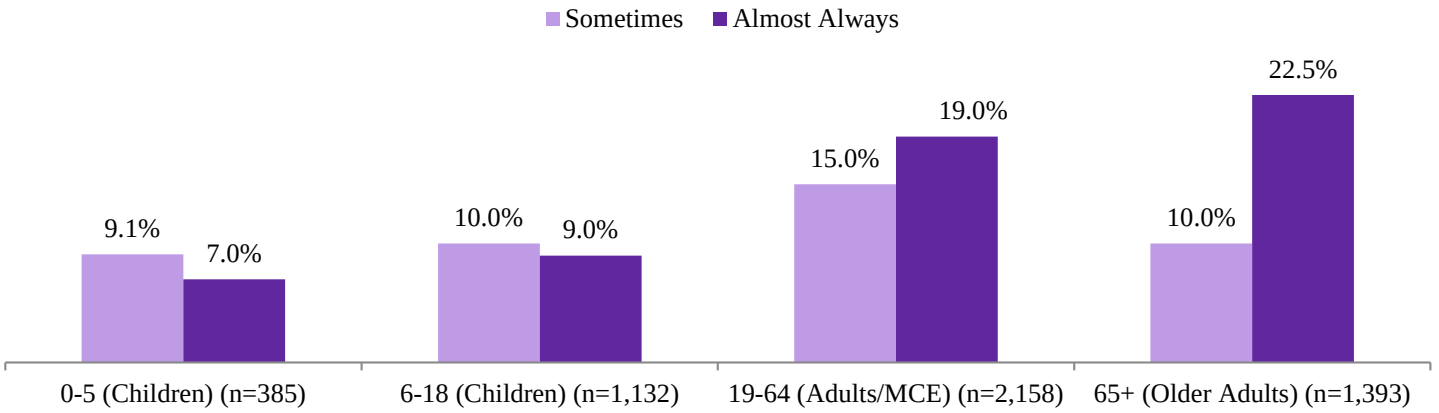


Housing:

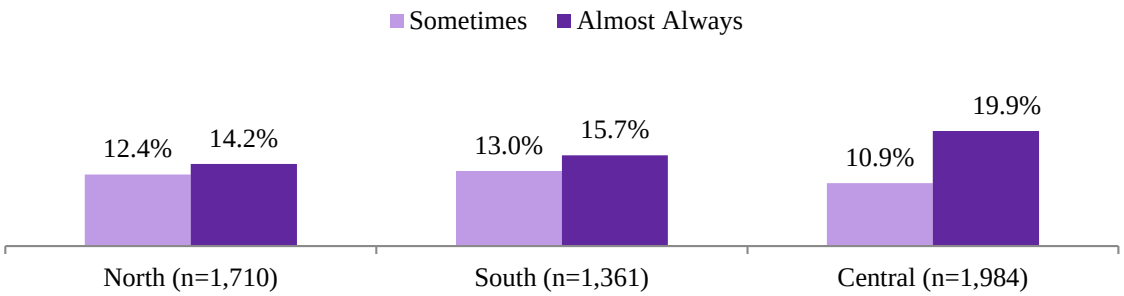
CalOptima language:



Age Category:

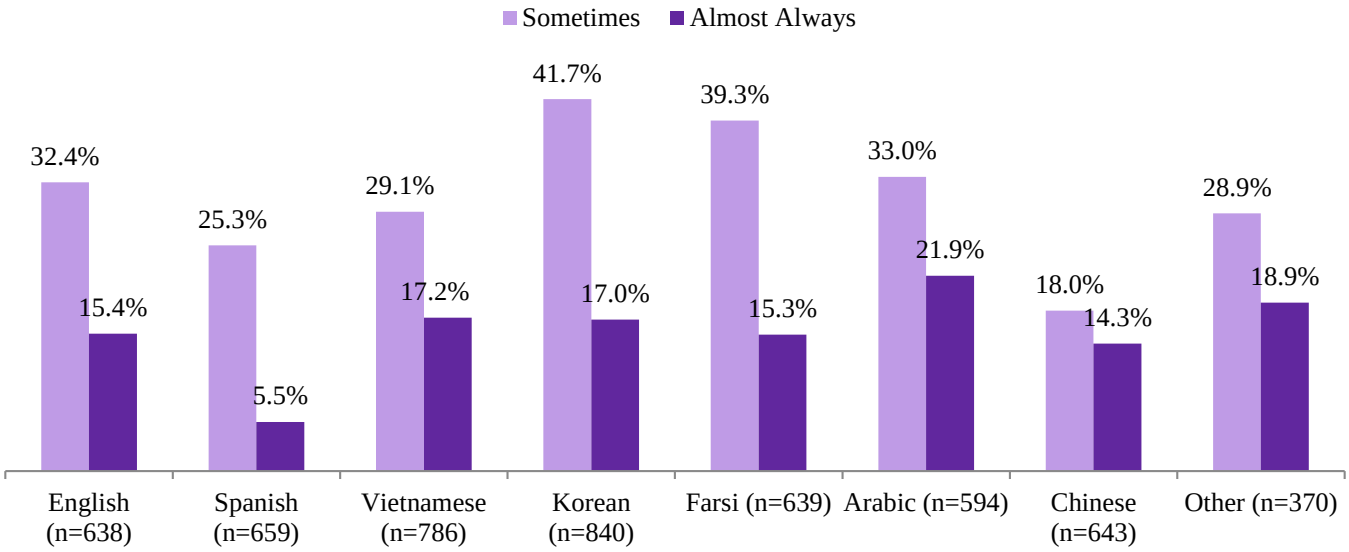


Region:

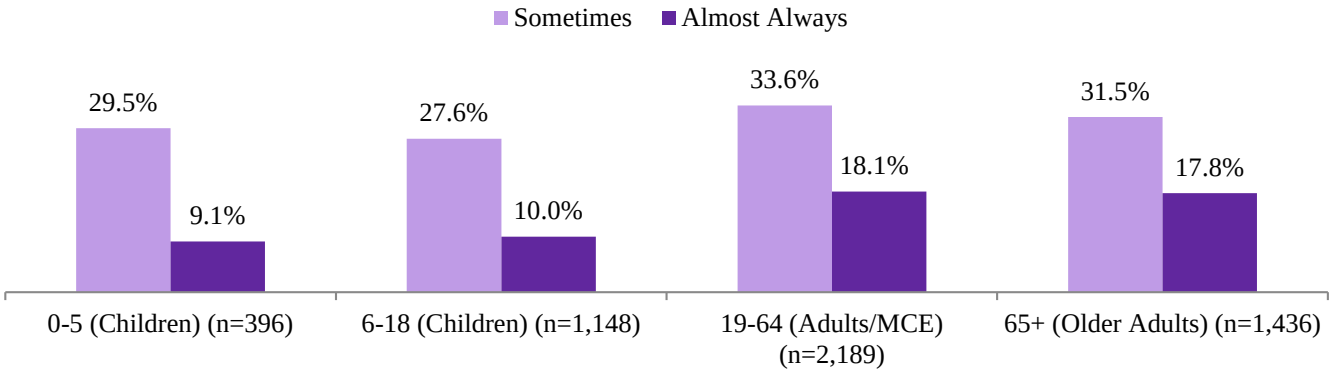


Money to buy things need:

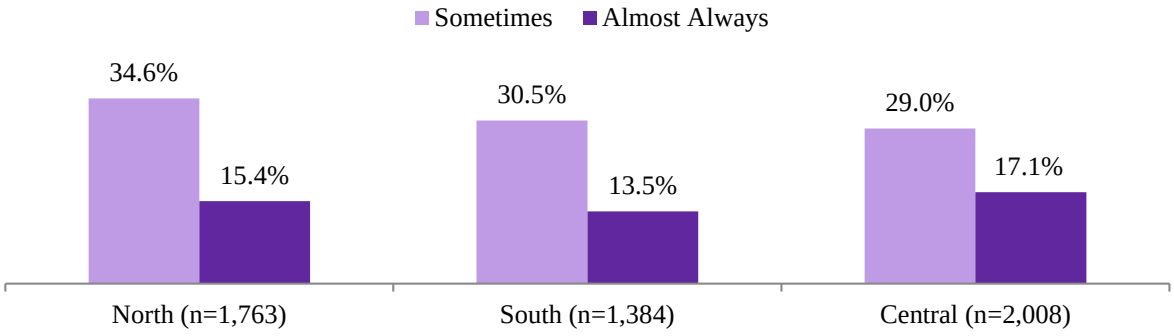
CalOptima language:



Age Category:

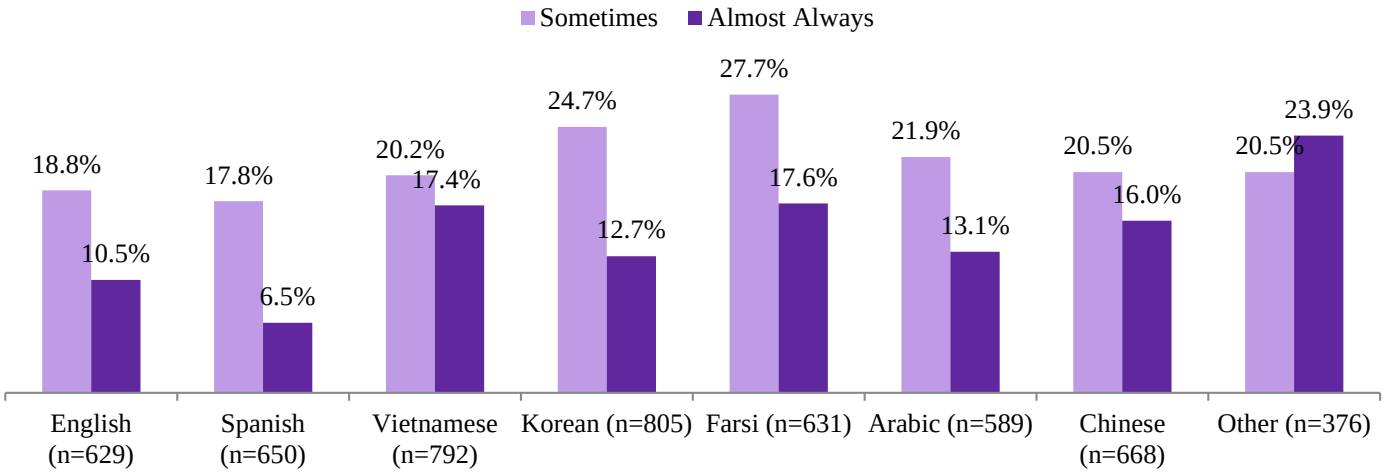


Region:

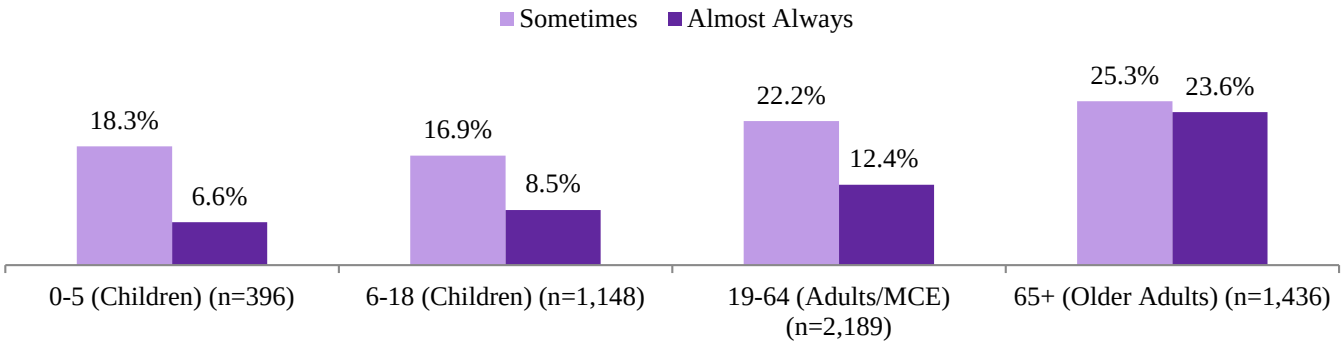


Transportation:

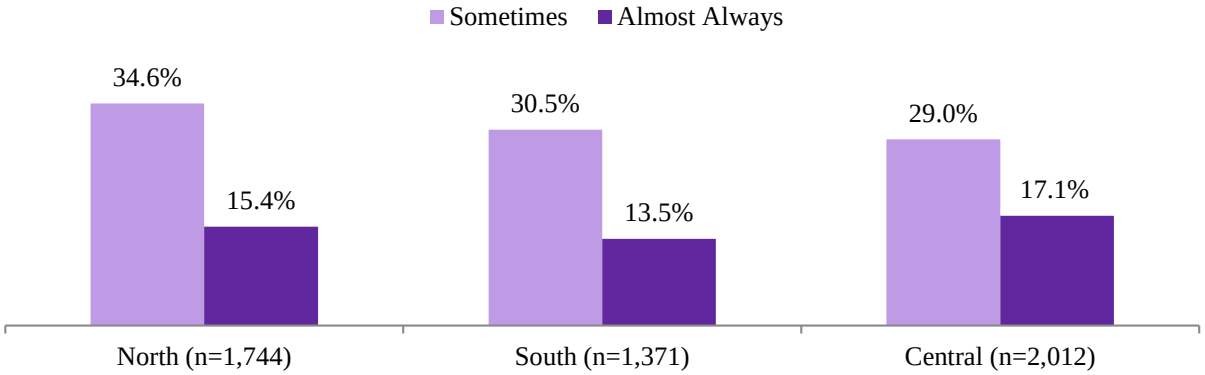
CalOptima language:



Age Category:

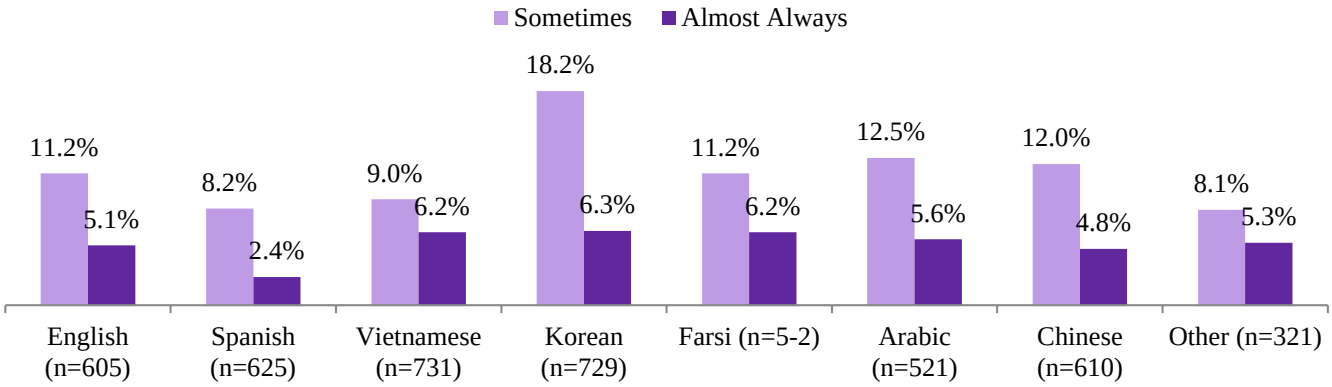


Region:

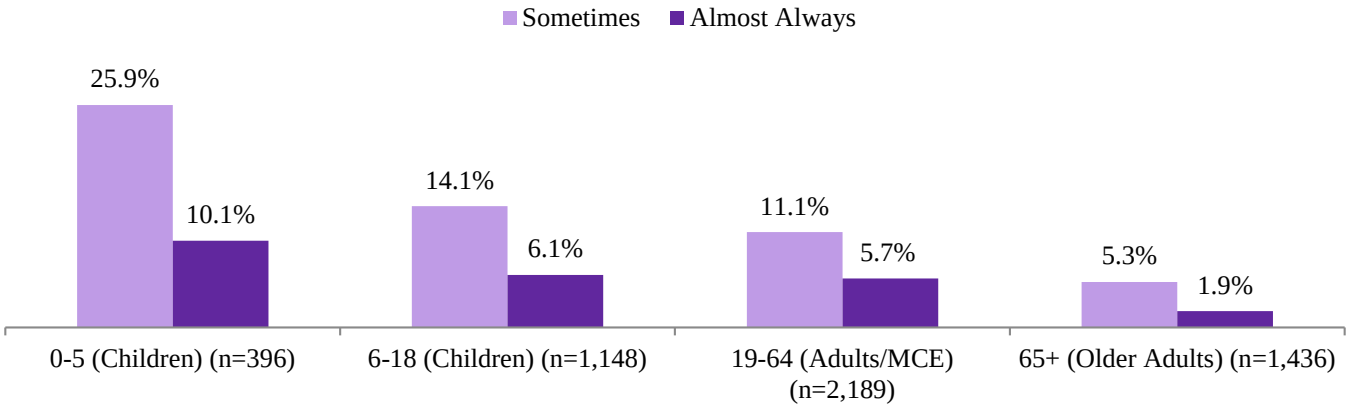


Child care:

CalOptima language:



Age Category:



Region:

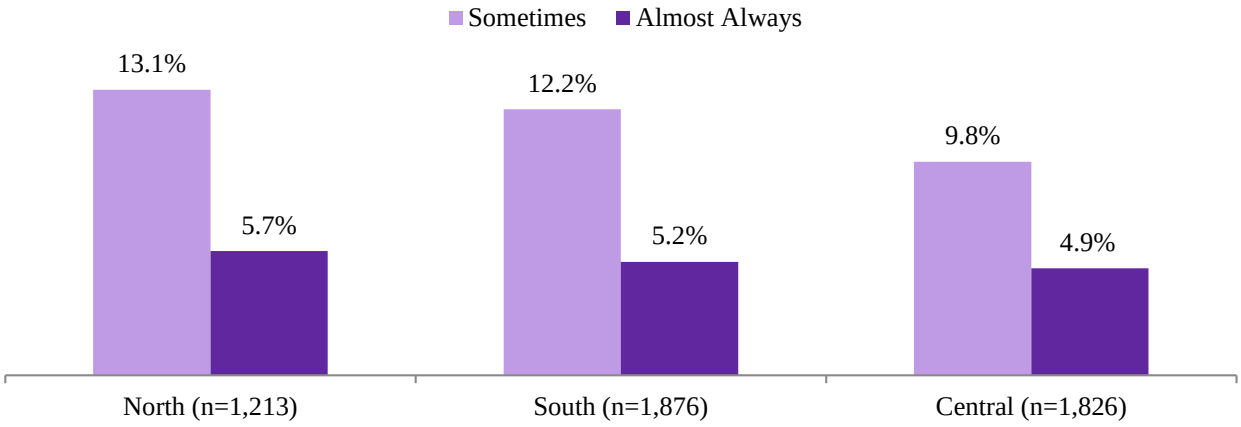
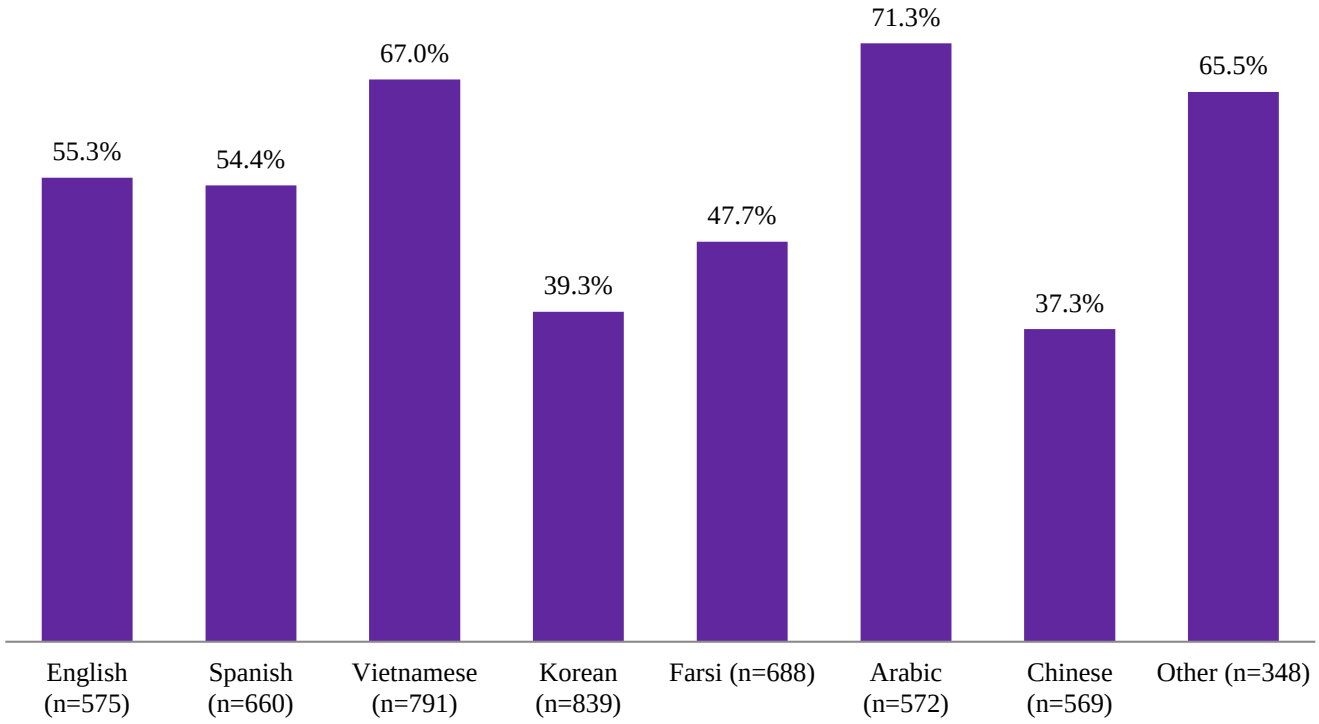


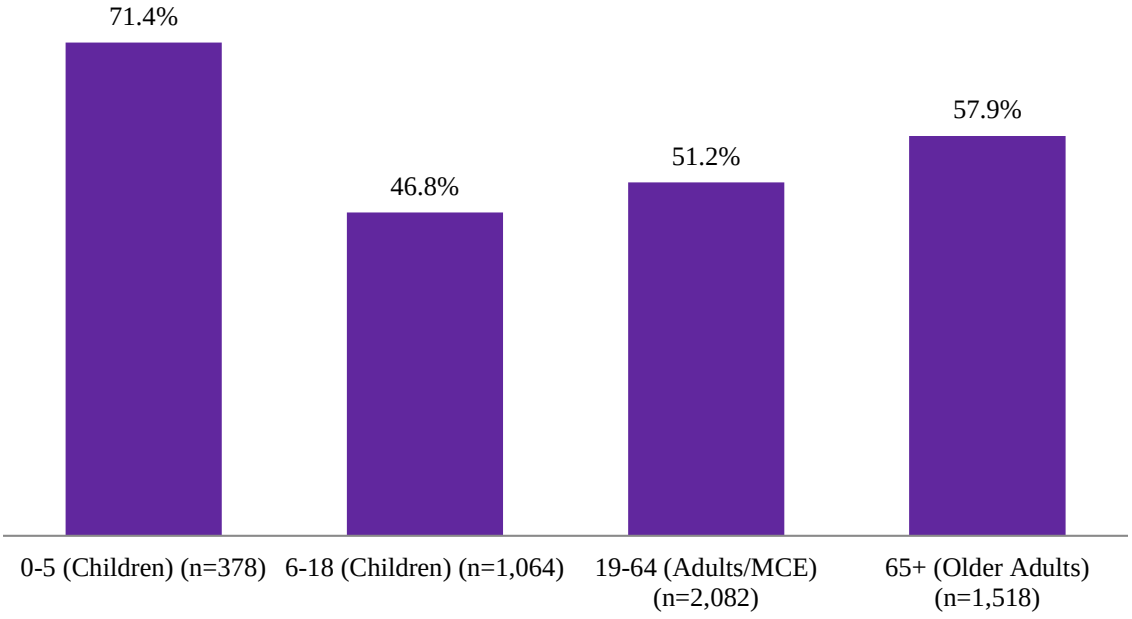
Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

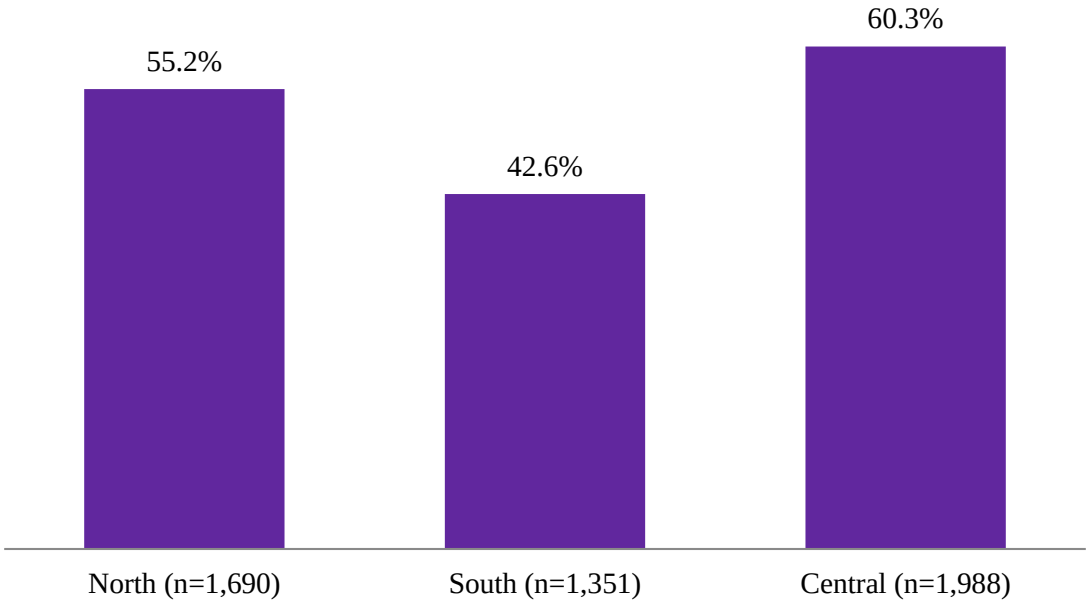
CalOptima language:



Age Category:



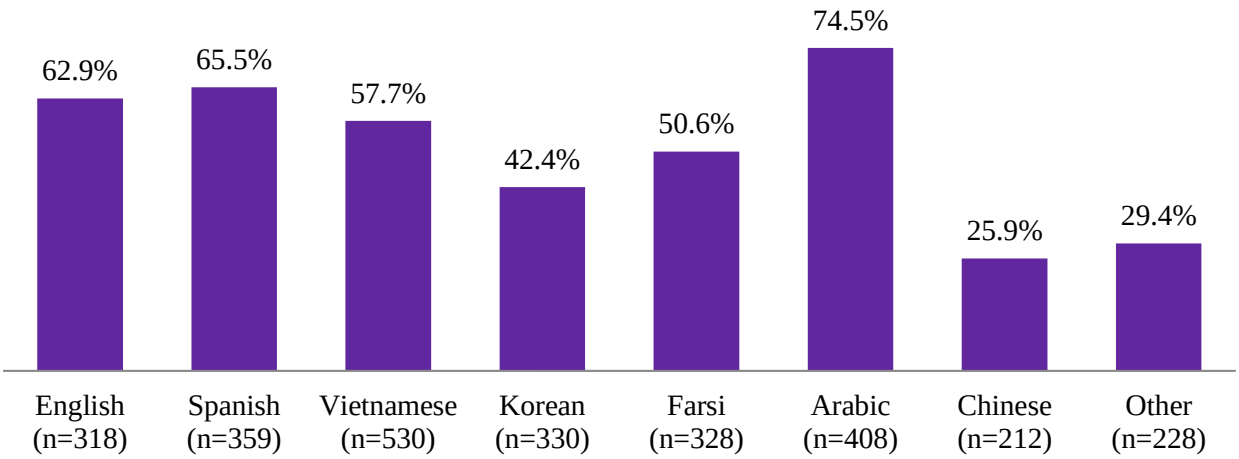
Region:



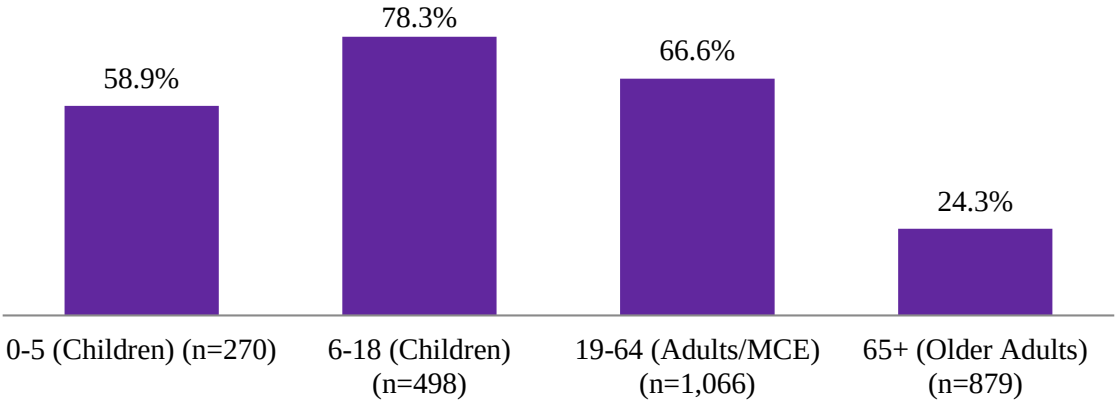
Type of public benefits that members receive[8]:

Receive CalFresh as a public benefit:

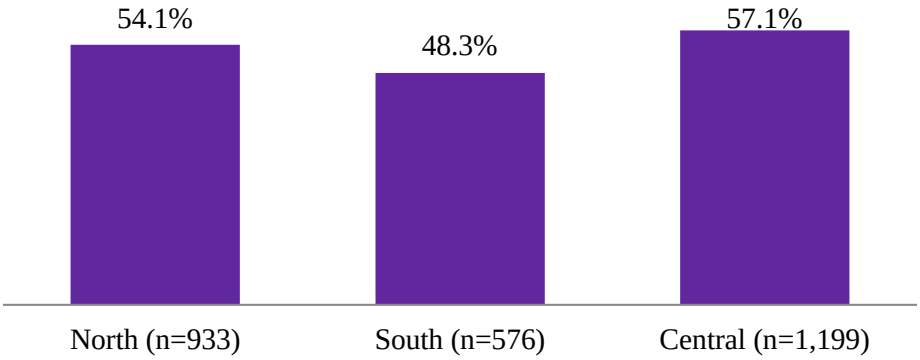
CalOptima language:



Age Category:



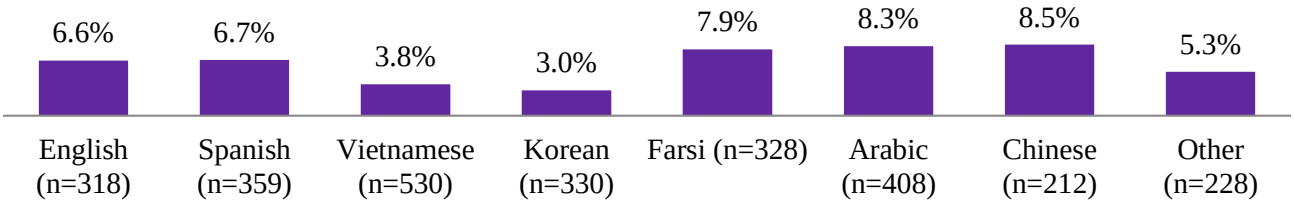
Region:



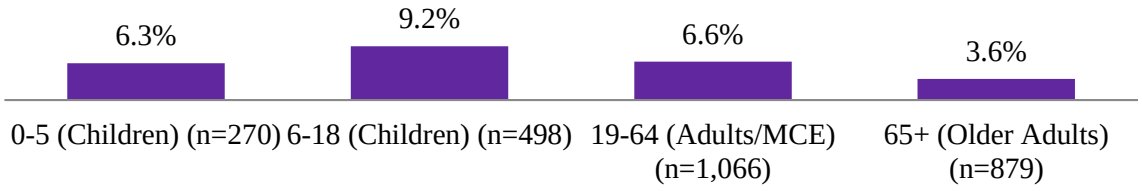
[8] Only reporting those who reported that they received at least one public benefit.

Receive TANF or CalWorks as a public benefit:

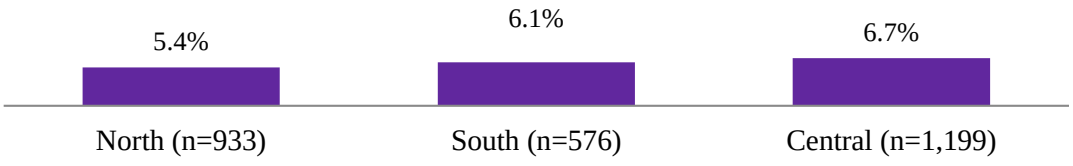
CalOptima language:



Age Category:

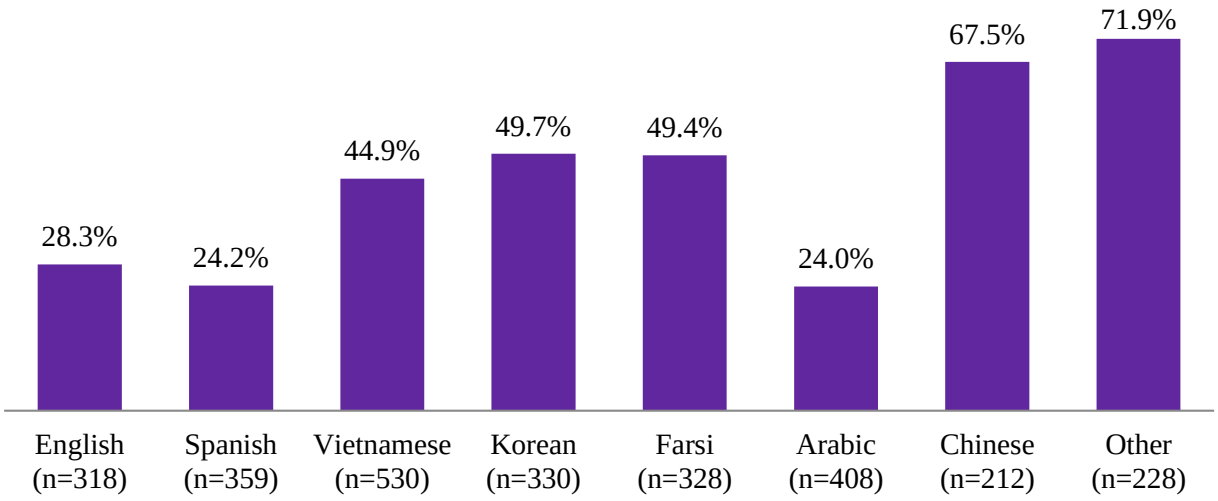


Region:

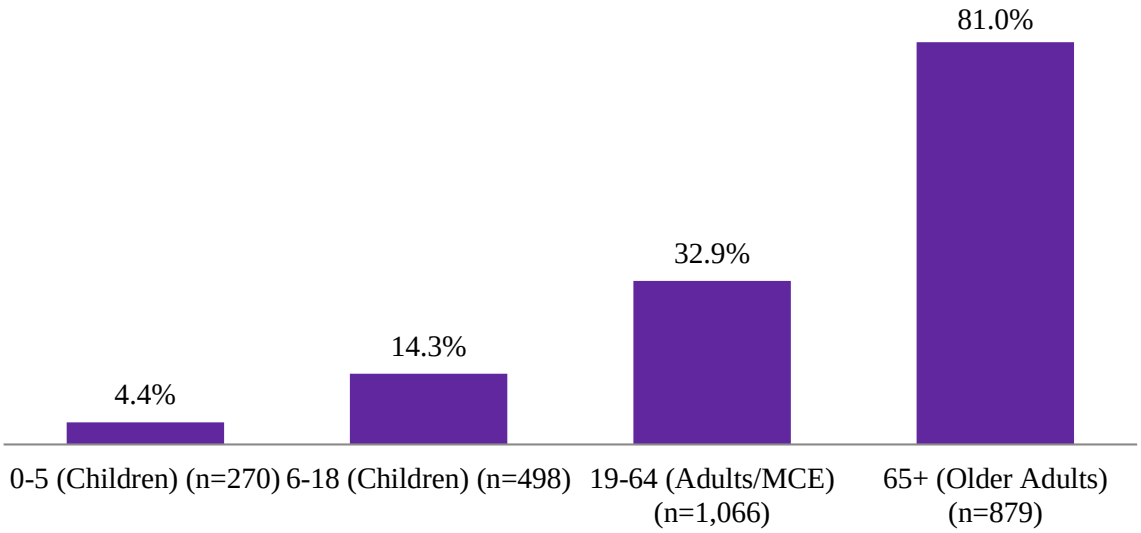


Receive SSI or SSDI as a public benefit:

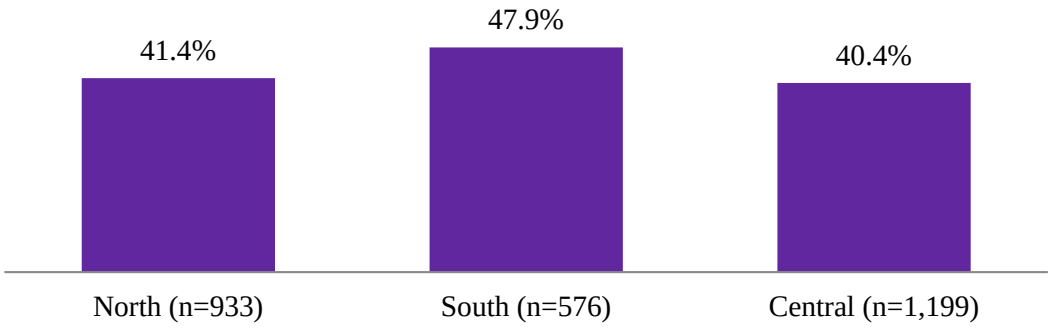
CalOptima language:



Age Category:

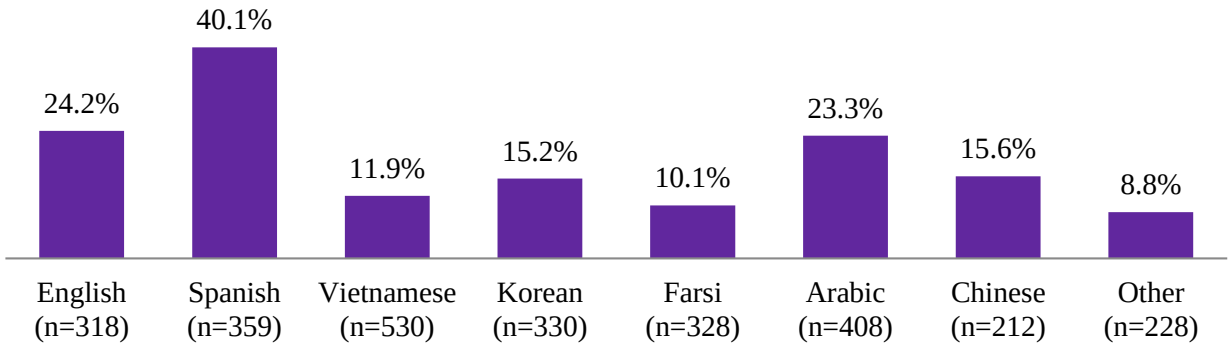


Region:

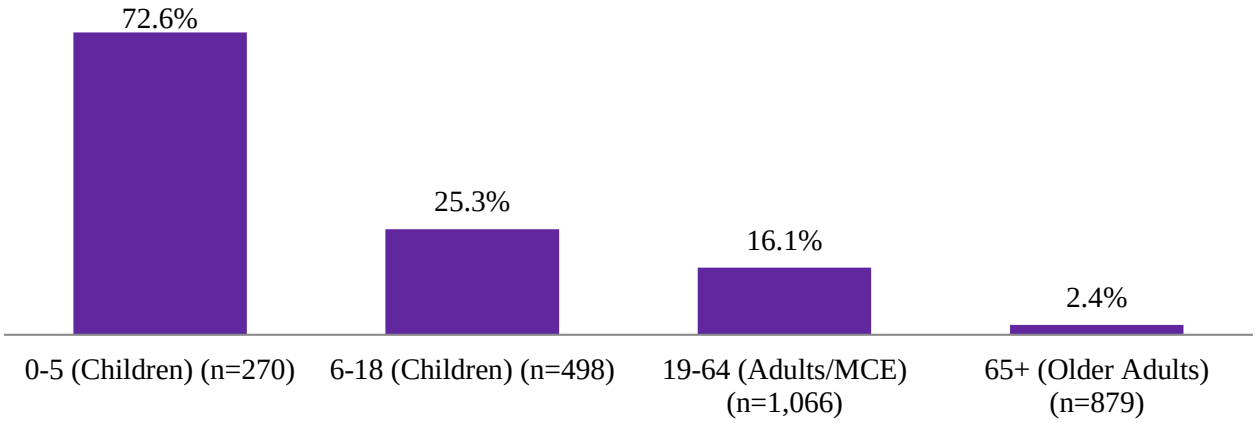


Receive WIC as a public benefit:

CalOptima language:



Age Category:



Region:

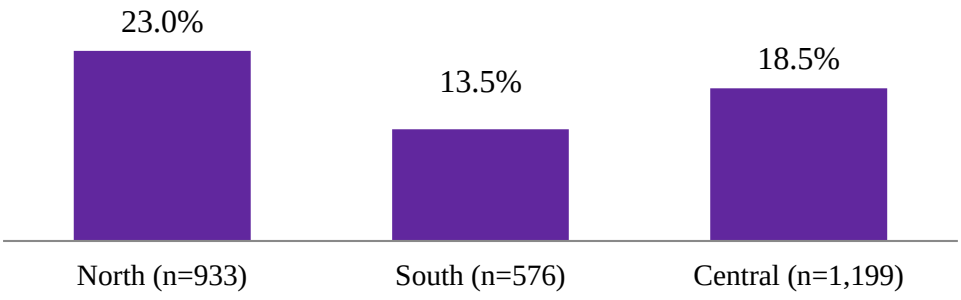


Exhibit 15. Personal activities participation:

CalOptima language:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	41.2%	6.4%	6.4%	45.9%	621
Spanish	19.1%	4.3%	3.1%	73.5%	607
Vietnamese	53.5%	3.3%	4.3%	38.9%	766
Korean	35.4%	6.3%	2.3%	56.0%	809
Farsi	28.5%	3.2%	3.4%	65.0%	537
Arabic	47.2%	5.9%	1.9%	45.0%	540
Chinese	16.8%	3.8%	3.1%	76.3%	583
Other	32.3%	4.0%	5.1%	58.6%	350
Do fun activities with others	**Once a week %**	**Once a month %**	**Once in the last 6 months %**	**Never %**	**n**
English	63.3%	18.3%	7.4%	11.0%	635
Spanish	61.8%	13.0%	4.0%	21.2%	647
Vietnamese	49.6%	19.5%	9.3%	21.7%	789
Korean	51.9%	22.7%	7.3%	18.0%	859
Farsi	39.5%	25.0%	10.2%	**25.3%**	608
Arabic	54.8%	20.6%	6.7%	17.9%	586
Chinese	45.4%	12.1%	5.8%	**36.7%**	619
Other	46.3%	21.6%	11.6%	20.5%	361

Volunteer or charity	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	16.2%	15.8%	19.4%	48.6%	628
Spanish	15.9%	10.0%	9.9%	64.2%	628
Vietnamese	15.8%	19.1%	26.7%	38.3%	752
Korean	21.0%	13.2%	15.6%	50.2%	825
Farsi	15.4%	13.8%	19.9%	50.9%	578
Arabic	23.5%	18.1%	14.3%	44.2%	575
Chinese	16.5%	11.9%	14.0%	57.7%	607
Other	9.9%	7.0%	12.1%	71.0%	355

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	68.7%	11.5%	6.0%	13.7%	633
Spanish	66.0%	8.7%	2.8%	22.5%	644
Vietnamese	69.6%	6.6%	4.0%	19.8%	807
Korean	75.1%	10.1%	3.7%	11.2%	874
Farsi	68.9%	7.7%	5.6%	17.9%	627
Arabic	59.1%	11.8%	4.4%	24.7%	587
Chinese	71.9%	7.3%	3.8%	17.1%	661
Other	57.6%	10.2%	4.7%	27.5%	363

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	83.3%	6.0%	1.0%	9.6%	612
Spanish	85.1%	5.3%	1.0%	8.6%	590
Vietnamese	78.0%	5.1%	1.5%	15.4%	740
Korean	88.2%	6.3%	1.0%	4.5%	842
Farsi	84.3%	4.8%	1.9%	8.9%	516
Arabic	83.2%	5.5%	1.5%	9.8%	531
Chinese	86.9%	5.2%	1.1%	6.7%	610
Other	80.3%	6.7%	3.5%	9.5%	315

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
English	76.7%	12.2%	2.9%	8.2%	621
Spanish	80.1%	7.7%	2.9%	9.3%	613
Vietnamese	78.2%	7.7%	1.9%	12.1%	725
Korean	73.6%	13.8%	4.6%	8.0%	864
Farsi	78.4%	9.9%	3.7%	8.0%	538
Arabic	74.5%	11.4%	2.7%	11.4%	553
Chinese	85.9%	5.3%	2.4%	6.3%	618
Other	82.9%	9.2%	3.5%	4.4%	315

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
English	0.8%	1.1%	6.2%	91.9%	632
Spanish	0.2%	0.3%	2.5%	97.1%	651
Vietnamese	2.6%	0.6%	3.1%	93.7%	772
Korean	0.8%	0.8%	6.5%	91.8%	846
Farsi	1.3%	1.0%	2.9%	94.8%	594
Arabic	5.0%	2.4%	1.0%	91.6%	582
Chinese	7.5%	2.3%	3.3%	86.8%	598
Other	2.2%	2.0%	8.1%	87.7%	358

Age Category:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	32.2%	3.4%	2.0%	62.4%	348
6-18 (Children)	33.0%	3.9%	2.5%	60.6%	1,077
19-64 (Adults/MCE)	43.2%	5.6%	4.2%	47.0%	2,093
65+ (Older Adults)	24.3%	4.3%	4.2%	67.2%	1,295

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	75.0%	9.8%	2.9%	12.2%	376
6-18 (Children)	72.5%	12.3%	4.7%	10.6%	1,137
19-64 (Adults/MCE)	43.6%	24.2%	9.3%	23.0%	2,190
65+ (Older Adults)	41.9%	19.2%	8.6%	30.3%	1,401

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	14.5%	10.4%	11.0%	64.1%	365
6-18 (Children)	22.7%	18.3%	17.2%	41.8%	1,117
19-64 (Adults/MCE)	18.0%	14.9%	20.8%	46.3%	2,142
65+ (Older Adults)	12.1%	10.1%	12.2%	65.6%	1,324

Physical fitness	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	69.2%	7.0%	1.9%	21.9%	370
6-18 (Children)	77.9%	8.4%	3.2%	10.5%	1,148
19-64 (Adults/MCE)	62.2%	12.6%	5.7%	19.5%	2,211
65+ (Older Adults)	69.3%	4.9%	3.6%	22.2%	1,467

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	89.8%	3.6%	0.6%	6.1%	362
6-18 (Children)	90.2%	4.5%	0.9%	4.3%	1,084
19-64 (Adults/MCE)	80.5%	6.7%	1.7%	11.0%	2,061
65+ (Older Adults)	82.4%	5.2%	1.6%	10.8%	1,249

Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
0-5 (Children)	79.0%	6.4%	3.6%	11.0%	362
6-18 (Children)	83.2%	7.7%	2.4%	6.7%	1,110
19-64 (Adults/MCE)	70.7%	14.3%	4.3%	10.8%	2,105
65+ (Older Adults)	86.5%	5.3%	1.7%	6.5%	1,270

Visit a casino or gamble on the internet	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
0-5 (Children)	3.0%	0.5%	1.6%	94.8%	368
6-18 (Children)	2.3%	0.6%	1.8%	95.3%	1,134
19-64 (Adults/MCE)	1.9%	1.0%	5.4%	91.7%	2,171
65+ (Older Adults)	3.2%	2.3%	4.6%	89.9%	1,360

Region:

Care for a family member	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	35.3%	5.4%	3.7%	55.6%	1,639
South	28.8%	4.2%	4.0%	62.9%	1,252
Central	38.8%	4.4%	3.4%	53.4%	1,910

Do fun activities with others	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	51.8%	20.1%	8.0%	20.0%	1,757
South	47.7%	21.1%	8.0%	23.2%	1,345
Central	55.0%	16.6%	6.9%	21.5%	1,989

Volunteer or charity	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	17.7%	13.8%	16.0%	52.5%	1,702
South	16.8%	13.2%	16.8%	53.3%	1,307
Central	17.1%	14.9%	17.9%	50.1%	1,927

Physical fitness	Once a week %	Once a month %	Once in the last 6 months %	Never %	n
North	67.4%	10.2%	4.9%	17.5%	1,780
South	69.4%	8.8%	4.4%	17.4%	1,387
Central	67.9%	8.3%	3.7%	20.1%	2,017

Get enough sleep	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	86.8%	4.7%	0.8%	7.7%	1,668
South	86.0%	5.3%	1.8%	6.9%	1,230
Central	79.9%	6.6%	1.7%	11.8%	1,848

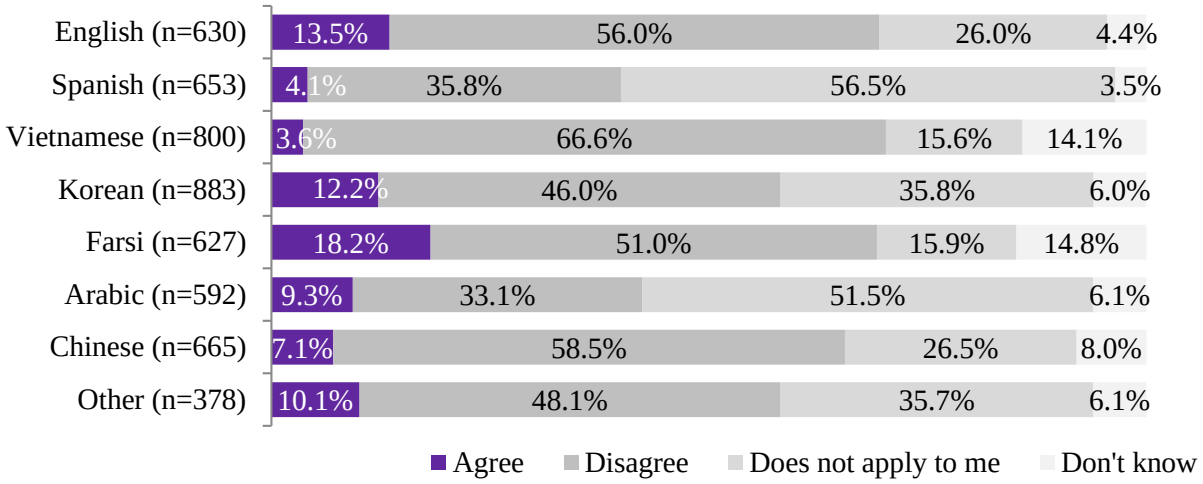
Have enough time for self	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	76.2%	10.9%	3.8%	9.1%	1,694
South	81.0%	9.2%	3.3%	6.5%	1,263
Central	78.5%	9.2%	2.3%	9.9%	1,880

Visit a casino or gamble on the internet	Once a week	Once a month	Once in the last 6 months	Never	n
	%	%	%	%	
North	1.5%	0.9%	4.5%	93.2%	1,726
South	4.0%	1.1%	3.7%	91.3%	1,327
Central	2.2%	1.7%	4.0%	92.1%	1,969

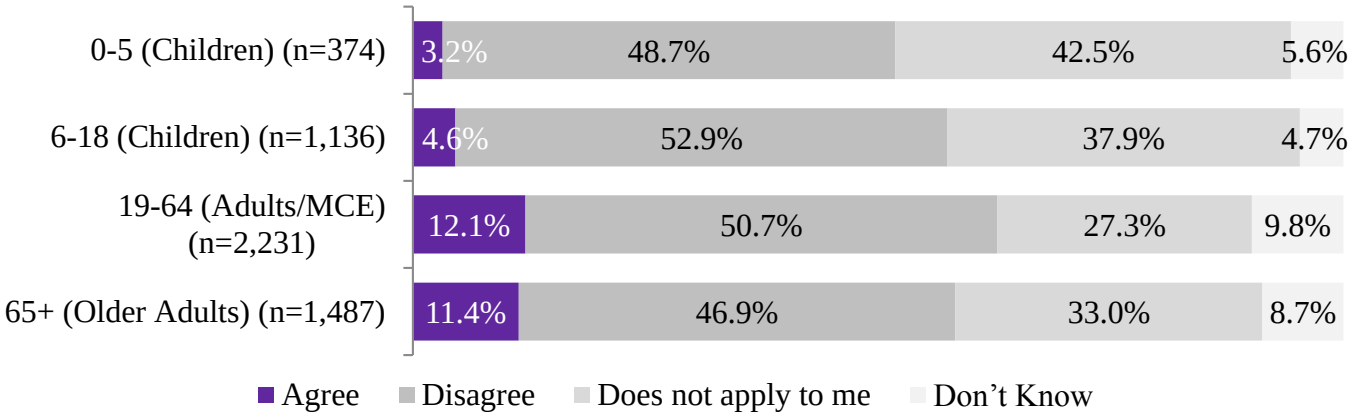
Exhibit 16. Feelings towards community and home enviroment:

Feeling lonely and isolated:

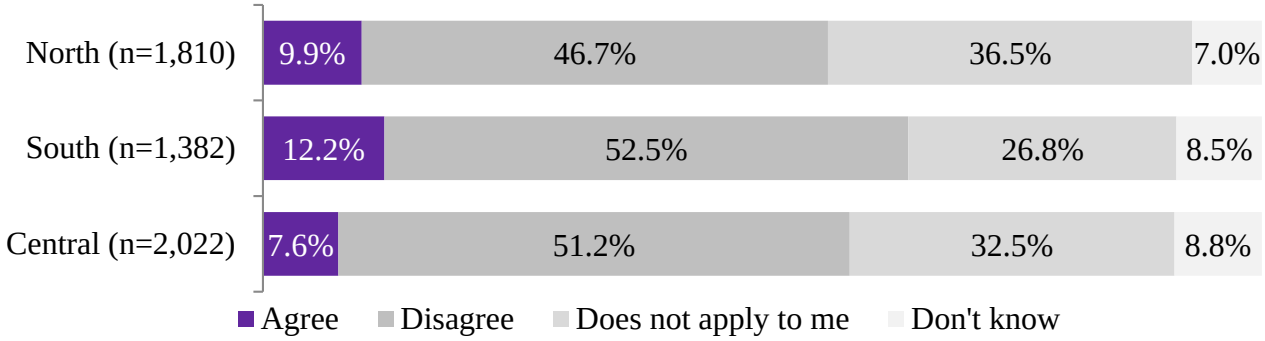
CalOptima language:



Age Category:

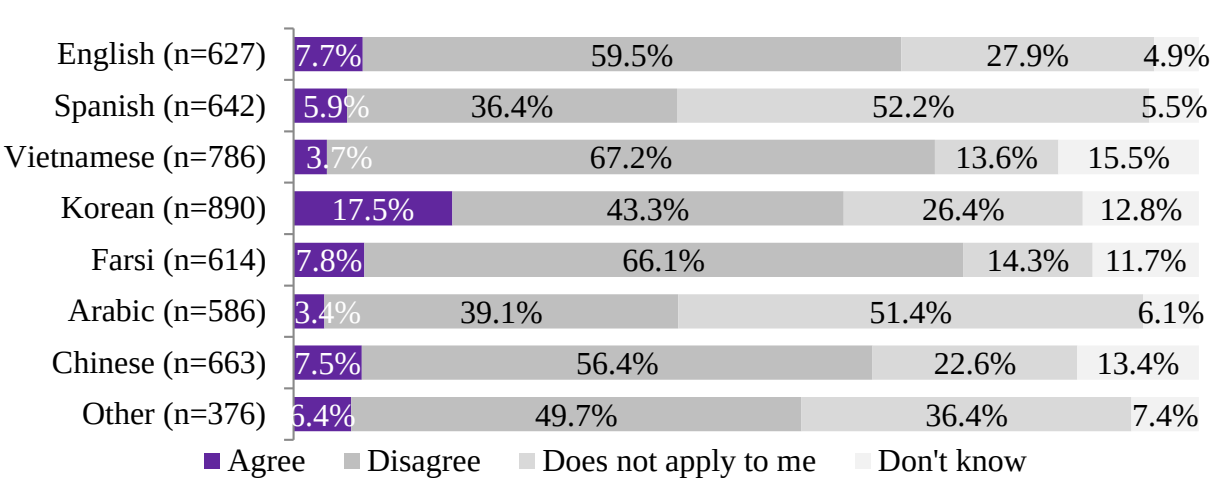


Region:

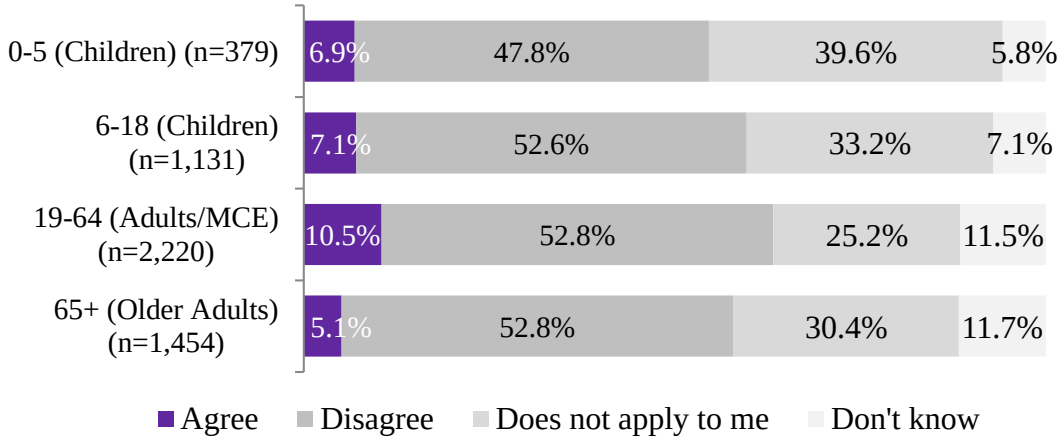


Feel not treated equally because of ethnic and culutral backgrounds:

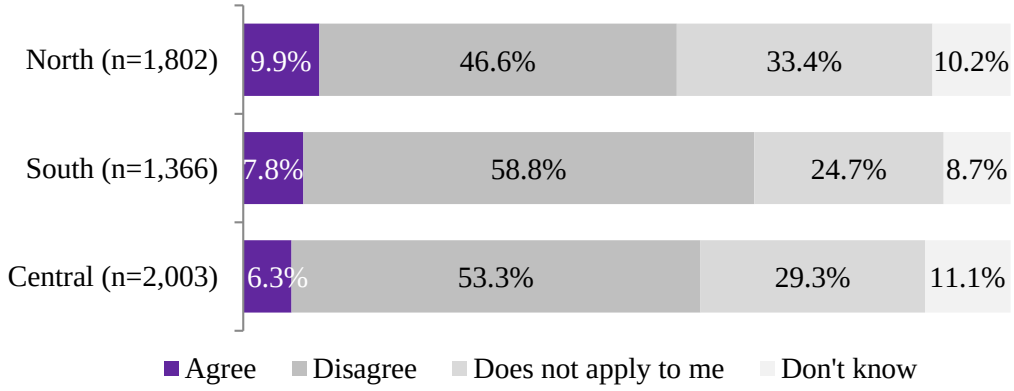
CalOptima language:



Age Category:

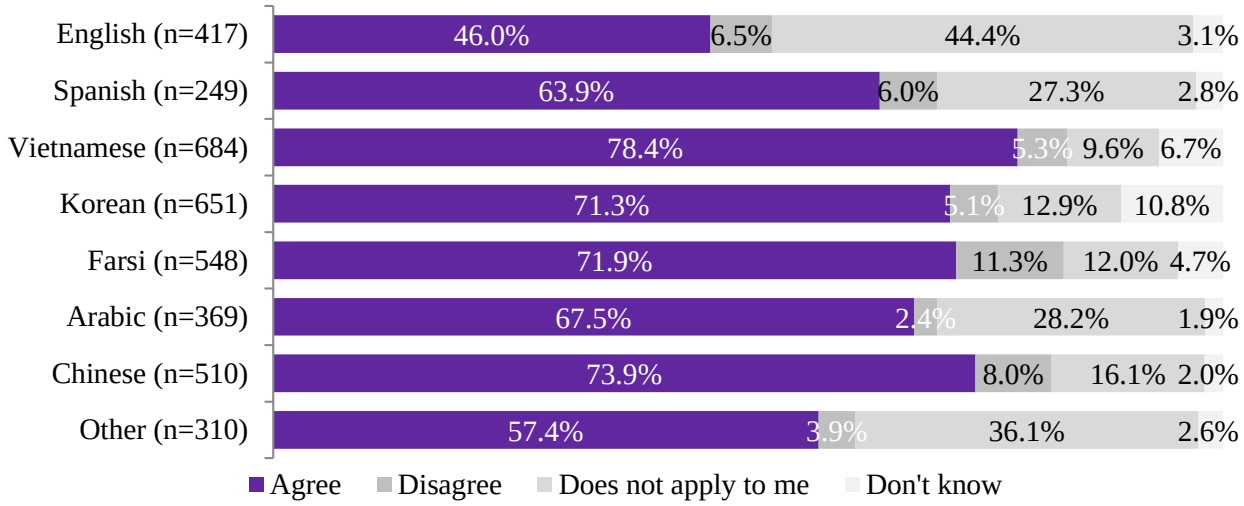


Region:

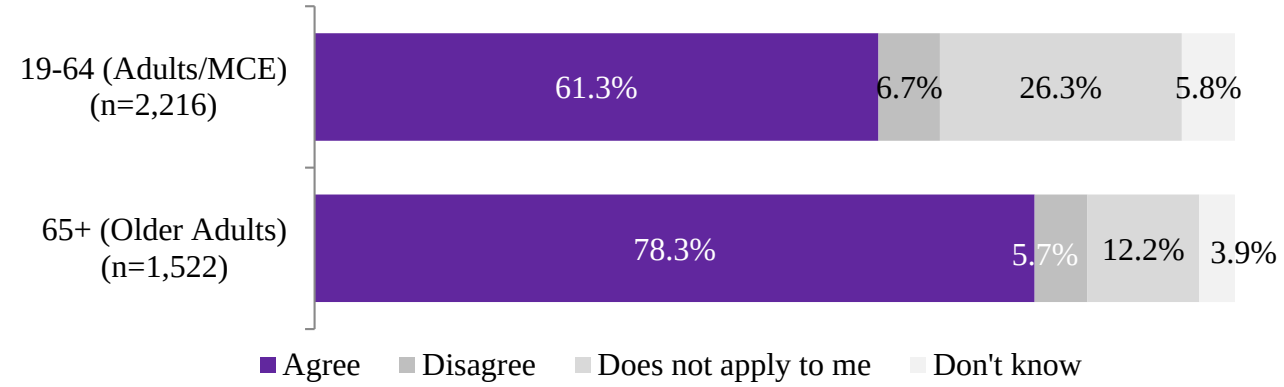


Feel child respects them as a parent[9]:

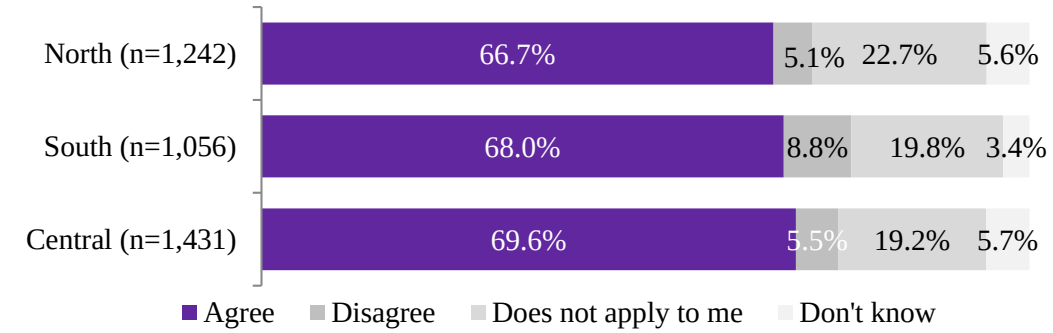
CalOptima language:



Age Category:



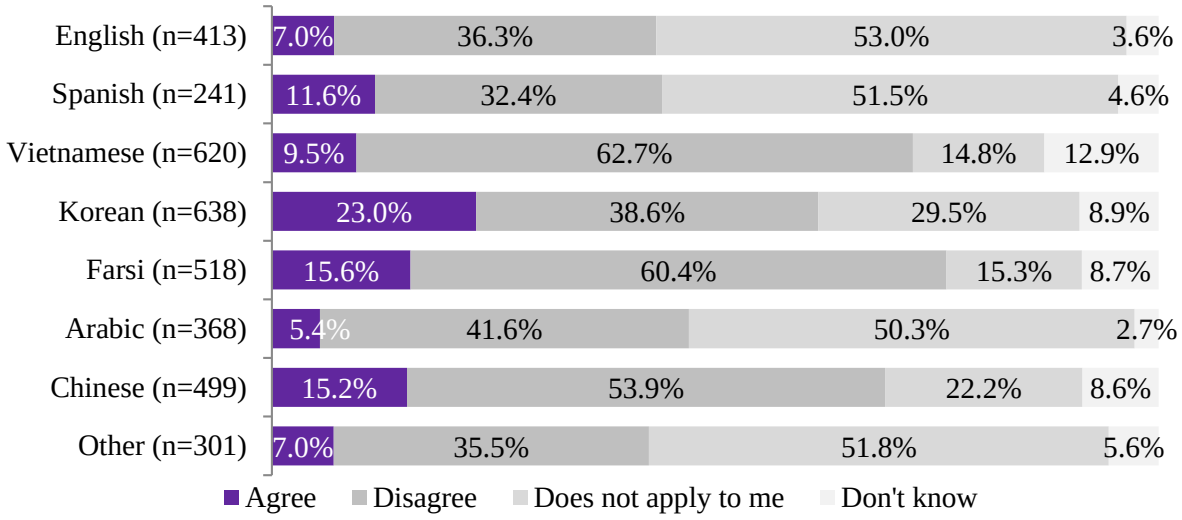
Region:



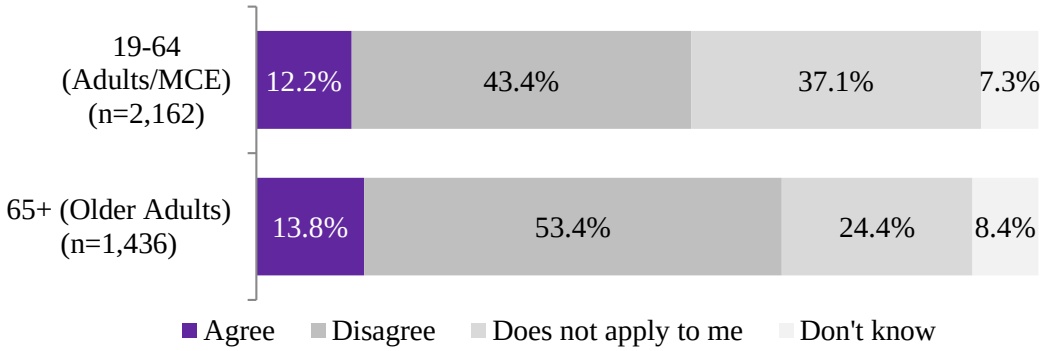
[9] Only reported those who are over 18 years old.

Feel child's attitudes and behavior conflict with cultural values[10]:

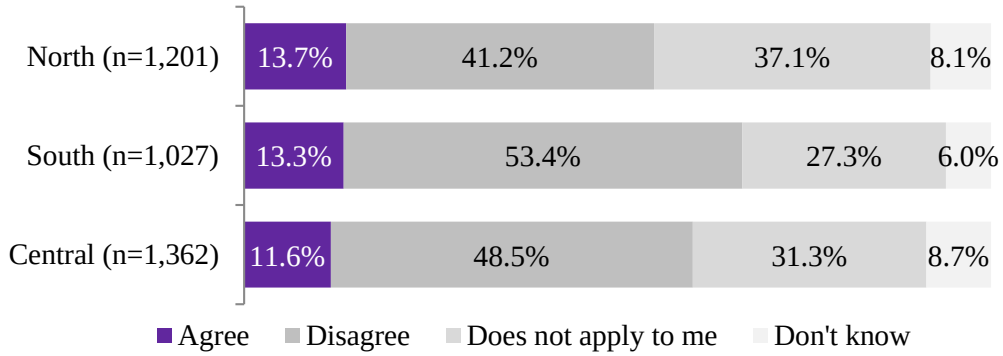
CalOptima language:



Age Category:



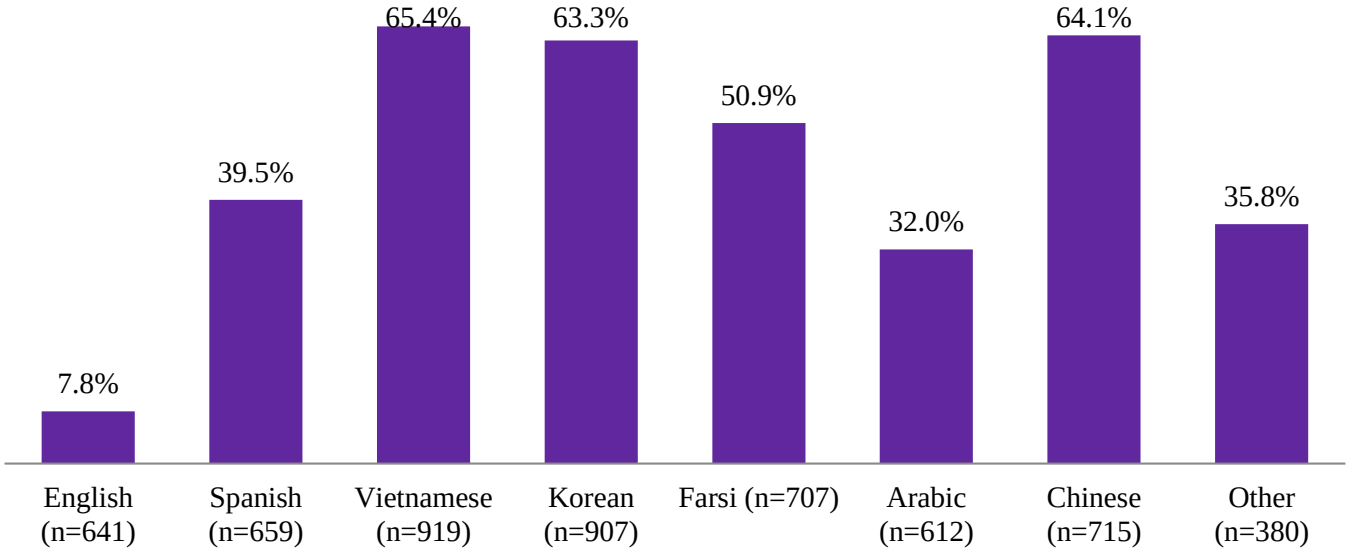
Region:



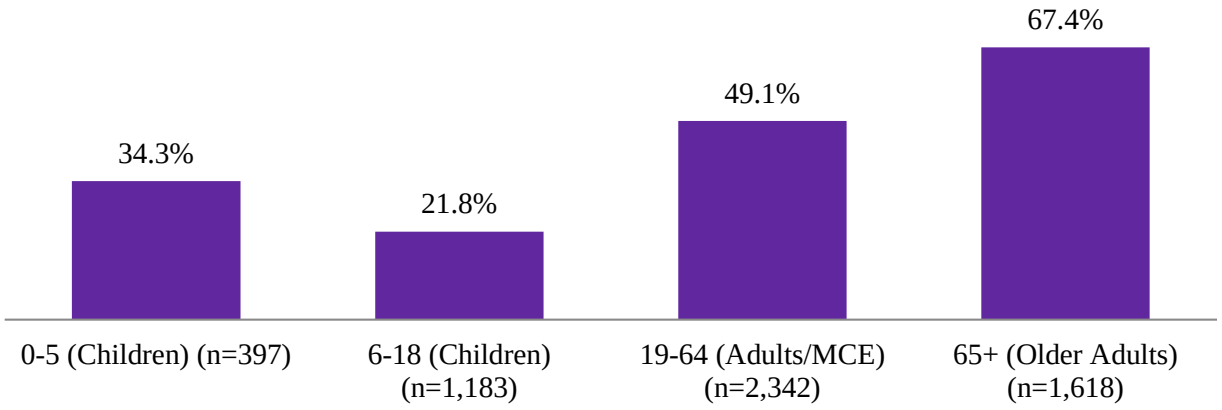
[10] Only reported those who are over 18 years old.

Exhibit 17. Members who reported that they speak English "not well":

CalOptima language:



Age Category:



Region:

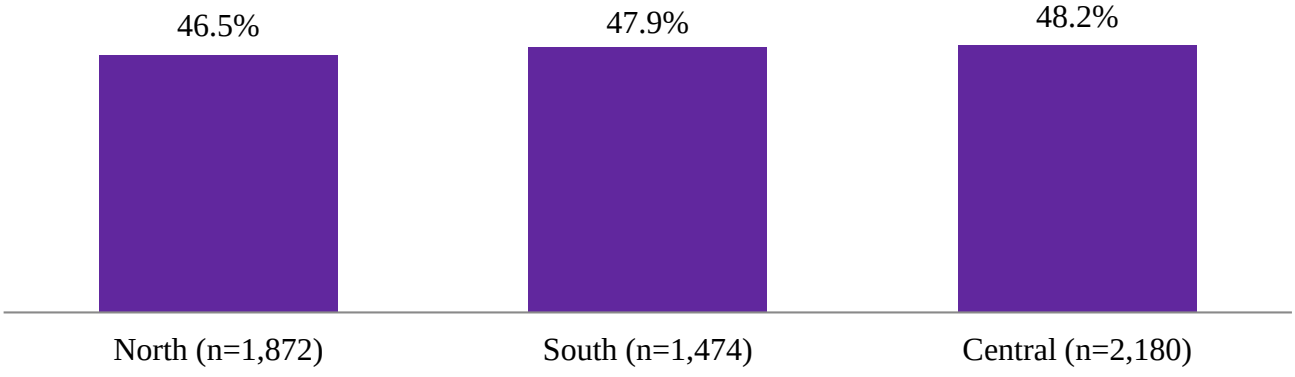


Exhibit 18. Employment status[11,12]

CalOptima language:

CalOptima language	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
English	36.7%	9.8%	7.2%	9.4%	13.4%	15.8%	20.4%	417
Spanish	21.7%	7.8%	11.6%	4.7%	21.3%	17.1%	28.3%	258
Vietnamese	32.1%	1.8%	12.1%	6.6%	24.4%	17.0%	20.0%	761
Korean	18.2%	11.6%	21.3%	6.9%	24.5%	10.0%	16.5%	638
Farsi	18.0%	4.4%	15.3%	7.6%	19.5%	26.5%	29.9%	616
Arabic	25.5%	4.2%	21.1%	9.4%	15.7%	11.9%	22.0%	427
Chinese	14.0%	3.8%	14.2%	4.9%	45.0%	6.8%	19.5%	529
Other	15.7%	3.4%	8.9%	3.7%	37.5%	10.2%	30.8%	325

Age Category:

Age Category	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
19-64 (Adults/MCE)	35.8%	8.3%	17.5%	10.9%	5.9%	17.6%	15.3%	2,370
65+ (Older Adults)	4.1%	1.7%	10.1%	0.7%	53.7%	10.5%	33.3%	1,601

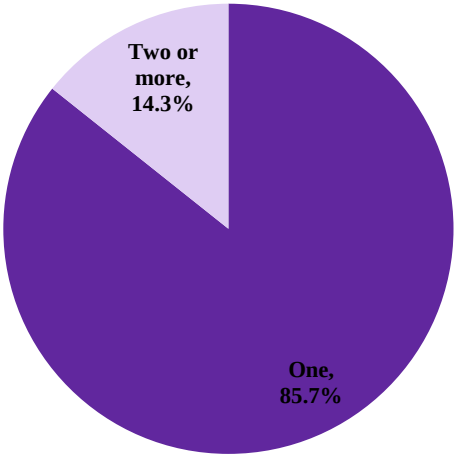
Region:

Region	Employed %	Self-employed %	Homemaker %	Student %	Retired %	Out of work %	Unable to work %	n
North	24.0%	6.7%	15.9%	6.7%	23.6%	12.7%	22.5%	1,269
South	17.3%	6.6%	16.7%	7.3%	26.6%	17.3%	22.1%	1,129
Central	26.1%	4.0%	11.7%	6.5%	25.6%	14.7%	23.2%	1,561

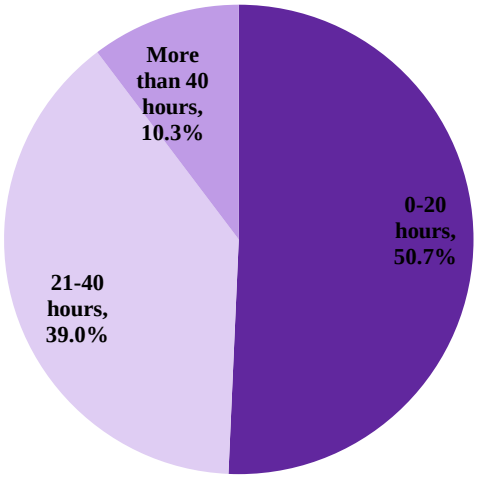
[11] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[12] Only reported the members who are over 18 years old.

Exhibit 19. Number of jobs (n=1,523) and hours worked (n=1,756)[13]

Number of jobs members have

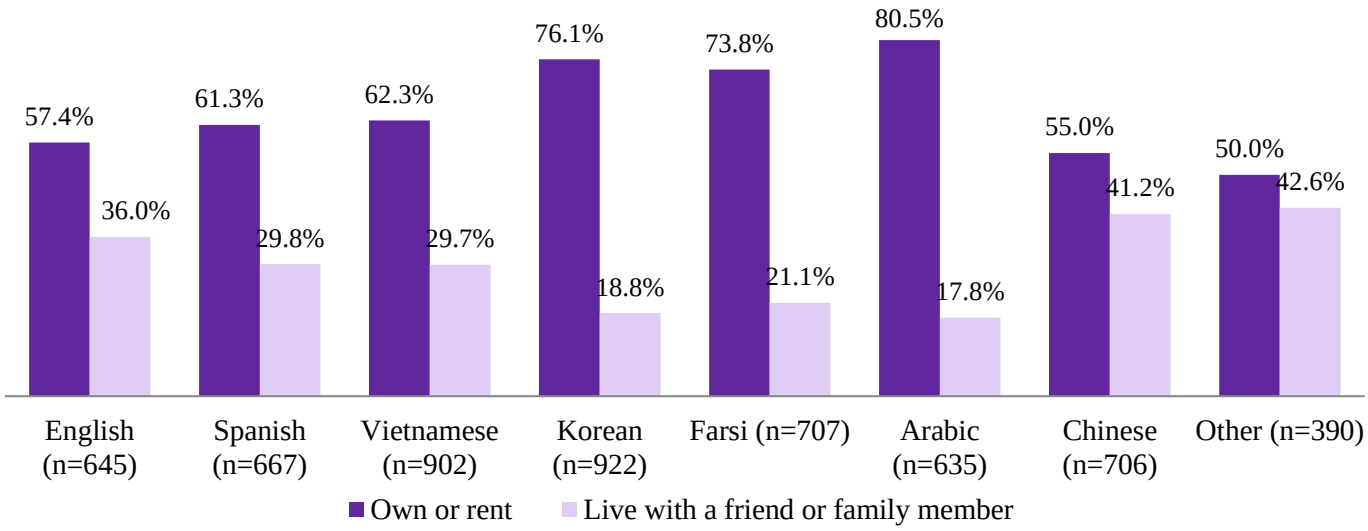


Number of hours that members work each week

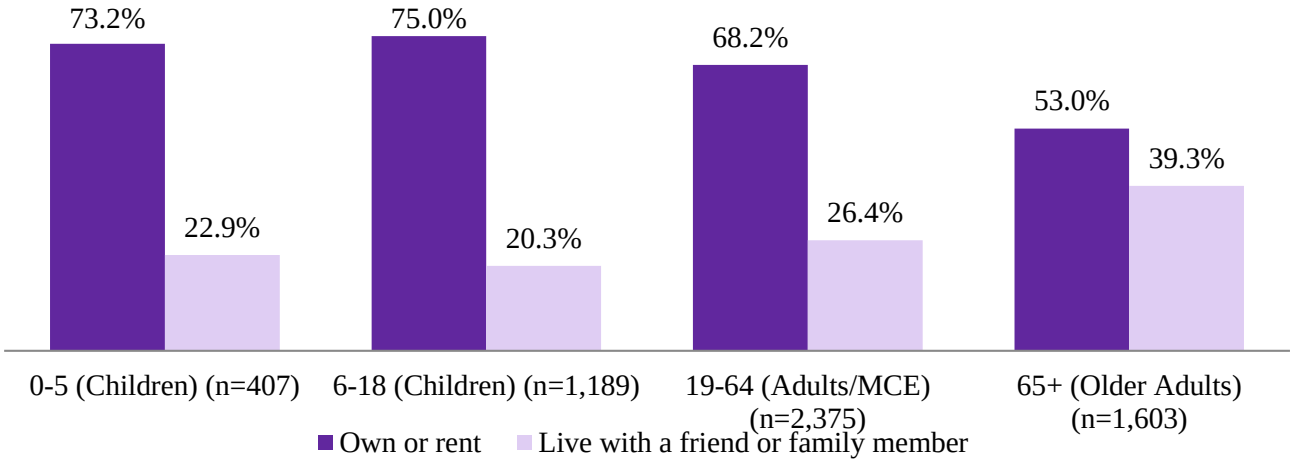


[13] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

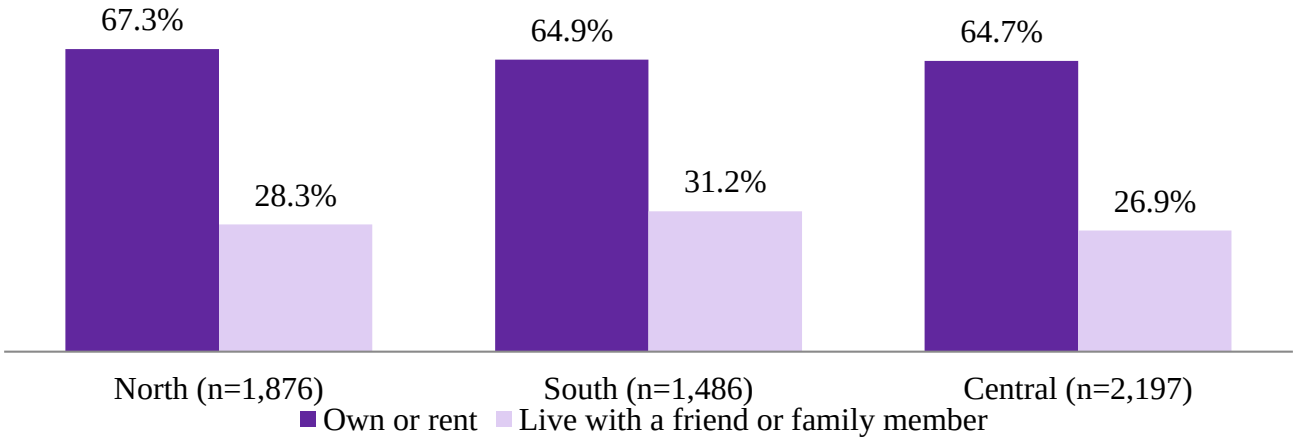
Exhibit 20. Members' living situation[14]



Age Category:



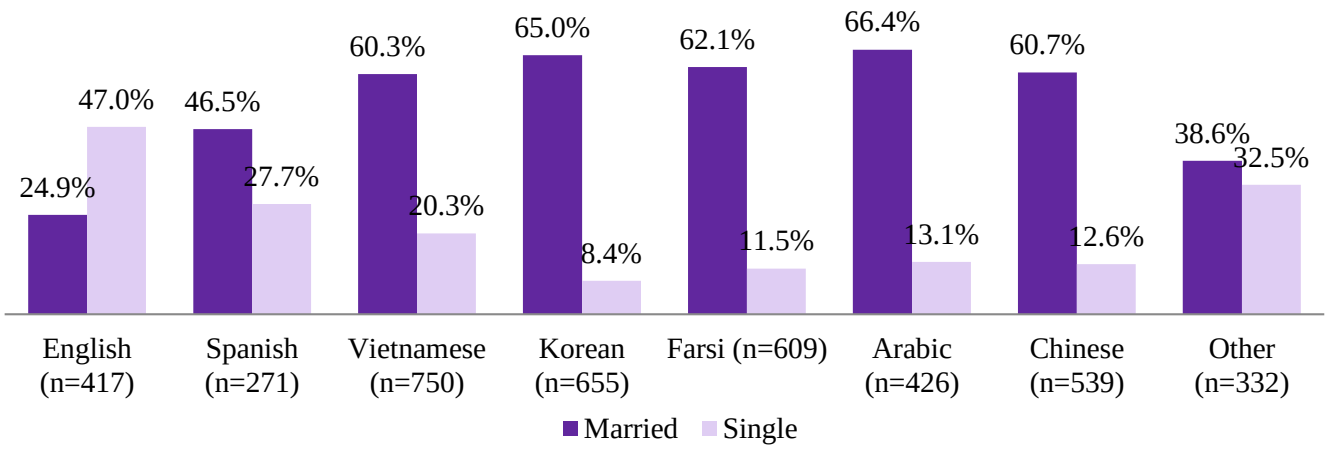
Region:



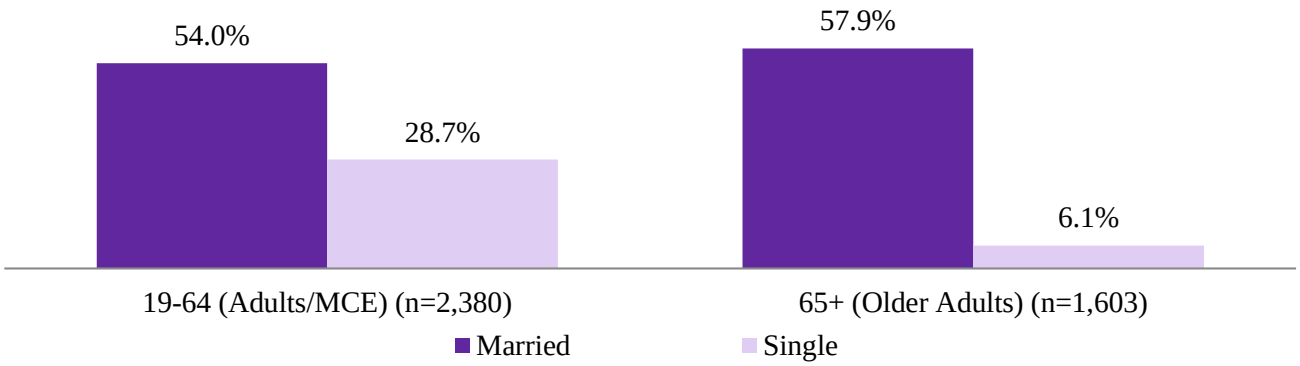
[14] Shelter, hotel or motel, homeless, and other are not shown due to low response rates.

Exhibit 21. Marital status of members[15],[16]

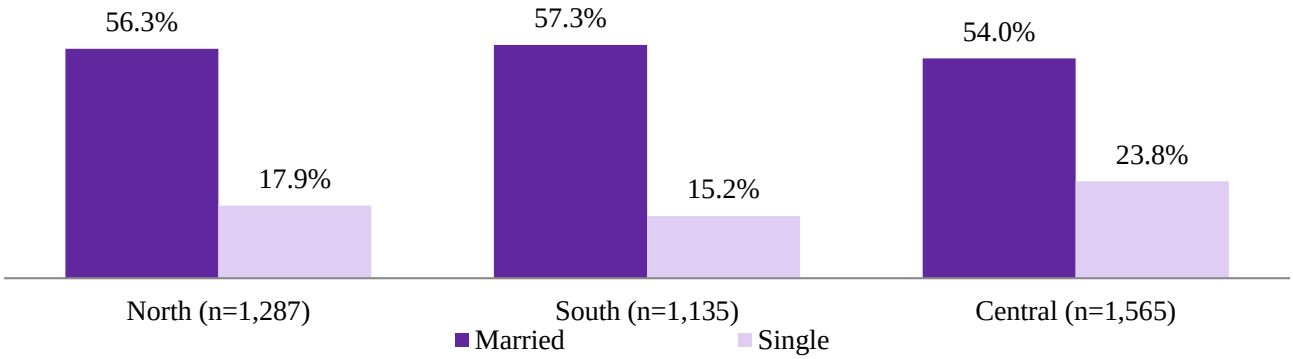
CalOptima language:



Age Category:



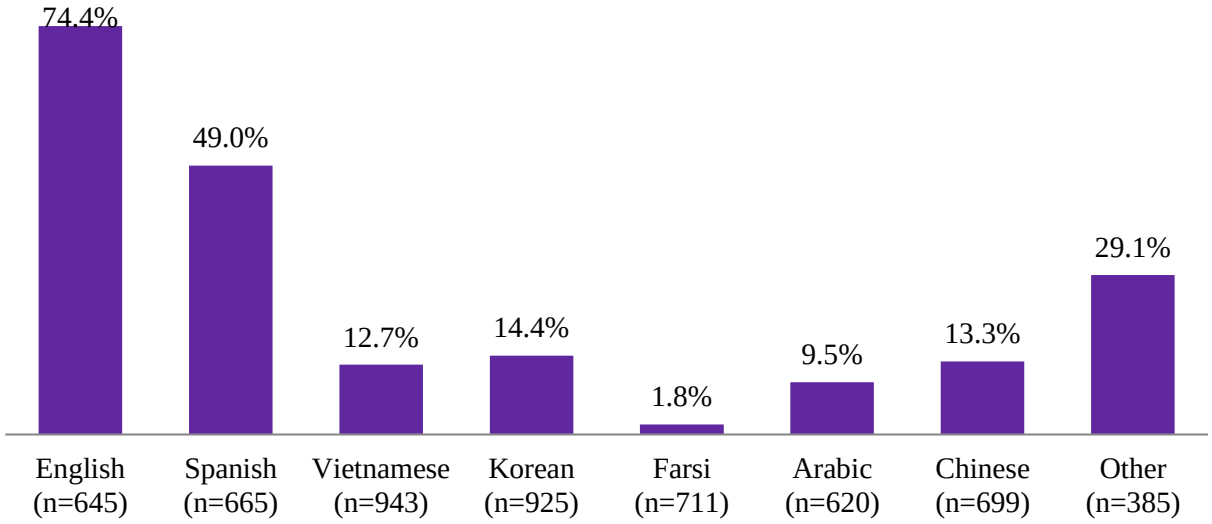
Region:



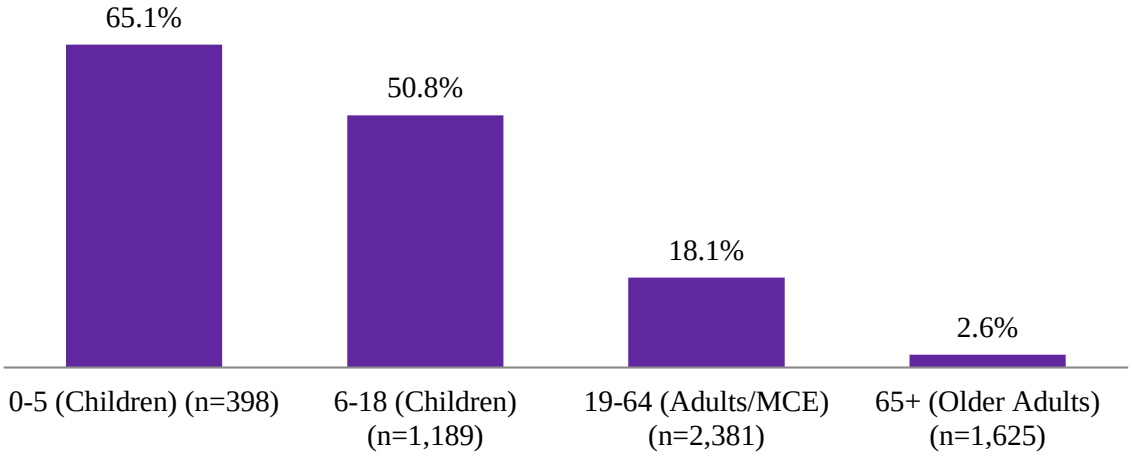
[15] Living with a partner, Widowed, and Divorced or sepated are not shown due to low response rates.
[16] Only reported those who are over 18 years old.

Exhibit 22. Percent of members who were born in the United States:

CalOptima language:



Age Category:



Region:

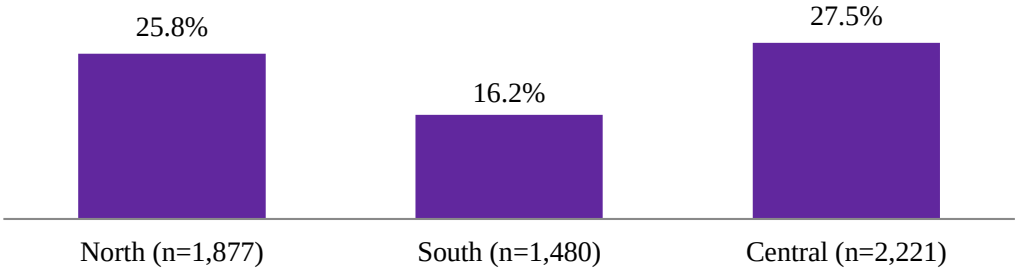
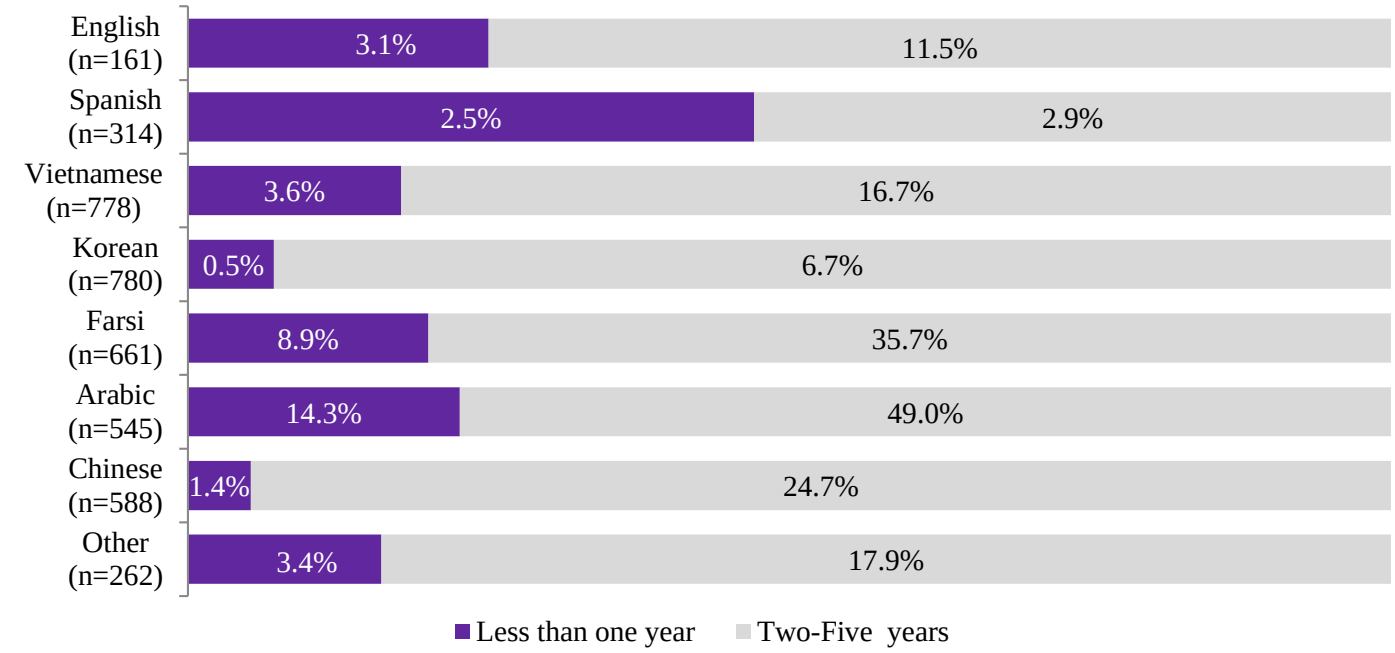
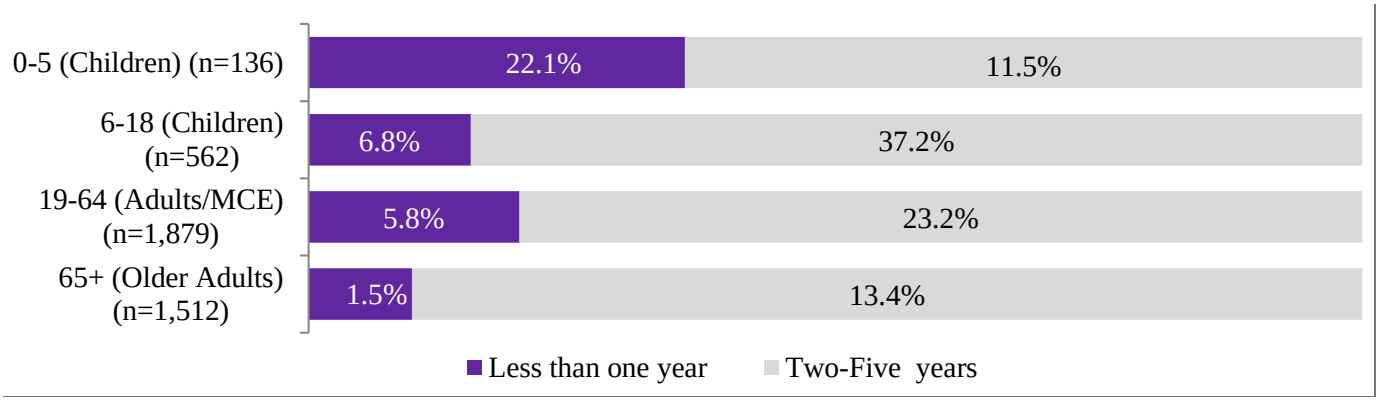


Exhibit 23. Length of time lived in the United States of those not born in the United States

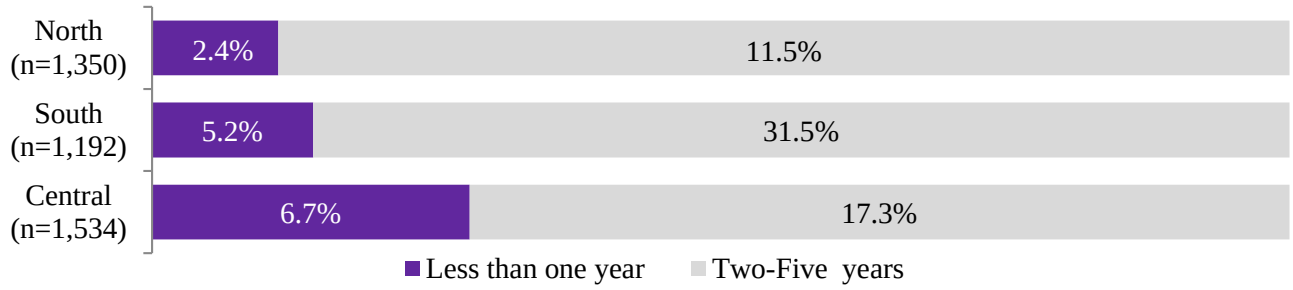
CalOptima language:



Age Category:



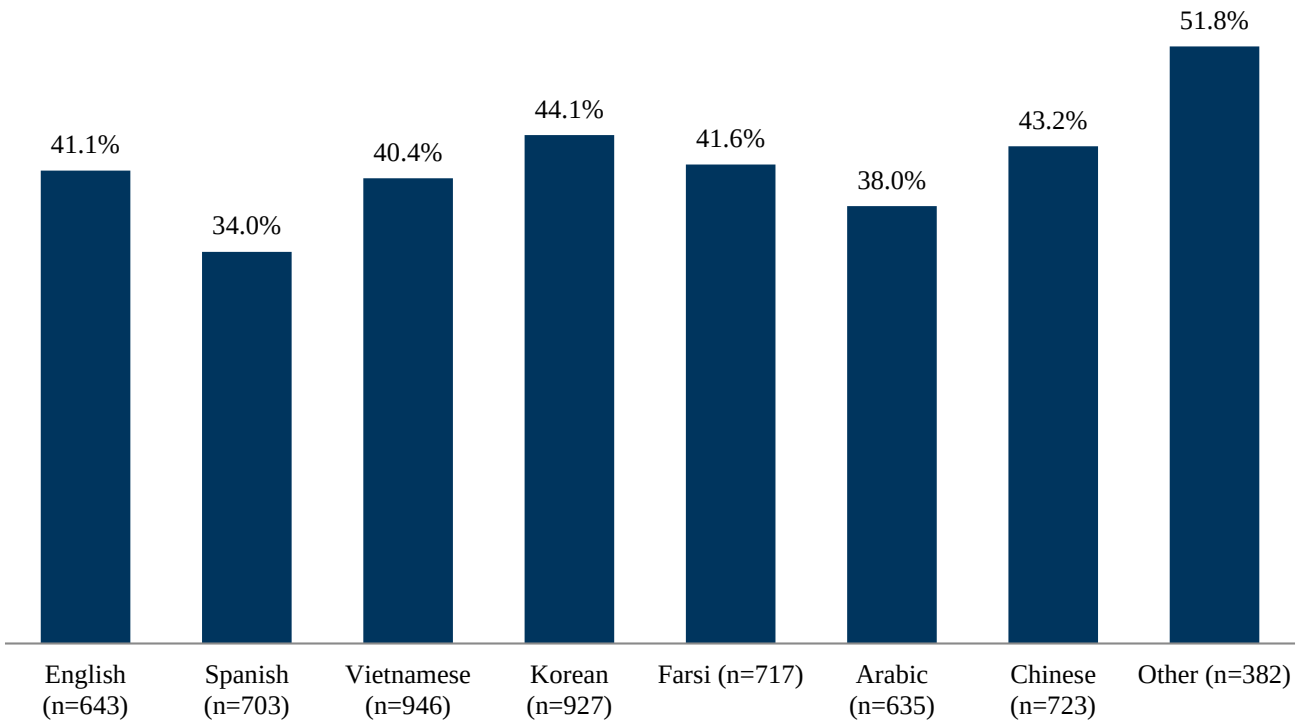
Region:



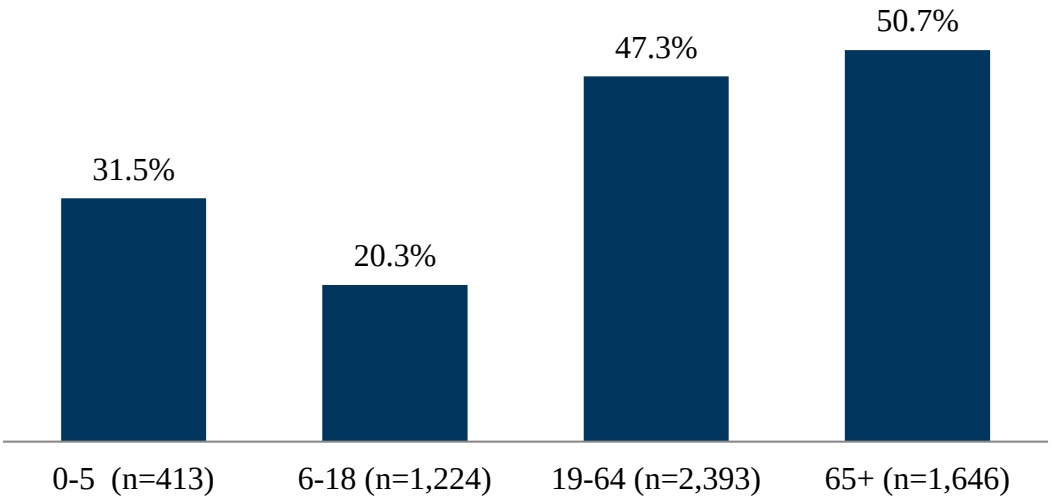
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:



Age Category:



Region:

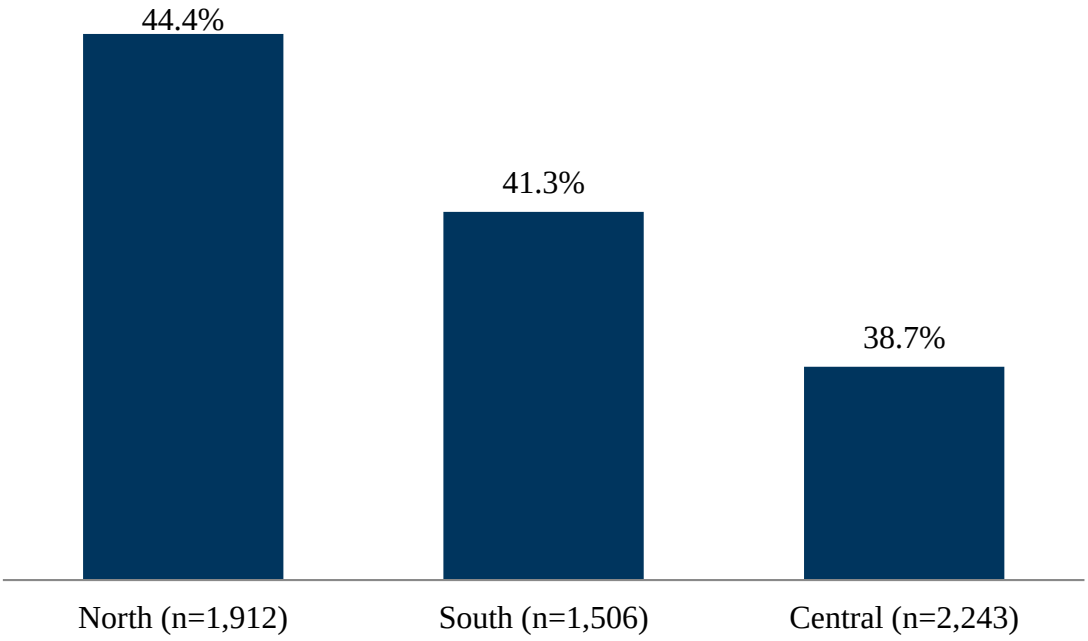


Exhibit 25. Reasons for not seeing dentist within the past 12 months[17,18]

CalOptima Language:

CalOptima Language	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
English	43.8%	28.3%	6.6%	8.1%	258
Spanish	39.5%	17.6%	4.9%	12.2%	205
Vietnamese	26.6%	15.7%	5.0%	13.0%	338
Korean	64.2%	35.3%	4.1%	5.1%	391
Farsi	53.1%	23.8%	5.1%	8.1%	273
Arabic	62.9%	16.3%	1.8%	11.8%	221
Chinese	40.6%	21.1%	7.7%	14.1%	298
Other	33.1%	23.2%	5.5%	12.7%	181

Age Category:

CalOptima Age Category	Cost %	Don't have/know dentist %	No transportation %	Don't know %	n
0-5 (Children)	19.5%	23.7%	3.4%	14.4%	118
6-18 (Children)	34.7%	25.6%	1.8%	15.1%	219
19-64 (Adults/MCE)	52.7%	27.3%	4.1%	9.0%	1,062
65+ (Older Adults)	19.5%	23.7%	3.4%	14.4%	766

[17] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

[18] Only reported those who have not seen a dentist within the past 12 months.

Region:

CalOptima Region	Cost	Don't have/know dentist	No transportation	Don't know	n
	%	%	%	%	
North	48.9%	22.3%	5.5%	9.9%	798
South	51.6%	28.2%	4.6%	9.4%	585
Central	39.2%	20.9%	5.2%	11.3%	776

Exhibit 26. Days per week member had at least one drink of alcoholic beverage during the past 30 days [19]

CalOptima language:

CalOptima Language	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
English	71.7%	19.6%	4.0%	2.0%	2.7%	403
Spanish	83.5%	10.4%	1.3%	0.9%	3.9%	230
Vietnamese	81.3%	10.7%	1.9%	1.8%	4.3%	738
Korean	77.1%	15.5%	3.0%	1.5%	2.9%	593
Farsi	74.8%	19.3%	1.2%	0.2%	4.4%	497
Arabic	87.6%	4.5%	0.6%	0.8%	6.5%	355
Chinese	84.9%	8.0%	1.2%	0.6%	5.4%	503
Other	83.7%	7.7%	1.6%	1.3%	5.8%	312

Age Category:

CalOptima Age Category	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
19-64 (Adults/MCE)	78.7%	13.0%	2.3%	1.0%	4.9%	2,163
65+ (Older Adults)	82.2%	11.4%	1.4%	1.4%	3.5%	1,468

[19] Only reported those who are 18 years or older.

Region:

CalOptima Region	No drinks in past 30 days %	1-2 days per week %	3-4 days per week %	5-7 days per week %	Don't know %	n
North	81.1%	11.9%	1.2%	1.5%	4.3%	1,156
South	79.5%	14.5%	1.8%	0.7%	3.5%	1,000
Central	79.7%	11.4%	2.5%	1.3%	5.1%	1,465

January 2018

CalOptima Member Survey Data Book:

Weighted Population Estimates

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Navigating the Healthcare System

Exhibit 27. Percent who report at least one person as their doctor (n=5,749)

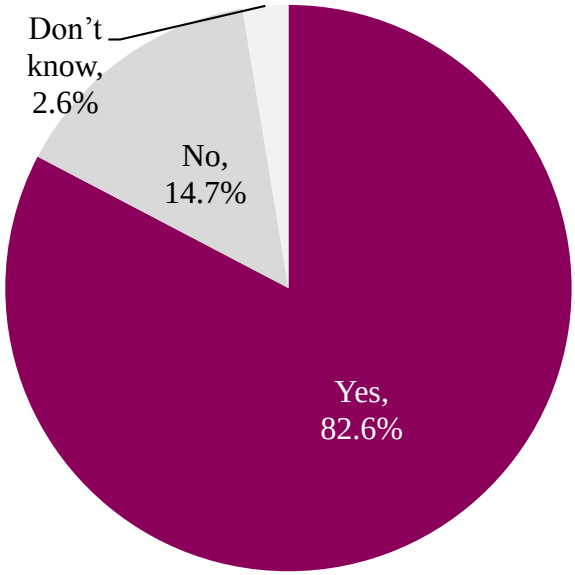


Exhibit 28. Where respondents go to see their doctor (n=5,743)

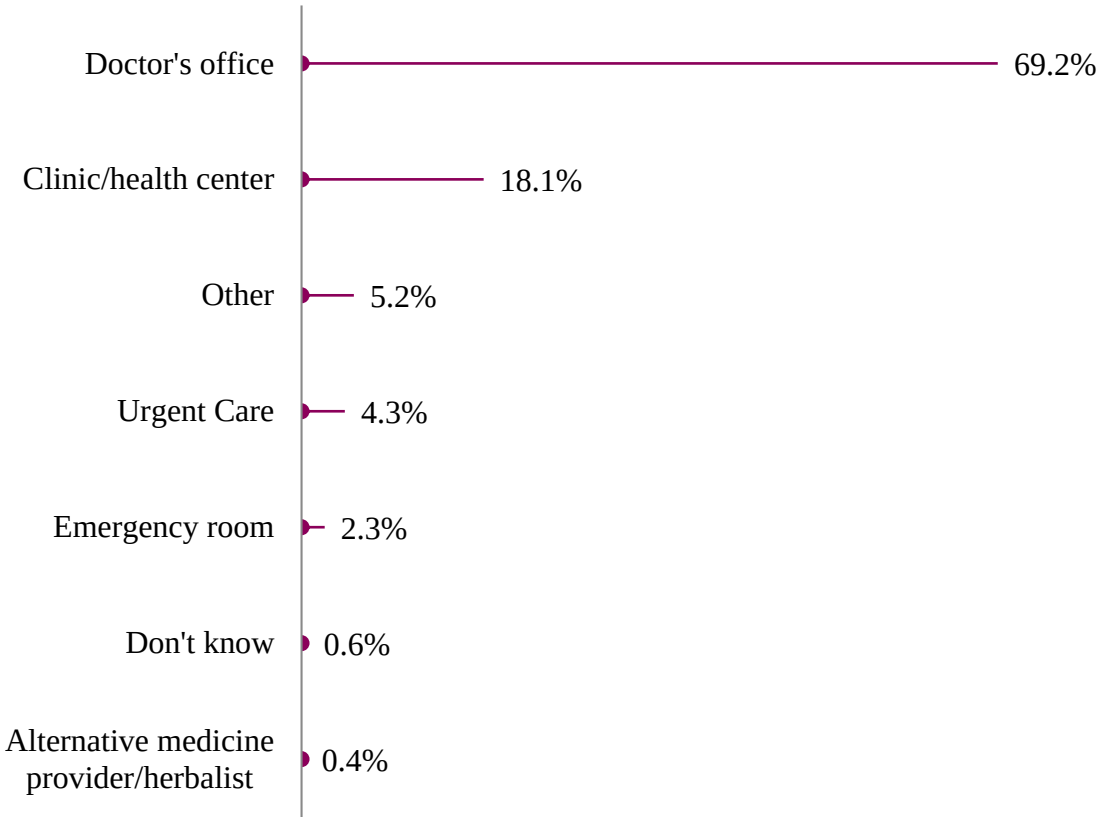


Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

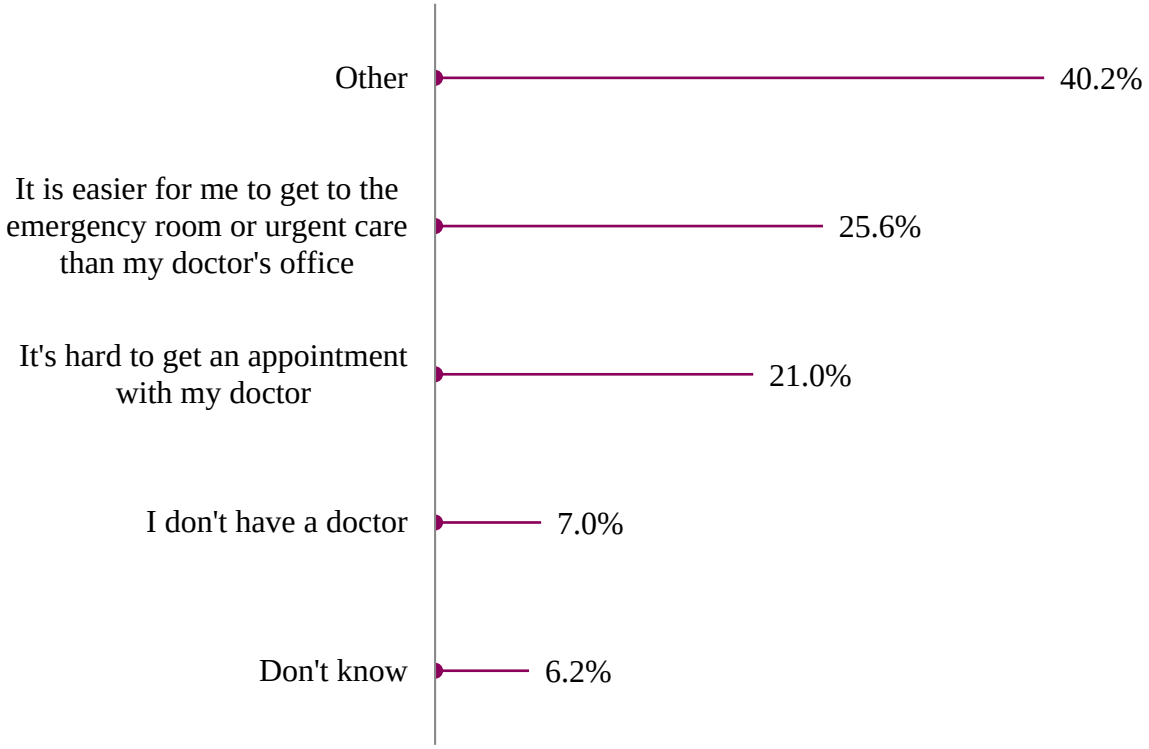


Exhibit 30. When do members make an appointment to see doctor (n=5,764)[20]

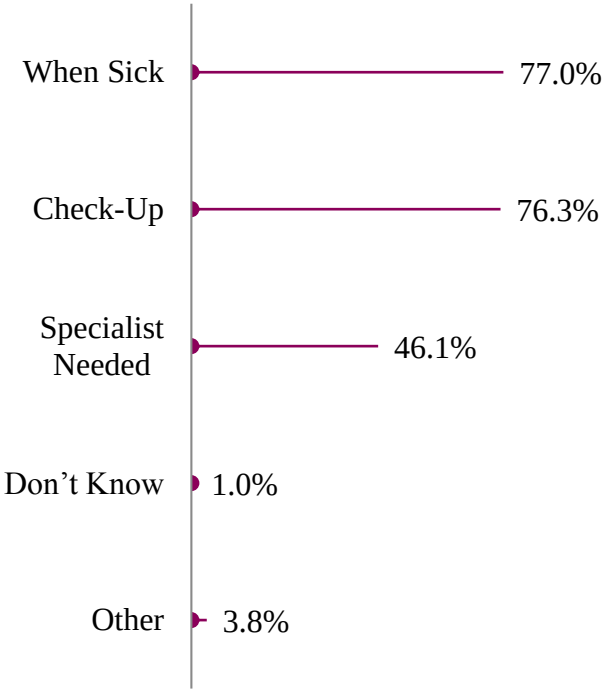
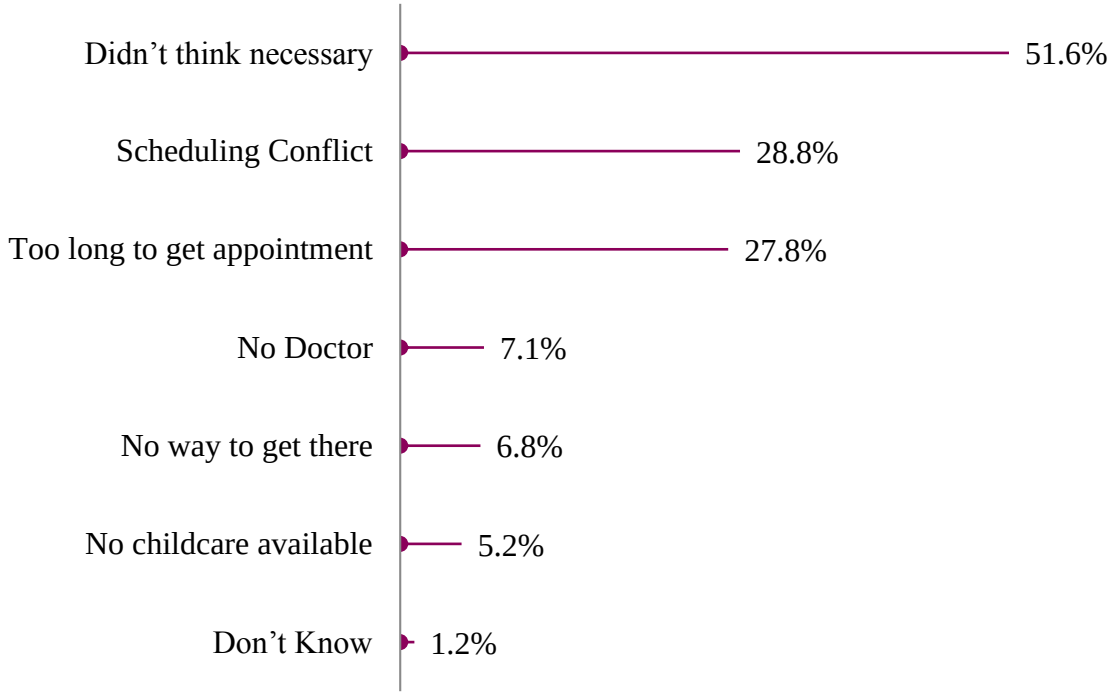


Exhibit 31. Reasons why members don't make an appointment to see doctor (n=4,598)[21]



[20] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[21] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 32. When do members make an appointment to see a specialist (n=5,590)[22]

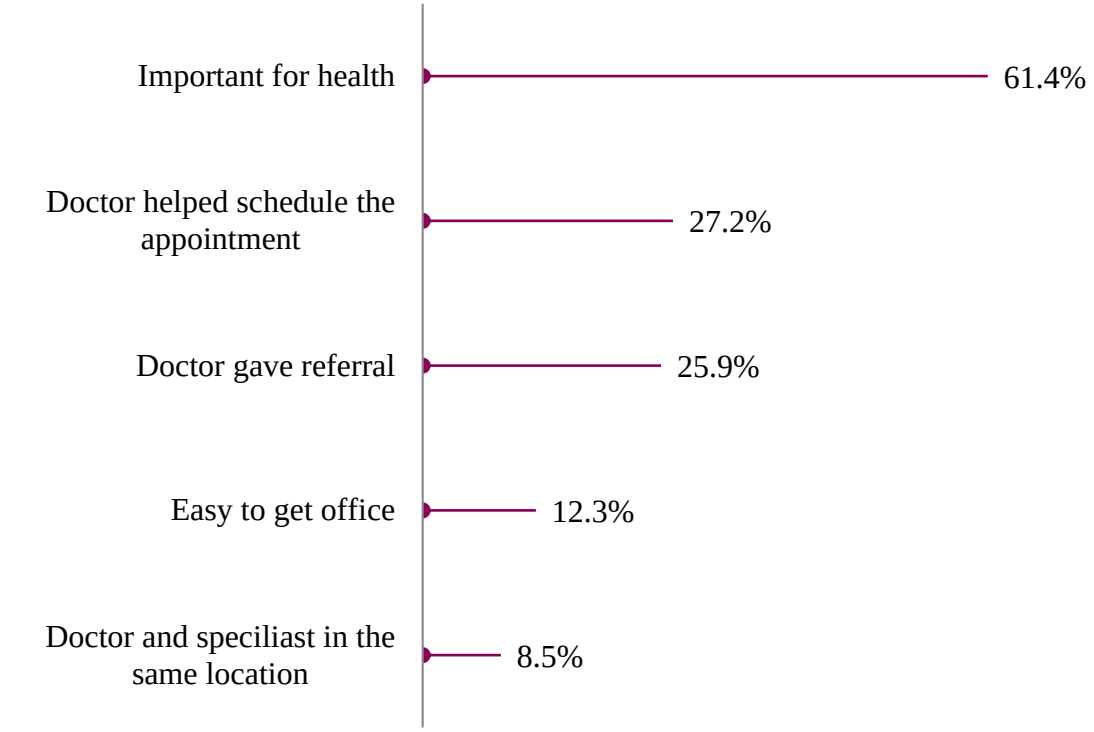
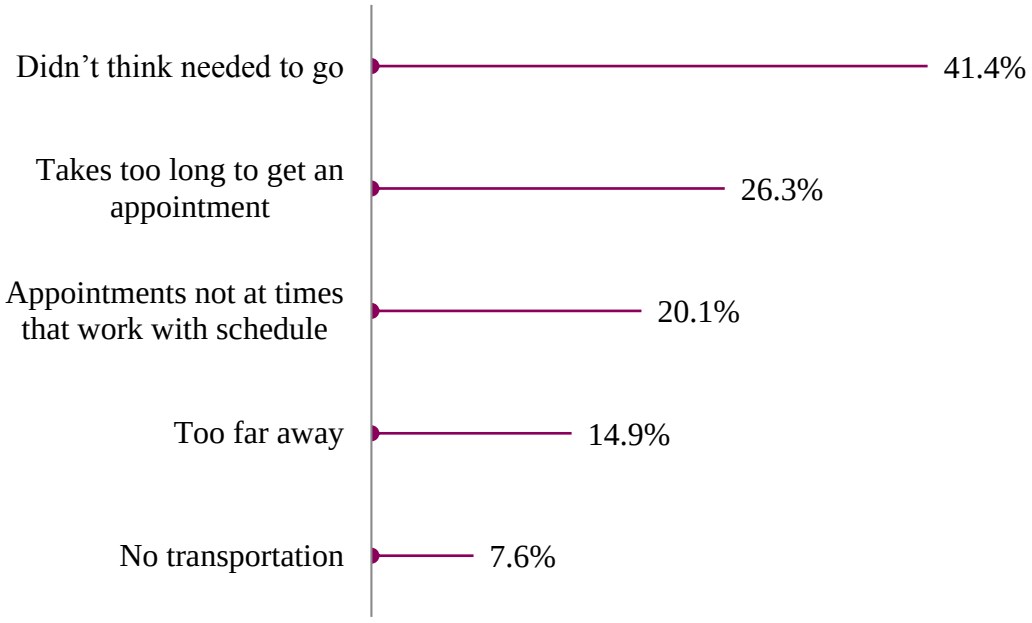
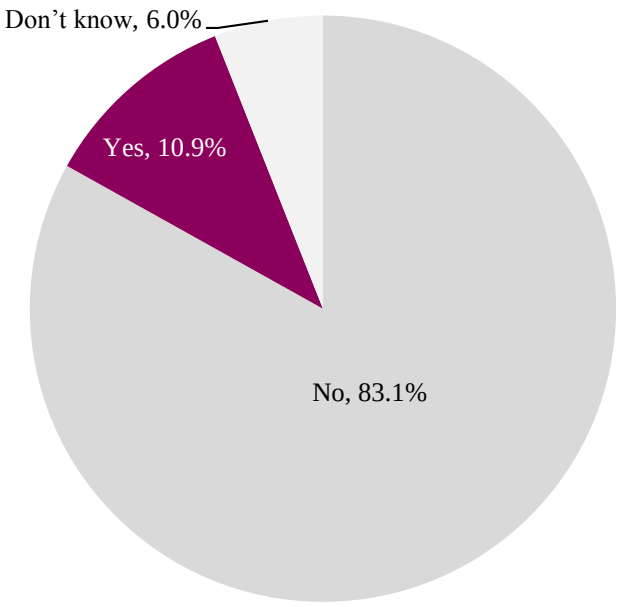


Exhibit 33. Reasons why members don't make an appointment to see a specialist (n=4,713)[23]



[22] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[23] Members were allowed to choose multiple answers; thus, the total does not equal 100%.

Exhibit 34. Members who have a disability that limits their ability to physically access health care, communicate effectively or follow directions given by doctor (n=4,955)



Social and Emotional Well-Being

Exhibit 35. Percent of members who indicated they needed to see a mental health specialist (n=5,723)

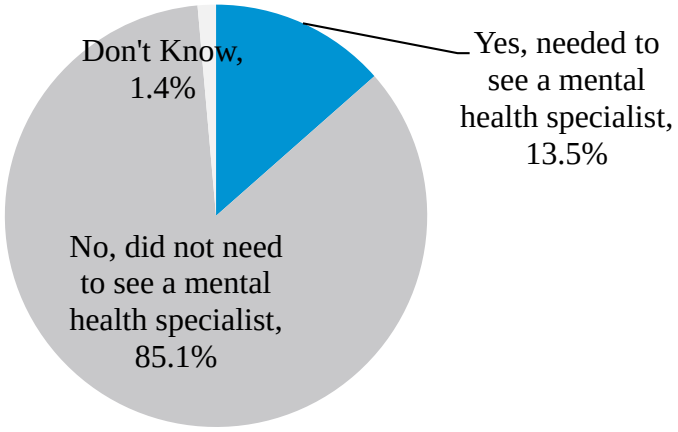


Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn't see one (n=771)

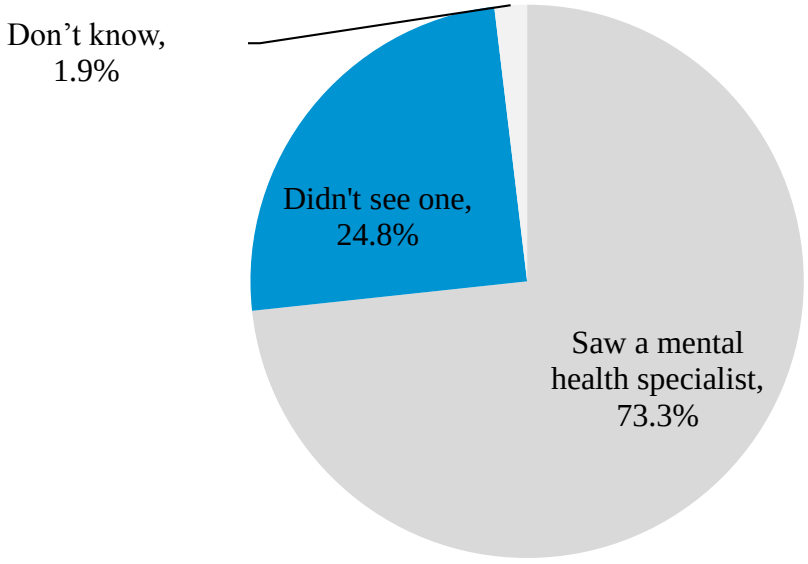


Exhibit 37. Reasons why members didn't see mental health specialist[24]

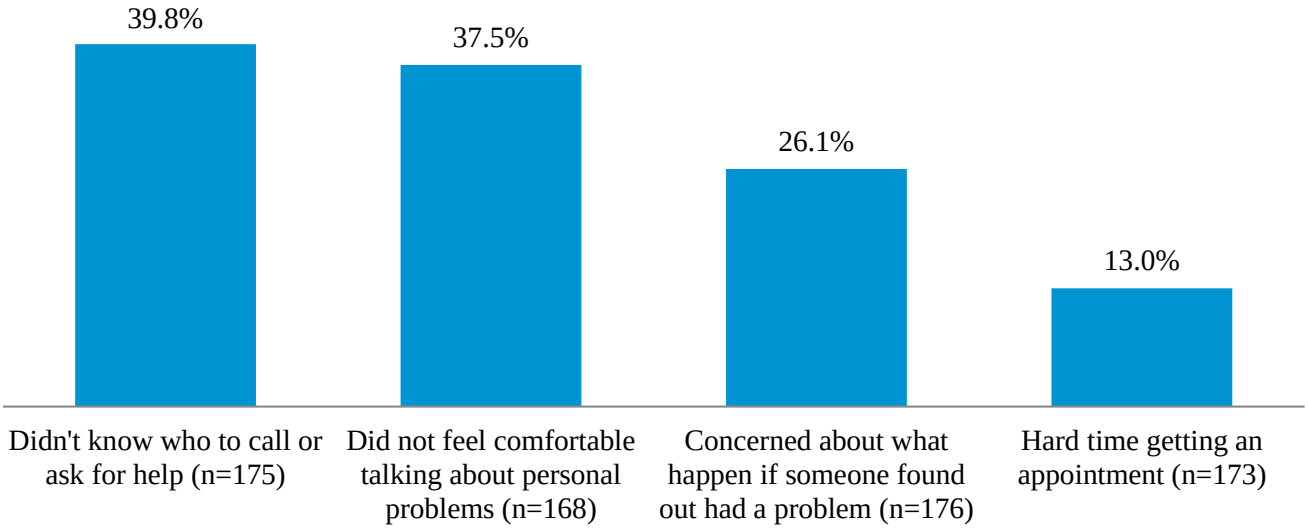
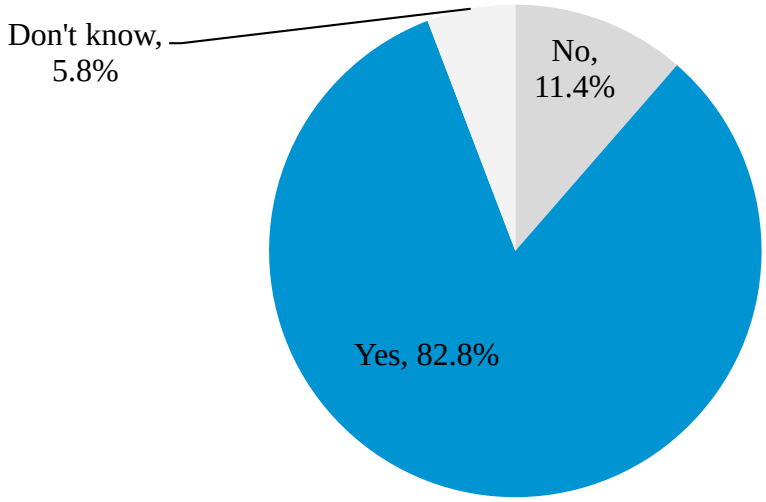


Exhibit 38. Percent of members who can share their worries with family members (n=5,670)



[24] Among those who indicated that they needed to see a mental health specialist but did not see one.

Social Determinants of Health

Exhibit 39. Percent of members who needed help with basic needs in the past 6 months:

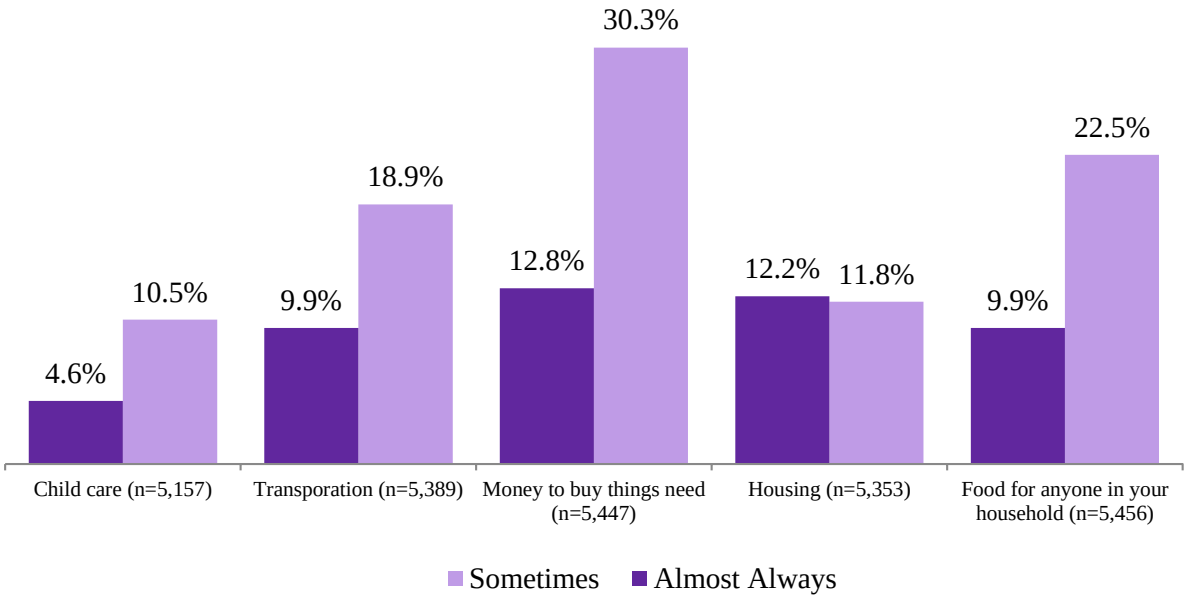


Exhibit 41. Percent of members who receive public benefits (n=5,117):

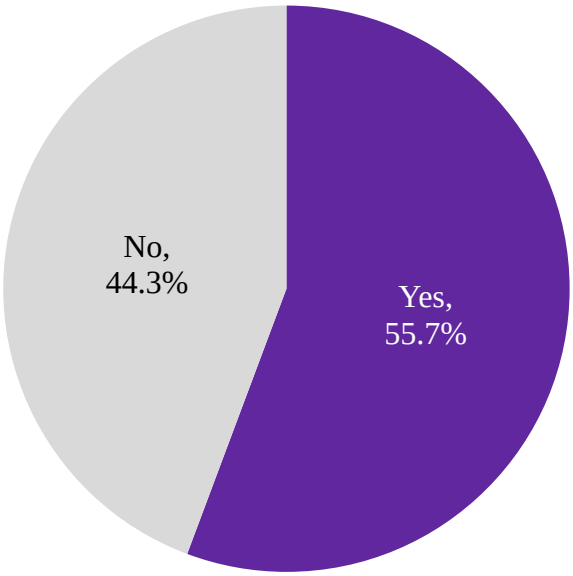
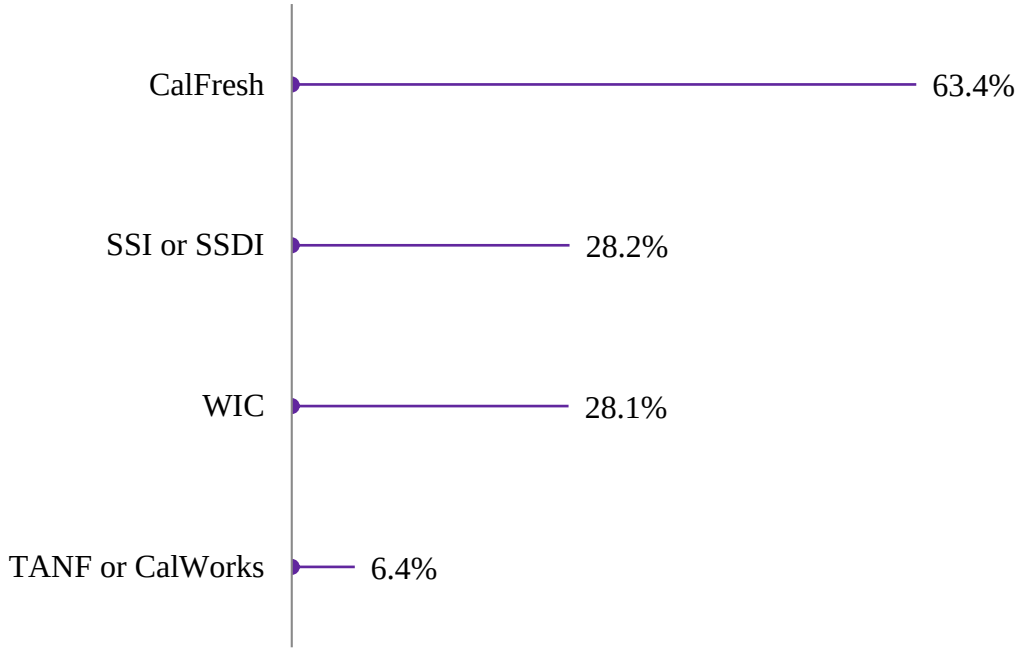


Exhibit 42. Type of public benefits that members receive (n=2,849)[25]:

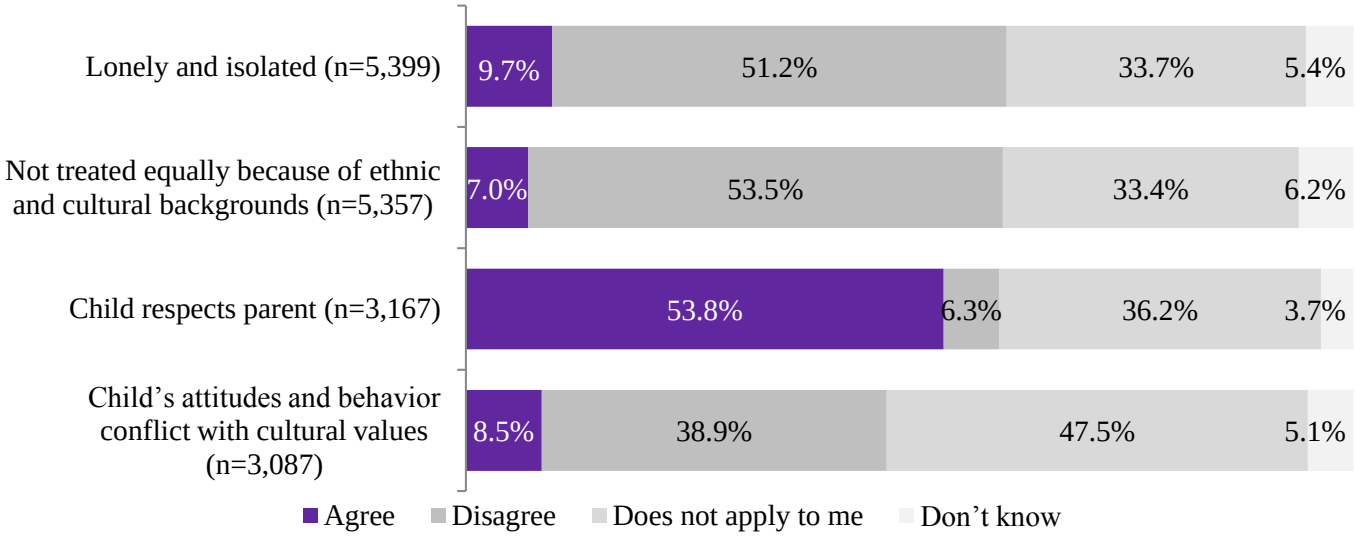


[25] Only reporting those who reported that they received at least one public benefit. Respondents were allowed to choose more than one option; thus, the total is over 100%.

Exhibit 43. Personal activities members participant in:

	Once a week	Once a month	Once in the last 6 months	Never	n
Care for a family member	36.2%	5.6%	5.1%	53.1%	5,209
Fun with others	61.9%	17.0%	6.6%	14.6%	5,396
Volunteer or Charity	16.4%	14.2%	17.3%	52.1%	5,288
Physical fitness	68.4%	10.2%	4.8%	16.7%	5,393
Attend religious centers	48.7%	11.1%	10.8%	29.4%	5,470
Get enough sleep	83.5%	5.8%	1.1%	9.6%	5,119
Enough time for self	77.4%	10.6%	3.1%	8.8%	5,209
Enough time for family	81.5%	8.5%	3.1%	6.9%	5,274
Gambling activities	0.9%	0.8%	4.8%	93.5%	5,378

Exhibit 44. Feelings towards community and home enviroment[26]:



[26] Only reported for those over 18 years old for "Child respects parent" and "Child's attitudes and behavior conflict with cultural values."

Exhibit 45. How well members speak English (n=5,549)

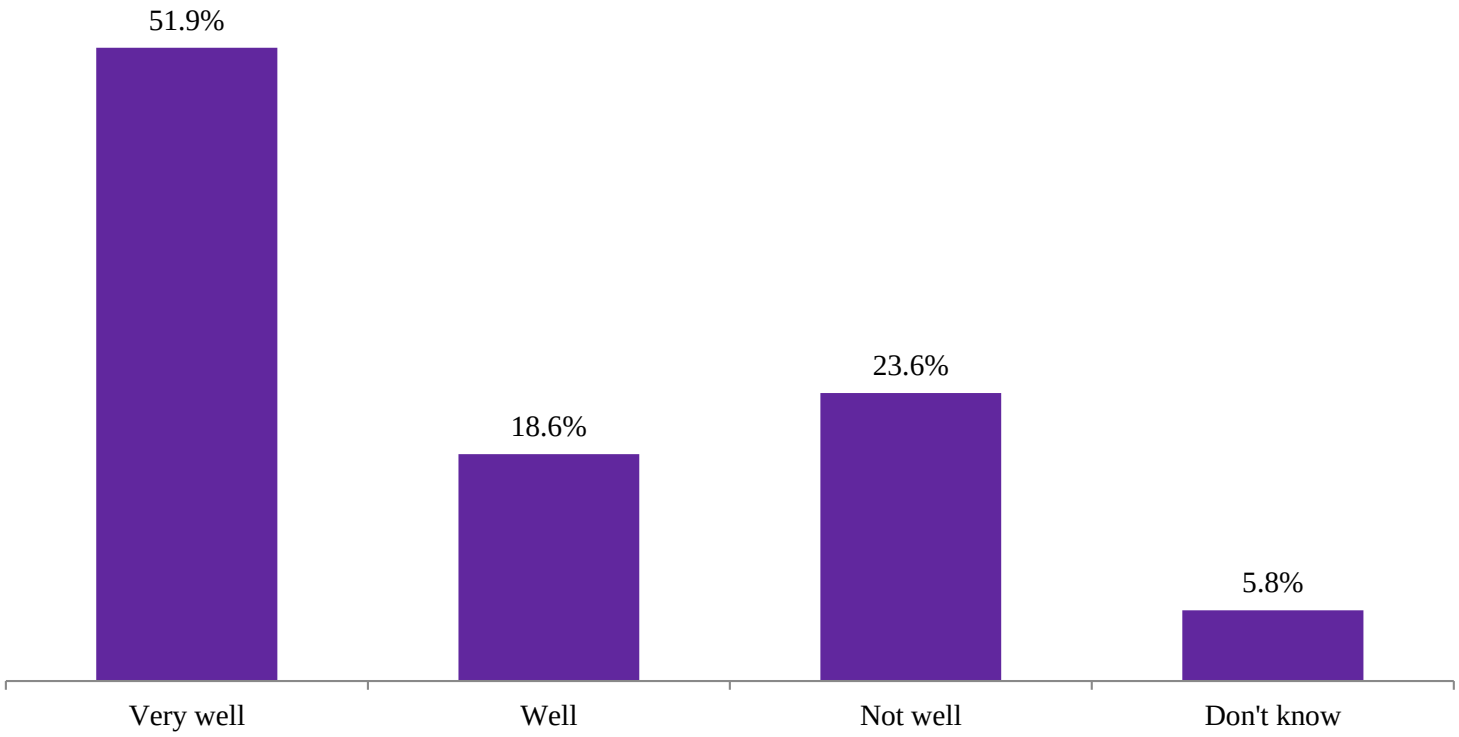


Exhibit 46. Employment status for members over 18 (n=3,244)[27,28]

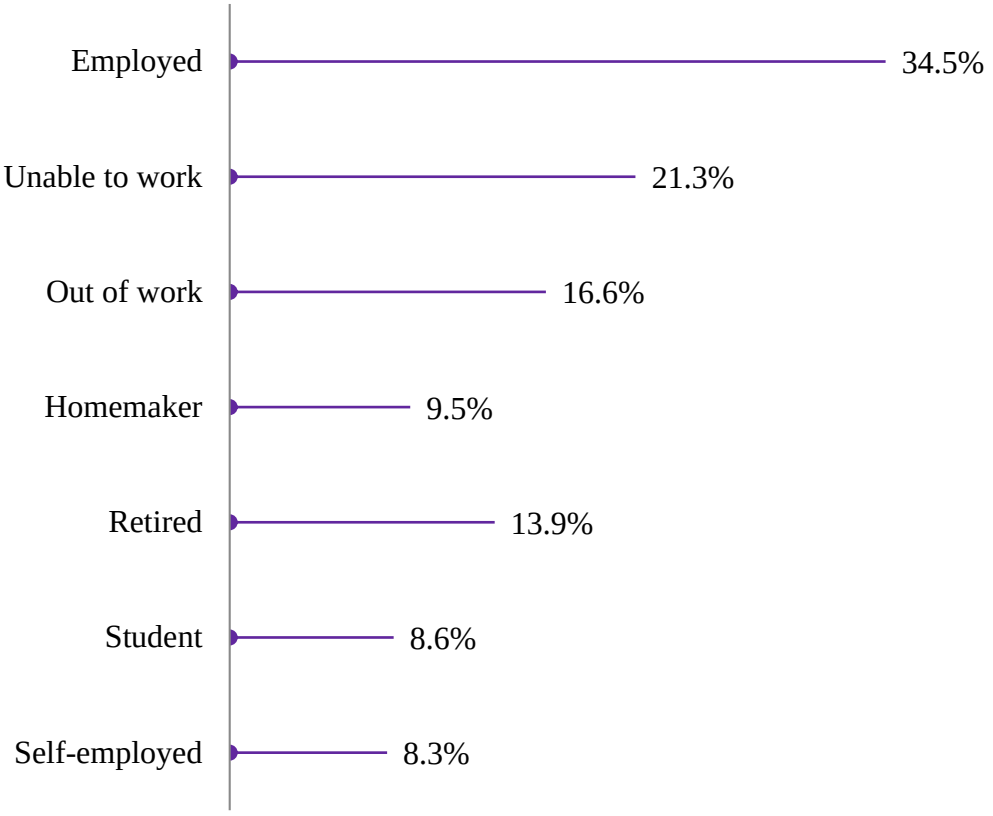
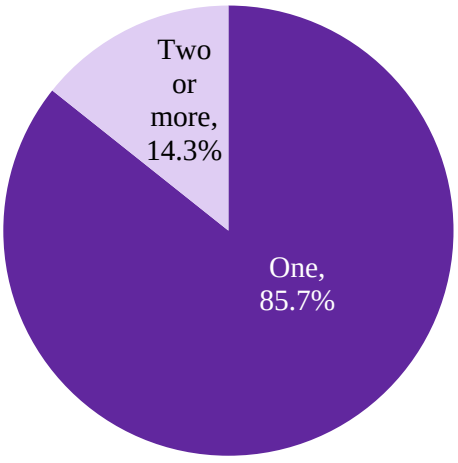
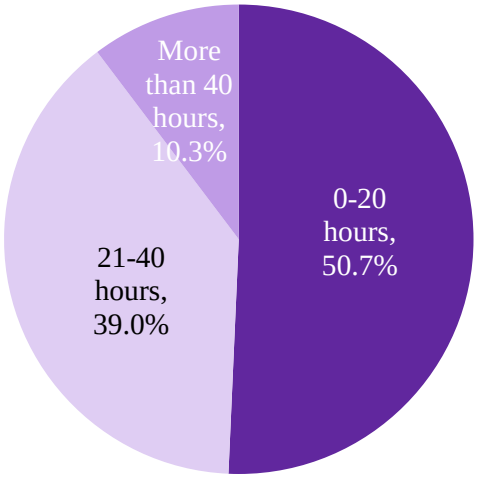


Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)[29]

Number of jobs members have



Number of hours that members work each week



[27] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[28] Only reported the members who are over 18 years old.
[29] Only reported those that indicated that they are "Employed" or "Self-employed" (n=1,802).

Exhibit 48. Members' living situation (n=5,590)

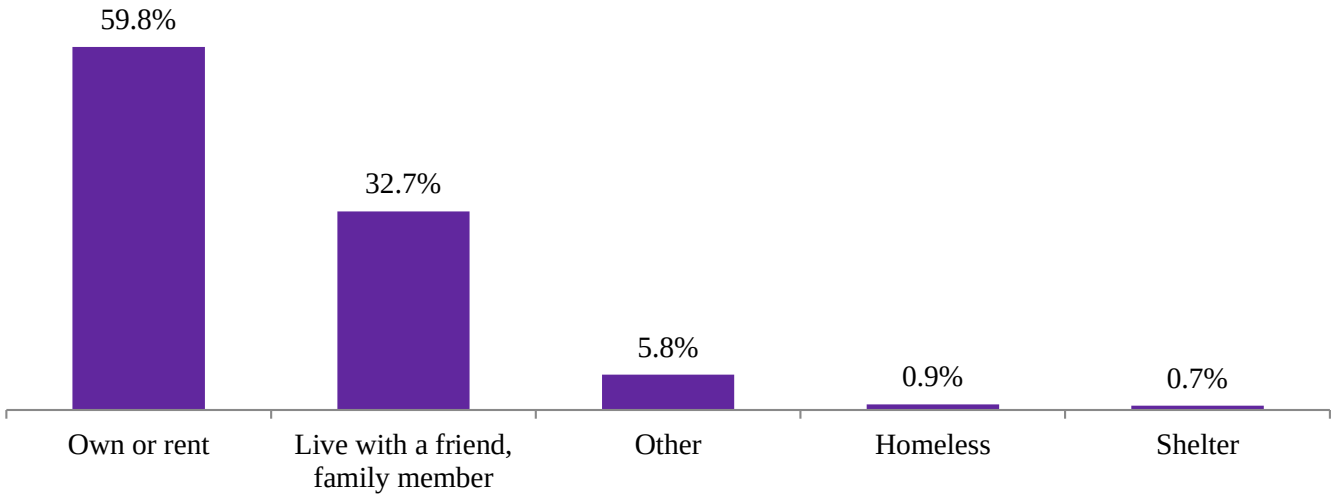
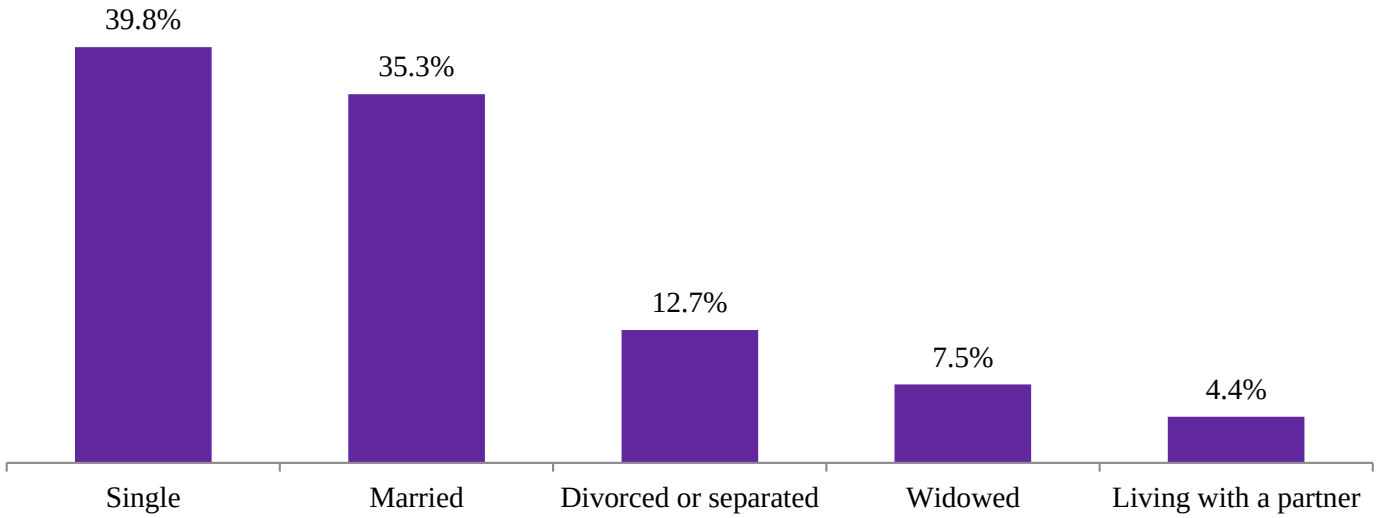


Exhibit 49. Marital status of members (n=3,271)[30]



[30] Only reported those who are over 18 years old.

Exhibit 50. Percent of members who were born in the United States (n=5,599)

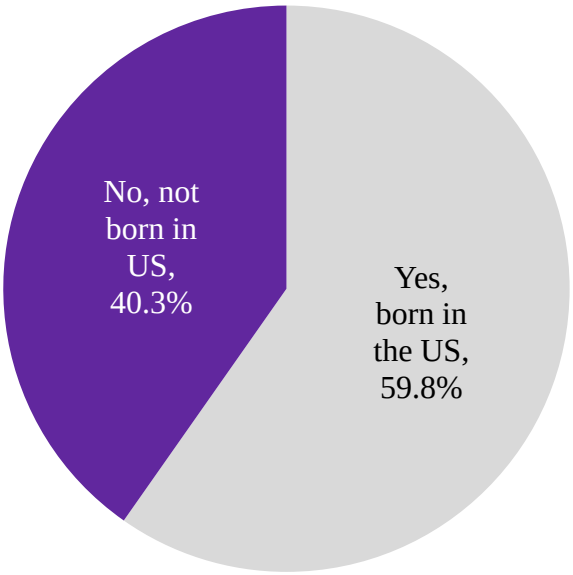
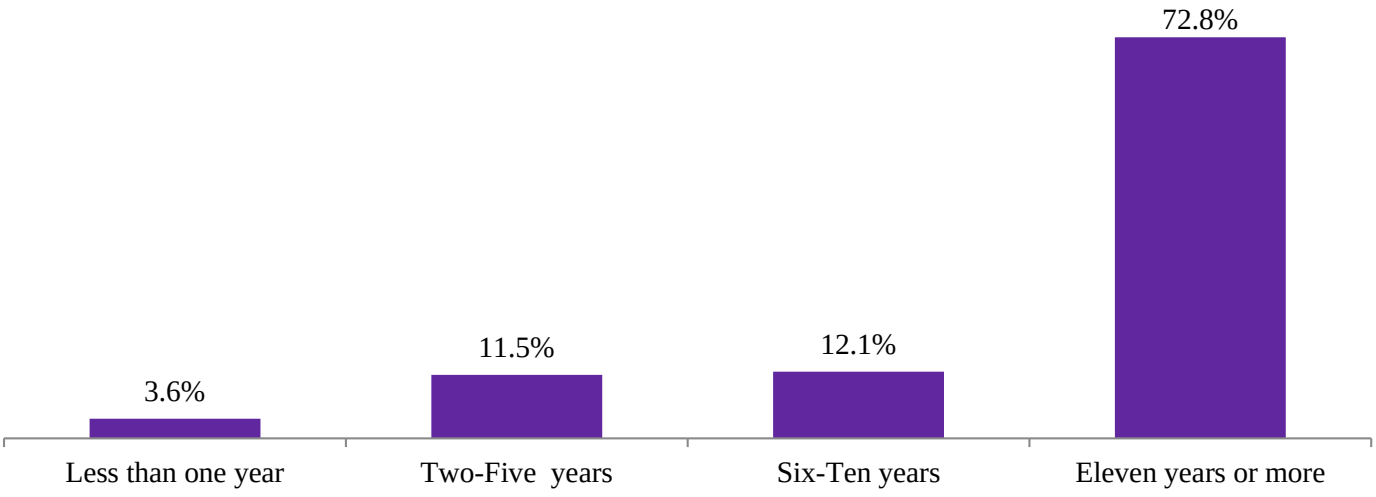


Exhibit 51. Length of time lived in the United States of those not born in the United States (n=2,151)[31]



[31] Of those who were born outside of the U.S.

Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

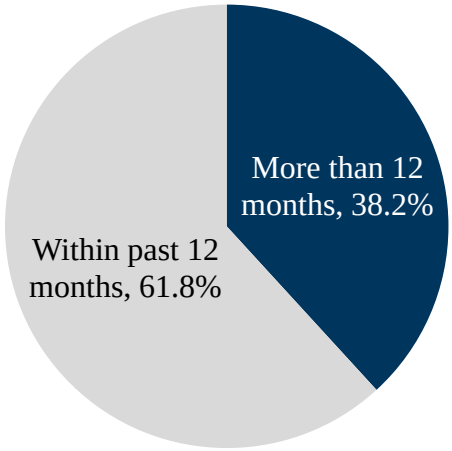
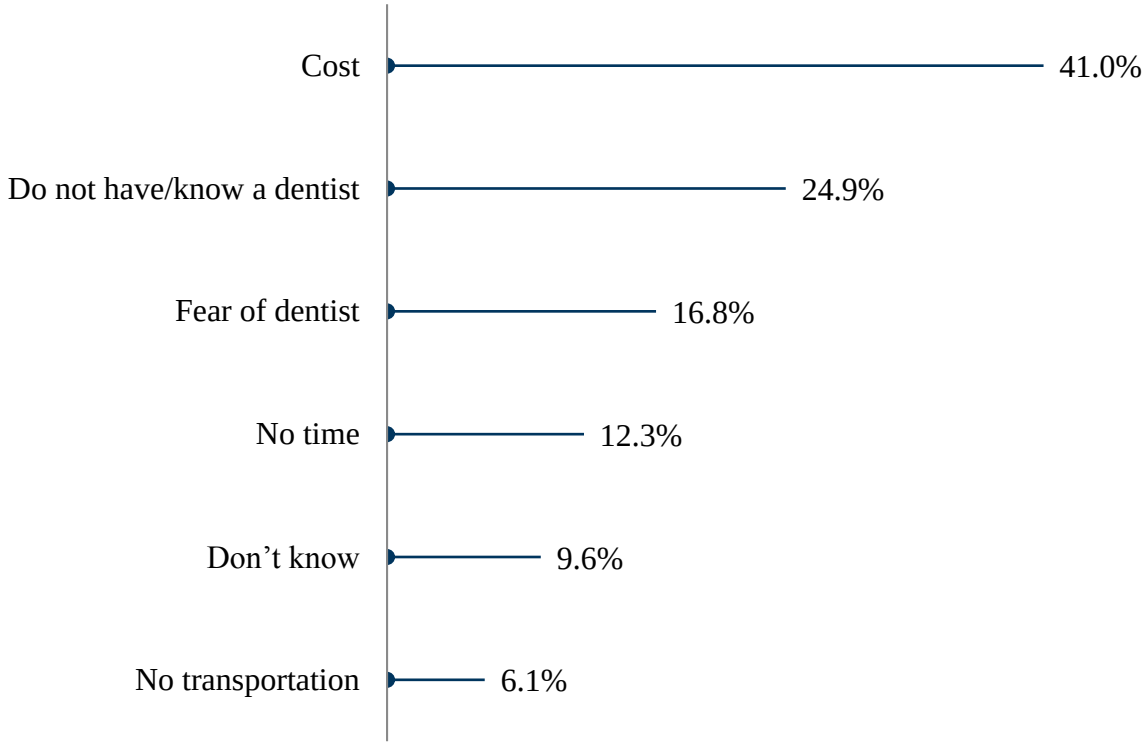
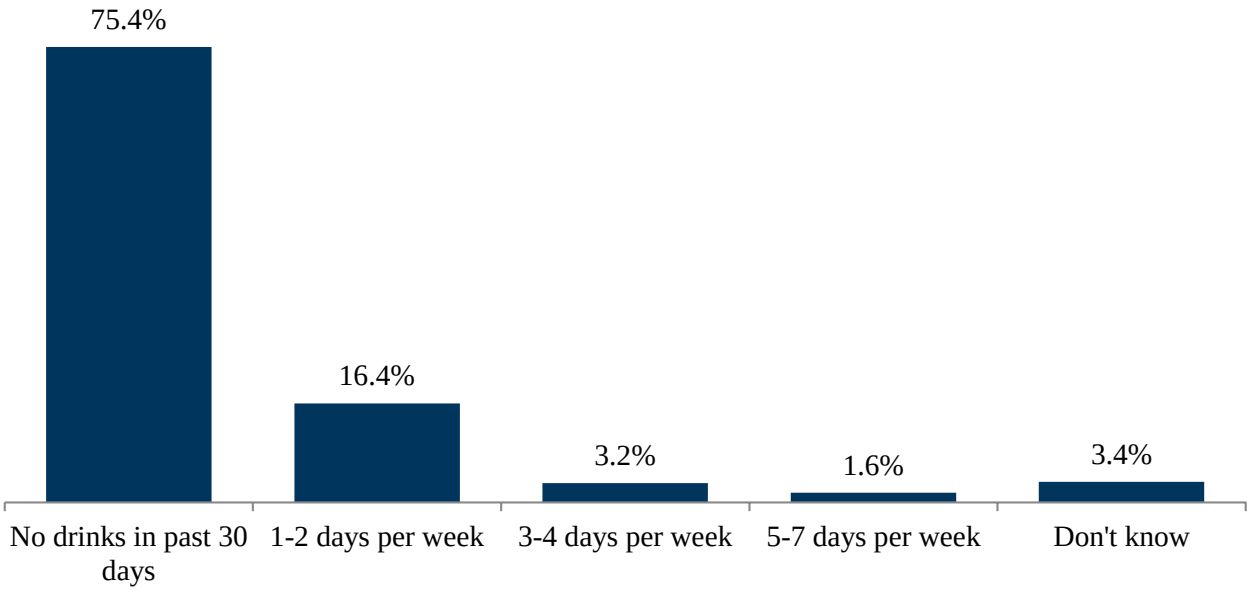


Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)[32,33]



[32] Members were allowed to choose multiple answers; thus, the total does not equal 100%.
[33] Only reported those who have not seen a dentist within the past 12 months.

Exhibit 54. Days per week member had at least one drink of alcoholic beverage during the past 30 days (n=3,083)[34]



[34] Only reported those who are 18 years or older.

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item

12. Consider Authorizing Expenditures in Support of CalOptima's Participation in Community Events

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 events:
    a. Up to $5,000 and staff participation at the CEAVA Foundation and OC Parks Tet Festival 2018 Year of the Dog in Fountain Valley on February 16-18, 2018;
    b. Up to $5,000 and staff participation at the Union of Vietnamese Student Associations Southern California (UVSA) 37th Annual Tet Festival Year of the Dog in Costa Mesa on February 16-18, 2018; and
    c. Up to $10,000 and staff participation at the Age Well Senior Services' 2018 South County Senior Summit in Laguna Woods Village Performing Art Center on April 20, 2018.
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

Staff recommends the authorization of expenditures for participation in the two Lunar New Year Tet Festivals scheduled in Orange County (Fountain Valley and Costa Mesa). The events will provide CalOptima with opportunities to conduct outreach and education about our programs and services to Vietnamese-speaking members, who comprise approximately twelve percent of our total membership.

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Staff also recommends the authorization of expenditures for participation in the 2018 South County Senior Summit to promote the PACE expansion in south county and OneCare Connect program. This event is a unique opportunity to provide information about CalOptima and its program to South Orange County seniors, potentially increasing enrollment in these programs.

These events will provide CalOptima with opportunities to conduct outreach and education to current and potential members, increasing access to health care services, and meeting the needs of our community.

a. A $5,000 financial commitment for CEAVA Foundation and OC Parks Tet Festival 2018 Year of the Dog in Fountain Valley includes: One (1) 20x20 exhibitor booth in a prime location, two (2) banner displays, twenty (20) mentions on stage, twenty-five (25) radio impressions, and full ad on fliers distributed throughout the OC and LA prior to the event. Employee time will be used to participate in this event. Approximately $1568 will be spent in staff time and $4,233 will be spent on promotional items for the event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services. The Fountain Valley festival will take place locally near the largest Vietnamese community in Orange County as well as draw from communities throughout the county. Last year's event drew in over 20,000 attendees.

b. A $5,000 financial commitment for UVSA's 37th Annual Tet Festival Year of the Dog in Costa Mesa includes: One (1) 20x10 exhibitor booths in prime location, one (1) CalOptima banner at the gate and food court, booth listing in festival program booklet, CalOptima's logo on promotional posters and fliers; UVSA's Tet Festival website for one (1) year; forty (40) admission tickets; four (4) VIP admission badges; and four (4) VIP parking permits. Employee time will be used to participate in this event. Approximately $1568 will be spent in staff time and $4,233 will be spent on promotional items for the event. Employees will have an opportunity to interact with current and potential members to share information about CalOptima's programs and services. The Costa Mesa festival attracts over 60,000 attendees from outside of the county in addition to local communities.

c. A $10,000 financial commitment for Age Well Senior Services' 2018 South County Senior Summit includes: A five (5) minute speaking opportunity at the event, one (1) premier exhibit booth location, CalOptima logo on event advertising, half-page advertisement in event program, large event banner at event, CalOptima information in each attendee's event bag and verbal recognition at the event. CalOptima staff time will be used to participate in this event. This eleventh annual event is expected to draw over twelve hundred (1,200) older adults and will be televised in thousands of households throughout South Orange County. CalOptima CEO, Michael Schrader will be included in the program and will be speaking on our senior-related lines of business, including the PACE Center and OneCare Connect programs.

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Fiscal Impact
Funding for the recommended action of up to $20,000, 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. This is in addition to the staff time referenced above.

Rationale for Recommendation
Staff recommends approval of the recommended action in order to support events that help our members, reflect CalOptima's mission, and opportunity to engage with our members in the community.

Concurrence
Gary Crockett, Chief Counsel

Attachments
Event Informational Packets

/s/ Michael Schrader — *1/25/2018*
Authorized Signature — **Date**

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VĂN PHÒNG GIÁM SÁT VIÊN ANDREW ĐỖ
VÀ CEAVA FOUNDATION HÂN HẠNH GIỚI THIỆU

2018 HỘI CHỢ TẾT MẬU TUẤT

KỶ NIỆM 1080 NĂM CHIẾN THẮNG BẠCH ĐẰNG GIANG

MILE SQUARE PARK
FEBRUARY 16-18, 2018

Bạch Đằng Giang
(938 - 2018)

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TẾT
FESTIVAL

FEBRUARY 16-18, 2018

YEAR OF THE DOG
2018 SPONSORSHIP PROPOSAL

OC FAIR & EVENT CENTER, COSTA MESA, CA

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The Union of Vietnamese Student Associations Southern California (UVSA) is proud to submit this proposal for your review. We wish to provide your organization with unique and advantageous marketing opportunities to promote your brand and business to the Vietnamese community.

The 37th Annual UVSA Tet Festival will take place between February 16 and February 18, 2018 at OC Fair & Event Center—adjacent to Costa Mesa, Newport Beach, Santa Ana, and Irvine. The event attracts over 60,000 attendees, encompassing a multi-ethnic populace with strong Asian American presence.

UVSA Tet Festival is recognized as the most distinguished Vietnamese Lunar New Year celebration in the nation for many reasons:

- **We are the largest Tet Festival in the world with 36 years of success**
- **UVSA is one of the four pillars upholding the Vietnamese community in cooperation with the Vietnamese American Federation of Southern California, the Coalition of Vietnamese Armed Forces, and the Association of Vietnamese Language & Culture Schools of Southern California**
- **We are the strongest Vietnamese youth organization in the country and we represent students and young leaders in the Santa Barbara, Los Angeles, Riverside, San Bernardino, and San Diego counties**
- **Our involvement in the Vietnamese community is built upon cultural awareness, education, and social and civic engagement**
- **We join together 300+ youth volunteers and provide them with opportunities for community service and real-life application of leadership development at Tet Festival**
- **UVSA is a 501(c)3 grant-giving organization and has awarded over $1,000,000 in festival proceeds to deserving non-profit organizations across Southern California**

We cordially invite your team to join us this year in making UVSA Tet Festival 2018 the most spectacular yet! We are confident that your participation will acquire benefits that only UVSA can offer, with increased publicity, prestigious affiliation, customer contact, and community impact.

We look forward to building a prolific partnership with you as we welcome the Year of the Dog, with prosperity and success for all. Thank you for your consideration to support UVSA Tet Festival 2018!

Sincerely,

Thao-Chi Pham

Thao-Chi (TC) Pham
Sponsorship Director
thaochi.pham@uvsa.org

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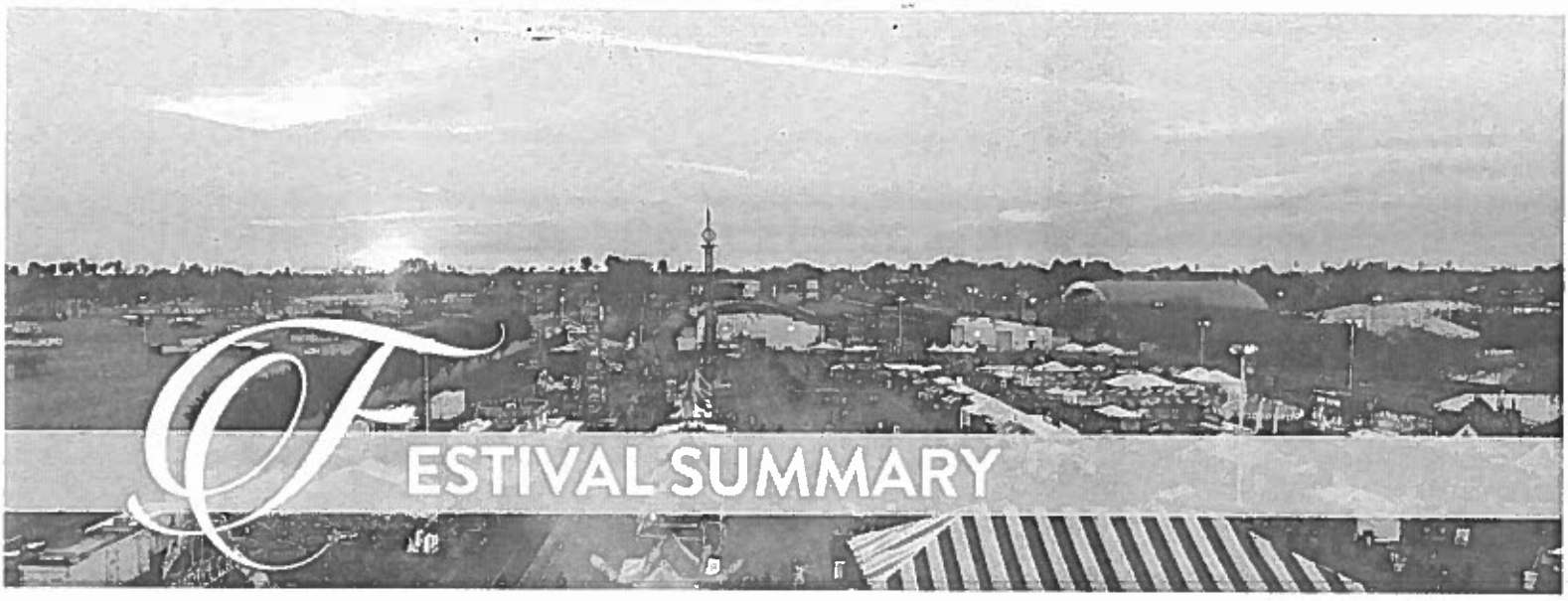

EVENT 37th Annual UVSA Tet Festival

DESCRIPTION Tet is a celebration of the Lunar New Year, the most observed holiday for Vietnamese people

OBJECTIVES

1. To celebrate the new lunar year
2. To preserve and promote Vietnamese culture
3. To share Vietnamese tradition with surrounding communities
4. To provide opportunities for organizations to promote their products and services to the Vietnamese American market
5. To raise funds to support educational and cultural programs in the community
6. To bring Vietnamese youths together and provide them with opportunities for leadership development and community service


Lion dancers performing at the Saturday Opening Ceremony

DATES
Friday, February 16, 2018; 3PM - 10PM
Saturday, February 17, 2018; 10AM - 10PM
Sunday, February 18, 2018; 10AM - 9PM

LOCATION
OC Fair & Event Center
88 Fair Dr., Costa Mesa, CA 92626

60,000+ patrons
300+ vendors and sponsors
500+ volunteers

ACTIVITIES

- Lion Dancing
- Firecrackers
- Carnival Games
- Children's Pageant
- Cultural Ceremony
- Cultural Village
- Fashion Show
- Prize Booths
- Miss Vietnam of SoCal Pageant
- Traditional Dances
- Martial Arts
- Carnival Rides
- Military Exhibits
- Cultural Foods
- Grand Concert
- Talent Show
- Youth Night
- Pho Eating Contest
- Contests
- Chinese Chess Competitions
- Vendors
- Community Exhibitions
- Special Guests

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HOSTING ORGANIZATION

ABOUT The Union of Vietnamese Student Associations Southern California (UVSA) is a 501(c)3 non-profit, non-partisan, community-based organization founded in 1982. UVSA consists of alumni, college students, and high school students from various Vietnamese Student Associations across Southern California.

MISSION To bring together Vietnamese American students from different colleges and high schools throughout Southern California to build unity, serve our community, and advocate for social justice issues that affect our community domestically and worldwide.

GRANTS Over the years, nearly $1,000,000 in festival proceeds have been awarded to non-profit organizations in the community such as the Boy & Girl Scouts of America, American Red Cross, Vietnamese language schools, and many more.

MEMBERS

- Cal Poly Pomona
- CSU Los Angeles
- CSU San Bernardino
- San Diego State University
- UC Los Angeles
- UC Santa Barbara
- CSU Fullerton
- CSU Long Beach
- Golden West College
- UC Irvine
- UC Riverside
- UC San Diego
- University of Southern California
- Vietnamese American High School Alliance (VAHSA)

DEMOGRAPHICS & STATISTICS

According to the 2010 U.S. Census, 1,548,449 people identify as Vietnamese, ranking them fourth among the Asian American groups; 447,032 (40%) of them live in California. The largest Vietnamese population outside of Vietnam is found in Southern California—totaling over 300,000 members from Los Angeles, Orange, and San Diego counties. Vietnamese American businesses continue to grow in areas such as Garden Grove and Westminster while rapidly extending lucrative development to surrounding cities.

KEY BENEFITS

The success of this event depends on the generosity of sponsors. In return, UVSA staff is dedicated to helping sponsors gain maximum benefits from their participation, including:

- Brand awareness and brand loyalty from current and prospective buyers
- High-level media exposure from local television stations, radio stations, magazines, newspapers, and advertisements
- Large-scale onsite product promotion and face-to-face customer interaction
- Positive public outreach and market response
- Tax-deductible contribution to a certified 501(c)3 non-profit and charitable organization
- Recognition as an industry leader above competitors

Toyota showcases their vehicles in a custom booth

The Miss Vietnam of Southern California Royal Court pose in front of Toyota's booth

The Miss Vietnam of Southern California Royal Court pose for Western Union

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SPONSORSHIP PACKAGES

Your company's sponsorship directly impacts the success of Tet Festival, UVSA's ability to provide funding to nearly one hundred non-profit organizations across Southern California, and UVSA's ability to provide leadership and community programming to the youth. We offer the following packages, which include standard benefits or the option to tailor your participation to meet company goals. We hope that you take this opportunity to sponsor Tet Festival as a means to promote brand loyalty from a very accomplished community. All monetary sponsorships to the Tet Festival are tax-deductible.
Please contact our Sponsorship Director for more information.

THAO-CHI (TC) PHAM
Sponsorship Director
Tel: 949.237.2887
Email: thaochi.pham@uvsa.org

BRONZE SPONSOR
$3,500

- 10' x 10' booth in prime location at Tet Festival
- One (1) 2.5' x 8' banner display at the Front Gate
- Booth listing in Festival program booklet
- Sponsor logo on promotional posters & flyers
- Sponsor logo on UVSA Tet Festival website for one (1) year
- Thirty (30) Tet Festival admission tickets
- Two (2) VIP admission badges
- Two (2) VIP parking permits

SILVER SPONSOR
$6,000

- 20' x 10' booth in prime location at Tet Festival
- Two (2) 2.5' x 8' banner displays: Front Gate, Food Court
- Three (3) graphic ad impressions on Main Stage
- One (1) mention on Main Stage
- Booth listing in Festival program booklet
- Sponsor logo on all promotional posters & flyers
- Sponsor logo on Tet Festival website for one (1) year
- Forty (40) Tet Festival admission tickets
- Four (4) VIP admission badges
- Four (4) VIP parking permits

GOLD SPONSOR
$12,000

- 20' x 20' booth in prime location at Tet Festival
- Three (3) 2.5' x 8' banner displays: Front Gate, Food Court, Main Stage
- Three (3) graphic ad impressions Main Stage
- Five (5) mentions on Main Stage
- Recognition and award during Opening Ceremony
- Half-page color ad in Tet Festival program booklet
- Fifteen (15) Vietnamese radio impressions (200,000 reached)
- Booth listing in Festival program booklet
- Sponsor logo on promotional posters and flyers
- Sponsor logo on Tet Festival website for one (1) year
- Sixty (60) Tet Festival admission tickets
- Six (6) VIP admission badges
- Six (6) VIP parking permits

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DIAMOND SPONSOR
$23,000

- 30' x 20' booth in prime location at Tet Festival
- Six (6) graphic ad impressions on Main Stage
- Four (4) 2.5' x 8' banner displays: Front Gate, Food Court, Main Stage, Exit
- Ten (10) mentions on Main Stage
- Recognition and award during Opening Ceremony
- Full page color ad in Festival program booklet
- Thirty (30) Vietnamese radio impressions (200,000 reached)
- Fifteen (15) Vietnamese newspaper and magazine impressions (10,000 reached)
- Five (5) Vietnamese television impressions (200,000 reached)
- One (1) social media impression (6,000 reached)
- One (1) 12" x 12" sign or decal at ticket booth window
- Logo on Tet Festival staff and volunteer t-shirts
- Three (3) 30-second video ad impressions on Main Stage
- Half-page color ad in Miss Vietnam Southern California Pageant program
- Booth listing in Festival program booklet
- Medium sponsor logo on promotional posters and flyers
- Medium sponsor logo on Tet Festival website for one (1) year
- One hundred (100) Tet Festival admission tickets
- Eight (8) VIP admission badges
- Eight (8) VIP parking permits

TITLE SPONSOR
$40,000

- 40' x 20' booth in prime location at Tet Festival
- Six (6) 2.5' x 8' banner displays: Front Gate, Food Court, Main Stage, Exit
- Twelve (12) graphic ad impressions on Main Stage
- Fifteen (15) mentions on Main Stage
- Recognition and award during Opening Ceremony
- Full page color ad on back cover in Festival program booklet
- Sixty (60) Vietnamese radio impressions (200,000 reached)
- Thirty (30) Vietnamese newspaper and magazine impressions (10,000 reached)
- Ten (10) Vietnamese television impressions (200,000 reached)
- Two (2) social media impressions (6,000 reached)
- Two (2) 12" x 12" signs or decals at ticket booth window
- Logo on Tet Festival staff and volunteer t-shirts
- Six (6) 30-second video ad impressions on Main Stage
- Full page editorial in Miss Vietnam Southern California Pageant program
- Two (2) 33" x 33" cube banners near information booth
- One (1) banner ad link on Tet Festival website
- Logo on Tet Festival billboard in Little Saigon
- Logo on all Tet Festival online tickets
- Logo on the back of all Tet Festival admission tickets
- Five (5) minutes Title Sponsor speech at Opening Ceremony
- Present winning check at Miss Vietnam Southern California Pageant
- Five (5) minutes Title Sponsor speech at Miss Vietnam Southern California Pageant
- Booth listing in Tet Festival program booklet
- Large sponsor logo on promotional posters and flyers
- Large sponsor logo on Tet Festival website for one (1) year
- One hundred and fifty (150) Tet Festival admission tickets
- Twelve (12) VIP admission badges
- Twelve (12) VIP parking permits

ADDITIONAL BENEFITS

- 2.5' x 8' Color Banner Printing — $150
- 33" x 33" cube banner near Info Booth (limit 1) — $500
- Banner display near Tet Festival Front Gate — $500
- Banner display near Tet Festival Food Court — $750
- 6" x 6" decal at Ticket Booth window (limit 1) — $750
- Flyer distribution at Tet Festival Information Booth (10,000):
  - Before 12/31/17 — $500
  - After 12/31/17 — $750
- Logo link on Tet Festival website for one (1) year — $500
- Banner ad link on Tet Festival website for one (1) year — $750
- Logo on Tet Festival staff and volunteer t-shirts — $500
- Social media impression on Tet Festival page — $500 (1x)
- Social Media promo video production — $1,000 (1 min)
- Tet Festival Main Stage Ad impression:
  - Graphic — $500 (3x)
  - 30-second video — $750 (3x)
  - Prime Time video — $1,000 (3x)
- Tet Festival Program Booklet Ad (60,000)
  - Quarter-page color — $1,000
  - Half-page color — $2,000
  - Full page color — $3,000
- Presenting Sponsor (please ask for full list of benefits):
  - Pho Eating Contest — $1,500
  - Children's Pageant — $3,000
  - Talent Show — $3,000
  - Youth Night — $3,000
  - Grand Concert — $5,000
- Additional 10' x 10' booth in prime location — $3,000
- Prize Donations — VARIES

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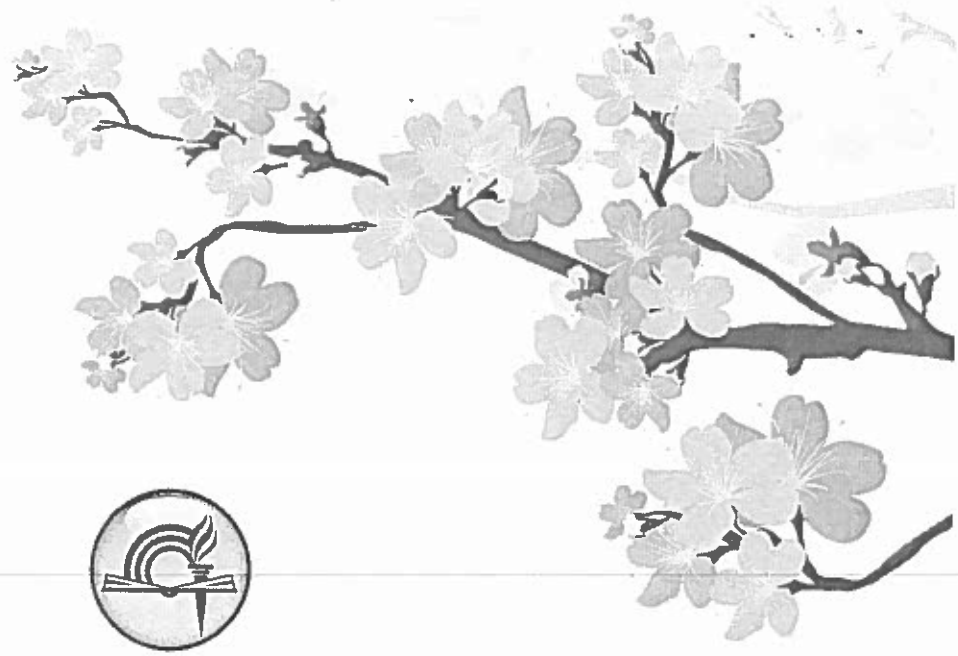

UNION OF VIETNAMESE STUDENT ASSOCIATIONS SOUTHERN CALIFORNIA
12831 WESTERN AVE., UNIT B
GARDEN GROVE, CA 92841

MAILING ADDRESS
P.O. BOX 2069
WESTMINSTER, CA 92684

E-MAIL
CONTACT@UVSA.ORG

TEL
(714) 890-1418

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Age Well Senior Services
A NONPROFIT SERVING ORANGE COUNTY'S OLDER ADULTS

Nutritional Services
Senior Centers
Transportation
Volunteer Opportunities

Fax: (949) 855-8025

November 30, 2018

As the lead sponsoring nonprofit agency, Age Well Senior Services, Inc. cordially invites you to support the 2018 South County Senior Summit!

This popular 11th annual event is being presented by Orange County Supervisor Lisa Bartlett in partnership with the Office on Aging, Laguna Woods Village, and Age Well Senior Services, Inc. The 2018 Senior Summit will take place Friday, April 20, 2018 inside the Laguna Woods Village Performing Art Center (formerly Clubhouse 3).

The program will feature a panel of experts providing timely presentations related to our theme, ***"Life Can Change in an Instant: Are You Ready?"*** As such, the 2018 Senior Summit will offer valuable information on Disaster Preparedness for Seniors; Unexpected Life-Altering Events, including strokes, heart attacks, and falls; as well as the importance of End-of-Life Planning.

Over 1,200 older adults are expected to attend the 2018 Senior Summit, which will be televised to thousands of households throughout South County. As always, the event will begin at 8 AM with an exciting vendor fair and a complimentary breakfast, followed by an informative and stimulating program commencing at 9 AM with a welcome address by OC Supervisor Lisa Bartlett. At the conclusion of the program, a complimentary lunch will also be provided for all attendees.

By becoming a sponsor of the 11th annual South County Senior Summit, your organization will be officially recognized in the event program attendees will receive upon arrival. Your ***tax-deductible*** donation will also provide your organization with the options and incentives listed in the attached Sponsor Pledge Form

As an organizational sponsor not only will you be supporting the South County Senior Summit, but you will also benefit from a unique opportunity to directly connect with hundreds of older adults in one convenient location, while demonstrating your care and concern for them.

To become a sponsor of the 11th annual South County Senior Summit, please complete and return the attached Pledge Form by Friday, March 23. Thank you so much for your kind consideration. We look forward to seeing you at the South County Senior Summit!

Sincerely,

Steve Moyer
Acting Chief Executive Officer
Age Well Senior Services, Inc.

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SPONSOR PLEDGE FORM

Organization: _____

Contact Person: _____ **Phone:** ( ) _____

Address: _____

Fax: ( ) _____ **Email:** _____

Sponsorship Levels:

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Age Well Senior Services, Inc.
c/o South County Senior Summit Rep
24461 Ridge Route Drive, Suite 220
Laguna Hills, CA 92653

Phone: (949) 855-8033
Fax: (949) 855-8025

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Pulled from Agenda 2/1/2018

CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 1, 2018
Regular Meeting of the CalOptima Board of Directors

Report Item
13. Consider Vendor Selection and Contracting for State Legislative Advocacy Services

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

Recommended Actions
1. Select Edelstein Gilbert Robson & Smith (GRS)as the lead state legislative advocacy firm to represent CalOptima for state advocacy services;
2. Select Townsend Public Affairs (Townsend) as the state legislative advocacy firm to be utilized on an as-needed basis;
3. Authorize the Chief Executive Officer, with the assistance of Legal Counsel, to enter into contracts with the recommended firms, each contract for a two–year term commencing February 1, 2018, and with three one–year extension options, with each extension option exercisable at CalOptima's sole discretion. The GRS contract will be at a rate of $95,000/year, and the Townsend contract at a rate of $24,000/year.

Background
As part of its government affairs program, CalOptima retains representatives in Sacramento to assist in a wide array of areas including tracking and advocating on legislation, analyzing and developing positions on bills and analyzing recommended actions pertaining to state budget and regulatory issues. In addition, CalOptima representatives continually develop and maintain relationships with members of the California State Legislature, legislative committee staff and consultants as well as applicable state departments and regulatory agencies.

As part of CalOptima's standard and routine procurement process, a Request for Proposal (RFP) for state legislative advocacy services was issued in August 2017 and two proposals were received. A proposal evaluation committee comprised of members of CalOptima staff and external subject matter experts reviewed and scored the submitted proposals. Subsequently, the two firms were interviewed by members of a State Lobbyist RFP Ad Hoc committee appointed by the Board Chair.

The State Lobbyist RFP Ad Hoc committee interviews took place on January 4, 2018.

Discussion
Based on both the written proposal scores and the results of the State Lobbyist RFP Ad Hoc interviews, the Ad Hoc committee is recommending Edelstein Gilbert Robson & Smith as the lead state legislative advocacy firm due to its substantive knowledge of healthcare issues that are of importance to CalOptima. These issues include experience and knowledge regarding the

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transition of the California Children's Services (CCS) program, the County Organized Health System (COHS) model, the Cal MediConnect program (CalOptima's OneCare Connect program), Denti-Cal, Medi-Cal funding issues including the impact of actions on the Affordable Care Act (ACA) on the Medi-Cal program, to name a few.

As recommended the contract amendment with Edelstein Gilbert Robson & Smith would be for a two (2) year term with three (3) one-year extension options, each exercisable at CalOptima's sole discretion. As submitted by Edelstein, the Edelstein contract fee and price will be $95,000 annually or $7,916.67 per month.

The State Lobbyist RFP Ad Hoc committee is also recommending entering into a contract with Townsend Public Affairs on an as-needed basis. With potentially impactful actions beginning in 2018 to the Medi-Cal program, the COHS model and CalOptima specifically, the ad hoc committee believes Townsend Public Affairs is uniquely situated to assist CalOptima through its extensive, principal-level and bi-partisan relationships. As specific actions and circumstances arise out of Sacramento, Townsend Public Affairs would be available, at the direction of the CEO, to engage in high-level lobbying and advocacy efforts in the best interests of CalOptima.

The State Lobbyist RFP Ad Hoc committee is recommending the Townsend contract length be a two (2) year term with three (3) one-year options, each exercisable at CalOptima's sole discretion with a fee and price to be $24,000 annually or $2,000 per month.

Going forward, staff will monitor the performance of both Edelstein Gilbert Robson & Smith and Townsend Public Affairs to ensure that the deliverables and components outlined in the RFP applicable to each firm as well as within their respective contracts are being achieved. Deliverables include, but are not limited to written and verbal monthly reports and updates. It is also anticipated that occasional verbal updates will be provided at the Board of Directors' meetings when appropriate.

Fiscal Impact

Funding for the recommended action is included as part of the Professional Fees budget under the CalOptima Fiscal Year 2017-18 Operating Budget approved by the CalOptima Board of Directors on June 1, 2017. Staff will include updated administrative expenses for state legislative advocacy services in future operating budgets.

Rationale for Recommendation

State legislative advocacy efforts continue to be of importance to CalOptima given the health care- related priorities that Sacramento and Washington, DC are addressing. It is anticipated that there will be several important issues that require CalOptima's ongoing focus, attention, involvement and advocacy, including protection of the Medi-Cal program and specifically CalOptima.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. State Legislative Advocacy Services Firm Interview Evaluation
2. State Legislative Advocacy Services Firm Proposal Evaluation
3. State Legislative Advocacy Services Request for Proposal 18-004 Statement of Work

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

1/25/2018 — **Date**

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State Legislative Advocacy Services RFP 18-004
Interview Evaluation Summary

Thursday, January 4, 2018

All firms were evaluated on a five point scale, 0-5.

Townsend Public Affairs

	Firm Presentation (25% of Overall Score)	Question 1 re: Medi-Cal (25%)	Question 2 re: Medicaid (25%)	Question 3 re: COHS (25%)	Total (Out of 5.0)
Average Score of Interview Evaluation	4.25 x 0.25 = 1.0625	3.0 x 0.25 = 0.75	2.75 x 0.25 = 0.6875	2.5 x 0.25 = 0.625	**3.125**

Edelstein

	Firm Presentation (25% of Overall Score)	Question 1 re: Medi-Cal (25%)	Question 2 re: Medicaid (25%)	Question 3 re: COHS (25%)	Total (Out of 5.0)
Average Score of Interview Evaluation	2.75 x 0.25 = 0.6875	3.25 x 0.25 = 0.8125	3.75 x 0.25 = 0.9375	4.0 x 0.25 = 1.0	**3.4375**

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State Legislative Advocacy Services RFP 18-004
Firm Proposal Evaluation Summary

Thursday, October 12, 2017

All firms were evaluated on a five point scale, 0-5.

Townsend Public Affairs

	Technical Capabilities (20% of overall score)	Qualifications (25%)	Proposal (10%)	Pricing (20%)	COHS Experience (25%)	Total (Out of 5.0)
Average Score of Evaluation Committee	3.25 x 0.2 = 0.65	3.5 x 0.25 = 0.88	4.25 x 0.1 = 0.43	4.0 x 0.2 = 0.80	0.375 x 0.25 = 0.09	**2.84**

Edelstein

	Technical Capabilities (20% of overall score)	Qualifications (25%)	Proposal (10%)	Pricing (20%)	COHS Experience (25%)	Total (Out of 5.0)
Average Score of Evaluation Committee	4.75 x 0.20 = .95	5.0 x 0.25 = 1.25	2.75 x 0.10 = 0.28	4.25 x 0.20 = 0.85	5.0 x 0.25 = 1.25	**4.58**

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RFP 18-004 Scope of Work

Exhibit A

A. SCOPE OF WORK

CONSULTANT shall represent CalOptima's interests in Sacramento with the California State Legislature, the Administration, and other relevant departments and agencies, offering legislative monitoring and other necessary advocacy services to CalOptima.

B. REPORTING RELATIONSHIP

The Chief Executive Officer; Executive Director, Public Policy and Public Affairs; and Director, Government Affairs (Business Owners) and/or their designee(s) will be the primary contacts and will direct the work of the CONSULTANT. All work in excess of that expressed in this Scope of Work shall be approved by the Business Owners in conjunction with the Purchasing department. This additional work will be evidenced in an amendment to this Contract prior to the work commencing.

C. OBJECTIVES/DELIVERABLES

CONSULTANT shall:

1. Maintain regular contact with members of the California Legislature, committee staff, and other state departments, agencies, boards and commissions, to identify impending changes in laws, regulations and funding priorities that relate to CalOptima.
2. Provide a written monthly report that shall accompany the invoice to describe the nature and extent of the services or actions taken on behalf of CalOptima as well as report on issues in Sacramento that may impact CalOptima's programs and funding. Written reports should also include general information regarding the health care industry in California that may have a direct or indirect impact on CalOptima.
3. Notify CalOptima of anticipated, introduced or amended state legislation, and regulations that could impact CalOptima. These activities include but are not limited to:
    - Providing the bill number and a brief summary of introduced or amended state legislation;
    - Providing copies of legislation and committee analysis; and
    - Providing information related to legislative hearings.
4. Advocate for CalOptima's programs and positions on proposed legislation, proposed regulations, and funding priorities as directed. These activities shall include by are not limited to:
    - Informing CalOptima of upcoming legislative proposals, budget forecasts and relevant policy issues;
    - Assisting in securing authors and drafting language for sponsored bills;
    - Assisting in drafting amendments to legislation;
    - Testifying on behalf of CalOptima at legislative hearings; and
    - Monitoring, reviewing and providing ongoing advice regarding the impact of the State budget on CalOptima's programs
    - Drafting letters of support/opposition

Provide copies of all written correspondence, testimony and position papers given on behalf of CalOptima, as well as provide copies of the State Budget and any related documents to the Business Owners.

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Board of Directors Meeting
February 1, 2018

Member Advisory Committee Update

At the January 11, 2018 Member Advisory Committee (MAC) meeting, MAC received the following informational updates. Dr. Sharps, Medical Director, Behavioral Health, reported that CalOptima successfully transitioned the management of Behavioral Health (BH) from Magellan to CalOptima, effective January 1, 2018. Debbie Kegel, Manager, Business Integration, provided an overview of the assisted living waiver (ALW) program, which is designed to assist Medi-Cal beneficiaries to remain in their community as an alternative to residing in a licensed health care facility. Belinda Abeyta, Director, Customer Service (Medi-Cal), provided an overview of Human Arc, CalOptima's contracted vendor that assists members who may potentially qualify for the Supplemental Security Income (SSI) Program with the application and approval process.

Chair Sally Molnar informed the MAC that Member Carlos Robles, Recipients of CalWORKs, has resigned from the MAC and recruitment for his seat will coincide with the annual recruitment beginning in March 2018. Chair Molnar updated the MAC on the joint advisory committee meeting scheduled for March 8, 2018. In addition to the Provider Advisory Committee (PAC), the OneCare Connect Member Advisory Committee (OCC MAC) will also be attending the meeting. Representatives from MAC, OCC MAC and PAC met on January 11, 2018 to discuss potential items for the agenda, including: the Orange County Coalition for Mental Health; the opioid epidemic; difficulty in accessing providers; Healthcare Effectiveness Data and Information Set (HEDIS) performance; and the results of the Member Health Needs Assessment. Chair Molnar also reminded the MAC that CalOptima is still recruiting for the Whole-Child Model Family Advisory Committee (WCM FAC), which will include two to four community representatives/advocates and seven to nine member/family member representatives for a total of 11 WCM FAC members. Chair Molnar urged the MAC to let CalOptima know of potential candidates. The application deadline was extended to February 28, 2018.

MAC received executive staff updates on items that impact CalOptima, including: the Whole-Child Model (WCM) that is incorporating California Children's Services (CCS) for Medi-Cal eligible children into a Medi-Cal Managed Care Plan benefit; CalOptima's progress to expand the Program of All-Inclusive Care for the Elderly (PACE) in Orange County; and the passage of H.R. 1, officially referred to as the Tax Cuts and Jobs Act, and H.R. 1370, a continuing resolution (CR) that funds the federal government at current levels through January 19, 2018.

The MAC appreciates the opportunity to provide the CalOptima Board with input and updates on the MAC's activities.

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Board of Directors Meeting
February 1, 2018

Provider Advisory Committee (PAC) Update

December 14, 2017 PAC Meeting

Twelve (12) PAC members were in attendance at the December PAC meeting.

PAC opened the meeting with a brief moment of silence in memory of Dr. Alan Edwards who served on the PAC for 11 years as the Orange County Health Care Agency (OCHCA) representative and who passed away on November 30, 2017.

Michael Schrader, Chief Executive Officer, discussed how the California Children's Services (CCS) is a high CalOptima priority and that a stakeholder meeting would be forthcoming in January 2018.

Ladan Khamseh, Chief Operations Officer, discussed the Part A qualification through Social Services. Ms. Khamseh also discussed the behavioral health transition and noted that some providers sent in their contract after the deadline, therefore the members who were being seen by these providers received letters stating their provider was not contracted. Fortunately, this affected a small number of members. Members are currently being notified if their provider has signed a contract, so they are aware they can continue with the same provider. Mr. Schrader also noted during Ms. Khamseh's update that a behavioral health orientation would be held on December 20, 2017 at the Garden Grove Courtyard for newly contracted behavioral health providers.

Richard Helmer, M.D., Chief Medical Officer discussed Senate Bill 1004 – CalOptima and its health networks are responsible to provide Palliative Care services to Medi-Cal members effective January 1, 2018. CalOptima continues to ensure they have provider network adequacy for the CalOptima members assigned to them. CalOptima is still waiting on the Department of Health Care Services (DHCS) to provide more information and will share it with the health networks as they receive it.

Richard Bock, M.D., Deputy Chief Medical Officer, presented an update on the opioid epidemic and the impact in Orange County. He also shared the interventions CalOptima is taking to help reduce the number of CalOptima members addicted to Opioids including: Formulary restrictions, Pharmacy Home Program, outreach to the highest MED prescribers and Quality Measures. Dr. Bock also discussed a Strep-test educational campaign for providers.

Michelle Laughlin, Executive Director Network Operations, provided the PAC with an update on the behavioral health transition and noted the DHCS had certified CalOptima's behavioral health provider network. She noted that there were approximately 150 Applied Behavioral Analysis (ABA) members who would need to change their providers. CalOptima will create Letters of Agreement (LOAs) so these affected members can stay with their current provider. Ms. Laughlin also shared the visit CalOptima had at the Inland Empire Health Plan (IEHP). IEHP

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shared their best practices they have in place including a center of excellence for autism screening. Ms. Laughlin also shared the OneCare (OC) and OneCare Connect (OCC) sales team started performing telephone enrollments and were also assisting with the completion of the members Health Risk Assessment through a hand off to Care Management team.

Other updates included a financial report from Greg Hamblin, Chief Financial Officer, and an update from Phil Tsunoda on the current status at the State and Federal level including the re-authorization of CHIP funding, Cost-sharing for the Exchanges and the current state of the Tax Reform bill.

PAC Member John Nishimoto, OD, provided the PAC with an informative and interesting presentation on Optometry's Role in Patient Care including early detection and intervention and Diabetic exams.

PAC in preparation for their joint meeting with the Member Advisory Committee (MAC) and OCC MAC solicited volunteers for an ad hoc committee to formulate the agenda for the meeting on March 8, 2018.

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
February 1, 2018

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

At the December 14, 2017 meeting, OneCare Connect Member Advisory Committee (OCC MAC) members received the following informational updates. Tracy Hitzeman, Executive Director, Clinical Operations, provided a Palliative Care Update, explaining the goal is to optimize quality of life and address physical, intellectual, emotional, social and spiritual needs. Maria Wahab, Manager, Outreach and Education, discussed the OneCare Connect enrollment process and the marketing/outreach campaign.

OCC MAC received executive staff updates on items that impact CalOptima, including CalOptima's ongoing efforts to outreach to providers on the appropriate prescribing patterns of opioids. In addition, Congress passed a continuing resolution (CR) to fund the operations of the federal government, including the Medicaid and Medicare programs, through December 22, 2017, avoiding a shutdown of the federal government.

Vice Chair Patty Mouton asked if OCC MAC members were interested in convening a joint advisory committee meeting with the Member Advisory Committee (MAC) and Provider Advisory Committee (PAC). Upon OCC MAC members agreement, Vice Chair Mouton asked for volunteers to serve on an ad hoc subcommittee with MAC and PAC representatives to develop an agenda. Chair Gio Corzo and Vice Chair Mouton will serve on the ad hoc. In addition, Vice Chair Mouton reviewed OCC MAC's progress towards meeting its FY 2017-18 Goals and Objectives, reporting that OCC MAC has completed most of its targets.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on OCC MAC activities.

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Financial Summary

December 2017

Board of Directors Meeting

February 1, 2018

Greg Hamblin

Chief Financial Officer

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FY 2017-18: Consolidated Enrollment

- December 2017 MTD:
  - Overall enrollment was 791,476 member months
    - Actual lower than budget by 11,880 or 1.5%
      - Medi-Cal: unfavorable variance of 11,548 members
        - TANF unfavorable variance of 12,853 members
        - SPD unfavorable variance of 2,550 members
        - Medi-Cal Expansion (MCE) favorable variance of 3,653 members
        - LTC favorable variance of 202 members
      - OneCare Connect: unfavorable variance of 335 members
    - 6,531 or 0.8% increase from prior month
      - Medi-Cal: increase of 6,566 from November
      - OneCare Connect: decrease of 31 from November
      - OneCare: decrease of 6 from November
      - PACE: increase of 2 from November

FY 2017-18: Consolidated Enrollment

- December 2017 YTD:
  - Overall enrollment was 4,738,924 member months
    - Actual lower than budget by 76,296 or 1.6%
      - Medi-Cal: unfavorable variance of 74,994 members or 1.6%
        - TANF unfavorable variance of 73,891 members
        - SPD unfavorable variance of 15,898 members
        - MCE favorable variance of 13,778 members
        - LTC favorable variance of 1,017 members
      - OneCare Connect: unfavorable variance of 1,569 members or 1.7%
      - OneCare: favorable variance of 279 members or 3.5%
      - PACE: unfavorable variance of 12 member or 0.9%

FY 2017-18: Consolidated Revenues

- December 2017 MTD:
  - ➢ Actual higher than budget by $7.7 million or 2.8%
    - Medi-Cal: favorable to budget by $6.3 million or 2.6%
      - Unfavorable volume variance of $3.6 million
      - Favorable price variance of $9.9 million due to:
        - ➢ $6.2 million of FY18 Coordinated Care Initiative (CCI) revenues including In Home Supportive Services (IHSS) Dual and Non-Dual revenue
        - ➢ $2.0 million of FY18 revenue including LTC Revenue from Non-LTC members and Non-Medical Transportation
        - ➢ $1.7 million of FY18 Behavioral Health Treatment (BHT) revenue

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FY 2017-18: Consolidated Revenues (cont.)

- December 2017 MTD:
  - OneCare Connect: favorable to budget by $1.2 million or 4.3%
    - Unfavorable volume variance of $0.6 million due to lower enrollment
    - Favorable price variance of $1.8 million due to FY18 rate increase
  - OneCare: favorable to budget by $0.1 million or 8.5%
    - Favorable volume variance of $9.3 thousand
    - Favorable price variance of $0.1 million due rate increase
  - PACE: favorable to budget by $86.7 thousand or 5.5%
    - Unfavorable volume variance of $39.5 thousand
    - Favorable price variance of $126.2 thousand

FY 2017-18: Consolidated Revenues (cont.)

- December 2017 YTD:
  - Actual higher than budget by $55.7 million or 3.4%
    - Medi-Cal: favorable to budget by $48.1 million or 3.3%
      - Unfavorable volume variance of $23.4 million
      - Favorable price variance of $71.5 million due to:
        - $30.3 million of FY18 CCI revenues including IHSS Dual and Non-Dual revenue
        - $9.4 million of FY18 BHT revenue
        - $6.0 million of FY17 LTC Revenue from Non-LTC members
        - $22.9 million of prior year revenue

FY 2017-18: Consolidated Revenues (cont.)

- December 2017 YTD:
  - OneCare Connect: favorable to budget by $8.5 million or 5.2%
    - Unfavorable volume variance of $2.8 million
    - Favorable price variance of $11.3 million due to 15% rate increase
  - OneCare: Unfavorable to budget by $1.5 million or 17.5%
    - Favorable volume variance of $0.3 million
    - Unfavorable price variance of $1.7 million
      - Due to Part D and Hierarchical Condition Category (HCC) reconciliation
  - PACE: favorable to budget by $0.6 million or 6.4%
    - Favorable price variance of $0.7 million due to Part D true-up

FY 2017-18: Consolidated Medical Expenses

- December 2017 MTD:
  - ➢ Actual lower than budget by $1.8 million or 0.7%
    - Medi-Cal: favorable variance of $3.0 million
      - Favorable volume variance of $3.5 million
      - Unfavorable price variance of $0.5 million
        - ➢ Prescription Drugs favorable variance of $4.5 million due to lower drug costs and $0.8 million in adjustments
        - ➢ Managed Long-Term Services and Support (MLTSS) unfavorable variance of $3.4 million due to $4.1 million for IHSS offset by favorable IBNR
        - ➢ Professional Claims unfavorable variance of $0.5 million
        - ➢ Facilities expenses favorable variance of $1.9 million
    - OneCare Connect: unfavorable variance of $0.4 million
      - Favorable volume variance of $0.5 million
      - Unfavorable price variance of $0.9 million

FY 2017-18: Consolidated Medical Expenses (cont.)

- December 2017 YTD:
  - Actual higher than budget by $63.7 million or 4.0%
    - Medi-Cal: unfavorable variance of $61.5 million
      - Favorable volume variance of $22.4 million
      - Unfavorable price variance of $83.9 million
        - MLTSS expenses unfavorable variance of $38.5 million
        - Provider Capitation expenses unfavorable variance of $12.1 million
        - Professional Claims expenses unfavorable variance of $11.1 million
        - Facilities expenses unfavorable variance of $2.5 million
    - OneCare Connect: unfavorable variance of $5.1 million
      - Favorable volume variance of $2.6 million
      - Unfavorable price variance of $7.6 million
- Medical Loss Ratio (MLR):
  - December 2017 MTD: Actual: 93.5% Budget: 96.7%
  - December 2017 YTD: Actual: 95.9% Budget: 95.3%

FY 2017-18: Consolidated Administrative Expenses

- December 2017 MTD:
  - Actual lower than budget by $2.7 million or 21.3%
    - Purchased Services: favorable variance of $1.4 million due to lower claims processing fees
    - Other categories: favorable variance of $1.2 million

- December 2017 YTD:
  - Actual lower than budget by $16.0 million or 21.7%
    - Purchased Services: favorable variance of $6.8 million driven lower claims processing fees
    - Other categories: favorable variance of $9.1 million

- Administrative Loss Ratio (ALR):
  - December 2017 MTD: Actual: 3.5% Budget: 4.5%
  - December 2017 YTD: Actual: 3.4% Budget: 4.4%

FY 2017-18: Change in Net Assets

- December 2017 MTD:
  - $10.4 million surplus
  - $13.6 million favorable to budget
    - Higher than budgeted revenue of $7.7 million
    - Lower than budgeted medical expenses of $1.8 million
    - Lower than budgeted administrative expenses of $2.7 million
    - Higher than budgeted investment and other income of $1.5 million

- December 2017 YTD:
  - $23.0 million surplus
  - $17.0 million favorable to budget
    - Higher than budgeted revenue of $55.7 million
    - Higher than budgeted medical expenses of $63.7 million
    - Lower than budgeted administrative expenses of $16.0 million
    - Higher than budgeted investment and other income of $9.0 million

Enrollment Summary: December 2017

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
62,897	63,796	(899)	(1.4%)	Aged	371,472	376,943	(5,471)	(1.5%)
617	618	(1)	(0.2%)	BCCTP	3,667	3,708	(41)	(1.1%)
47,146	48,796	(1,650)	(3.4%)	Disabled	282,234	292,620	(10,386)	(3.5%)
324,940	329,355	(4,415)	(1.3%)	TANF Child	1,954,853	1,978,286	(23,433)	(1.2%)
95,221	103,659	(8,438)	(8.1%)	TANF Adult	572,853	623,311	(50,458)	(8.1%)
3,470	3,268	202	6.2%	LTC	20,625	19,608	1,017	5.2%
240,355	236,702	3,653	1.5%	MCE	1,431,978	1,418,200	13,778	1.0%
774,646	**786,194**	**(11,548)**	**(1.5%)**	**Medi-Cal**	**4,637,682**	**4,712,676**	**(74,994)**	**(1.6%)**
15,223	**15,558**	**(335)**	**(2.2%)**	**OneCare Connect**	**91,570**	**93,139**	**(1,569)**	**(1.7%)**
235	**241**	**(6)**	**(2.5%)**	**PACE**	**1,359**	**1,371**	**(12)**	**(0.9%)**
1,372	**1,363**	**9**	**0.7%**	**OneCare**	**8,313**	**8,034**	**279**	**3.5%**
791,476	**803,356**	**(11,880)**	**(1.5%)**	**CalOptima Total**	**4,738,924**	**4,815,220**	**(76,296)**	**(1.6%)**

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Financial Highlights: December 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
791,476	803,356	(11,880)	(1.5%)	Member Months	4,738,924	4,815,220	(76,296)	(1.6%)
283,343,384	275,693,125	7,650,259	2.8%	Revenues	1,707,910,458	1,652,163,156	55,747,302	3.4%
264,819,397	266,593,714	1,774,317	0.7%	Medical Expenses	1,637,889,772	1,574,189,765	(63,700,007)	(4.0%)
9,868,144	12,531,002	2,662,858	21.3%	Administrative Expenses	57,484,517	73,447,504	15,962,987	21.7%
8,655,843	**(3,431,591)**	**12,087,434**	**352.2%**	**Operating Margin**	**12,536,170**	**4,525,887**	**8,010,282**	**177.0%**
1,753,228	231,157	1,522,071	658.5%	Non Operating Income (Loss)	10,463,272	1,429,716	9,033,556	631.8%
10,409,072	**(3,200,434)**	**13,609,506**	**425.2%**	**Change in Net Assets**	**22,999,442**	**5,955,603**	**17,043,839**	**286.2%**
93.5%	96.7%	3.2%		Medical Loss Ratio	95.9%	95.3%	(0.6%)	
3.5%	4.5%	1.1%		Administrative Loss Ratio	3.4%	4.4%	1.1%	
3.1%	(1.2%)	4.3%		Operating Margin Ratio	0.7%	0.3%	0.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: December (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
8.6	(3.4)	12.0	Medi-Cal	6.0	4.9	1.1
0.9	0.1	0.8	OCC	5.3	0.7	4.6
(0.9)	(0.1)	(0.8)	OneCare	0.4	(0.8)	1.2
0.1	0.0	0.1	PACE	0.7	(0.3)	1.0
8.7	**(3.4)**	**12.1**	**Operating**	**12.5**	**4.5**	**8.0**
1.8	0.2	1.5	Inv./Rental Inc, MCO tax	10.5	1.4	9.0
1.8	**0.2**	**1.5**	**Non-Operating**	**10.5**	**1.4**	**9.0**
10.4	**(3.2)**	**13.6**	**TOTAL**	**23.0**	**6.0**	**17.0**

Consolidated Revenue & Expense: December 2017 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	534,291	240,355	774,646	15,223	1,372	235	791,476
REVENUES							
Capitation Revenue	$ 149,550,891	$ 102,135,233	$ 251,686,124	$ 28,448,503	$ 1,534,959	$ 1,673,799	$ 283,343,384
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	149,550,891	102,135,233	251,686,124	28,448,503	1,534,959	1,673,799	283,343,384
MEDICAL EXPENSES							
Provider Capitation	36,303,674	50,858,648	87,162,322	11,235,554	447,657	-	98,845,532
Facilities	23,872,453	18,656,453	42,528,906	3,210,266	1,104,483	362,097	47,205,752
Ancillary	-	-	-	616,337	37,263	-	653,599
Skilled Nursing	-	-	-	-	37,274	-	37,274
Professional Claims	7,131,177	8,009,498	15,140,675	-	-	364,135	15,504,810
Prescription Drugs	17,569,103	15,156,897	32,726,000	4,664,471	366,475	115,465	37,872,411
Quality Incentives	-	-	-	-	-	-	-
MLTSS Facility Payments	52,418,742	2,507,446	54,926,188	5,128,691	-	-	60,054,879
Medical Management	1,433,200	707,697	2,140,898	656,180	244,767	524,928	3,566,773
Reinsurance & Other	514,736	306,787	821,524	149,243	6,556	101,045	1,078,367
Total Medical Expenses	139,243,086	96,203,426	235,446,512	25,660,741	2,244,474	1,467,669	264,819,397
Medical Loss Ratio	**93.1%**	**94.2%**	**93.5%**	**90.2%**	**146.2%**	**87.7%**	**93.5%**
GROSS MARGIN	**10,307,805**	**5,931,807**	**16,239,612**	**2,787,762**	**(709,515)**	**206,129**	**18,523,988**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,946,204	942,919	31,110	93,341	7,013,574
Professional fees			(12,396)	(41,108)	13,333	1,333	(38,837)
Purchased services			574,731	157,754	20,880	5,269	758,635
Printing and Postage			168,884	113,562	25,677	16,238	324,361
Depreciation and Amortization			363,827	-	-	2,168	365,995
Other expenses			1,065,091	10,826	0	8,730	1,084,647
Indirect cost allocation, Occupancy expense			(486,904)	746,957	93,065	6,652	359,770
Total Administrative Expenses			7,619,437	1,930,910	184,066	133,732	9,868,144
Admin Loss Ratio			**3.0%**	**6.8%**	**12.0%**	**8.0%**	**3.5%**
INCOME (LOSS) FROM OPERATIONS			8,620,175	856,852	(893,581)	72,398	8,655,843
INVESTMENT INCOME			-	-	-	-	1,741,395
NET RENTAL INCOME			-	-	-	-	10,623
NET GRANT INCOME			1,202	-	-	-	1,202
OTHER INCOME			9	-	-	-	9
CHANGE IN NET ASSETS			**$ 8,621,386**	**$ 856,852**	**$ (893,581)**	**$ 72,398**	**$ 10,409,072**
BUDGETED CHANGE IN ASSETS			(3,359,402)	84,693	(137,190)	(19,692)	(3,200,434)
VARIANCE TO BUDGET - FAV (UNFAV)			11,980,788	772,159	(756,391)	92,090	13,609,505

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Consolidated Revenue & Expense: December 2017 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	3,205,704	1,431,978	4,637,682	91,570	8,313	1,359	4,738,924
REVENUES							
Capitation Revenue	$ 896,748,544	$ 621,909,649	$ 1,518,658,193	$ 172,821,540	6,827,621	$ 9,603,105	$ 1,707,910,458
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	896,748,544	621,909,649	1,518,658,193	172,821,540	6,827,621	9,603,105	1,707,910,458
MEDICAL EXPENSES							
Provider Capitation	232,526,166	301,737,891	534,264,057	66,959,450	(82,082)	-	601,141,425
Facilities	150,939,577	114,544,752	265,484,329	16,958,305	2,493,220	1,669,718	286,605,573
Ancillary	-	-	-	3,671,043	259,231	-	3,930,274
Skilled Nursing	-	-	-	-	137,375	-	137,375
Professional Claims	45,190,403	50,012,643	95,203,046	-	-	2,092,469	97,295,516
Prescription Drugs	106,067,583	107,258,732	213,326,314	30,570,998	2,694,595	686,870	247,278,778
MLTSS Facility Payments	322,052,369	15,282,844	337,335,213	31,955,995	-	17,511	369,308,718
Medical Management	11,564,805	4,414,375	15,979,180	5,936,423	313,962	3,144,440	25,374,005
Reinsurance & Other	3,366,596	1,789,334	5,155,930	1,025,648	44,691	591,838	6,818,107
Total Medical Expenses	871,707,498	595,040,572	1,466,748,070	157,077,862	5,860,993	8,202,847	1,637,889,772
Medical Loss Ratio	**97.2%**	**95.7%**	**96.6%**	**90.9%**	**85.8%**	**85.4%**	**95.9%**
GROSS MARGIN	**25,041,045**	**26,869,078**	**51,910,123**	**15,743,679**	**966,628**	**1,400,257**	**70,020,687**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			32,115,166	4,614,066	147,105	445,788	37,322,124
Professional fees			910,290	101,538	92,349	16,672	1,120,849
Purchased services			4,142,909	913,306	116,036	30,413	5,202,664
Printing and Postage			1,631,480	461,190	56,758	21,416	2,170,844
Depreciation and Amortization			2,473,970	-	-	12,936	2,486,906
Other expenses			6,748,013	241,462	(32)	89,710	7,079,154
Indirect cost allocation, Occupancy expense			(2,173,902)	4,070,948	160,830	44,100	2,101,976
Total Administrative Expenses			45,847,925	10,402,510	573,046	661,036	57,484,517
Admin Loss Ratio			**3.0%**	**6.0%**	**8.4%**	**6.9%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			6,062,198	5,341,169	393,582	739,222	12,536,170
INVESTMENT INCOME			-	-	-	-	10,480,161
NET RENTAL INCOME			-	-	-	-	54,103
NET GRANT INCOME			(71,525)	-	-	-	(71,525)
OTHER INCOME			533	-	-	-	533
CHANGE IN NET ASSETS			**$ 5,991,207**	**$ 5,341,169**	**$ 393,582**	**$ 739,222**	**$ 22,999,442**
BUDGETED CHANGE IN ASSETS			4,922,764	717,666	(835,563)	(278,979)	5,955,603
VARIANCE TO BUDGET - FAV (UNFAV)			1,068,443	4,623,503	1,229,145	1,018,201	17,043,839

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Balance Sheet:
As of December 2017

ASSETS			LIABILITIES & FUND BALANCES	
Current Assets			Current Liabilities	
	Operating Cash	$481,885,979	Accounts payable	$13,807,781
	Investments	833,329,387	Medical claims liability	964,364,976
	Capitation receivable	383,482,587	Accrued payroll liabilities	9,341,768
	Receivables - Other	17,374,740	Deferred revenue	167,061,116
	Prepaid Expenses	4,986,816	Deferred lease obligations	158,970
			Capitation and withholds	382,720,721
	Total Current Assets	**1,721,059,509**	**Total Current Liabilities**	**1,537,455,331**
Capital Assets	Furniture and equipment	34,039,048	Other employment benefits liability	29,618,397
	Building/Leasehold improvements	6,228,243		
	505 City Parkway West	49,433,337	Net Pension Liabilities	16,365,263
		89,700,629	Long Term Liabilities	100,000
	Less: accumulated depreciation	(38,197,224)		
	Capital assets, net	**51,503,404**	**TOTAL LIABILITIES**	**1,583,538,991**
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	30,352,767	Tangible net equity (TNE)	88,937,308
	Long term investments	506,544,015	Funds in excess of TNE	647,520,526
	Total Board-designated Assets	536,896,783		
	Total Other Assets	**537,196,783**	**Net Assets**	**736,457,834**
	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		**2,321,336,835**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,321,336,835**

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CalOptima A Public Agency Better. Together.

Board Designated Reserve and TNE Analysis
As of December 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,736,596				
	Tier 1 - Logan Circle	146,622,040				
	Tier 1 - Wells Capital	146,295,076				
Board-designated Reserve		439,653,712	301,731,893	469,161,551	137,921,819	(29,507,839)
TNE Requirement	Tier 2 - Logan Circle	97,243,070	88,937,308	88,937,308	8,305,763	8,305,763
	Consolidated:	536,896,783	390,669,201	558,098,859	146,227,581	(21,202,076)
	Current reserve level	*1.92*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

December 2017

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CalOptima - Consolidated
Financial Highlights
For the Six Months Ended December 31, 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
791,476	803,356	(11,880)	(1.5%)	Member Months	4,738,924	4,815,220	(76,296)	(1.6%)
283,343,384	275,693,125	7,650,259	2.8%	Revenues	1,707,910,458	1,652,163,156	55,747,302	3.4%
264,819,397	266,593,714	1,774,317	0.7%	Medical Expenses	1,637,889,772	1,574,189,765	(63,700,007)	(4.0%)
9,868,144	12,531,002	2,662,858	21.3%	Administrative Expenses	57,484,517	73,447,504	15,962,987	21.7%
8,655,843	**(3,431,591)**	**12,087,434**	**352.2%**	**Operating Margin**	**12,536,170**	**4,525,887**	**8,010,282**	**177.0%**
1,753,228	231,157	1,522,071	658.5%	Non Operating Income (Loss)	10,463,272	1,429,716	9,033,556	631.8%
10,409,072	**(3,200,434)**	**13,609,506**	**425.2%**	**Change in Net Assets**	**22,999,442**	**5,955,603**	**17,043,839**	**286.2%**
93.5%	96.7%	3.2%		Medical Loss Ratio	95.9%	95.3%	(0.6%)	
3.5%	4.5%	1.1%		Administrative Loss Ratio	3.4%	4.4%	1.1%	
3.1%	(1.2%)	4.3%		Operating Margin Ratio	0.7%	0.3%	0.5%	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima
Financial Dashboard
For the Six Months Ended December 31, 2017

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	774,646	786,194	(11,548)	(1.5%)
OneCare Connect	15,223	15,558	(335)	(2.2%)
OneCare	1,372	1,363	9	0.7%
PACE	235	241	(6)	(2.5%)
Total	791,476	803,356	(11,880)	(1.5%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 8,621	$ (3,359)	$ 11,981	356.6%
OneCare Connect	857	85	772	911.7%
OneCare	(894)	(137)	(756)	(551.3%)
PACE	72	(20)	92	467.7%
505 Bldg.	11	(19)	29	156.4%
Investment Income & Other	1,741	250	1,491	596.6%
Total	$ 10,409	$ (3,200)	$ 13,610	425.2%

MLR

	Actual	Budget	% Point Var
Medi-Cal	93.5%	97.1%	3.6
OneCare Connect	90.2%	92.6%	2.4
OneCare	146.2%	102.9%	(43.4)

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 7,619	$ 10,354	$ 2,735	26.4%
OneCare Connect	1,931	1,931	0	0.0%
OneCare	184	97	(87)	(90.3%)
PACE	134	149	15	10.1%
Total	$ 9,868	$ 12,531	$ 2,663	21.3%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	912	900	(11)
OneCare Connect	217	237	20
OneCare	3	3	0
PACE	57	64	7
Total	1,189	1,205	16

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	850	873	(23)
OneCare Connect	70	66	4
OneCare	460	454	5
PACE	4	4	0
Total	1,384	1,397	(13)

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	4,637,682	4,712,676	(74,994)	(1.6%)
OneCare Connect	91,570	93,139	(1,569)	(1.7%)
OneCare	8,313	8,034	279	3.5%
PACE	1,359	1,371	(12)	(0.9%)
Total	4,738,924	4,815,220	(76,296)	(1.6%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 5,991	$ 4,923	$ 1,068	21.7%
OneCare Connect	5,341	718	4,624	644.2%
OneCare	394	(836)	1,229	147.1%
PACE	739	(279)	1,018	365.0%
505 Bldg.	54	(70)	124	177.0%
Investment Income & Other	10,480	1,500	8,980	598.7%
Total	$ 22,999	$ 5,956	$ 17,044	286.2%

MLR

	Actual	Budget	% Point Var
Medi-Cal	96.6%	95.6%	(1.0)
OneCare Connect	90.9%	92.5%	1.6
OneCare	85.8%	103.0%	17.1

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 45,848	$ 60,410	$ 14,562	24.1%
OneCare Connect	10,403	11,553	1,151	10.0%
OneCare	573	590	17	2.8%
PACE	661	895	234	26.1%
Total	$ 57,485	$ 73,448	$ 15,963	21.7%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	5,301	5,403	102
OneCare Connect	1,336	1,422	86
OneCare	18	18	(0)
PACE	321	380	58
Total	6,976	7,222	246

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	875	872	3
OneCare Connect	69	65	3
OneCare	451	446	5
PACE	4	4	1
Total	1,399	1,388	11

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CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended December 31, 2017

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	791,476		803,356		(11,880)	
Revenues						
Medi-Cal	$ 251,686,124	$ 324.90	$ 245,405,770	$ 312.14	$ 6,280,354	$ 12.76
OneCare Connect	28,448,503	1,868.78	27,285,160	1,753.77	1,163,343	115.01
OneCare	1,534,959	1,118.77	1,415,050	1,038.19	119,909	80.59
PACE	1,673,799	7,122.55	1,587,145	6,585.66	86,654	536.88
Total Operating Revenue	283,343,384	357.99	275,693,125	343.18	7,650,259	14.82
Medical Expenses						
Medi-Cal	235,446,512	303.94	238,411,015	303.25	2,964,503	(0.69)
OneCare Connect	25,660,741	1,685.66	25,269,108	1,624.19	(391,633)	(61.47)
OneCare	2,244,474	1,635.91	1,455,527	1,067.88	(788,947)	(568.03)
PACE	1,467,669	6,245.40	1,458,064	6,050.06	(9,605)	(195.34)
Total Medical Expenses	264,819,397	334.59	266,593,714	331.85	1,774,317	(2.74)
Gross Margin	18,523,988	23.40	9,099,411	11.33	9,424,577	12.08
Administrative Expenses						
Salaries and Benefits	7,013,574	8.86	7,044,809	8.77	31,235	(0.09)
Professional fees	(38,837)	(0.05)	384,191	0.48	423,028	0.53
Purchased services	758,635	0.96	2,196,942	2.73	1,438,307	1.78
Printing and Postage	324,361	0.41	551,874	0.69	227,513	0.28
Depreciation and Amortization	365,995	0.46	463,298	0.58	97,303	0.11
Other	1,084,647	1.37	1,549,471	1.93	464,824	0.56
Indirect cost allocation, Occupancy expense	359,770	0.45	340,417	0.42	(19,353)	(0.03)
Total Administrative Expenses	9,868,144	12.47	12,531,002	15.60	2,662,858	3.13
Income (Loss) From Operations	8,655,843	10.94	(3,431,591)	(4.27)	12,087,434	15.21
Investment income						
Interest income	2,376,206	3.00	250,000	0.31	2,126,206	2.69
Realized gain/(loss) on investments	(303,855)	(0.38)	-	-	(303,855)	(0.38)
Unrealized gain/(loss) on investments	(330,957)	(0.42)	-	-	(330,957)	(0.42)
Total Investment Income	1,741,395	2.20	250,000	0.31	1,491,395	1.89
Net Rental Income	10,623	0.01	(18,843)	(0.02)	29,466	0.04
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	1,202	0.00	-	-	1,202	0.00
QAF/IGT	-	-	-	-	-	-
Other Income	9	0.00	-	-	9	0.00
Change In Net Assets	**10,409,072**	**13.15**	**(3,200,434)**	**(3.98)**	**13,609,506**	**17.14**
Medical Loss Ratio	**93.5%**		**96.7%**		**3.2%**	
Administrative Loss Ratio	**3.5%**		**4.5%**		**1.1%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

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CalOptima - Consolidated
Statement of Revenue and Expenses
For the Six Months Ended December 31, 2017

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	4,738,924		4,815,220		(76,296)	
Revenues						
Medi-Cal	$ 1,518,658,193	$ 327.46	$ 1,470,580,910	$ 312.05	$ 48,077,283	$ 15.41
OneCare Connect	172,821,540	1,887.32	164,281,426	1,763.83	8,540,114	123.49
OneCare	6,827,621	821.32	8,279,090	1,030.51	(1,451,469)	(209.19)
PACE	9,603,105	7,066.30	9,021,730	6,580.40	581,375	485.90
Total Operating Revenue	1,707,910,458	360.40	1,652,163,156	343.11	55,747,302	17.29
Medical Expenses						
Medi-Cal	1,466,748,070	316.27	1,405,248,630	298.18	(61,499,440)	(18.08)
OneCare Connect	157,077,862	1,715.39	152,010,381	1,632.08	(5,067,481)	(83.30)
OneCare	5,860,993	705.04	8,524,828	1,061.09	2,663,835	356.05
PACE	8,202,847	6,035.94	8,405,926	6,131.24	203,079	95.29
Total Medical Expenses	1,637,889,772	345.62	1,574,189,765	326.92	(63,700,007)	(18.71)
Gross Margin	70,020,687	14.78	77,973,391	16.19	(7,952,704)	(1.42)
Administrative Expenses						
Salaries and Benefits	37,322,124	7.88	41,931,512	8.71	4,609,388	0.83
Professional fees	1,120,849	0.24	2,321,637	0.48	1,200,788	0.25
Purchased services	5,202,664	1.10	12,022,550	2.50	6,819,886	1.40
Printing and Postage	2,170,844	0.46	3,198,738	0.66	1,027,894	0.21
Depreciation and Amortization	2,486,906	0.52	2,779,788	0.58	292,882	0.05
Other	7,079,154	1.49	9,150,777	1.90	2,071,623	0.41
Indirect cost allocation, Occupancy expense	2,101,976	0.44	2,042,502	0.42	(59,474)	(0.02)
Total Administrative Expenses	57,484,517	12.13	73,447,504	15.25	15,962,987	3.12
Income (Loss) From Operations	12,536,170	2.65	4,525,887	0.94	8,010,282	1.71
Investment income						
Interest income	13,415,192	2.83	1,500,000	0.31	11,915,192	2.52
Realized gain/(loss) on investments	(805,065)	(0.17)	-	-	(805,065)	(0.17)
Unrealized gain/(loss) on investments	(2,129,966)	(0.45)	-	-	(2,129,966)	(0.45)
Total Investment Income	10,480,161	2.21	1,500,000	0.31	8,980,161	1.90
Net Rental Income	54,103	0.01	(70,284)	(0.01)	124,387	0.03
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(71,525)	(0.02)	-	-	(71,525)	(0.02)
QAF/IGT	-	-	-	-	-	-
Other Income	533	0.00	-	-	533	0.00
Change In Net Assets	**22,999,442**	**4.85**	**5,955,603**	**1.24**	**17,043,839**	**3.62**
Medical Loss Ratio	**95.9%**		**95.3%**		**(0.6%)**	
Administrative Loss Ratio	**3.4%**		**4.4%**		**1.1%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended December 31, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	534,291	240,355	774,646	15,223	1,372	235	791,476
REVENUES							
Capitation Revenue	$ 149,550,891	$ 102,135,233	$ 251,686,124	$ 28,448,503	$ 1,534,959	$ 1,673,799	$ 283,343,384
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	149,550,891	102,135,233	251,686,124	28,448,503	1,534,959	1,673,799	283,343,384
MEDICAL EXPENSES							
Provider Capitation	36,303,674	50,858,648	87,162,322	11,235,554	447,657	-	98,845,532
Facilities	23,872,453	18,656,453	42,528,906	3,210,266	1,104,483	362,097	47,205,752
Ancillary	-	-	-	616,337	37,263	-	653,599
Skilled Nursing	-	-	-	-	37,274	-	37,274
Professional Claims	7,131,177	8,009,498	15,140,675	-	-	364,135	15,504,810
Prescription Drugs	17,569,103	15,156,897	32,726,000	4,664,471	366,475	115,465	37,872,411
Quality Incentives	-	-	-	-	-	-	-
MLTSS Facility Payments	52,418,742	2,507,446	54,926,188	5,128,691	-	-	60,054,879
Medical Management	1,433,200	707,697	2,140,898	656,180	244,767	524,928	3,566,773
Reinsurance & Other	514,736	306,787	821,524	149,243	6,556	101,045	1,078,367
Total Medical Expenses	139,243,086	96,203,426	235,446,512	25,660,741	2,244,474	1,467,669	264,819,397
Medical Loss Ratio	**93.1%**	**94.2%**	**93.5%**	**90.2%**	**146.2%**	**87.7%**	**93.5%**
GROSS MARGIN	**10,307,805**	**5,931,807**	**16,239,612**	**2,787,762**	**(709,515)**	**206,129**	**18,523,988**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,946,204	942,919	31,110	93,341	7,013,574
Professional fees			(12,396)	(41,108)	13,333	1,333	(38,837)
Purchased services			574,731	157,754	20,880	5,269	758,635
Printing and Postage			168,884	113,562	25,677	16,238	324,361
Depreciation and Amortization			363,827	-	-	2,168	365,995
Other expenses			1,065,091	10,826	0	8,730	1,084,647
Indirect cost allocation, Occupancy expense			(486,904)	746,957	93,065	6,652	359,770
Total Administrative Expenses			7,619,437	1,930,910	184,066	133,732	9,868,144
Admin Loss Ratio			**3.0%**	**6.8%**	**12.0%**	**8.0%**	**3.5%**
INCOME (LOSS) FROM OPERATIONS			8,620,175	856,852	(893,581)	72,398	8,655,843
INVESTMENT INCOME			-	-	-	-	1,741,395
NET RENTAL INCOME			-	-	-	-	10,623
NET GRANT INCOME			1,202	-	-	-	1,202
OTHER INCOME			9	-	-	-	9
CHANGE IN NET ASSETS			**$ 8,621,386**	**$ 856,852**	**$ (893,581)**	**$ 72,398**	**$ 10,409,072**
BUDGETED CHANGE IN ASSETS			(3,359,402)	84,693	(137,190)	(19,692)	(3,200,434)
VARIANCE TO BUDGET - FAV (UNFAV)			11,980,788	772,159	(756,391)	92,090	13,609,505

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Six Months Ended December 31, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	3,205,704	1,431,978	4,637,682	91,570	8,313	1,359	4,738,924
REVENUES							
Capitation Revenue	$ 896,748,544	$ 621,909,649	$ 1,518,658,193	$ 172,821,540	6,827,621	$ 9,603,105	$ 1,707,910,458
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	896,748,544	621,909,649	1,518,658,193	172,821,540	6,827,621	9,603,105	1,707,910,458
MEDICAL EXPENSES							
Provider Capitation	232,526,166	301,737,891	534,264,057	66,959,450	(82,082)	-	601,141,425
Facilities	150,939,577	114,544,752	265,484,329	16,958,305	2,493,220	1,669,718	286,605,573
Ancillary	-	-	-	3,671,043	259,231	-	3,930,274
Skilled Nursing	-	-	-	-	137,375	-	137,375
Professional Claims	45,190,403	50,012,643	95,203,046	-	-	2,092,469	97,295,516
Prescription Drugs	106,067,583	107,258,732	213,326,314	30,570,998	2,694,595	686,870	247,278,778
MLTSS Facility Payments	322,052,369	15,282,844	337,335,213	31,955,995	-	17,511	369,308,718
Medical Management	11,564,805	4,414,375	15,979,180	5,936,423	313,962	3,144,440	25,374,005
Reinsurance & Other	3,366,596	1,789,334	5,155,930	1,025,648	44,691	591,838	6,818,107
Total Medical Expenses	871,707,498	595,040,572	1,466,748,070	157,077,862	5,860,993	8,202,847	1,637,889,772
Medical Loss Ratio	**97.2%**	**95.7%**	**96.6%**	**90.9%**	**85.8%**	**85.4%**	**95.9%**
GROSS MARGIN	**25,041,045**	**26,869,078**	**51,910,123**	**15,743,679**	**966,628**	**1,400,257**	**70,020,687**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			32,115,166	4,614,066	147,105	445,788	37,322,124
Professional fees			910,290	101,538	92,349	16,672	1,120,849
Purchased services			4,142,909	913,306	116,036	30,413	5,202,664
Printing and Postage			1,631,480	461,190	56,758	21,416	2,170,844
Depreciation and Amortization			2,473,970	-	-	12,936	2,486,906
Other expenses			6,748,013	241,462	(32)	89,710	7,079,154
Indirect cost allocation, Occupancy expense			(2,173,902)	4,070,948	160,830	44,100	2,101,976
Total Administrative Expenses			45,847,925	10,402,510	573,046	661,036	57,484,517
Admin Loss Ratio			**3.0%**	**6.0%**	**8.4%**	**6.9%**	**3.4%**
INCOME (LOSS) FROM OPERATIONS			6,062,198	5,341,169	393,582	739,222	12,536,170
INVESTMENT INCOME			-	-	-	-	10,480,161
NET RENTAL INCOME			-	-	-	-	54,103
NET GRANT INCOME			(71,525)	-	-	-	(71,525)
OTHER INCOME			533	-	-	-	533
CHANGE IN NET ASSETS			**$ 5,991,207**	**$ 5,341,169**	**$ 393,582**	**$ 739,222**	**$ 22,999,442**
BUDGETED CHANGE IN ASSETS			4,922,764	717,666	(835,563)	(278,979)	5,955,603
VARIANCE TO BUDGET - FAV (UNFAV)			1,068,443	4,623,503	1,229,145	1,018,201	17,043,839

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SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $10.4 million, $13.6 million favorable to budget
- Operating surplus is $8.7 million with a surplus in non-operating of $1.8 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $23.0 million, $17.0 million favorable to budget
- Operating surplus is $12.5 million, $8.0 million favorable to budget

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
8.6	(3.4)	12.0	Medi-Cal	6.0	4.9	1.1
0.9	0.1	0.8	OCC	5.3	0.7	4.6
(0.9)	(0.1)	(0.8)	OneCare	0.4	(0.8)	1.2
0.1	0.0	0.1	PACE	0.7	(0.3)	1.0
8.7	**(3.4)**	**12.1**	**Operating**	**12.5**	**4.5**	**8.0**
1.8	0.2	1.5	Inv./Rental Inc, MCO tax	10.5	1.4	9.0
1.8	**0.2**	**1.5**	**Non-Operating**	**10.5**	**1.4**	**9.0**
10.4	**(3.2)**	**13.6**	**TOTAL**	**23.0**	**6.0**	**17.0**

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CalOptima

Enrollment Summary

For the Six Months Ended December 31, 2017

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
62,897	63,796	(899)	(1.4%)	Aged	371,472	376,943	(5,471)	(1.5%)
617	618	(1)	(0.2%)	BCCTP	3,667	3,708	(41)	(1.1%)
47,146	48,796	(1,650)	(3.4%)	Disabled	282,234	292,620	(10,386)	(3.5%)
324,940	329,355	(4,415)	(1.3%)	TANF Child	1,954,853	1,978,286	(23,433)	(1.2%)
95,221	103,659	(8,438)	(8.1%)	TANF Adult	572,853	623,311	(50,458)	(8.1%)
3,470	3,268	202	6.2%	LTC	20,625	19,608	1,017	5.2%
240,355	236,702	3,653	1.5%	MCE	1,431,978	1,418,200	13,778	1.0%
774,646	**786,194**	**(11,548)**	**(1.5%)**	**Medi-Cal**	**4,637,682**	**4,712,676**	**(74,994)**	**(1.6%)**
15,223	**15,558**	**(335)**	**(2.2%)**	**OneCare Connect**	**91,570**	**93,139**	**(1,569)**	**(1.7%)**
235	**241**	**(6)**	**(2.5%)**	**PACE**	**1,359**	**1,371**	**(12)**	**(0.9%)**
1,372	**1,363**	**9**	**0.7%**	**OneCare**	**8,313**	**8,034**	**279**	**3.5%**
791,476	**803,356**	**(11,880)**	**(1.5%)**	**CalOptima Total**	**4,738,924**	**4,815,220**	**(76,296)**	**(1.6%)**

				Enrollment (By Network)				
170,698	174,384	(3,686)	(2.1%)	HMO	1,024,860	1,045,052	(20,192)	(1.9%)
222,780	225,829	(3,049)	(1.4%)	PHC	1,337,108	1,359,201	(22,093)	(1.6%)
198,753	209,052	(10,299)	(4.9%)	Shared Risk Group	1,203,405	1,259,095	(55,690)	(4.4%)
182,415	176,929	5,486	3.1%	Fee for Service	1,072,309	1,049,328	22,981	2.2%
774,646	**786,194**	**(11,548)**	**(1.5%)**	**Medi-Cal**	**4,637,682**	**4,712,676**	**(74,994)**	**(1.6%)**
15,223	**15,558**	**(335)**	**(2.2%)**	**OneCare Connect**	**91,570**	**93,139**	**(1,569)**	**(1.7%)**
235	**241**	**(6)**	**(2.5%)**	**PACE**	**1,359**	**1,371**	**(12)**	**(0.9%)**
1,372	**1,363**	**9**	**0.7%**	**OneCare**	**8,313**	**8,034**	**279**	**3.5%**
791,476	**803,356**	**(11,880)**	**(1.5%)**	**CalOptima Total**	**4,738,924**	**4,815,220**	**(76,296)**	**(1.6%)**

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CalOptima
Enrollment Trend by Network Type
Fiscal Year 2018

Network Type	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	MMs
HMO													
Aged	4,058	4,045	4,051	3,864	4,020	3,980	-	-	-	-	-	-	24,018
BCCTP	1	1	1	5	1	5	-	-	-	-	-	-	14
Disabled	6,749	6,740	6,729	6,703	6,733	6,743	-	-	-	-	-	-	40,397
TANF Child	61,492	61,733	61,361	61,023	60,598	60,595	-	-	-	-	-	-	366,802
TANF Adult	30,429	30,420	30,313	30,127	29,905	30,059	-	-	-	-	-	-	181,253
LTC	3	4	6	4	4	3	-	-	-	-	-	-	24
MCE	68,020	68,792	69,169	68,294	68,764	69,313	-	-	-	-	-	-	412,352
	170,752	171,735	171,630	170,020	170,025	170,698	-	-	-	-	-	-	1,024,860
PHC													
Aged	1,480	1,493	1,530	1,401	1,561	1,581	-	-	-	-	-	-	9,046
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	7,318	7,264	7,258	7,236	7,229	7,221	-	-	-	-	-	-	43,526
TANF Child	162,801	163,976	163,202	162,046	162,030	162,046	-	-	-	-	-	-	976,101
TANF Adult	12,604	12,571	12,410	12,356	12,311	12,312	-	-	-	-	-	-	74,564
LTC	-	-	1	1	-	-	-	-	-	-	-	-	2
MCE	38,398	38,821	39,088	38,681	39,261	39,620	-	-	-	-	-	-	233,869
	222,601	224,125	223,489	221,721	222,392	222,780	-	-	-	-	-	-	1,337,108
Shared Risk Group													
Aged	3,809	3,756	3,831	3,029	3,765	3,641	-	-	-	-	-	-	21,831
BCCTP	-	-	-	1	-	-	-	-	-	-	-	-	1
Disabled	8,108	8,058	8,035	7,951	7,978	7,887	-	-	-	-	-	-	48,017
TANF Child	72,723	72,861	72,102	71,427	71,139	70,753	-	-	-	-	-	-	431,005
TANF Adult	32,775	32,737	32,316	31,441	31,785	31,475	-	-	-	-	-	-	192,529
LTC	-	1	2	-	-	2	-	-	-	-	-	-	5
MCE	85,799	86,330	86,191	81,677	85,025	84,995	-	-	-	-	-	-	510,017
	203,214	203,743	202,477	195,526	199,692	198,753	-	-	-	-	-	-	1,203,405
Fee for Service (Dual)													
Aged	48,036	48,599	48,846	48,863	49,108	49,578	-	-	-	-	-	-	293,030
BCCTP	25	22	25	23	22	23	-	-	-	-	-	-	140
Disabled	20,343	20,528	20,516	20,448	20,494	20,691	-	-	-	-	-	-	123,020
TANF Child	3	3	2	2	1	1	-	-	-	-	-	-	12
TANF Adult	1,205	1,226	1,184	1,156	1,118	1,165	-	-	-	-	-	-	7,054
LTC	3,002	3,124	3,126	3,068	3,137	3,112	-	-	-	-	-	-	18,569
MCE	2,816	2,848	2,758	2,831	2,113	1,660	-	-	-	-	-	-	15,026
	75,430	76,350	76,457	76,391	75,993	76,230	-	-	-	-	-	-	456,851
Fee for Service (Non-Dual)													
Aged	3,580	3,855	4,031	3,714	4,250	4,117	-	-	-	-	-	-	23,547
BCCTP	601	602	599	523	598	589	-	-	-	-	-	-	3,512
Disabled	4,466	4,559	4,578	4,364	4,703	4,604	-	-	-	-	-	-	27,274
TANF Child	27,513	31,414	31,119	30,822	28,520	31,545	-	-	-	-	-	-	180,933
TANF Adult	18,753	19,744	20,087	19,517	19,142	20,210	-	-	-	-	-	-	117,453
LTC	372	364	379	194	363	353	-	-	-	-	-	-	2,025
MCE	43,457	44,664	44,438	40,986	42,402	44,767	-	-	-	-	-	-	260,714
	98,742	105,202	105,231	100,120	99,978	106,185	-	-	-	-	-	-	615,458
MEDI-CAL TOTAL													
Aged	60,963	61,748	62,289	60,871	62,704	62,897	-	-	-	-	-	-	371,472
BCCTP	627	625	625	552	621	617	-	-	-	-	-	-	3,667
Disabled	46,984	47,149	47,116	46,702	47,137	47,146	-	-	-	-	-	-	282,234
TANF Child	324,532	329,987	327,786	325,320	322,288	324,940	-	-	-	-	-	-	1,954,853
TANF Adult	95,766	96,698	96,310	94,597	94,261	95,221	-	-	-	-	-	-	572,853
LTC	3,377	3,493	3,514	3,267	3,504	3,470	-	-	-	-	-	-	20,625
MCE	238,490	241,455	241,644	232,469	237,565	240,355	-	-	-	-	-	-	1,431,978
	770,739	781,155	779,284	763,778	768,080	774,646	-	-	-	-	-	-	4,637,682
PACE	215	221	228	227	233	235	-	-	-	-	-	-	1,359
OneCare	1,367	1,386	1,404	1,406	1,378	1,372	-	-	-	-	-	-	8,313
OneCare Connect	15,365	15,229	15,265	15,234	15,254	15,223	-	-	-	-	-	-	91,570
TOTAL	787,686	797,991	796,181	780,645	784,945	791,476	-	-	-	-	-	-	4,738,924

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ENROLLMENT:

Overall MTD enrollment was 791,476

- Unfavorable to budget by 11,880 or 1.1%
- Increased 6,531 or 0.8% from prior month
- Decreased 8,525 from prior year (December 2016)

Medi-Cal enrollment was 774,646

- Unfavorable to budget by 11,548
    - TANF unfavorable by 12,853
    - SPD unfavorable by 2,550
    - Medi-Cal Expansion favorable by 3,653
    - LTC favorable by 202

- Increased 6,566 from prior month

OneCare Connect enrollment was 15,223

- Unfavorable to budget by 335
- Decreased 31 from prior month

OneCare enrollment was 1,372

- Favorable to budget by 9
- Decreased 6 from prior month

PACE enrollment was 235

- Unfavorable to budget by 6
- Increased 2 from prior month

CalOptima - Medi-Cal Total
Statement of Revenues and Expenses
For the Six Months Ended December 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
774,646	786,194	(11,548)	(1.5%)	Member Months	4,637,682	4,712,676	(74,994)	(1.6%)
				Revenues				
251,686,124	245,405,770	6,280,354	2.6%	Capitation revenue	1,518,658,193	1,470,580,910	48,077,283	3.3%
251,686,124	245,405,770	6,280,354	2.6%	Total Operating Revenues	1,518,658,193	1,470,580,910	48,077,283	3.3%
				Medical Expenses				
87,162,322	86,932,521	(229,801)	(0.3%)	Provider capitation	534,264,057	522,157,714	(12,106,343)	(2.3%)
42,528,906	44,446,053	1,917,147	4.3%	Facilities	265,484,329	262,940,821	(2,543,508)	(1.0%)
15,140,675	14,659,256	(481,419)	(3.3%)	Professional Claims	95,203,046	84,146,802	(11,056,244)	(13.1%)
32,726,000	37,218,229	4,492,229	12.1%	Prescription drugs	213,326,314	216,084,580	2,758,266	1.3%
54,926,188	51,568,950	(3,357,238)	(6.5%)	MLTSS	337,335,213	298,814,188	(38,521,025)	(12.9%)
2,140,898	3,270,989	1,130,091	34.5%	Medical Management	15,979,180	19,214,423	3,235,243	16.8%
821,524	315,017	(506,507)	(160.8%)	Reinsurance & other	5,155,930	1,890,102	(3,265,828)	(172.8%)
235,446,512	238,411,015	2,964,503	1.2%	Total Medical Expenses	1,466,748,070	1,405,248,630	(61,499,440)	(4.4%)
16,239,612	6,994,755	9,244,857	132.2%	Gross Margin	51,910,123	65,332,280	(13,422,157)	(20.5%)
				Administrative Expenses				
5,946,204	6,016,614	70,410	1.2%	Salaries, wages & employee benefits	32,115,166	35,793,020	3,677,855	10.3%
(12,396)	327,524	339,920	103.8%	Professional fees	910,290	1,981,638	1,071,348	54.1%
574,731	1,923,948	1,349,217	70.1%	Purchased services	4,142,909	10,384,437	6,241,528	60.1%
168,884	423,238	254,354	60.1%	Printing and postage	1,631,480	2,419,422	787,942	32.6%
363,827	461,246	97,419	21.1%	Depreciation & amortization	2,473,970	2,767,476	293,506	10.6%
1,065,091	1,480,372	415,281	28.1%	Other operating expenses	6,748,013	8,736,234	1,988,221	22.8%
(486,904)	(278,785)	208,119	74.7%	Indirect cost allocation	(2,173,902)	(1,672,710)	501,192	30.0%
7,619,437	10,354,157	2,734,720	26.4%	Total Administrative Expenses	45,847,925	60,409,517	14,561,591	24.1%
				Operating Tax				
10,093,118	0	(10,093,118)	0.0%	Tax Revenue	74,512,221	0	(74,512,221)	0.0%
10,190,882	0	(10,190,882)	0.0%	Premium tax expense	61,232,883	0	(61,232,883)	0.0%
(97,764)	0	97,764	0.0%	Sales tax expense	13,279,338	0	(13,279,338)	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
96,516	291,249	(194,733)	(66.9%)	Grant Revenue	116,799	1,747,494	(1,630,695)	(93.3%)
84,703	258,276	173,573	67.2%	Grant expense - Service Partner	104,501	1,549,656	1,445,155	93.3%
10,610	32,973	22,363	67.8%	Grant expense - Administrative	83,823	197,838	114,015	57.6%
1,202	0	1,202	0.0%	Total Net Grant Income	(71,525)	0	(71,525)	0.0%
9	0	9	0.0%	Other income	533	0	533	0.0%
8,621,386	(3,359,402)	11,980,788	356.6%	Change in Net Assets	5,991,207	4,922,764	1,068,443	21.7%
93.5%	97.1%	3 6%	3.7%	Medical Loss Ratio	96.6%	95.6%	-1 0%	-1.1%
3.0%	4.2%	1 2%	28.2%	Admin Loss Ratio	3.0%	4.1%	1.1%	26.5%

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MEDI-CAL INCOME STATEMENT – DECEMBER MONTH:

REVENUES of $251.7 million are favorable to budget by $6.3 million, driven by:

- Unfavorable volume related variance of $3.6 million
- Favorable price related variance of $9.9 million due to:
  - $6.2 million of fiscal year 2018 Coordinated Care Initiative (CCI) revenues including In-Home Supportive Services (IHSS) Dual and Non-Dual revenue
  - $2.0 million of fiscal year 2018 revenue including Long Term Care (LTC) Revenue from Non-LTC members and Non-Medical Transportation
  - $1.7 million of fiscal year 2018 Behavioral Health Treatment (BHT) Revenue

MEDICAL EXPENSES: Overall $235.4 million, favorable to budget by $3.0 million due to:

- **Prescription Drug** expense is favorable to budget $4.5 million due to lower drug costs and $0.8 million prior year rebate
- **Managed Long-Term Services and Support (MLTSS)** is unfavorable to budget $3.4 million due to IHSS expense of $4.1
- **Facility** expense is favorable to budget $1.9 million due to Crossover of $1.5 million

ADMINISTRATIVE EXPENSES are $7.6 million, favorable to budget $2.7 million, driven by:

- Purchased Services: $1.3 million favorable to budget due to lower claims processing fees, mostly from mental health claims processing being brought in-house.
- Salary & Benefits: in line with budget
- Other Non-Salary: $1.3 million favorable to budget

CHANGE IN NET ASSETS is $8.6 million for the month, favorable to budget by $12.0 million

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Six Months Ended December 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
15,223	15,558	(335)	(2.2%)	Member Months	91,570	93,139	(1,569)	(1.7%)
				Revenues				
7,192,713	7,495,752	(303,039)	(4.0%)	Medi-Cal Capitation revenue	43,510,574	45,021,155	(1,510,581)	(3.4%)
16,219,508	14,663,334	1,556,174	10.6%	Medicare Capitation revenue part C	96,588,174	87,529,360	9,058,814	10.3%
5,036,281	5,126,074	(89,793)	(1.8%)	Medicare Capitation revenue part D	32,722,792	31,730,911	991,881	3.1%
28,448,503	27,285,160	1,163,343	4.3%	Total Operating Revenue	172,821,540	164,281,426	8,540,114	5.2%
				Medical Expenses				
11,235,554	8,510,479	(2,725,075)	(32.0%)	Provider capitation	66,959,450	50,764,866	(16,194,584)	(31.9%)
3,210,266	5,167,247	1,956,981	37.9%	Facilities	16,958,305	30,428,816	13,470,511	44.3%
616,337	634,609	18,272	2.9%	Ancillary	3,671,043	3,739,928	68,885	1.8%
5,128,691	4,273,142	(855,549)	(20.0%)	Long Term Care	31,955,995	25,419,683	(6,536,312)	(25.7%)
4,664,471	5,411,129	746,658	13.8%	Prescription drugs	30,570,998	33,738,989	3,167,991	9.4%
656,180	1,165,624	509,444	43.7%	Medical management	5,936,423	7,245,898	1,309,475	18.1%
149,243	106,878	(42,365)	(39.6%)	Other medical expenses	1,025,648	672,201	(353,447)	(52.6%)
25,660,741	25,269,108	(391,633)	(1.5%)	Total Medical Expenses	157,077,862	152,010,381	(5,067,481)	(3.3%)
2,787,762	2,016,052	771,710	38.3%	Gross Margin	15,743,679	12,271,045	3,472,634	28.3%
				Administrative Expenses				
942,919	914,507	(28,412)	(3.1%)	Salaries, wages & employee benefits	4,614,066	5,452,262	838,196	15.4%
(41,108)	38,334	79,442	207.2%	Professional fees	101,538	230,001	128,463	55.9%
157,754	239,868	82,114	34.2%	Purchased services	913,306	1,439,308	526,002	36.5%
113,562	103,801	(9,761)	(9.4%)	Printing and postage	461,190	622,806	161,616	25.9%
10,826	50,421	39,595	78.5%	Other operating expenses	241,462	302,435	60,973	20.2%
746,957	584,428	(162,529)	(27.8%)	Indirect cost allocation, Occupancy Expense	4,070,948	3,506,568	(564,380)	(16.1%)
1,930,910	1,931,359	449	0.0%	Total Administrative Expenses	10,402,510	11,553,379	1,150,869	10.0%
				Operating Tax				
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
856,852	84,693	772,159	911.7%	Change in Net Assets	5,341,169	717,666	4,623,503	644.2%
90.2%	92.6%	2.4%	2.6%	Medical Loss Ratio	90.9%	92.5%	1.6%	1.8%
6.8%	7.1%	0.3%	4.1%	Admin Loss Ratio	6.0%	7.0%	1.0%	14.4%

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ONECARE CONNECT INCOME STATEMENT – DECEMBER MONTH:

REVENUES of $28.4 million are favorable to budget by $1.2 million driven by:

- Unfavorable volume related variance of $0.6 million due to lower enrollment
- Favorable price related variance of $1.8 million due to fiscal year 2018 rate adjustment

MEDICAL EXPENSES of $25.7 million are unfavorable to budget $0.4 million due to:

- Favorable volume related variance of $0.5 million due to lower enrollment
- Unfavorable price related variance of $0.9 million due to increase IHSS expense

ADMINISTRATIVE EXPENSES of 1.9 million are in line with budget

CHANGE IN NET ASSETS is $0.9 million, $0.8 million favorable to budget

CalOptima - OneCare
Statement of Revenues and Expenses
For the Six Months Ended December 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,372	1,363	9	0.7%	Member Months	8,313	8,034	279	3.5%
				Revenues				
69,464	47,347	22,117	46.7%	Medi-Cal Capitation revenue	420,887	279,129	141,758	50.8%
1,118,145	879,846	238,299	27.1%	Medicare Part C Revenue	4,144,068	5,154,339	(1,010,271)	(19.6%)
347,350	487,857	(140,507)	(28.8%)	Medicare Part D Revenue	2,262,666	2,845,622	(582,956)	(20.5%)
1,534,959	1,415,050	119,909	8 5%	Total Operating Revenue	6,827,621	8,279,090	(1,451,469)	(17.5%)
				Medical Expenses				
447,657	387,409	(60,248)	(15.6%)	Provider capitation	(82,082)	2,271,305	2,353,387	103.6%
1,104,483	453,559	(650,924)	(143.5%)	Inpa ient	2,493,220	2,660,738	167,518	6.3%
37,263	49,345	12,082	24 5%	Ancillary	259,231	288,046	28,815	10.0%
37,274	42,956	5,682	13 2%	Skilled nursing facilities	137,375	249,285	111,910	44.9%
366,475	493,091	126,616	25.7%	Prescription drugs	2,694,595	2,875,708	181,113	6.3%
244,767	21,911	(222,856)	(1,017.1%)	Medical management	313,962	134,602	(179,360)	(133 3%)
6,556	7,256	700	9.7%	Other medical expenses	44,691	45,144	453	1.0%
2,244,474	1,455,527	(788,947)	(54.2%)	Total Medical Expenses	5,860,993	8,524,828	2,663,835	31.2%
(709,515)	(40,477)	(669,038)	(1,652.9%)	Gross Margin	966,628	(245,738)	1,212,366	493.4%
				Administrative Expenses				
31,110	20,020	(11,090)	(55.4%)	Salaries, wages & employee benefits	147,105	122,071	(25,034)	(20.5%)
13,333	13,333	(0)	(0.0%)	Professional fees	92,349	79,998	(12,351)	(15.4%)
20,880	11,990	(8,890)	(74.1%)	Purchased services	116,036	71,990	(44,046)	(61.2%)
25,677	19,288	(6,389)	(33.1%)	Prin ing and postage	56,758	123,228	66,470	53.9%
0	172	172	99 8%	Other operating expenses	(32)	1,078	1,110	102.9%
93,065	31,910	(61,155)	(191.6%)	Indirect cost allocation, Occupancy Expense	160,830	191,460	30,630	16.0%
184,066	96,713	(87,353)	(90.3%)	Total Administrative Expenses	573,046	589,825	16,779	2.8%
(893,581)	(137,190)	(756,391)	(551.3%)	Change in Net Assets	393,582	(835,563)	1,229,145	147.1%
146.2%	102.9%	-43.4%	-42 2%	Medical Loss Ra io	85.8%	103.0%	17.1%	16.6%

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CalOptima - PACE
Statement of Revenues and Expenses
For the Six Months Ended December 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
235	241	(6)	(2.5%)	Member Months	1,359	1,371	(12)	(0.9%)
				Revenues				
1,166,177	1,219,032	(52,855)	(4.3%)	Medi-Cal capitation revenue	7,081,861	6,933,016	148,845	2.1%
318,558	289,136	29,422	10 2%	Medicare part C revenue	2,023,170	1,642,480	380,690	23.2%
189,064	78,977	110,087	139.4%	Medicare part D revenue	498,074	446,234	51,840	11.6%
1,673,799	1,587,145	86,654	5 5%	Total Operating Revenues	9,603,105	9,021,730	581,375	6.4%
				Medical Expenses				
524,928	581,193	56,265	9.7%	Medical Management	3,144,440	3,499,036	354,596	10.1%
362,097	347,966	(14,131)	(4.1%)	Claims payments to hospitals	1,669,718	1,959,162	289,444	14.8%
364,135	287,222	(76,913)	(26.8%)	Professional Claims	2,092,469	1,617,095	(475,374)	(29.4%)
115,465	120,772	5,307	4.4%	Prescription drugs	686,870	680,323	(6,547)	(1.0%)
0	11,350	11,350	100 0%	Long-term care facility payments	17,511	70,084	52,573	75.0%
93,045	99,561	6,516	6 5%	Patient Transportation	559,838	560,226	388	0.1%
0	0	0	0 0%	Reinsurance	0	0	0	0.0%
8,000	10,000	2,000	20 0%	Other Expenses	32,000	20,000	(12,000)	(60.0%)
1,467,669	1,458,064	(9,605)	(0.7%)	Total Medical Expenses	8,202,847	8,405,926	203,079	2.4%
206,129	129,081	77,048	59.7%	Gross Margin	1,400,257	615,804	784,453	127.4%
				Administrative Expenses				
93,341	93,668	327	0 3%	Salaries, wages & employee benefits	445,788	564,159	118,371	21.0%
1,333	5,000	3,667	73 3%	Professional fees	16,672	30,000	13,328	44.4%
5,269	21,136	15,867	75.1%	Purchased services	30,413	126,816	96,403	76.0%
16,238	5,547	(10,691)	(192.7%)	Printing and postage	21,416	33,282	11,866	35.7%
2,168	2,052	(116)	(5.7%)	Depreciation & amortization	12,936	12,312	(624)	(5.1%)
8,730	18,506	9,776	52 8%	Other operating expenses	89,710	111,030	21,320	19.2%
6,652	2,864	(3,788)	(132.2%)	Indirect cost allocation, Occupancy Expense	44,100	17,184	(26,916)	(156.6%)
133,732	148,773	15,041	10.1%	Total Administrative Expenses	661,036	894,783	233,747	26.1%
				Operating Tax				
3,281	0	3,281	0 0%	Tax Revenue	34,660	0	34,660	0.0%
3,281	0	(3,281)	0 0%	Premium tax expense	34,660	0	(34,660)	0.0%
0	0	0	0 0%	Total Net Operating Tax	0	0	0	0.0%
72,398	(19,692)	92,090	467.7%	Change in Net Assets	739,222	(278,979)	1,018,201	365.0%
87.7%	91.9%	4.2%	4 6%	Medical Loss Ratio	85.4%	93.2%	7 8%	8.3%
8 0%	9.4%	1.4%	14 8%	Admin Loss Ratio	6.9%	9.9%	3 0%	30.6%

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CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Six Months Ended December 31, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
10,598	0	10,598	0.0%	Rental income	155,426	42,774	112,652	263.4%
10,598	0	10,598	0.0%	Total Operating Revenue	155,426	42,774	112,652	263.4%
				Administrative Expenses				
29,467	23,186	(6,282)	(27.1%)	Purchase services	191,499	139,115	(52,384)	(37.7%)
159,543	161,474	1,930	1.2%	Depreciation & amortization	957,931	968,842	10,911	1.1%
14,913	9,117	(5,797)	(63.6%)	Insurance expense	89,480	54,700	(34,780)	(63.6%)
134,044	158,122	24,078	15.2%	Repair and maintenance	687,737	948,730	260,992	27.5%
28,560	0	(28,560)	0.0%	Other Operating Expense	285,484	0	(285,484)	0.0%
(366,553)	(333,055)	33,498	10.1%	Indirect allocation, Occupancy Expense	(2,110,808)	(1,998,329)	112,478	5.6%
(25)	18,843	18,868	100.1%	Total Administrative Expenses	101,324	113,058	11,734	10.4%
10,623	(18,843)	29,466	156.4%	Change in Net Assets	54,103	(70,284)	124,387	177.0%

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OTHER STATEMENTS – DECEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is ($893.6) thousand, $756.4 thousand unfavorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $72.4 thousand, $92.1 thousand favorable to budget

505 CITY PARKWAY BUILDING INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $10.6 thousand, $29.5 thousand favorable to budget

CalOptima
BALANCE SHEET
December 31, 2017

ASSETS			**LIABILITIES & FUND BALANCES**		
Current Assets			Current Liabilities		
	Operating Cash	$481,885,979		Accounts payable	$13,807,781
	Investments	833,329,387		Medical claims liability	964,364,976
	Capitation receivable	383,482,587		Accrued payroll liabilities	9,341,768
	Receivables - Other	17,374,740		Deferred revenue	167,061,116
	Prepaid Expenses	4,986,816		Deferred lease obligations	158,970
				Capitation and withholds	382,720,721
	Total Current Assets	**1,721,059,509**		**Total Current Liabilities**	**1,537,455,331**
Capital Assets	Furniture and equipment	34,039,048	Other employment benefits liability		29,618,397
	Building/Leasehold improvements	6,228,243			
	505 City Parkway West	49,433,337	Net Pension Liabilities		16,365,263
		89,700,629	Long Term Liabilities		100,000
	Less: accumulated depreciation	(38,197,224)			
	Capital assets, net	**51,503,404**	**TOTAL LIABILITIES**		**1,583,538,991**
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	30,352,767	Tangible net equity (TNE)		88,937,308
	Long term investments	506,544,015	Funds in excess of TNE		647,520,526
	Total Board-designated Assets	536,896,783			
	Total Other Assets	**537,196,783**	**Net Assets**		**736,457,834**
	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		**2,321,336,835**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**		**2,321,336,835**

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CalOptima
Board Designated Reserve and TNE Analysis
as of December 31, 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,736,596				
	Tier 1 - Logan Circle	146,622,040				
	Tier 1 - Wells Capital	146,295,076				
Board-designated Reserve		439,653,712	301,731,893	469,161,551	137,921,819	(29,507,839)
TNE Requirement	Tier 2 - Logan Circle	97,243,070	88,937,308	88,937,308	8,305,763	8,305,763
	Consolidated:	536,896,783	390,669,201	558,098,859	146,227,581	(21,202,076)
	Current reserve level	*1.92*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
December 31, 2017

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	10,409,072	22,999,442
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	525,539	3,444,837
Changes in assets and liabilities:		
Prepaid expenses and other	(81,418)	667,830
Catastrophic reserves		
Capitation receivable	(13,520,961)	142,691,408
Medical claims liability	(54,629,776)	(282,061,044)
Deferred revenue	2,901,424	63,087,991
Payable to providers	(62,126,110)	(198,118,990)
Accounts payable	(25,008,390)	(26,614,827)
Other accrued liabilities	456,865	1,928,744
Net cash provided by/(used in) operating activities	(141,073,756)	(271,974,607)
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	174,386,193	249,096,365
Change in property and equipment	(192,801)	(647,215)
Change in Board designated reserves	(323,992)	(1,758,409)
Net cash provided by/(used in) investing activities	173,869,400	246,690,742
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	32,795,643	(25,283,866)
CASH AND CASH EQUIVALENTS, beginning of period	$449,090,336	507,169,844
CASH AND CASH EQUIVALENTS, end of period	**$ 481,885,979**	**$ 481,885,979**

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BALANCE SHEET:

ASSETS decreased $128.0 million from November

- **Investments** decreased $174.4 million due to transfer of funds for shared risk, Manages Care Organization (MCO) tax and claim payments
- **Cash and Cash Equivalents** increased by $32.8 million due to transfer of funds from investment and payment receipt timing
- **Net Capitation Receivables** increased $11.1 million based upon payment receipt timing and receivables

LIABILITIES decreased $138.4 million from November

- **Capitation Payable** decreased $62.1 million due to payment of shared risk group
- **Medical Claims Liability** by line of business decreased $54.6 million due to recoupment of overpayments
- **Accrued Expenses** decreased $22.7 million due to timing of payments

NET ASSETS are $736.5 million, an increase of $10.4 million from November

CalOptima Foundation
Statement of Revenues and Expenses
For the Six Months Ended December 31, 2017
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	0	0	0.0%	Total Operating Revenue	0	0	0	0.0%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	0	37,105	37,105	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	17,909	17,909	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	12,498	1,391,538	1,379,040	99.1%
2,083	241,092	239,009	99.1%	Total Operating Expenditures	12,498	1,446,552	1,434,054	99.1%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
(2,083)	(241,092)	(239,009)	(99.1%)	Program Income	(12,498)	(1,446,552)	(1,434,054)	(99.1%)

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CalOptima Foundation
Balance Sheet
December 31, 2017

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,868,139	Accounts payable-Current	12,498
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	**12,498**
		Total Liabilities	12,498
		Net Assets	**2,855,641**
TOTAL ASSETS	**2,868,139**	**TOTAL LIABILITIES & NET ASSETS**	**2,868,139**

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CALOPTIMA FOUNDATION - DECEMBER MONTH

INCOME STATEMENT:

OPERATING REVENUE

- No activity

OPERATING EXPENSES

- Audit Fees $2.1 thousand

BALANCE SHEET:

ASSETS

- Cash--$2.8 million remains from the FY14 $3.0 million transferred by CalOptima for grants and programs in support of providers and community

LIABILITIES

- Accrued Payables--$12.5 thousand for Audit fees

NET INCOME is ($12.5) thousand

Budget Allocation Changes
Reporting Changes for December 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 o her initiatives)	$25,000	Re-Purpose $25,000 from Purchased Services (Pediatric Weight Management Vendor) to pay for Captivate contract and other initiatives	2018
August	PACE	PACE Administrative - Purchased Services (Encounter Reporting & Translation Services)	PACE Administrative - Purchased Services (Satisfaction Survey)	$12,208	Re-Purpose $12,208 from Purchased Services (Encounter Reporting & Translation Services) to pay for Satisfaction Survey	2018
August	Medi-Cal	Facilities - Capital Project (Upgrade CalOptima and Building Access System)	Facilities - Capital Project (Mail Room/Basement/ Property Management Office)	$15,000	Reallocate $15,000 from Capital Project (Upgrade CalOptima and Building Access System) to Capital Project (Mail Room/Basement/Property Management Office)	2018
September	Medi-Cal	Other G&A - Other Operating Expenses	Facilities - Building Repair and Maintenance	$65,000	Reallocate $65,000 from Other G&A (o her operating expenses) to cover cost to conduct a review/study from soil engineer and he necessary repairs of the 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 additional funding needed on CareNet in OneCare Connect.	2018
November	Medi-Cal	Human Resources - Purchased Services -Temporary Outsource Service	Human Resources - Purchased Services - General	$10,000	Re-Purpose $10,000 from Purchased Services (Temporary Outsource Service) to fund for training module design and other department initiatives in Purchased Services	2018

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A Public Agency

CalOptima

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Financial Summary

November 2017

Board of Directors Meeting

February 1, 2018

Greg Hamblin

Chief Financial Officer

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FY 2017-18: Consolidated Enrollment

- November 2017 MTD:
  - Overall enrollment was 784,945 member months
    - Actual lower than budget by 18,082 or 2.3%
      - Medi-Cal: unfavorable variance of 17,815 members
        - TANF unfavorable variance of 16,702 members
        - SPD unfavorable variance of 2,347 members
        - Medi-Cal Expansion (MCE) favorable variance of 998 members
        - LTC favorable variance of 236 members
      - OneCare Connect: unfavorable variance of 289 members
    - 4,300 or 0.6% increase from prior month
      - Medi-Cal: increase of 4,302 from October
      - OneCare Connect: increase of 20 from October
      - OneCare: decrease of 28 from October
      - PACE: increase of 6 from October

FY 2017-18: Consolidated Enrollment

- November 2017 YTD:
  - Overall enrollment was 3,947,448 member months
    - Actual lower than budget by 64,416 or 1.6%
      - Medi-Cal: unfavorable variance of 63,446 members or 1.6%
        - TANF unfavorable variance of 61,038 members
        - SPD unfavorable variance of 13,348 members
        - MCE favorable variance of 10,125 members
        - LTC favorable variance of 815 members
      - OneCare Connect: unfavorable variance of 1,234 members or 1.6%
      - OneCare: favorable variance of 270 members or 4.0%
      - PACE: unfavorable variance of 6 member or 0.5%

FY 2017-18: Consolidated Revenues

- November 2017 MTD:
  - Actual higher than budget by $10.0 million or 3.6%
    - Medi-Cal: favorable to budget by $8.3 million or 3.4%
      - Unfavorable volume variance of $5.6 million
      - Favorable price variance of $13.9 million due to:
        - $6.0 million of FY18 Coordinated Care Initiative (CCI) including In Home Supportive Services (IHSS) Dual and Non-Dual revenue
        - $3.0 million of FY18 revenue such as LTC Revenue from Non-LTC members and Non-Medical Transportation
        - $1.9 million of FY18 Behavioral Health Treatment (BHT) revenue
        - $2.5 million of FY17 revenue

FY 2017-18: Consolidated Revenues (cont.)

- November 2017 MTD:
  - OneCare Connect: favorable to budget by $1.4 million or 5.3%
    - Unfavorable volume variance of $0.5 million due to lower enrollment
    - Favorable price variance of $1.9 million due to higher than anticipated RAF score and prior year revenue
  - OneCare: favorable to budget by $0.2 million or 15.9%
    - Favorable volume variance of $25.8 thousand
    - Favorable price variance of $0.2 million due to higher than anticipated RAF score and prior year adjustments
  - PACE: favorable to budget by $38.0 thousand or 2.4%
    - Unfavorable volume variance of $20.0 thousand
    - Favorable price variance of $57.8 thousand

FY 2017-18: Consolidated Revenues (cont.)

- November 2017 YTD:
  - Actual higher than budget by $48.1 million or 3.5%
    - Medi-Cal: favorable to budget by $41.8 million or 3.4%
      - Unfavorable volume variance of $19.8 million
      - Favorable price variance of $61.6 million due to:
        - $24.1 million of FY18 Coordinated Care Initiative (CCI) including In Home Supportive Services (IHSS) Dual and Non-Dual revenue
        - $10.2 million of FY18 Behavioral Health Treatment (BHT) revenue
        - $10.4 million of FY17 LTC Revenue from Non-LTC members
        - $6.3 million of FY17 CCI including IHSS Dual and Non-Dual revenue
        - $6.1 million of prior years release of general reserve due to DHCS member month adjustments

FY 2017-18: Consolidated Revenues (cont.)

- November 2017 YTD:
  - OneCare Connect: favorable to budget by $7.4 million or 5.4%
    - Unfavorable volume variance of $2.2 million
    - Favorable price variance of $9.6 million due to higher than anticipated RAF score and prior year revenue
  - OneCare: Unfavorable to budget by $1.6 million or 22.9%
    - Favorable volume variance of $0.3 million
    - Unfavorable price variance of $1.8 million
      - $2.8 million due to CMS recoupment for prior years
      - Offset by higher than anticipated RAF score
  - PACE: favorable to budget by $0.5 million or 6.7%
    - Favorable price variance of $0.5 million due to higher than anticipated RAF score and prior year revenue

FY 2017-18: Consolidated Medical Expenses

- November 2017 MTD:
  - Actual higher than budget by $16.0 million or 6.1%
    - Medi-Cal: unfavorable variance of $15.2 million
      - Favorable volume variance of $5.3 million
      - Unfavorable price variance of $20.4 million
        - MLTSS unfavorable variance of $10.0 million
          - IHSS unfavorable variance of $4.8 million
          - LTC unfavorable variance of $5.0 million
        - Provider Capitation unfavorable variance of $4.3 million
        - Professional Claims unfavorable variance of $3.3 million
        - Facilities expenses unfavorable variance of $2.9 million
    - OneCare Connect: unfavorable variance of $1.0 million
      - Favorable volume variance of $0.5 million
      - Unfavorable price variance of $1.5 million due to IHSS

FY 2017-18: Consolidated Medical Expenses (cont.)

- November 2017 YTD:
  - Actual higher than budget by $65.5 million or 5.0%
    - Medi-Cal: unfavorable variance of $64.5 million
      - Favorable volume variance of $18.9 million
      - Unfavorable price variance of $83.3 million
        - MLTSS expense $39.2 million higher than budget
        - Provider Capitation $18.9 million higher than budget
        - Professional Claims $11.7 million higher than budget
        - Facilities $8.0 million higher than budget
    - OneCare Connect: unfavorable variance of $4.7 million
      - Favorable volume variance of $2.0 million
      - Unfavorable price variance of $6.7 million
- Medical Loss Ratio (MLR):
  - November 2017 MTD: Actual: 97.0% Budget: 94.7%
  - November 2017 YTD: Actual: 96.4% Budget: 95.0%

FY 2017-18: Consolidated Administrative Expenses

- November 2017 MTD:
  - Actual lower than budget by $2.5 million or 19.7%
    - Salaries and Benefits: favorable variance of $1.1 million
    - Other categories: favorable variance of $1.4 million

- November 2017 YTD:
  - Actual lower than budget by $13.3 million or 21.8%
    - Salaries and Benefits: favorable variance of $4.6 million driven by lower than budgeted FTE
    - Other categories: favorable variance of $8.7 million

- Administrative Loss Ratio (ALR):
  - November 2017 MTD: Actual: 3.6% Budget: 4.6%
  - November 2017 YTD: Actual: 3.3% Budget: 4.4%

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FY 2017-18: Change in Net Assets

- November 2017 MTD:
  - $1.2 million deficit
  - $3.3 million unfavorable to budget
    - Higher than budgeted revenue of $10.0 million
    - Higher than budgeted medical expenses of $16.0 million
    - Lower than budgeted administrative expenses of $2.5 million
    - Higher than budgeted investment and other income of $0.2 million

- November 2017 YTD:
  - $12.6 million surplus
  - $3.4 million favorable to budget
    - Higher than budgeted revenue of $48.1 million
    - Higher than budgeted medical expenses of $65.5 million
    - Lower than budgeted administrative expenses of $13.3 million
    - Higher than budgeted investment and other income of $7.5 million

Enrollment Summary: November 2017

Month-to-Date					Year-to-Date			
Actual	Budget	Variance	%	Enrollment (By Aid Category)	Actual	Budget	Variance	%
62,704	63,406	(702)	(1.1%)	Aged	308,575	313,147	(4,572)	(1.5%)
621	618	3	0.5%	BCCTP	3,050	3,090	(40)	(1.3%)
47,137	48,785	(1,648)	(3.4%)	Disabled	235,088	243,824	(8,736)	(3.6%)
322,288	329,502	(7,214)	(2.2%)	TANF Child	1,629,913	1,648,931	(19,018)	(1.2%)
94,261	103,749	(9,488)	(9.1%)	TANF Adult	477,632	519,652	(42,020)	(8.1%)
3,504	3,268	236	7.2%	LTC	17,155	16,340	815	5.0%
237,565	236,567	998	0.4%	MCE	1,191,623	1,181,498	10,125	0.9%
768,080	**785,895**	**(17,815)**	**(2.3%)**	**Medi-Cal**	**3,863,036**	**3,926,482**	**(63,446)**	**(1.6%)**
15,254	**15,543**	**(289)**	**(1.9%)**	**OneCare Connect**	**76,347**	**77,581**	**(1,234)**	**(1.6%)**
233	**236**	**(3)**	**(1.3%)**	**PACE**	**1,124**	**1,130**	**(6)**	**(0.5%)**
1,378	**1,353**	**25**	**1.8%**	**OneCare**	**6,941**	**6,671**	**270**	**4.0%**
784,945	**803,027**	**(18,082)**	**(2.3%)**	**CalOptima Total**	**3,947,448**	**4,011,864**	**(64,416)**	**(1.6%)**

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Financial Highlights: November 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
784,945	803,027	(18,082)	(2.3%)	Member Months	3,947,448	4,011,864	(64,416)	(1.6%)
285,485,855	275,462,239	10,023,616	3.6%	Revenues	1,424,567,074	1,376,470,031	48,097,043	3.5%
276,911,087	260,936,827	(15,974,260)	(6.1%)	Medical Expenses	1,373,070,375	1,307,596,051	(65,474,324)	(5.0%)
10,226,511	12,733,080	2,506,569	19.7%	Administrative Expenses	47,616,373	60,916,502	13,300,129	21.8%
(1,651,743)	**1,792,332**	**(3,444,075)**	**(192.2%)**	**Operating Margin**	**3,880,326**	**7,957,478**	**(4,077,152)**	**(51.2%)**
423,148	231,157	191,991	83.1%	Non Operating Income (Loss)	8,710,044	1,198,559	7,511,485	626.7%
(1,228,595)	**2,023,489**	**(3,252,084)**	**(160.7%)**	**Change in Net Assets**	**12,590,370**	**9,156,037**	**3,434,333**	**37.5%**
97.0%	94.7%	(2.3%)		Medical Loss Ratio	96.4%	95.0%	(1.4%)	
3.6%	4.6%	1.0%		Administrative Loss Ratio	3.3%	4.4%	1.1%	
(0.6%)	0.7%	(1.2%)		Operating Margin Ratio	0.3%	0.6%	(0.3%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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Consolidated Performance Actual vs. Budget: November (in millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(2.6)	1.6	(4.2)	Medi-Cal	(2.6)	8.3	(10.9)
0.7	0.4	0.3	OCC	4.5	0.6	3.9
0.3	(0.1)	0.5	OneCare	1.3	(0.7)	2.0
(0.1)	0.0	0.0	PACE	0.7	(0.3)	0.9
(1.7)	**1.9**	**(3.4)**	**Operating**	**3.9**	**7.9**	**(4.1)**
0.4	0.2	0.2	Inv./Rental Inc, MCO tax	8.8	1.2	7.6
0.4	**0.2**	**0.2**	**Non-Operating**	**8.8**	**1.2**	**7.6**
(1.2)	**2.0**	**(3.3)**	**TOTAL**	**12.6**	**9.2**	**3.4**

Consolidated Revenue & Expense: November 2017 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	530,515	237,565	768,080	15,254	1,378	233	784,945
REVENUES							
Capitation Revenue	$ 151,985,935	$ 101,616,349	$ 253,602,284	$ 28,672,713	$ 1,620,154	$ 1,590,703	$ 285,485,855
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	151,985,935	101,616,349	253,602,284	28,672,713	1,620,154	1,590,703	285,485,855
MEDICAL EXPENSES							
Provider Capitation	39,609,588	49,693,262	89,302,850	10,364,079	378,428	-	100,045,357
Facilities	27,986,269	17,261,143	45,247,412	2,460,173	229,417	370,440	48,307,442
Ancillary	-	-	-	658,020	69,269	-	727,289
Skilled Nursing	-	-	-	-	5,418	-	5,418
Professional Claims	7,817,321	8,925,403	16,742,724	-	-	387,108	17,129,831
Prescription Drugs	16,965,570	17,785,115	34,750,685	5,253,605	418,035	128,628	40,550,954
Quality Incentives	-	-	-	-	-	-	-
MLTSS Facility Payments	55,885,162	2,860,753	58,745,914	5,942,841	-	1,209	64,689,965
Medical Management	1,847,971	887,687	2,735,657	1,078,869	-	564,797	4,379,323
Reinsurance & Other	481,235	335,970	817,206	150,000	7,100	101,204	1,075,509
Total Medical Expenses	150,593,115	97,749,333	248,342,448	25,907,587	1,107,667	1,553,386	276,911,087
Medical Loss Ratio	**99.1%**	**96.2%**	**97.9%**	**90.4%**	**68.4%**	**97.7%**	**97.0%**
GROSS MARGIN	**1,392,821**	**3,867,016**	**5,259,836**	**2,765,127**	**512,488**	**37,318**	**8,574,768**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,410,150	663,318	20,139	74,618	6,168,224
Professional fees			235,343	108,033	79,016	4,085	426,477
Purchased services			697,604	502,279	45,594	8,730	1,254,207
Printing and Postage			373,219	90,406	10,595	0	474,220
Depreciation and Amortization			366,560	-	-	2,168	368,728
Other expenses			1,167,984	38,103	0	9,677	1,215,765
Indirect cost allocation, Occupancy expense			(362,512)	664,798	13,553	3,052	318,891
Total Administrative Expenses			7,888,347	2,066,938	168,896	102,330	10,226,511
Admin Loss Ratio			**3.1%**	**7.2%**	**10.4%**	**6.4%**	**3.6%**
INCOME (LOSS) FROM OPERATIONS			(2,628,510)	698,189	343,592	(65,013)	(1,651,743)
INVESTMENT INCOME			-	-	-	-	415,351
NET RENTAL INCOME			-	-	-	-	23,099
NET GRANT INCOME			(15,408)	-	-	-	(15,408)
OTHER INCOME			106	-	-	-	106
CHANGE IN NET ASSETS			**$ (2,643,813)**	**$ 698,189**	**$ 343,592**	**$ (65,013)**	**$ (1,228,595)**
BUDGETED CHANGE IN ASSETS			1,567,139	366,820	(115,676)	(25,951)	2,023,489
VARIANCE TO BUDGET - FAV (UNFAV)			(4,210,952)	331,369	459,268	(39,062)	(3,252,084)

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CalOptima A Public Agency Better. Together.

Consolidated Revenue & Expense: November 2017 YTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	2,671,413	1,191,623	3,863,036	76,347	6,941	1,124	3,947,448
REVENUES							
Capitation Revenue	$ 747,252,854	$ 519,719,215	$ 1,266,972,069	$ 144,373,037	5,292,662	$ 7,929,306	$ 1,424,567,074
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	747,252,854	519,719,215	1,266,972,069	144,373,037	5,292,662	7,929,306	1,424,567,074
MEDICAL EXPENSES							
Provider Capitation	196,222,492	250,879,244	447,101,735	55,723,896	(529,739)	-	502,295,893
Facilities	127,067,124	95,888,299	222,955,423	13,748,039	1,388,737	1,307,622	239,399,821
Ancillary	-	-	-	3,054,706	221,969	-	3,276,675
Skilled Nursing	-	-	-	-	100,101	-	100,101
Professional Claims	38,059,226	42,003,145	80,062,372	-	-	1,728,334	81,790,706
Prescription Drugs	88,498,480	92,101,835	180,600,315	25,906,527	2,328,120	571,405	209,406,367
MLTSS Facility Payments	269,633,627	12,775,398	282,409,025	26,827,304	-	17,511	309,253,839
Medical Management	10,131,604	3,706,678	13,838,282	5,280,243	69,195	2,619,513	21,807,233
Reinsurance & Other	2,689,222	1,645,185	4,334,407	876,405	38,135	490,793	5,739,740
Total Medical Expenses	732,301,775	498,999,783	1,231,301,558	131,417,121	3,616,519	6,735,178	1,373,070,375
Medical Loss Ratio	**98.0%**	**96.0%**	**97.2%**	**91.0%**	**68.3%**	**84.9%**	**96.4%**
GROSS MARGIN	**14,951,079**	**20,719,432**	**35,670,511**	**12,955,917**	**1,676,143**	**1,194,128**	**51,496,699**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			26,168,962	3,671,147	115,994	352,446	30,308,550
Professional fees			922,685	142,646	79,016	15,339	1,159,686
Purchased services			3,568,178	755,552	95,156	25,144	4,444,029
Printing and Postage			1,462,596	347,628	31,081	5,178	1,846,483
Depreciation and Amortization			2,110,143	-	-	10,768	2,120,911
Other expenses			5,682,922	230,636	(32)	80,980	5,994,506
Indirect cost allocation, Occupancy expense			(1,686,998)	3,323,991	67,765	37,448	1,742,206
Total Administrative Expenses			38,228,488	8,471,600	388,980	527,304	47,616,373
Admin Loss Ratio			**3.0%**	**5.9%**	**7.3%**	**6.7%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			(2,557,977)	4,484,317	1,287,163	666,824	3,880,326
INVESTMENT INCOME			-	-	-	-	8,738,766
NET RENTAL INCOME			-	-	-	-	43,480
NET GRANT INCOME			(72,727)	-	-	-	(72,727)
OTHER INCOME			525	-	-	-	525
CHANGE IN NET ASSETS			**$ (2,630,179)**	**$ 4,484,317**	**$ 1,287,163**	**$ 666,824**	**$ 12,590,370**
BUDGETED CHANGE IN ASSETS			8,282,165	632,973	(698,373)	(259,287)	9,156,037
VARIANCE TO BUDGET - FAV (UNFAV)			(10,912,344)	3,851,344	1,985,536	926,111	3,434,333

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CalOptima A Public Agency Better. Together.

Balance Sheet:
As of November 2017

ASSETS			LIABILITIES & FUND BALANCES	
Current Assets			Current Liabilities	
	Operating Cash	$449,090,336	Accounts payable	$36,494,046
	Investments	1,007,715,579	Medical claims liability	1,018,994,753
	Capitation receivable	372,373,146	Accrued payroll liabilities	11,663,892
	Receivables - Other	14,963,220	Deferred revenue	164,159,692
	Prepaid Expenses	4,905,399	Deferred lease obligations	165,329
			Capitation and withholds	444,846,831
	Total Current Assets	**1,849,047,680**	**Total Current Liabilities**	**1,676,324,543**
Capital Assets	Furniture and equipment	34,039,048	Other employment benefits liability	29,443,803
	Building/Leasehold improvements	5,983,412		
	505 City Parkway West	49,433,337	Net Pension Liabilities	16,076,633
		89,455,798	Long Term Liabilities	100,000
	Less: accumulated depreciation	(37,619,657)		
	Capital assets, net	**51,836,141**	**TOTAL LIABILITIES**	**1,721,944,980**
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	23,610,493	Tangible net equity (TNE)	89,592,047
	Long term investments	512,962,298	Funds in excess of TNE	636,456,715
	Total Board-designated Assets	536,572,791		
	Total Other Assets	**536,872,791**	**Net Assets**	**726,048,762**
	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		**2,449,333,752**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**	**2,449,333,752**

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Board Designated Reserve and TNE Analysis As of November 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,641,999				
	Tier 1 - Logan Circle	146,498,235				
	Tier 1 - Wells Capital	146,246,368				
Board-designated Reserve		439,386,601	309,435,704	480,447,597	129,950,897	(41,060,996)
TNE Requirement	Tier 2 - Logan Circle	97,186,190	89,592,046	89,592,046	7,594,144	7,594,144
	Consolidated:	536,572,791	399,027,750	570,039,643	137,545,041	(33,466,852)
	Current reserve level	*1.88*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

November 2017

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CalOptima - Consolidated
Financial Highlights
For the Five Months Ended November 30, 2017

Month-to-Date					Year-to-Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
784,945	803,027	(18,082)	(2.3%)	Member Months	3,947,448	4,011,864	(64,416)	(1.6%)
285,485,855	275,462,239	10,023,616	3.6%	Revenues	1,424,567,074	1,376,470,031	48,097,043	3.5%
276,911,087	260,936,827	(15,974,260)	(6.1%)	Medical Expenses	1,373,070,375	1,307,596,051	(65,474,324)	(5.0%)
10,226,511	12,733,080	2,506,569	19.7%	Administrative Expenses	47,616,373	60,916,502	13,300,129	21.8%
(1,651,743)	**1,792,332**	**(3,444,075)**	**(192.2%)**	**Operating Margin**	**3,880,326**	**7,957,478**	**(4,077,152)**	**(51.2%)**
423,148	231,157	191,991	83.1%	Non Operating Income (Loss)	8,710,044	1,198,559	7,511,485	626.7%
(1,228,595)	**2,023,489**	**(3,252,084)**	**(160.7%)**	**Change in Net Assets**	**12,590,370**	**9,156,037**	**3,434,333**	**37.5%**
97.0%	94.7%	(2.3%)		Medical Loss Ratio	96.4%	95.0%	(1.4%)	
3.6%	4.6%	1.0%		Administrative Loss Ratio	3.3%	4.4%	1.1%	
(0.6%)	0.7%	(1.2%)		Operating Margin Ratio	0.3%	0.6%	(0.3%)	
100.0%	100.0%			Total Operating	100.0%	100.0%		

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CalOptima
Financial Dashboard
For the Five Months Ended November 30, 2017

MONTH - TO - DATE

Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	768,080	785,895	(17,815)	(2.3%)
OneCare Connect	15,254	15,543	(289)	(1.9%)
OneCare	1,378	1,353	25	1.8%
PACE	233	236	(3)	(1.3%)
Total	784,945	803,027	(18,082)	(2.3%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (2,644)	$ 1,567	$ (4,211)	(268.7%)
OneCare Connect	698	367	331	90.3%
OneCare	344	(116)	459	397.0%
PACE	(65)	(26)	(39)	(150.5%)
505 Bldg.	23	(19)	42	222.6%
Investment Income & Other	415	250	165	66.1%
Total	$ (1,229)	$ 2,023	$ (3,252)	(160.7%)

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.9%	95.1%	(2.9)
OneCare Connect	90.4%	91.5%	1.1
OneCare	68.4%	101.3%	33.0

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 7,888	$ 10,526	$ 2,637	25.1%
OneCare Connect	2,067	1,958	(109)	(5.6%)
OneCare	169	97	(72)	(73.7%)
PACE	102	152	50	32.7%
Total	$ 10,227	$ 12,733	$ 2,507	19.7%

Total FTE's Month

	Actual	Budget	Fav / (Unfav)
Medi-Cal	894	900	6
OneCare Connect	215	237	22
OneCare	3	3	0
PACE	55	64	9
Total	1,167	1,205	37

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	859	873	(14)
OneCare Connect	71	66	5
OneCare	461	451	10
PACE	4	4	1
Total	1,394	1,393	1

YEAR - TO - DATE

Year To Date Enrollment

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	3,863,036	3,926,482	(63,446)	(1.6%)
OneCare Connect	76,347	77,581	(1,234)	(1.6%)
OneCare	6,941	6,671	270	4.0%
PACE	1,124	1,130	(6)	(0.5%)
Total	3,947,448	4,011,864	(64,416)	(1.6%)

Change in Net Assets (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ (2,630)	$ 8,282	$ (10,912)	(131.8%)
OneCare Connect	4,484	633	3,851	608.5%
OneCare	1,287	(698)	1,986	284.3%
PACE	667	(259)	926	357.2%
505 Bldg.	43	(51)	95	184.5%
Investment Income & Other	8,739	1,250	7,489	599.1%
Total	$ 12,590	$ 9,156	$ 3,434	37.5%

MLR

	Actual	Budget	% Point Var
Medi-Cal	97.2%	95.2%	(1.9)
OneCare Connect	91.0%	92.5%	1.5
OneCare	68.3%	103.0%	34.7

Administrative Cost (000)

	Actual	Budget	Fav / (Unfav)	
Medi-Cal	$ 38,228	$ 50,055	$ 11,827	23.6%
OneCare Connect	8,472	9,622	1,150	12.0%
OneCare	389	493	104	21.1%
PACE	527	746	219	29.3%
Total	$ 47,616	$ 60,917	$ 13,300	21.8%

Total FTE's YTD

	Actual	Budget	Fav / (Unfav)
Medi-Cal	4,385	4,502	117
OneCare Connect	1,118	1,185	67
OneCare	15	15	(0)
PACE	264	315	51
Total	5,783	6,018	235

MM per FTE

	Actual	Budget	Fav / (Unfav)
Medi-Cal	881	872	9
OneCare Connect	68	65	3
OneCare	449	445	5
PACE	4	4	1
Total	1,403	1,386	17

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CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended November 30, 2017

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	784,945		803,027		(18,082)	
Revenues						
Medi-Cal	$ 253,602,284	$ 330.18	$ 245,282,587	$ 312.11	$ 8,319,697	$ 18.07
OneCare Connect	28,672,713	1,879.68	27,229,316	1,751.87	1,443,397	127.81
OneCare	1,620,154	1,175.73	1,397,670	1,033.02	222,484	142.71
PACE	1,590,703	6,827.05	1,552,666	6,579.09	38,037	247.96
Total Operating Revenue	285,485,855	363.70	275,462,239	343.03	10,023,616	20.67
Medical Expenses						
Medi-Cal	248,342,448	323.33	233,189,629	296.72	(15,152,819)	(26.61)
OneCare Connect	25,907,587	1,698.41	24,904,512	1,602.30	(1,003,075)	(96.12)
OneCare	1,107,667	803.82	1,416,123	1,046.65	308,456	242.83
PACE	1,553,386	6,666.89	1,426,563	6,044.76	(126,823)	(622.13)
Total Medical Expenses	276,911,087	352.78	260,936,827	324.94	(15,974,260)	(27.84)
Gross Margin	8,574,768	10.92	14,525,412	18.09	(5,950,644)	(7.16)
Administrative Expenses						
Salaries and Benefits	6,168,224	7.86	7,271,987	9.06	1,103,763	1.20
Professional fees	426,477	0.54	376,191	0.47	(50,286)	(0.07)
Purchased services	1,254,207	1.60	2,204,941	2.75	950,734	1.15
Printing and Postage	474,220	0.60	529,874	0.66	55,654	0.06
Depreciation and Amortization	368,728	0.47	463,298	0.58	94,570	0.11
Other	1,215,765	1.55	1,546,372	1.93	330,607	0.38
Indirect cost allocation, Occupancy expense	318,891	0.41	340,417	0.42	21,526	0.02
Total Administrative Expenses	10,226,511	13.03	12,733,080	15.86	2,506,569	2.83
Income (Loss) From Operations	(1,651,743)	(2.10)	1,792,332	2.23	(3,444,075)	(4.34)
Investment income						
Interest income	2,337,088	2.98	250,000	0.31	2,087,088	2.67
Realized gain/(loss) on investments	(91,087)	(0.12)	-	-	(91,087)	(0.12)
Unrealized gain/(loss) on investments	(1,830,649)	(2.33)	-	-	(1,830,649)	(2.33)
Total Investment Income	415,351	0.53	250,000	0.31	165,351	0.22
Net Rental Income	23,099	0.03	(18,843)	(0.02)	41,942	0.05
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(15,408)	(0.02)	-	-	(15,408)	(0.02)
QAF/IGT	-	-	-	-	-	-
Other Income	106	0.00	-	-	106	0.00
Change In Net Assets	**(1,228,595)**	**(1.57)**	**2,023,489**	**2.52**	**(3,252,084)**	**(4.09)**
Medical Loss Ratio	**97.0%**		**94.7%**		**(2.3%)**	
Administrative Loss Ratio	**3.6%**		**4.6%**		**1.0%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

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CalOptima - Consolidated
Statement of Revenue and Expenses
For the Five Months Ended November 30, 2017

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	3,947,448		4,011,864		(64,416)	
Revenues						
Medi-Cal	$ 1,266,972,069	$ 327.97	$ 1,225,175,140	$ 312.03	$ 41,796,929	$ 15.94
OneCare Connect	144,373,037	1,891.01	136,996,266	1,765.85	7,376,771	125.16
OneCare	5,292,662	762.52	6,864,040	1,028.94	(1,571,378)	(266.42)
PACE	7,929,306	7,054.54	7,434,585	6,579.28	494,721	475.26
Total Operating Revenue	1,424,567,074	360.88	1,376,470,031	343.10	48,097,043	17.78
Medical Expenses						
Medi-Cal	1,231,301,558	318.74	1,166,837,615	297.17	(64,463,943)	(21.57)
OneCare Connect	131,417,121	1,721.31	126,741,273	1,633.66	(4,675,848)	(87.65)
OneCare	3,616,519	521.04	7,069,301	1,059.71	3,452,782	538.67
PACE	6,735,178	5,992.15	6,947,862	6,148.55	212,684	156.40
Total Medical Expenses	1,373,070,375	347.84	1,307,596,051	325.93	(65,474,324)	(21.91)
Gross Margin	51,496,699	13.05	68,873,980	17.17	(17,377,281)	(4.12)
Administrative Expenses						
Salaries and Benefits	30,308,550	7.68	34,886,703	8.70	4,578,153	1.02
Professional fees	1,159,686	0.29	1,937,446	0.48	777,760	0.19
Purchased services	4,444,029	1.13	9,825,609	2.45	5,381,579	1.32
Printing and Postage	1,846,483	0.47	2,646,864	0.66	800,381	0.19
Depreciation and Amortization	2,120,911	0.54	2,316,490	0.58	195,579	0.04
Other	5,994,506	1.52	7,601,306	1.89	1,606,799	0.38
Indirect cost allocation, Occupancy expense	1,742,206	0.44	1,702,085	0.42	(40,121)	(0.02)
Total Administrative Expenses	47,616,373	12.06	60,916,502	15.18	13,300,129	3.12
Income (Loss) From Operations	3,880,326	0.98	7,957,478	1.98	(4,077,152)	(1.00)
Investment income						
Interest income	11,038,986	2.80	1,250,000	0.31	9,788,986	2.48
Realized gain/(loss) on investments	(501,211)	(0.13)	-	-	(501,211)	(0.13)
Unrealized gain/(loss) on investments	(1,799,009)	(0.46)	-	-	(1,799,009)	(0.46)
Total Investment Income	8,738,766	2.21	1,250,000	0.31	7,488,766	1.90
Net Rental Income	43,480	0.01	(51,441)	(0.01)	94,921	0.02
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	(72,727)	(0.02)	-	-	(72,727)	(0.02)
QAF/IGT	-	-	-	-	-	-
Other Income	525	0.00	-	-	525	0.00
Change In Net Assets	**12,590,370**	**3.19**	**9,156,037**	**2.28**	**3,434,333**	**0.91**
Medical Loss Ratio	**96.4%**		**95.0%**		**(1.4%)**	
Administrative Loss Ratio	**3.3%**		**4.4%**		**1.1%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended November 30, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	530,515	237,565	768,080	15,254	1,378	233	784,945
REVENUES							
Capitation Revenue	$ 151,985,935	$ 101,616,349	$ 253,602,284	$ 28,672,713	$ 1,620,154	$ 1,590,703	$ 285,485,855
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	151,985,935	101,616,349	253,602,284	28,672,713	1,620,154	1,590,703	285,485,855
MEDICAL EXPENSES							
Provider Capitation	39,609,588	49,693,262	89,302,850	10,364,079	378,428	-	100,045,357
Facilities	27,986,269	17,261,143	45,247,412	2,460,173	229,417	370,440	48,307,442
Ancillary	-	-	-	658,020	69,269	-	727,289
Skilled Nursing	-	-	-	-	5,418	-	5,418
Professional Claims	7,817,321	8,925,403	16,742,724	-	-	387,108	17,129,831
Prescription Drugs	16,965,570	17,785,115	34,750,685	5,253,605	418,035	128,628	40,550,954
Quality Incentives	-	-	-	-	-	-	-
MLTSS Facility Payments	55,885,162	2,860,753	58,745,914	5,942,841	-	1,209	64,689,965
Medical Management	1,847,971	887,687	2,735,657	1,078,869	-	564,797	4,379,323
Reinsurance & Other	481,235	335,970	817,206	150,000	7,100	101,204	1,075,509
Total Medical Expenses	150,593,115	97,749,333	248,342,448	25,907,587	1,107,667	1,553,386	276,911,087
Medical Loss Ratio	**99.1%**	**96.2%**	**97.9%**	**90.4%**	**68.4%**	**97.7%**	**97.0%**
GROSS MARGIN	**1,392,821**	**3,867,016**	**5,259,836**	**2,765,127**	**512,488**	**37,318**	**8,574,768**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			5,410,150	663,318	20,139	74,618	6,168,224
Professional fees			235,343	108,033	79,016	4,085	426,477
Purchased services			697,604	502,279	45,594	8,730	1,254,207
Printing and Postage			373,219	90,406	10,595	0	474,220
Depreciation and Amortization			366,560	-	-	2,168	368,728
Other expenses			1,167,984	38,103	0	9,677	1,215,765
Indirect cost allocation, Occupancy expense			(362,512)	664,798	13,553	3,052	318,891
Total Administrative Expenses			7,888,347	2,066,938	168,896	102,330	10,226,511
Admin Loss Ratio			**3.1%**	**7.2%**	**10.4%**	**6.4%**	**3.6%**
INCOME (LOSS) FROM OPERATIONS			(2,628,510)	698,189	343,592	(65,013)	(1,651,743)
INVESTMENT INCOME			-	-	-	-	415,351
NET RENTAL INCOME			-	-	-	-	23,099
NET GRANT INCOME			(15,408)	-	-	-	(15,408)
OTHER INCOME			106	-	-	-	106
CHANGE IN NET ASSETS			**$ (2,643,813)**	**$ 698,189**	**$ 343,592**	**$ (65,013)**	**$ (1,228,595)**
BUDGETED CHANGE IN ASSETS			1,567,139	366,820	(115,676)	(25,951)	2,023,489
VARIANCE TO BUDGET - FAV (UNFAV)			(4,210,952)	331,369	459,268	(39,062)	(3,252,084)

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CalOptima - Consolidated - Year to Date
Statement of Revenues and Expenses by LOB
For the Five Months Ended November 30, 2017

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare Connect	OneCare	PACE	Consolidated
Member Months	2,671,413	1,191,623	3,863,036	76,347	6,941	1,124	3,947,448
REVENUES							
Capitation Revenue	$ 747,252,854	$ 519,719,215	$ 1,266,972,069	$ 144,373,037	5,292,662	$ 7,929,306	$ 1,424,567,074
Other Income	-	-	-	-	0	-	-
Total Operating Revenues	747,252,854	519,719,215	1,266,972,069	144,373,037	5,292,662	7,929,306	1,424,567,074
MEDICAL EXPENSES							
Provider Capitation	196,222,492	250,879,244	447,101,735	55,723,896	(529,739)	-	502,295,893
Facilities	127,067,124	95,888,299	222,955,423	13,748,039	1,388,737	1,307,622	239,399,821
Ancillary	-	-	-	3,054,706	221,969	-	3,276,675
Skilled Nursing	-	-	-	-	100,101	-	100,101
Professional Claims	38,059,226	42,003,145	80,062,372	-	-	1,728,334	81,790,706
Prescription Drugs	88,498,480	92,101,835	180,600,315	25,906,527	2,328,120	571,405	209,406,367
MLTSS Facility Payments	269,633,627	12,775,398	282,409,025	26,827,304	-	17,511	309,253,839
Medical Management	10,131,604	3,706,678	13,838,282	5,280,243	69,195	2,619,513	21,807,233
Reinsurance & Other	2,689,222	1,645,185	4,334,407	876,405	38,135	490,793	5,739,740
Total Medical Expenses	732,301,775	498,999,783	1,231,301,558	131,417,121	3,616,519	6,735,178	1,373,070,375
Medical Loss Ratio	**98.0%**	**96.0%**	**97.2%**	**91.0%**	**68.3%**	**84.9%**	**96.4%**
GROSS MARGIN	**14,951,079**	**20,719,432**	**35,670,511**	**12,955,917**	**1,676,143**	**1,194,128**	**51,496,699**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Benefits			26,168,962	3,671,147	115,994	352,446	30,308,550
Professional fees			922,685	142,646	79,016	15,339	1,159,686
Purchased services			3,568,178	755,552	95,156	25,144	4,444,029
Printing and Postage			1,462,596	347,628	31,081	5,178	1,846,483
Depreciation and Amortization			2,110,143	-	-	10,768	2,120,911
Other expenses			5,682,922	230,636	(32)	80,980	5,994,506
Indirect cost allocation, Occupancy expense			(1,686,998)	3,323,991	67,765	37,448	1,742,206
Total Administrative Expenses			38,228,488	8,471,600	388,980	527,304	47,616,373
Admin Loss Ratio			**3.0%**	**5.9%**	**7.3%**	**6.7%**	**3.3%**
INCOME (LOSS) FROM OPERATIONS			(2,557,977)	4,484,317	1,287,163	666,824	3,880,326
INVESTMENT INCOME			-	-	-	-	8,738,766
NET RENTAL INCOME			-	-	-	-	43,480
NET GRANT INCOME			(72,727)	-	-	-	(72,727)
OTHER INCOME			525	-	-	-	525
CHANGE IN NET ASSETS			**$ (2,630,179)**	**$ 4,484,317**	**$ 1,287,163**	**$ 666,824**	**$ 12,590,370**
BUDGETED CHANGE IN ASSETS			8,282,165	632,973	(698,373)	(259,287)	9,156,037
VARIANCE TO BUDGET - FAV (UNFAV)			(10,912,344)	3,851,344	1,985,536	926,111	3,434,333

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SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is ($1.2) million, $3.3 million unfavorable to budget
- Operating deficit is $1.7 million with a surplus in non-operating of $0.4 million

YEAR TO DATE RESULTS:

- Change in Net Assets is $12.6 million, $3.4 million favorable to budget
- Operating surplus is $3.9 million, $4.1 million unfavorable to budget

Change in Net Assets by LOB ($millions)

MONTH-TO-DATE				YEAR-TO-DATE		
Actual	Budget	Variance		Actual	Budget	Variance
(2.6)	1.6	(4.2)	Medi-Cal	(2.6)	8.3	(10.9)
0.7	0.4	0.3	OCC	4.5	0.6	3.9
0.3	(0.1)	0.5	OneCare	1.3	(0.7)	2.0
(0.1)	0.0	0.0	PACE	0.7	(0.3)	0.9
(1.7)	**1.9**	**(3.4)**	**Operating**	**3.9**	**7.9**	**(4.1)**
0.4	0.2	0.2	Inv./Rental Inc, MCO tax	8.8	1.2	7.6
0.4	**0.2**	**0.2**	**Non-Operating**	**8.8**	**1.2**	**7.6**
(1.2)	**2.0**	**(3.3)**	**TOTAL**	**12.6**	**9.2**	**3.4**

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CalOptima

Enrollment Summary

For the Five Months Ended November 30, 2017

Month-to-Date					Year-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
62,704	63,406	(702)	(1.1%)	Aged	308,575	313,147	(4,572)	(1.5%)
621	618	3	0.5%	BCCTP	3,050	3,090	(40)	(1.3%)
47,137	48,785	(1,648)	(3.4%)	Disabled	235,088	243,824	(8,736)	(3.6%)
322,288	329,502	(7,214)	(2.2%)	TANF Child	1,629,913	1,648,931	(19,018)	(1.2%)
94,261	103,749	(9,488)	(9.1%)	TANF Adult	477,632	519,652	(42,020)	(8.1%)
3,504	3,268	236	7.2%	LTC	17,155	16,340	815	5.0%
237,565	236,567	998	0.4%	MCE	1,191,623	1,181,498	10,125	0.9%
768,080	**785,895**	**(17,815)**	**(2.3%)**	**Medi-Cal**	**3,863,036**	**3,926,482**	**(63,446)**	**(1.6%)**
15,254	**15,543**	**(289)**	**(1.9%)**	**OneCare Connect**	**76,347**	**77,581**	**(1,234)**	**(1.6%)**
233	**236**	**(3)**	**(1.3%)**	**PACE**	**1,124**	**1,130**	**(6)**	**(0.5%)**
1,378	**1,353**	**25**	**1.8%**	**OneCare**	**6,941**	**6,671**	**270**	**4.0%**
784,945	**803,027**	**(18,082)**	**(2.3%)**	**CalOptima Total**	**3,947,448**	**4,011,864**	**(64,416)**	**(1.6%)**

				Enrollment (By Network)				
170,025	174,301	(4,276)	(2.5%)	HMO	854,162	870,668	(16,506)	(1.9%)
222,392	226,114	(3,722)	(1.6%)	PHC	1,114,328	1,133,372	(19,044)	(1.7%)
199,692	209,369	(9,677)	(4.6%)	Shared Risk Group	1,004,652	1,050,043	(45,391)	(4.3%)
175,971	176,111	(140)	(0.1%)	Fee for Service	889,894	872,399	17,495	2.0%
768,080	**785,895**	**(17,815)**	**(2.3%)**	**Medi-Cal**	**3,863,036**	**3,926,482**	**(63,446)**	**(1.6%)**
15,254	**15,543**	**(289)**	**(1.9%)**	**OneCare Connect**	**76,347**	**77,581**	**(1,234)**	**(1.6%)**
233	**236**	**(3)**	**(1.3%)**	**PACE**	**1,124**	**1,130**	**(6)**	**(0.5%)**
1,378	**1,353**	**25**	**1.8%**	**OneCare**	**6,941**	**6,671**	**270**	**4.0%**
784,945	**803,027**	**(18,082)**	**(2.3%)**	**CalOptima Total**	**3,947,448**	**4,011,864**	**(64,416)**	**(1.6%)**

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CalOptima
Enrollment Trend by Network Type
Fiscal Year 2018

Network Type	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	MMs
HMO													
Aged	4,058	4,045	4,051	3,864	4,020	-	-	-	-	-	-	-	20,038
BCCTP	1	1	1	5	1	-	-	-	-	-	-	-	9
Disabled	6,749	6,740	6,729	6,703	6,733	-	-	-	-	-	-	-	33,654
TANF Child	61,492	61,733	61,361	61,023	60,598	-	-	-	-	-	-	-	306,207
TANF Adult	30,429	30,420	30,313	30,127	29,905	-	-	-	-	-	-	-	151,194
LTC	3	4	6	4	4	-	-	-	-	-	-	-	21
MCE	68,020	68,792	69,169	68,294	68,764	-	-	-	-	-	-	-	343,039
	170,752	171,735	171,630	170,020	170,025	-	-	-	-	-	-	-	854,162
PHC													
Aged	1,480	1,493	1,530	1,401	1,561	-	-	-	-	-	-	-	7,465
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	7,318	7,264	7,258	7,236	7,229	-	-	-	-	-	-	-	36,305
TANF Child	162,801	163,976	163,202	162,046	162,030	-	-	-	-	-	-	-	814,055
TANF Adult	12,604	12,571	12,410	12,356	12,311	-	-	-	-	-	-	-	62,252
LTC	-	-	1	1	-	-	-	-	-	-	-	-	2
MCE	38,398	38,821	39,088	38,681	39,261	-	-	-	-	-	-	-	194,249
	222,601	224,125	223,489	221,721	222,392	-	-	-	-	-	-	-	1,114,328
Shared Risk Group													
Aged	3,809	3,756	3,831	3,029	3,765	-	-	-	-	-	-	-	18,190
BCCTP	-	-	-	1	-	-	-	-	-	-	-	-	1
Disabled	8,108	8,058	8,035	7,951	7,978	-	-	-	-	-	-	-	40,130
TANF Child	72,723	72,861	72,102	71,427	71,139	-	-	-	-	-	-	-	360,252
TANF Adult	32,775	32,737	32,316	31,441	31,785	-	-	-	-	-	-	-	161,054
LTC	-	1	2	-	-	-	-	-	-	-	-	-	3
MCE	85,799	86,330	86,191	81,677	85,025	-	-	-	-	-	-	-	425,022
	203,214	203,743	202,477	195,526	199,692	-	-	-	-	-	-	-	1,004,652
Fee for Service (Dual)													
Aged	48,036	48,599	48,846	48,863	49,108	-	-	-	-	-	-	-	243,452
BCCTP	25	22	25	23	22	-	-	-	-	-	-	-	117
Disabled	20,343	20,528	20,516	20,448	20,494	-	-	-	-	-	-	-	102,329
TANF Child	3	3	2	2	1	-	-	-	-	-	-	-	11
TANF Adult	1,205	1,226	1,184	1,156	1,118	-	-	-	-	-	-	-	5,889
LTC	3,002	3,124	3,126	3,068	3,137	-	-	-	-	-	-	-	15,457
MCE	2,816	2,848	2,758	2,831	2,113	-	-	-	-	-	-	-	13,366
	75,430	76,350	76,457	76,391	75,993	-	-	-	-	-	-	-	380,621
Fee for Service (Non-Dual)													
Aged	3,580	3,855	4,031	3,714	4,250	-	-	-	-	-	-	-	19,430
BCCTP	601	602	599	523	598	-	-	-	-	-	-	-	2,923
Disabled	4,466	4,559	4,578	4,364	4,703	-	-	-	-	-	-	-	22,670
TANF Child	27,513	31,414	31,119	30,822	28,520	-	-	-	-	-	-	-	149,388
TANF Adult	18,753	19,744	20,087	19,517	19,142	-	-	-	-	-	-	-	97,243
LTC	372	364	379	194	363	-	-	-	-	-	-	-	1,672
MCE	43,457	44,664	44,438	40,986	42,402	-	-	-	-	-	-	-	215,947
	98,742	105,202	105,231	100,120	99,978	-	-	-	-	-	-	-	509,273
MEDI-CAL TOTAL													
Aged	60,963	61,748	62,289	60,871	62,704	-	-	-	-	-	-	-	308,575
BCCTP	627	625	625	552	621	-	-	-	-	-	-	-	3,050
Disabled	46,984	47,149	47,116	46,702	47,137	-	-	-	-	-	-	-	235,088
TANF Child	324,532	329,987	327,786	325,320	322,288	-	-	-	-	-	-	-	1,629,913
TANF Adult	95,766	96,698	96,310	94,597	94,261	-	-	-	-	-	-	-	477,632
LTC	3,377	3,493	3,514	3,267	3,504	-	-	-	-	-	-	-	17,155
MCE	238,490	241,455	241,644	232,469	237,565	-	-	-	-	-	-	-	1,191,623
	770,739	781,155	779,284	763,778	768,080	-	-	-	-	-	-	-	3,863,036
PACE	215	221	228	227	233	-	-	-	-	-	-	-	1,124
OneCare	1,367	1,386	1,404	1,406	1,378	-	-	-	-	-	-	-	6,941
OneCare Connect	15,365	15,229	15,265	15,234	15,254	-	-	-	-	-	-	-	76,347
TOTAL	787,686	797,991	796,181	780,645	784,945	-	-	-	-	-	-	-	3,947,448

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ENROLLMENT:

Overall MTD enrollment was 784,945

- Unfavorable to budget by 18,082 or 2.3%
- Increased 4,300 or 0.6% from prior month
- Decreased 13,614 from prior year (November 2016)

Medi-Cal enrollment was 768,080

- Unfavorable to budget by 17,815
    - TANF unfavorable by 16,702
    - SPD unfavorable by 2,347
    - Expansion favorable by 998
    - LTC favorable by 236
- Increased 4,302 from prior month

OneCare Connect enrollment was 15,254

- Unfavorable to budget by 289
- Increased 20 from prior month

OneCare enrollment was 1,378

- Favorable to budget by 25
- Decreased 28 from prior month

PACE enrollment was 233

- Unfavorable to budget by 3
- Increased 6 from prior month

CalOptima - Medi-Cal Total
Statement of Revenues and Expenses
For the Five Months Ended November 30, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
768,080	785,895	(17,815)	(2.3%)	Member Months	3,863,036	3,926,482	(63,446)	(1.6%)
				Revenues				
253,602,284	245,282,587	8,319,697	3.4%	Capitation revenue	1,266,972,069	1,225,175,140	41,796,929	3.4%
253,602,284	245,282,587	8,319,697	3.4%	Total Operating Revenues	1,266,972,069	1,225,175,140	41,796,929	3.4%
				Medical Expenses				
89,302,850	86,969,902	(2,332,948)	(2.7%)	Provider capitation	447,101,735	435,225,193	(11,876,542)	(2.7%)
45,247,412	43,336,626	(1,910,786)	(4.4%)	Facilities	222,955,423	218,494,768	(4,460,655)	(2.0%)
16,742,724	13,786,690	(2,956,034)	(21.4%)	Professional Claims	80,062,372	69,487,546	(10,574,826)	(15.2%)
34,750,685	35,554,033	803,348	2.3%	Prescription drugs	180,600,315	178,866,351	(1,733,964)	(1.0%)
58,745,914	49,865,300	(8,880,614)	(17.8%)	MLTSS	282,409,025	247,245,238	(35,163,787)	(14.2%)
2,735,657	3,362,061	626,404	18.6%	Medical Management	13,838,282	15,943,434	2,105,152	13.2%
817,206	315,017	(502,189)	(159.4%)	Reinsurance & other	4,334,407	1,575,085	(2,759,322)	(175.2%)
248,342,448	233,189,629	(15,152,819)	(6.5%)	Total Medical Expenses	1,231,301,558	1,166,837,615	(64,463,943)	(5.5%)
5,259,836	12,092,958	(6,833,122)	(56.5%)	Gross Margin	35,670,511	58,337,525	(22,667,014)	(38.9%)
				Administrative Expenses				
5,410,150	6,213,104	802,954	12.9%	Salaries, wages & employee benefits	26,168,962	29,776,406	3,607,444	12.1%
235,343	319,524	84,181	26.3%	Professional fees	922,685	1,654,114	731,429	44.2%
697,604	1,931,947	1,234,343	63.9%	Purchased services	3,568,178	8,460,489	4,892,311	57.8%
373,219	401,238	28,019	7.0%	Printing and postage	1,462,596	1,996,184	533,588	26.7%
366,560	461,246	94,686	20.5%	Depreciation & amortization	2,110,143	2,306,230	196,087	8.5%
1,167,984	1,477,545	309,561	21.0%	Other operating expenses	5,682,922	7,255,862	1,572,940	21.7%
(362,512)	(278,785)	83,727	30.0%	Indirect cost allocation	(1,686,998)	(1,393,925)	293,073	21.0%
7,888,347	10,525,819	2,637,472	25.1%	Total Administrative Expenses	38,228,488	50,055,360	11,826,872	23.6%
				Operating Tax				
10,021,418	0	(10,021,418)	0.0%	Tax Revenue	64,419,103	0	(64,419,103)	0.0%
10,021,418	0	(10,021,418)	0.0%	Premium tax expense	51,042,001	0	(51,042,001)	0.0%
0	0	0	0.0%	Sales tax expense	13,377,102	0	(13,377,102)	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
127,951	291,249	(163,298)	(56.1%)	Grant Revenue	20,283	1,456,245	(1,435,962)	(98.6%)
129,604	258,276	128,672	49.8%	Grant expense - Service Partner	19,798	1,291,380	1,271,582	98.5%
13,755	32,973	19,218	58.3%	Grant expense - Administrative	73,213	164,865	91,652	55.6%
(15,408)	0	(15,408)	0.0%	Total Net Grant Income	(72,727)	0	(72,727)	0.0%
106	0	106	0.0%	Other income	525	0	525	0.0%
(2,643,813)	1,567,139	(4,210,952)	(268.7%)	Change in Net Assets	(2,630,179)	8,282,165	(10,912,344)	(131.8%)
97.9%	95.1%	-2 9%	-3.0%	Medical Loss Ratio	97.2%	95.2%	-1 9%	-2.0%
3.1%	4.3%	1 2%	27.5%	Admin Loss Ratio	3.0%	4.1%	1.1%	26.1%

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MEDI-CAL INCOME STATEMENT – NOVEMBER MONTH:

REVENUES of $253.6 million are favorable to budget by $8.3 million, driven by:

- Unfavorable volume related variance of $5.6 million
- Favorable price related variance of $13.9 million due to:
  - $6.0 million of fiscal year 2018 Coordinated Care Initiative (CCI) including In-Home Supportive Services (IHSS) Dual and NonDual revenue
  - $3.0 million of fiscal year 2018 revenue such as LTC Revenue from Non-LTC members and Non-Medical Transportation
  - $1.9 million of fiscal year 2018 Behavioral Health Treatment (BHT) Revenue
  - $2.5 million of fiscal year 2017 revenue

MEDICAL EXPENSES: Overall $248.3 million, unfavorable to budget by $15.2 million due to:

- **Managed Long-Term Services and Support (MLTSS)** is unfavorable to budget $8.9 million due to IHSS expense of $3.8, LTC of $4.0M and CBAS $1.0M
- **Professional Claim** expense is unfavorable to budget $3.0 million due to prior period IBNR and Crossover
- **Provider Capitation** is unfavorable $2.3 million due to BHT capitation $2.9M
- **Facility** expense is unfavorable $1.9 million due to Shared Risk of $1. 3M and prior period IBNR of $0.7M
- **Prescription Drug** expense is favorable $0.8 million

ADMINISTRATIVE EXPENSES are $7.9 million, favorable to budget $2.6 million, driven by:

- Purchased Services: $1.2 million favorable to budget
- Salary & Benefits: $0.8 million favorable to budget due to open positions
- Other Non-Salary: $0.6 million favorable to budget

CHANGE IN NET ASSETS is ($2.6) million for the month, unfavorable to budget by $4.2 million

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the Five Months Ended November 30, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
15,254	15,543	(289)	(1.9%)	Member Months	76,347	77,581	(1,234)	(1.6%)
				Revenues				
7,163,459	7,496,395	(332,936)	(4.4%)	Medi-Cal Capitation revenue	36,317,861	37,525,403	(1,207,542)	(3.2%)
15,973,937	14,754,867	1,219,070	8.3%	Medicare Capitation revenue part C	80,368,666	72,866,026	7,502,640	10.3%
5,535,317	4,978,054	557,263	11.2%	Medicare Capitation revenue part D	27,686,511	26,604,837	1,081,674	4.1%
28,672,713	27,229,316	1,443,397	5.3%	Total Operating Revenue	144,373,037	136,996,266	7,376,771	5.4%
				Medical Expenses				
10,364,079	8,565,608	(1,798,471)	(21.0%)	Provider capitation	55,723,896	42,254,387	(13,469,509)	(31.9%)
2,460,173	4,981,076	2,520,903	50.6%	Facilities	13,748,039	25,261,569	11,513,530	45.6%
658,020	613,016	(45,004)	(7.3%)	Ancillary	3,054,706	3,105,319	50,613	1.6%
5,942,841	4,190,544	(1,752,297)	(41.8%)	Long Term Care	26,827,304	21,146,541	(5,680,763)	(26.9%)
5,253,605	5,241,959	(11,646)	(0.2%)	Prescription drugs	25,906,527	28,327,860	2,421,333	8.5%
1,078,869	1,203,372	124,503	10.3%	Medical management	5,280,243	6,080,274	800,031	13.2%
150,000	108,937	(41,063)	(37.7%)	Other medical expenses	876,405	565,323	(311,082)	(55.0%)
25,907,587	24,904,512	(1,003,075)	(4.0%)	Total Medical Expenses	131,417,121	126,741,273	(4,675,848)	(3.7%)
2,765,127	2,324,804	440,323	18.9%	Gross Margin	12,955,917	10,254,993	2,700,924	26.3%
				Administrative Expenses				
663,318	941,404	278,086	29.5%	Salaries, wages & employee benefits	3,671,147	4,537,755	866,608	19.1%
108,033	38,334	(69,699)	(181.8%)	Professional fees	142,646	191,667	49,020	25.6%
502,279	239,868	(262,411)	(109.4%)	Purchased services	755,552	1,199,440	443,888	37.0%
90,406	103,801	13,395	12.9%	Printing and postage	347,628	519,005	171,377	33.0%
38,103	50,149	12,046	24.0%	Other operating expenses	230,636	252,014	21,378	8.5%
664,798	584,428	(80,370)	(13.8%)	Indirect cost allocation, Occupancy Expense	3,323,991	2,922,140	(401,851)	(13.8%)
2,066,938	1,957,984	(108,954)	(5.6%)	Total Administrative Expenses	8,471,600	9,622,020	1,150,420	12.0%
				Operating Tax				
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
698,189	366,820	331,369	90.3%	Change in Net Assets	4,484,317	632,973	3,851,344	608.5%
90.4%	91.5%	1.1%	1.2%	Medical Loss Ratio	91.0%	92.5%	1.5%	1.6%
7.2%	7.2%	0.0%	-0.3%	Admin Loss Ratio	5.9%	7.0%	1.2%	16.5%

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ONECARE CONNECT INCOME STATEMENT – NOVEMBER MONTH:

REVENUES of $28.7 million are favorable to budget by $1.4 million driven by:

- Unfavorable volume related variance of $0.5 million due to lower enrollment
- Favorable price related variance of $1.9 million due to fiscal year 2018 rate adjustment

MEDICAL EXPENSES are unfavorable to budget $1.0 million due to:

- Favorable volume related variance of $0.5 million due to lower enrollment
- Unfavorable price related variance of $1.5 million due to increase In-Home Supportive Services (IHSS) expense

ADMINISTRATIVE EXPENSES are unfavorable to budget by $0.1 million

CHANGE IN NET ASSETS is $0.7 million, $0.3 million favorable to budget

CalOptima - OneCare
Statement of Revenues and Expenses
For the Five Months Ended November 30, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,378	1,353	25	1 8%	Member Months	6,941	6,671	270	4.0%
				Revenues				
69,768	47,017	22,751	48.4%	Medi-Cal Capitation revenue	351,423	231,782	119,641	51.6%
1,042,016	881,110	160,906	18 3%	Medicare Part C Revenue	3,025,923	4,274,493	(1,248,570)	(29.2%)
508,370	469,543	38,827	8 3%	Medicare Part D Revenue	1,915,316	2,357,765	(442,449)	(18.8%)
1,620,154	1,397,670	222,484	15 9%	Total Operating Revenue	5,292,662	6,864,040	(1,571,378)	(22.9%)
				Medical Expenses				
378,428	387,564	9,136	2.4%	Provider capitation	(529,739)	1,883,896	2,413,635	128.1%
229,417	436,704	207,287	47 5%	Inpa ient	1,388,737	2,207,179	818,442	37.1%
69,269	47,559	(21,710)	(45.6%)	Ancillary	221,969	238,701	16,732	7.0%
5,418	41,201	35,783	86 8%	Skilled nursing facilities	100,101	206,329	106,228	51.5%
418,035	473,909	55,874	11 8%	Prescription drugs	2,328,120	2,382,617	54,497	2.3%
0	21,820	21,820	100 0%	Medical management	69,195	112,691	43,496	38.6%
7,100	7,366	266	3.6%	Other medical expenses	38,135	37,888	(247)	(0.7%)
1,107,667	1,416,123	308,456	21 8%	Total Medical Expenses	3,616,519	7,069,301	3,452,782	48.8%
512,488	(18,453)	530,941	2,877 3%	Gross Margin	1,676,143	(205,261)	1,881,404	916.6%
				Administrative Expenses				
20,139	20,530	391	1 9%	Salaries, wages & employee benefits	115,994	102,051	(13,943)	(13.7%)
79,016	13,333	(65,683)	(492.6%)	Professional fees	79,016	66,665	(12,351)	(18.5%)
45,594	11,990	(33,604)	(280.3%)	Purchased services	95,156	60,000	(35,156)	(58.6%)
10,595	19,288	8,693	45.1%	Prin ing and postage	31,081	103,940	72,859	70.1%
0	172	172	100 0%	Other operating expenses	(32)	906	938	103.5%
13,553	31,910	18,357	57 5%	Indirect cost allocation, Occupancy Expense	67,765	159,550	91,785	57.5%
168,896	97,223	(71,673)	(73.7%)	Total Administrative Expenses	388,980	493,112	104,132	21.1%
343,592	(115,676)	459,268	397 0%	Change in Net Assets	1,287,163	(698,373)	1,985,536	284.3%
68.4%	101.3%	33.0%	32 5%	Medical Loss Ra io	68.3%	103.0%	34.7%	33.7%

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CalOptima - PACE
Statement of Revenues and Expenses
For the Five Months Ended November 30, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
233	236	(3)	(1.3%)	Member Months	1,124	1,130	(6)	(0.5%)
				Revenues				
1,190,325	1,191,984	(1,659)	(0.1%)	Medi-Cal capitation revenue	5,915,684	5,713,984	201,700	3.5%
291,619	284,875	6,744	2.4%	Medicare part C revenue	1,704,612	1,353,344	351,268	26.0%
108,759	75,807	32,952	43 5%	Medicare part D revenue	309,010	367,257	(58,247)	(15.9%)
1,590,703	1,552,666	38,037	2.4%	Total Operating Revenues	7,929,306	7,434,585	494,721	6.7%
				Medical Expenses				
564,797	593,315	28,518	4 8%	Medical Management	2,619,513	2,917,843	298,330	10.2%
370,440	330,396	(40,044)	(12.1%)	Claims payments to hospitals	1,307,622	1,611,196	303,574	18.8%
387,108	272,318	(114,790)	(42.2%)	Professional Claims	1,728,334	1,329,873	(398,461)	(30.0%)
128,628	114,556	(14,072)	(12.3%)	Prescription drugs	571,405	559,551	(11,854)	(2.1%)
1,209	11,628	10,419	89 6%	Long-term care facility payments	17,511	58,734	41,223	70.2%
93,204	94,350	1,146	1 2%	Patient Transportation	466,793	460,665	(6,128)	(1.3%)
0	0	0	0 0%	Reinsurance	0	0	0	0.0%
8,000	10,000	2,000	20 0%	Other Expenses	24,000	10,000	(14,000)	(140.0%)
1,553,386	1,426,563	(126,823)	(8.9%)	Total Medical Expenses	6,735,178	6,947,862	212,684	3.1%
37,318	126,103	(88,785)	(70.4%)	Gross Margin	1,194,128	486,723	707,405	145.3%
				Administrative Expenses				
74,618	96,949	22,331	23 0%	Salaries, wages & employee benefits	352,446	470,491	118,045	25.1%
4,085	5,000	915	18 3%	Professional fees	15,339	25,000	9,661	38.6%
8,730	21,136	12,406	58.7%	Purchased services	25,144	105,680	80,536	76.2%
0	5,547	5,547	100 0%	Printing and postage	5,178	27,735	22,557	81.3%
2,168	2,052	(116)	(5.7%)	Depreciation & amortization	10,768	10,260	(508)	(5.0%)
9,677	18,506	8,829	47.7%	Other operating expenses	80,980	92,524	11,544	12.5%
3,052	2,864	(188)	(6.6%)	Indirect cost allocation, Occupancy Expense	37,448	14,320	(23,128)	(161.5%)
102,330	152,054	49,724	32.7%	Total Administrative Expenses	527,304	746,010	218,706	29.3%
				Operating Tax				
3,253	0	3,253	0 0%	Tax Revenue	31,379	0	31,379	0.0%
3,253	0	(3,253)	0 0%	Premium tax expense	31,379	0	(31,379)	0.0%
0	0	0	0 0%	Total Net Operating Tax	0	0	0	0.0%
(65,013)	(25,951)	(39,062)	(150.5%)	Change in Net Assets	666,824	(259,287)	926,111	357.2%
97.7%	91.9%	-5.8%	-6 3%	Medical Loss Ratio	84.9%	93.5%	8 5%	9.1%
6.4%	9.8%	3.4%	34 3%	Admin Loss Ratio	6.7%	10.0%	3.4%	33.7%

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CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the Five Months Ended November 30, 2017

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
41,066	0	41,066	0.0%	Rental income	144,829	42,774	102,055	238.6%
41,066	0	41,066	0.0%	Total Operating Revenue	144,829	42,774	102,055	238.6%
				Administrative Expenses				
43,992	23,186	(20,807)	(89.7%)	Purchase services	162,032	115,930	(46,102)	(39.8%)
159,543	161,474	1,930	1.2%	Depreciation & amortization	798,388	807,369	8,981	1.1%
14,913	9,117	(5,797)	(63.6%)	Insurance expense	74,567	45,584	(28,983)	(63.6%)
97,769	158,122	60,352	38.2%	Repair and maintenance	553,694	790,608	236,914	30.0%
10,971	0	(10,971)	0.0%	Other Operating Expense	256,924	0	(256,924)	0.0%
(309,222)	(333,055)	(23,833)	(7.2%)	Indirect allocation, Occupancy Expense	(1,744,255)	(1,665,275)	78,981	4.7%
17,967	18,843	876	4.6%	Total Administrative Expenses	101,348	94,215	(7,133)	(7.6%)
23,099	(18,843)	41,942	222.6%	Change in Net Assets	43,480	(51,441)	94,921	184.5%

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OTHER STATEMENTS – NOVEMBER MONTH:

ONECARE INCOME STATEMENT

CHANGE IN NET ASSETS is $343.6 thousand, $459.3 thousand favorable to budget

PACE INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $(65.0) thousand, $39.1 thousand unfavorable to budget

505 CITY PARKWAY BUILDING INCOME STATEMENT

CHANGE IN NET ASSETS for the month is $23.1 thousand, $41.9 favorable to budget

CalOptima
BALANCE SHEET
November 30, 2017

ASSETS			**LIABILITIES & FUND BALANCES**		
Current Assets			Current Liabilities		
	Operating Cash	$449,090,336		Accounts payable	$36,494,046
	Investments	1,007,715,579		Medical claims liability	1,018,994,753
	Capitation receivable	372,373,146		Accrued payroll liabilities	11,663,892
	Receivables - Other	14,963,220		Deferred revenue	164,159,692
	Prepaid Expenses	4,905,399		Deferred lease obligations	165,329
				Capitation and withholds	444,846,831
	Total Current Assets	**1,849,047,680**		**Total Current Liabilities**	**1,676,324,543**
Capital Assets	Furniture and equipment	34,039,048	Other employment benefits liability		29,443,803
	Building/Leasehold improvements	5,983,412			
	505 City Parkway West	49,433,337	Net Pension Liabilities		16,076,633
		89,455,798	Long Term Liabilities		100,000
	Less: accumulated depreciation	(37,619,657)			
	Capital assets, net	**51,836,141**	**TOTAL LIABILITIES**		**1,721,944,980**
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	23,610,493	Tangible net equity (TNE)		89,592,047
	Long term investments	512,962,298	Funds in excess of TNE		636,456,715
	Total Board-designated Assets	536,572,791			
	Total Other Assets	**536,872,791**	**Net Assets**		**726,048,762**
	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		**2,449,333,752**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**		**2,449,333,752**

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CalOptima
Board Designated Reserve and TNE Analysis
as of November 30, 2017

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	146,641,999				
	Tier 1 - Logan Circle	146,498,235				
	Tier 1 - Wells Capital	146,246,368				
Board-designated Reserve		439,386,601	309,435,704	480,447,597	129,950,897	(41,060,996)
TNE Requirement	Tier 2 - Logan Circle	97,186,190	89,592,046	89,592,046	7,594,144	7,594,144
	Consolidated:	536,572,791	399,027,750	570,039,643	137,545,041	(33,466,852)
	Current reserve level	*1.88*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
November 30, 2017

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	(1,228,594)	12,590,371
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	528,271	2,919,299
Changes in assets and liabilities:		
Prepaid expenses and other	(579,027)	749,248
Catastrophic reserves		
Capitation receivable	(14,505,056)	156,212,369
Medical claims liability	(33,932,674)	(227,431,267)
Deferred revenue	7,535,195	60,186,567
Payable to providers	(577,159)	(135,992,879)
Accounts payable	9,109,544	(1,606,437)
Other accrued liabilities	(53,086)	1,471,879
Net cash provided by/(used in) operating activities	(33,702,586)	(130,900,850)
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Change in Investments	(113,758,385)	74,710,173
Change in property and equipment	(47,718)	(454,414)
Change in Board designated reserves	723,761	(1,434,417)
Net cash provided by/(used in) investing activities	(113,082,342)	72,821,342
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	(146,784,929)	(58,079,509)
CASH AND CASH EQUIVALENTS, beginning of period	$595,875,265	507,169,844
CASH AND CASH EQUIVALENTS, end of period	**$ 449,090,336**	**$ 449,090,336**

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BALANCE SHEET:

ASSETS decreased $19.1 million from October

- **Cash and Cash Equivalents** decreased by $146.8 million due to an $80 million non-recurring Coordinated Care Initiative (CCI) inflow in October (5/17 – 9/17), and current month disbursements for Intergovernmental Transfers (IGT) and CalOptima Care Networks (CCN).
- **Investments** increased $113.8 million relative to market rates of return.
- **Net Capitation Receivables** increased $23.6 million based upon payment receipt timing and receivables

LIABILITIES decreased $17.9 million from October

- **Medical Claims Liability** by line of business decreased $33.9 million due to recoupment of overpayments
- **Deferred Revenue** increased $7.5 million due to overpayment of LTC members
- **Accrued Expenses** increased $9.7 million due to timing of payments

NET ASSETS are $726.0 million, a decrease of $1.2 million from October

CalOptima Foundation
Statement of Revenues and Expenses
For the Five Months Ended November 30, 2017
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
0	0	0	0.0%	Total Operating Revenue	0	0	0	0.0%
				Operating Expenditures				
0	6,184	6,184	100.0%	Personnel	0	30,921	30,921	100.0%
0	2,985	2,985	100.0%	Taxes and Benefits	0	14,924	14,924	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	10,415	1,159,615	1,149,200	99.1%
2,083	241,092	239,009	99.1%	Total Operating Expenditures	10,415	1,205,460	1,195,045	99.1%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
(2,083)	(241,092)	(239,009)	(99.1%)	Program Income	(10,415)	(1,205,460)	(1,195,045)	(99.1%)

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CalOptima Foundation
Balance Sheet
November 30, 2017

ASSETS		**LIABILITIES & NET ASSETS**	
Operating cash	2,868,139	Accounts payable-Current	10,415
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	**10,415**
		Total Liabilities	10,415
		Net Assets	**2,857,724**
TOTAL ASSETS	**2,868,139**	**TOTAL LIABILITIES & NET ASSETS**	**2,868,139**

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CALOPTIMA FOUNDATION - NOVEMBER MONTH

INCOME STATEMENT:

OPERATING REVENUE

- No activity

OPERATING EXPENSES

- Audit Fees $2.0 thousand

BALANCE SHEET:

ASSETS

- Cash--$2.9 million remains from the FY14 $3.0 million transferred by CalOptima for grants and programs in support of providers and community

LIABILITIES

- Accrued Payables--$10.4 thousand for Audit fees

NET INCOME is ($10.4) thousand

Budget Allocation Changes
Reporting Changes for November 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 o her initiatives)	$25,000	Re-Purpose $25,000 from Purchased Services (Pediatric Weight Management Vendor) to pay for Captivate contract and other initiatives	2018
August	PACE	PACE Administrative - Purchased Services (Encounter Reporting & Translation Services)	PACE Administrative - Purchased Services (Satisfaction Survey)	$12,208	Re-Purpose $12,208 from Purchased Services (Encounter Reporting & Translation Services) to pay for Satisfaction Survey	2018
August	Medi-Cal	Facilities - Capital Project (Upgrade CalOptima and Building Access System)	Facilities - Capital Project (Mail Room/Basement/ Property Management Office)	$15,000	Reallocate $15,000 from Capital Project (Upgrade CalOptima and Building Access System) to Capital Project (Mail Room/Basement/Property Management Office)	2018
September	Medi-Cal	Other G&A - Other Operating Expenses	Facilities - Building Repair and Maintenance	$65,000	Reallocate $65,000 from Other G&A (o her operating expenses) to cover cost to conduct a review/study from soil engineer and he necessary repairs of the 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 additional funding needed on CareNet in OneCare Connect.	2018
November	Medi-Cal	Human Resources - Purchased Services -Temporary Outsource Service	Human Resources - Purchased Services - General	$10,000	Re-Purpose $10,000 from Purchased Services (Temporary Outsource Service) to fund for training module design and other department initiatives in Purchased Services	2018

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Board of Directors Meeting
February 1, 2018

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and health network audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by regulators.

A. Updates on Regulatory Audits

1. OneCare

- 2016 CMS Financial Audit:

  On August 24, 2017, the Centers for Medicare & Medicaid Services (CMS) notified CalOptima that its OneCare program has been selected for a 2016 financial audit. By way of background, at least one-third of Medicare Advantage Organizations (MAOs) are selected for CMS' annual audit of financial records, which will include data relating to Medicare utilization, costs, and computation of the bid. CMS contracted with Bland & Associates to conduct the review of claims data, solvency, enrollment, base year entries on the bids, medical and/or drug expenses, related party transactions, general administrative expenses, and direct and indirect remuneration (DIR). Starting on November 21, 2017 through January 10, 2018, Bland & Associates selected Parts C and D samples for review. All sample submissions are due no later than February 5, 2018. The onsite audit dates have been confirmed for February 28, 2018 through March 1, 2018.

- Timeliness Monitoring Project

  On December 12, 2017, CMS announced its efforts to collect data for organization determinations, appeals and grievances (ODAG) and coverage determinations, appeals and grievances (CDAG) for the requested review period of March 1, 2017 through May 31, 2017. CalOptima's OneCare program has not been formally notified of its submission date, but has already started to work with impacted business areas to collect the data.

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2. OneCare Connect

- 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 for the following measures for measurement year 2016:

  - Core 2.1: Members with an Assessment Completed within 90 Days of Enrollment
  - CA 1.2: High Risk Members with an Interdisciplinary Care Plan (ICP) within 30 Working Days After the Completion of the Health Risk Assessment (HRA)
  - CA 1.4: Low Risk Members with an ICP Within 30 Working Days After the Completion of the HRA

  On January 8, 2018, HSAG issued the final audit report, which indicated that CalOptima was compliant with CMS guidance for Medicare-Medicaid Plan reporting requirements for all measures.

- 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 auditor 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 onsite audit took place from November 6 – 9, 2017. CalOptima is currently awaiting final results from the independent auditor.

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 November 16, 2017, DHCS sent CalOptima a final report regarding the audit, which identified four (4) findings in the areas of utilization management, case management and coordination of care, and member rights. CalOptima submitted a timely corrective action plan (CAP) to DHCS regarding the findings, and currently awaits DHCS's review and approval of the CAP.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- 2018 Medi-Cal Audit:

  On November 29, 2017, the DHCS notified CalOptima of its intent to conduct its annual audit of CalOptima's Medi-Cal program from February 26, 2018 through March 9, 2018. The audit will cover the period from February 1, 2017 through January 31, 2018. The audit will consist of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, organization and administration of CalOptima, facility site reviews, and medical records review. CalOptima has submitted all requested data and documentation by the identified deadlines, and continues to prepare for the audit.

4. PACE

- 2018 PACE Mock Audit:

  Beginning in January 2018, CalOptima's Office of Compliance initiated its mock audit activities in anticipation of the upcoming CMS and DHCS 2018 PACE audit. CalOptima has not been formally engaged by CMS and DHCS for this audit yet.

B. Regulatory Notices of Non-Compliance

1. On December 27, 2017, the DHCS sent CalOptima a request for a CAP related to CalOptima's encounter data submissions. Specifically, CalOptima's Pharmacy encounter data contained partial gaps during two (2) months in 2015. CalOptima submitted a CAP to DHCS by the requested due date, and the CAP is under DHCS' review.

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
August 2017	40%	N/A	N/A	0%	0%	73%	90%	70%	90%	93%	0%	67%	76%
September 2017	40%	73%	78%	80%	60%	90%	89%	90%	97%	88%	100%	67%	84%
October 2017	0%	100%	90%	10%	90%	77%	84%	40%	100%	87%	0%	60%	51%

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- The lower scores for timeliness were due to the following reasons:
  - Failure to meet timeframe for decision (Urgent – 72 hours; Routine – 5 business days; Deferral– 14 business days)
  - Failure to meet timeframe for member notification (2 business days)
  - Failure to meet timeframe for provider written notification (2 business days)
  - Failure to meet timeframe for provider initial notification to the requesting provider (24 hours)

- The lower scores for clinical decision making were due to the following reasons:
  - Failure to cite criteria for decision
  - Failure to obtain adequate clinical information
  - Failure to have appropriate professional make decision

- The lower letter scores were due to the following reasons:
  - Failure to provide information on how to file a grievance
  - Failure to provide letter in member preferred language
  - Failure to provide language assistance program (LAP) insert with approved threshold languages
  - Failure to describe why the request did not meet criteria in lay language
  - Failure to provide description of services in lay language
  - Failure to provide alternative direction back to PCP on denial
  - Failure to provide name and contact information for health care professional responsible for decision to requesting provider
  - Failure to provide peer-to-peer discussion with medical reviewer
  - Failure to provide member notification of delayed decision
  - Failure to provide provider notification of delayed decision

- Medi-Cal Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2017	100%	90%	100%	90%
September 2017	100%	100%	100%	100%
October 2017	100%	100%	100%	80%

- The compliance rate for denied claims accuracy has decreased from 100% in September 2017 to 80% in October 2017 due to claims being denied in error.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- Medi-Cal Claims: Provider Dispute Resolutions (PDRs)

Month	Letter Accuracy	Determination Timeliness	Acknowledgement Timeliness
August 2017	100%	100%	90%
September 2017	100%	90%	100%
October 2017	100%	80%	100%

  - The compliance rate for determination timeliness has decreased from 90% in September 2017 to 80% in October 2017 due to untimely PDR processing.

- 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
August 2017	98%	100%
September 2017	100%	100%
October 2017	100%	100%

  - No significant trends to report.

2. Internal Audits: OneCare

- OneCare Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
August 2017	0%
September 2017	0%
October 2017	0%

  - No claims were rejected in error due to formulary restrictions from August through October 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.

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- 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
August 2017	100%
September 2017	100%
October 2017	100%

  - The compliance rate for coverage determination timeliness remains consistent at 100% from August through October 2017.
  -

- OneCare Utilization Management

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
August 2017	Nothing to Report	Nothing to Report	Nothing to Report	100%	0%	Nothing to Report	Nothing to Report	Nothing to Report
September 2017	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
October 2017	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report

  - Due to low membership for the months of September 2017 through October 2017, there were no denials, expedited organization determinations, or standard organization determinations reported for this time.

  - The lower letter scores were due to the following reasons:
    - Failure to use the approved CMS letter template
    - Failure to use the CalOptima logo

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- OneCare Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2017	90%	90%	100%	100%
September 2017	100%	100%	100%	100%
October 2017	70%	100%	100%	60%

  - The compliance rate for paid claims timeliness has decreased from 100% in September 2017 to 70% in October 2017 due to untimely processing of claims.

  - The compliance rate for denied claims accuracy has decreased from 100% in September 2017 to 60% in October 2017 due to inaccurate processing of claims.

- OneCare Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
August 2017	100%	100%	100%	100%
September 2017	100%	100%	100%	100%
October 2017	100%	100%	100%	100%

  - No significant trends to report.

- OneCare Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Customer Service
August 2017	100%
September 2017	100%
October 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.
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3. Internal Audits: OneCare Connect [a\]

- OneCare Connect Pharmacy: Formulary Rejected Claims Review

Month	% Claims Rejected in Error (Member Impact)
August 2017	0%
September 2017	0%
October 2017	0%

  - ➢ No claims were rejected in error due to formulary restrictions from August through October 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
August 2017	100%
September 2017	99.69%
October 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
August 2017	80%	N/A	50%	80%	15%	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	No hing to Report	Nothing to Report	Nothing to Report
September 2017	100%	100%	89%	80%	60%	100%	100%	88%	Nothing to Report	Nothing to Report	Nothing to Report	No hing to Report	Nothing to Report	Nothing to Report
October 2017	0%	100%	33%	20%	10%	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	No hing 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; Deferral– 14 business days)
    - Failure to meet timeframe for member notification (2 business days)
    - Failure to meet timeframe for provider written notification (2 business days)

  - ➢ The lower letter scores were due to the following reasons:
    - Failure to provide letter in member preferred language

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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  - Failure to provide language assistance program (LAP) insert with approved threshold languages
  - Failure to describe why the request did not meet criteria in lay language

- OneCare Connect Claims: Professional and Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2017	100%	100%	100%	90%
September 2017	100%	100%	100%	100%
October 2017	100%	100%	100%	100%

  - No significant trends to report.

- OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Timeliness	Payment Accuracy	Letter Accuracy	Check Lag
August 2017	100%	100%	100%	100%
September 2017	100%	92%	100%	100%
October 2017	100%	100%	100%	100%

  - No significant trends to report.

- OneCare Connect Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

Month	OneCare Connect Customer Service
August 2017	100%
September 2017	100%
October 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.

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4. Internal Audits: PACE

- PACE Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2017	100%	100%	100%	86%
September 2017	100%	100%	100%	100%
October 2017	100%	100%	100%	100%

  - No significant trends to report.

- PACE Claims: Provider Dispute Resolutions (PDRs)

Month	Determination Accuracy	Letter Accuracy	Acknowledgement Timeliness	Check LAG
August 2017	100%	100%	100%	100%
September 2017	100%	100%	100%	100%
October 2017	100%	100%	100%	N/A

  - No significant trends to report.

5. Health Network Audits: Medi-Cal [a\]

For the month of October 2017, monthly file reviews for health networks were suspended due to the 2017 Delegation Oversight Annual Audits. In lieu of the monthly file reviews, CalOptima's Audit & Oversight Department conducted webinar reviews to assess the processing of utilization management files and claims from each health network's system.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- Medi-Cal 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
August 2017	63%	79%	85%	61%	55%	85%	81%	70%	92%	97%	65%	89%	60%
September 2017	67%	76%	75%	63%	67%	57%	83%	82%	54%	83%	70%	67%	59%
October 2017	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2017	97%	99%	99%	87%
September 2017	96%	99%	98%	95%
October 2017	Exempt	Exempt	Exempt	Exempt

- Medi-Cal Claims: Misclassified Hospital Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
August 2017	100%	100%
September 2017	100%	98%
October 2017	Exempt	Exempt

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2017	100%	100%	100%	100%
September 2017	100%	100%	100%	100%
October 2017	Exempt	Exempt	Exempt	Exempt

6. Health Network Audits: OneCare [a\]

For the month of October 2017, monthly file reviews for health networks were suspended due to the 2017 Delegation Oversight Annual Audits. In lieu of the monthly file reviews, CalOptima's Audit & Oversight Department conducted webinar reviews to assess the processing of utilization management files and claims from each health network's system.

- 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
August 2017	86%	100%	72%	87%	76%	67%	56%	88%
September 2017	79%	50%	71%	78%	75%	33%	33%	59%
October 2017	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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- OneCare Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
August 2017	100%	98%
September 2017	100%	99%
October 2017	Exempt	Exempt

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2017	100%	100%	100%	96%
September 2017	100%	100%	99%	100%
October 2017	Exempt	Exempt	Exempt	Exempt

7. Health Network Audits: OneCare Connect [a\]

For the month of October 2017, all monthly file reviews for health networks were suspended due to the 2017 Delegation Oversight Annual Audits. In lieu of the monthly file reviews, CalOptima's Audit & Oversight Department conducted webinar reviews to assess the processing of utilization management files and claims from each health network's system.

- 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 Modified	CDM for Modified	Letter Score for Modified	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
August 2017	66%	75%	75%	66%	73%	54%	75%	82%	0%	N/A	38%	Nothing to Report	Nothing to Report	Nothing to Report
September 2017	60%	50%	76%	62%	78%`	48%	64%	70%	0%	0%	0%	0%	0%	0%
October 2017	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt	Exempt

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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- OneCare Connect Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
August 2017	99%	90%
September 2017	100%	93%
October 2017	Exempt	Exempt

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
August 2017	97%	95%	98%	87%
September 2017	92%	91%	97%	90%
October 2017	Exempt	Exempt	Exempt	Exempt

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.
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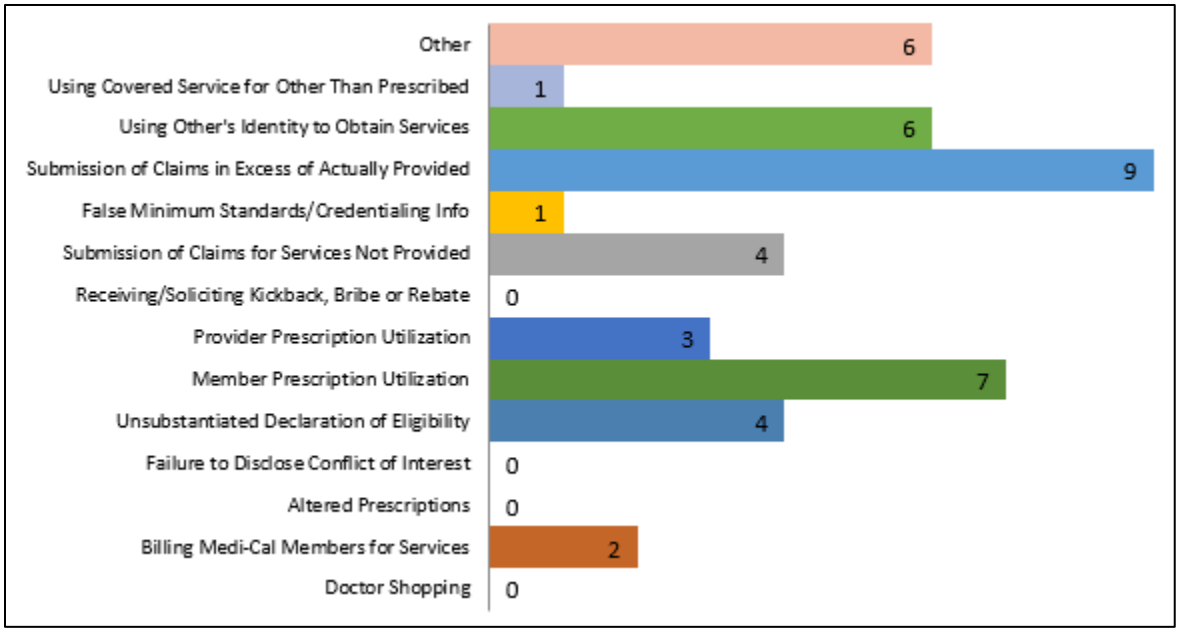
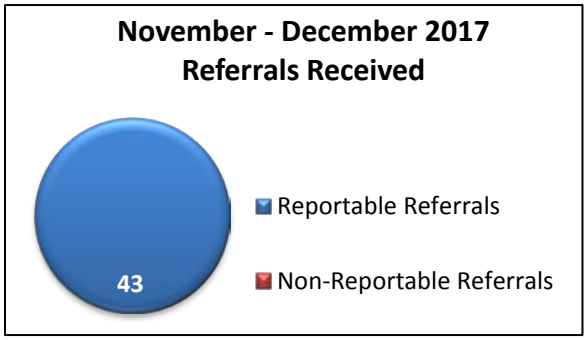
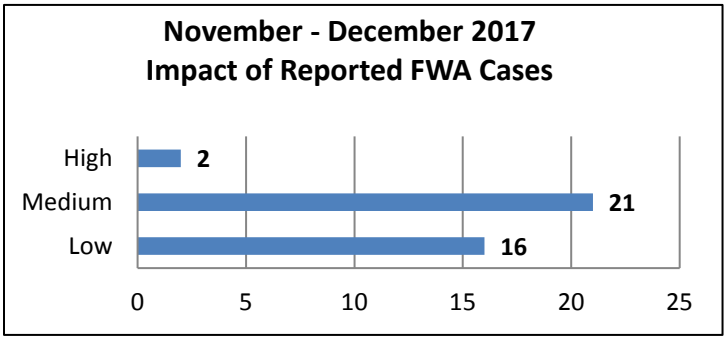
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

Types of FWA Cases: (Received in November and December 2017)







Note: Of the 43 referrals received by CalOptima's SIU, a risk assessment could not be performed for 4 of the referrals due to insufficient information provided in the referral.

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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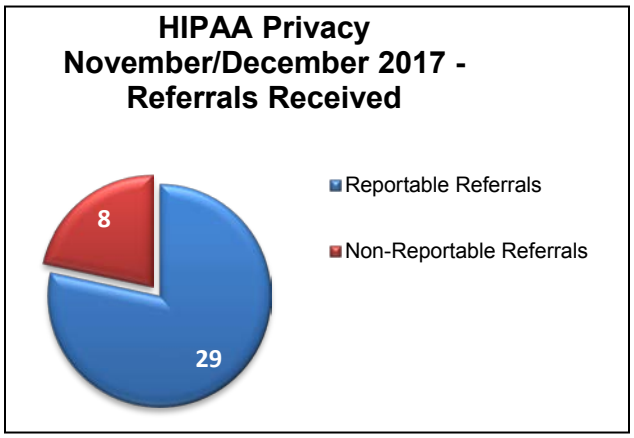
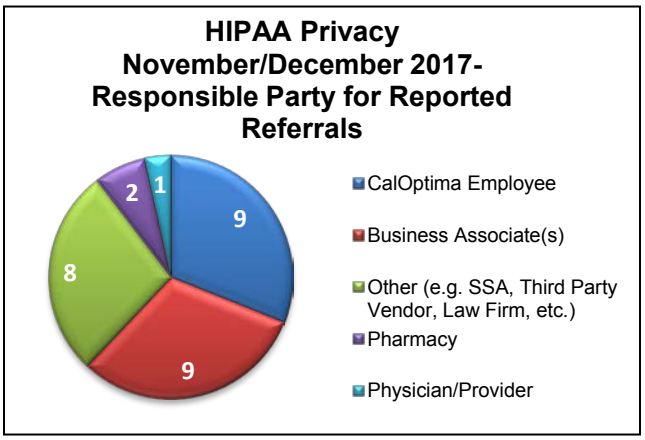
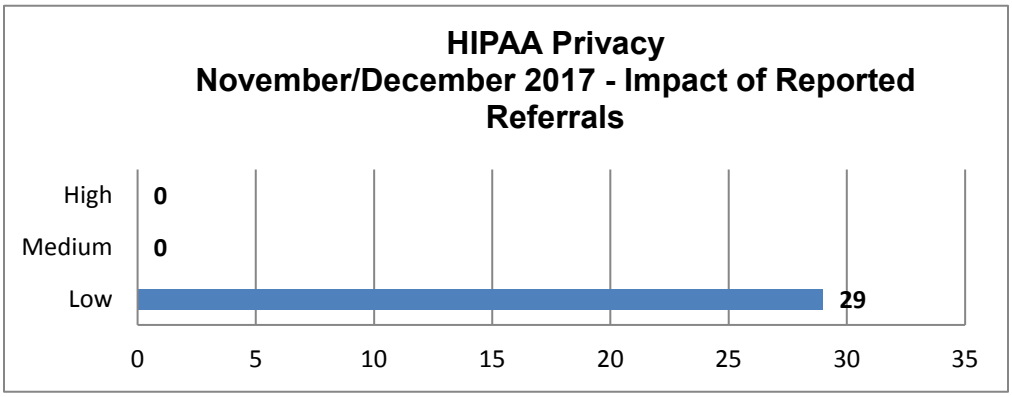
E. Privacy Update (November and December 2017)







PRIVACY STATISTICS

Total Number of Referrals Reported to DHCS (State)	29
Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)	0
Total Number of Referrals Reported	**29**

a\ "N/A" indicates that the category is not applicable to that file type. "Nothing to Report" indicates that there were no files submitted for review for that file type.

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CalOptima
A Public Agency
Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting
February 1, 2018

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith

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Akin Gump
STRAUSS HAUER & FELD LLP

M E M O R A N D U M

January 11, 2018

To: CalOptima

From: Akin Gump Strauss Hauer & Feld, LLP

Re: January Board of Directors Report

In the closing month of 2017, Congress demonstrated its continued inability to reach compromises on historically bipartisan issues and basic governance like annual appropriations. This theme manifested itself in several ways that affect health care policy, especially the failure to pass a long-term funding solution for the Children's Health Insurance Program (CHIP) and community health centers as well as the annual extension of certain Medicare payment policies known as "extenders". However, Congress was able to pass along party lines the most significant changes to the tax code in over thirty years. Although the Tax Cuts and Jobs Act is primarily a tax law, it may also be the most significant health care legislation passed last year since it also eliminates penalties for individuals who fail to buy health insurance. The story of the final month of 2017 and the opening weeks of 2018 is about continued uncertainty for CHIP, changes to the individual insurance market as a result of the new tax bill, and how the two interact.

Health Care Policy Complications from the Tax Cuts and Jobs Act

In December, Congressional attention focused almost exclusively on the majority's attempt to pass the Tax Cuts and Jobs Act using the budget process known as reconciliation that avoids a minority filibuster. With Republicans only holding a 52-48 majority in the Senate, Majority Leader Mitch McConnell could afford to lose only 2 votes at the start of the month. As the month wore on, however, McConnell's grip on the majority seemed increasingly tenuous. Senator John McCain (R-AZ) announced that he would have to return to Arizona to continue treatment for brain cancer and Senator Thad Cochran (R-MS) also had difficulty regularly attending votes due to his own failing health. And, then, on December 12, Democrat Doug Jones won a special election in Alabama to replace Attorney General Jeff Sessions, further narrowing the Republican majority to 51-49. The pressure was on to pass what would be its only significant legislative achievement of 2017 and then avoid a government shutdown that would occur on Friday December 22 when federal appropriations were set to expire.

Ultimately, Senator Jones (D-AL) was not seated until January 3, 2018, and the final tax cut legislation passed in the Senate on December 19 by a final vote of 51-48. All Senate Republicans voted for it and all Senate Democrats voted against it with Senator McCain missing the vote due to complications from his cancer treatments. The House passed it the following day and the President signed it into law on December 22.

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Although the Tax Cuts and Jobs Act is primarily about taxes, it includes critical health care provisions and in order to pass it Senator McConnell made significant health care policy promises. The most important health care provision of the law is Section 11081, which eliminates the penalties associated with the individual mandate. The non-partisan Congressional Budget Office (CBO), which is responsible for estimating the budgetary impact of bills for lawmakers, predicted that this provision would result in 13 million fewer individuals having health insurance and save the federal government nearly $338 billion over 10 years in forgone premium subsidies. In other words, the savings from not having to subsidize health insurance for those on the individual marketplaces helped pay for the lowered taxes in other parts of the bill.

In order to pass the tax bill with this provision – the same one that failed by 3 votes (Collins, McCain, and Murkowski) 3 months earlier – certain promises had to be made. Senator Collins (R-ME) expressed significant concern about the impact to the individual market from effectively repealing the individual mandate. In return for her vote for the tax bill, Senator Collins extracted a promise from Senator McConnell that the Senate would consider two bills intended to stabilize the individual insurance market: first, a bill negotiated by her and Senator Bill Nelson (D-FL) to establish a reinsurance fund shielding insurers from high cost patients, and, second, a bill negotiated by Senators Alexander (R-TN) and Murray (D-WA) to restore funding for the cost-sharing reduction payments.

The cost-sharing reduction payments were established by the Affordable Care Act (ACA) to help individuals and families that buy health insurance on the individual market pay deductibles and co-pays. However, due to a drafting error, the ACA authorized but did not appropriate funding for these payments. President Obama exercised his executive authority to make the payments, but in October, President Trump exercised his authority to withhold the payments. Following this announcement, the health care policy community lamented the likely impact on coverage that would result from higher premiums proposed by insurance companies to make up for the lost revenue. And, following the start of open enrollment, premiums rose, just as health care policy experts predicted. But, unlike the predictions, enrollment did not suffer. In fact, as open enrollment on the federally-operated marketplaces closed on December 15, enrollment beat expectations. In the 39 states relying on healthcare.gov more than 8.8 million Americans signed up for health insurance, nearly matching the enrollment from 2016.

Since the ACA's premium subsidies are tied to the cost of the plan as a percentage of an individual's income, as premiums rise so do the subsidies to pay for them as long as the individual applying for the plan makes less than 400 percent of the federal poverty line. In other words, just because premiums rise does not mean that the amount the individual pays also rises. Rather, the share the federal government pays rises. Ironically, as a result of cutting off the cost-

sharing payments intended to make health insurance plans more affordable, premiums rose, which led to an increase in subsidies, which led to plans with lower premium for lower-income individuals. In fact, in nearly every county in the country plans were available on the marketplace without premiums for subsidy-eligible individuals. However, those making too much money to qualify for premium subsidies were responsible for the full increase and bore the greatest burden from eliminating the cost-sharing reduction payments. The effect of eliminating the cost-sharing reduction payments was to make insurance plans on the exchanges more affordable for low-income individuals and more expensive for middle-class individuals.

Ultimately, the expert consensus on the importance of restoring the cost-sharing reduction payments that drove Senators Murray and Alexander to reach a bipartisan agreement has significantly faded, and Senate Democrats have little interest in helping Senator Collins fulfill a promise that she uses to justify her vote for a tax bill that they vehemently oppose. Senator Collins has not received votes yet on her stabilization bills, and the prospects for that occurring continue to dim.

Children's Health Insurance Program Funding

In the shadow of the tax debate, the stalemate on funding health insurance for children over how to pay for an additional five years of coverage persisted. By the time the tax bill passed on December 19, only three days remained before federal funding expired and still no long-term deal had been reached on funding the entire government. Another short-term deal had to be reached. By the end of the week, Congress quickly passed another continuing resolution keeping the government running through January 19. While the bill failed to include a long-term solution for CHIP funding, it did include provisions to extend funding through the end of March of this year. Specifically, the bill included $2.85 billion in federal funding for CHIP for the first half of fiscal year 2018. Yet, a significant change was also made to how remaining redistribution funds will be paid out to states. Going forward, the remaining funds that CMS has available to distribute to states from previous years (roughly $1.7 billion) will be paid out to states monthly on a first-come, first-serve basis as they exhaust their allotments. No amount is reserved for any specific state. When this emergency shortfall fund cannot meet the needs of all states, it will be prorated to states based on each state's proportional share of the total shortfall in that month. Because states are no longer guaranteed any share of redistribution funds, no state can rely on additional shortfall funding in any given month. Despite this funding patch for CHIP, some states may still exhaust federal funding as early as the end of February.

However, the elimination of the penalties for the individual mandate had a set of unintended consequences for the costs associated with CHIP. The bills to extend CHIP funding for five years were originally estimated to cost $8 billion over 10 years, and Congress could not agree on how

to offset those increased costs. But, on January 5, CBO provided a new estimate, finding that the cost of extending CHIP funding for five years would only cost $800 million over 10 years.

CBO attributed the reduction in CHIP costs to interactions with effect of eliminating the individual mandate penalties. First, CBO expects marketplace premiums under the health care law to be higher due to the lack of mandate penalties. If Congress funded CHIP for five years, more children could be covered under that program instead of the more costly exchanges. Because CHIP coverage would be cheaper than the exchange plans, marketplace spending would be lower than previously projected. Second, a greater share of parents could become uninsured without the individual mandate. If Congress does not act to provide more CHIP funding, parents may attempt to preserve their children's health care by enrolling them in a family plan through the marketplace. Some of these parents may have been previously uninsured, so that would increase federal costs. But if CHIP is renewed, CBO said that would reduce marketplace spending.

Moreover, once Congress understood the implications of this analysis, it asked for a second score. How much would a bill cost that extended CHIP for ten years rather than only five? On January 9, CBO found that extending CHIP funding for ten years would actually *save* the government $6 billion over ten years.

These two new CBO estimates completely change the political dynamic around its extension, making the earlier stalemate over how to pay for new CHIP funding moot. While this should significantly smooth the path for a long-term solution for CHIP, a new issue has taken center stage for the January 19 general funding deadline: immigration. Democrats have decided to use their leverage in these negotiations to demand a permanent fix for the so-called Dreamers, undocumented immigrants brought to the United States as children whose legal status was thrown into doubt earlier this year by the Trump administration. Until this issue can be resolved, most other pending issues that might be included in a package of bills on January 19 will have to wait.

Medicaid in the Crosshairs

Leaders in Congress and the President have not only been seeking leverage in their immediate negotiations but also staking out priorities for their 2018 legislative agendas and the future of Medicaid is one of the main dividing lines.

Speaker Ryan, who has long been a proponent of converting Medicaid funding from an open-ended federal entitlement into block grants, has said that he wants to continue to pursue this goal in 2018. On December 6, in an appearance on a radio talk show, Ryan said "We're going to have

to get back next year at entitlement reform, which is how you tackle the debt and the deficit... Frankly, it's the health care entitlements that are the big drivers of our debt, so we spend more time on the health care entitlements — because that's really where the problem lies, fiscally speaking."

However, in the Senate where eight Democratic votes are necessary to pass legislation that is not considered through the budget reconciliation process, Majority Leader McConnell is far more apprehensive about tackling the highly controversial plans to overhaul Medicaid again. In response to the buzz generated from Speaker Ryan's comments, Leader McConnell said in an interview that "I think Democrats are not going to be interested in entitlement reform, so I would not expect to see that on the agenda. What the Democrats are willing to do is important, because in the Senate, with rare exceptions like the tax bill, we have to have Democratic involvement."

Yet, conservatives in both the House and Senate who strenuously tried to repeal the ACA, especially its Medicaid expansion, responded to McConnell's statement with expressions of continued interest in taking on "Obamacare repeal". Rep. Mark Walker, chair of the conservative Republican Study Committee, said on December 26: "I still think there is enough bandwidth on the House side to get it done." He was supported by Senator Lindsey Graham (R-SC), who was the champion of the Graham-Cassidy proposal to block grant all of the ACA's funding including Medicaid. He posted a statement on Twitter: "To those who believe — including Senate Republican leadership — that in 2018 there will not be another effort to Repeal and Replace Obamacare — you are sadly mistaken. I'm fully committed to Repealing and Replacing Obamacare in 2018 by block-granting the money back to the states and away from Washington bureaucrats who are completely unaccountable to the patients of America." He supplemented that pledge with political calculus in a separate interview. "Obamacare doesn't get better over time, it gets worse. By repealing the mandate, we for sure own health care now. I think we can get 50 votes."

Despite this public pressure from conservatives, Speaker Ryan appeared to back off from his earlier commitment. In an event in Milwaukee on January 12, he said "I don't see us tackling [entitlement reform] this year…No matter what you do, you're going to have to find bipartisan consensus and we don't have that right now – that bipartisan consensus."

This debate on whether and how to overhaul Medicaid funding again in 2018 will continue within the Republican Party and reach some public conclusion with the budget resolution in the spring because it is then that Congressional Republicans must decide whether to include reconciliation instructions for any issues this year that would allow them to bypass Senate Democrats.

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CalOptima Legislative Report
By Don Gilbert and Trent Smith
January 8, 2018

The Legislature returned from its recess on January 3. While legislators were in their districts the last several months, there was no shortage of news and intrigue in Sacramento. Since the Legislature adjourned in September, two Assemblymen have resigned their seats due to allegations of sexual harassment. Another Assemblyman resigned due to health reasons.

Meanwhile, the Senate has hired an outside law firm to investigate allegations of sexual harassment against two Senators. One of those Senators was asked by leadership to take a leave of absence while the investigation concludes. He initially refused, but was eventually convinced to temporarily step aside when support in his own caucus began to erode. He has vowed to return on February 1, but Capitol insiders believe the results of the investigation will lead to his resignation or a vote to expel him.

The issue of sexual harassment and how the Legislature handles complaints and investigations has been the subject of at least one Legislative hearing. More hearings on the subject are scheduled in January. The issue of sexual harassment will cast a dark cloud over the Legislature this year and could impact the debate on many larger unrelated policy issues. There are also rumors that more legislators will be accused of sexual harassment in the coming weeks and months, which will heighten the debate further.

2018 is the second year of the two-year Legislative Session. Bills introduced last year that failed to make it out of the first policy committee must be heard and passed out of their house of origin by the end of January. So far, there are no bills pending from last year that are of interest to CalOptima, but we are monitoring these bills in case they are amended.

The deadline to introduce new bills for 2018 is February 16. At this point, there are no rumors of any major bills that could impact CalOptima. However, we will be on the lookout for any legislation requiring COHS to obtain a Knox Keene License, as patient advocates in Sacramento continue to push this issue.

We are also participating in discussions with health committee consultants regarding their interest in getting more health plans to participate in Covered California. They have a particular interest in getting more COHS to participate in the healthcare exchange. However, their primaryfocus is in underserved counties. Orange County does not appear to be of concern to the consultants at this time.

We will be reviewing the Governor's proposed budget very closely when he releases it on January 10. The uncertainty surrounding the Affordable Care Act (ACA) will require us to be vigilant in monitoring the State Budget, as changes to the ACA made by Congress could negatively impact state funding and the MediCal program.

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Overview of the Governor's Proposed 2018-19 State Budget
By Don Gilbert and Trent Smith
January 10, 2018

Governor Brown released his final Proposed Budget today. The proposal is a $190 billion budget with a general fund surplus of over $19 billion. In presenting the Budget, Governor Brown urged caution despite the abundance of surplus revenue. In what has become something of an annual warning, Governor Brown emphasized the fact that the current general fund surplus is still smaller than the general fund deficit at the height of the recession, and that 50 percent of income tax revenue comes from the volatile earnings of the top one percent of income earners. As has been the case in previous years, the Governor's Budget emphasizes saving in the State's rainy-day fund, reduction of state liabilities, and investment in the Governor's championed school funding formula.

It remains to be seen how the Legislature will react to this Budget. Last month, the Chair of the Assembly Budget Committee released his own blueprint of the State Budget. In a noticeable departure from the Governor's proposal, the blueprint opted to use some of the surplus revenue to support ongoing state funding for healthcare, education, and welfare benefits. While reinvesting in these programs has been a long-term priority for Democrats in the Legislature, the Governor has a well-established track record of success on the Budget.

There were not many health care related proposals included in his proposal. Rather, the Governor urged caution when it comes to healthcare spending. Specifically, he warned that there is great uncertainty surrounding federal funding to support the health and human service program. There is no shortage of rumors coming out of Washington D.C. concerning how Congress could reduce federal funding for the Affordable Care Act (ACA) and Medicaid. At this point, the Governor's Budget reflects no changes in federal funding, but he warns that there are any number of scenarios where federal actions can blow a hole in the State Budget.

The Budget Proposal highlights the fact that Proposition 56, the voter approved increase in tobacco taxes, is expected to generate $649.9 million for supplemental medical provider payments and rate increases. $163 million will be allocated for physician payments and $70 million is earmarked for dental payments. The Governor also warns that the success of the supplemental payments in increasing the number of Medi-Cal providers, consistent with the intent of the initiative, will be closely monitored and measured. If necessary, the Governor will work with the Legislature to modify expenditures to achieve better outcomes as intended by the initiative. Another $69.4 million of Proposition 56 funds will be allocated to support new growth in the Medi-Cal program. Finally, $64.5 million in Proposition 56 funds will be used for rate increases for home health providers that provide medically necessary in-home services to children and adults in the fee-for-service system. These rate increases will begin on July 1, 2018.

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Overall, Medi-Cal costs continue to grow. Since 2012-13, General Fund spending to support the Medi-Cal program has grown approximately six percent annually to $20.1 billion in 2017-18. Spending increases are attributed to a combination of higher health care cost inflation, program expansion, and caseload growth. In the current budget year, General Fund spending for Medi-Cal is projected to increase 11 percent, or $543.7 million, bringing the projected total to $21.6 billion. The increase is attributed primarily to retroactive payments of drug rebates to the federal government and a higher estimate of Medi-Cal managed care costs.

The only potentially controversial healthcare proposal in the Governor's Budget is a call to restrict 340B Drug Reimbursement within Medi-Cal starting July 1, 2019. The State claims the 340B program was designed to serve the uninsured, not Medi-Cal recipients. By shifting these drug purchases to the traditional pharmacy purchasing structure, the State hopes to gain more revenue in the form of rebates from drug companies. However, many clinics and hospitals rely on the 340B program to provide low cost drugs to their patients. The budget summary did not provide any projected state budget savings generated by discounting the use of the 340B program within Medi-Cal. It is likely that this proposal will be opposed by the hospitals, clinics, and some patient groups.

The Legislature is required to pass a State Budget by June 15 in time for the start of the new fiscal year, which begins July 1. The budget committees will soon begin holding hearings to consider various elements of the Governor's Proposed Budget. However, very little action will take place until after the Governor releases the May Revise, which reflects updated budget revenue generated from April tax returns.

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Board of Directors Meeting
February 1, 2018

CalOptima Community Outreach Summary — December 2017 and January 2018

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in a CalOptima program.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

We consider requests for sponsorship based on several factors as indicated pursuant to Policy AA. 1223: Participation in Community Events Involving External Entities, including, but not limited to: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates in 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.

CalOptima Community Events Update

On December 12, 2017 the Community Alliances Forum marked a significant milestone with its 40th forum over the past decade. Organized and hosted by CalOptima, the quarterly forums have served over six thousand community partners in local community-based organizations, health care providers, policymakers, and academic community. It has also provided a platform to discuss health issues impacting our county.

The December forum was held at the Delhi Center in Santa Ana. CalOptima's CEO, Michael Schrader shared opening remarks and provided an update on behavioral health services; CalOptima will begin administering behavioral health services for Medi-Cal members starting January 1, 2018. CalOptima's Behavioral Health department hosted a resource table and shared information about behavioral health benefits available to Medi-Cal members. OC Health Care Agency's OC Links hosted a resource table, answered questions and shared information about behavioral services available to Orange County residents.

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The featured speaker at the December forum was Randall Bell, Ph.D., author of the book *"Me We Do Be: The Four Cornerstones of Success."* He also is the CEO of Landmark Research Group, LLC. As a social economist, Bell has consulted on disasters around the world and shared what he has discovered as the foundation of recovery and great achievement. Bell shared stories from his professional work to demonstrate concepts of Core IQ and provided realistic and practical tools.

More than one hundred community partners attended the event and the feedback was extremely positive. Attendees appreciated this leadership training and shared that the content was applicable for their personal and professional development.

For additional information or questions, please contact Tiffany Kaaiakamanu, manager of Community Relations at **657-235-6872** or email tkaaiakamanu@caloptima.org.

Summary of Public Activities

During December 2017 and January 2018, CalOptima participated in 52 community events, coalitions and committee meetings:

TARGET AUDIENCE: HEALTH AND HUMAN SERVICES PROVIDERS

Date	Events/Meetings
12/01/17	• Covered Orange County General Meeting • Help Me Grow Advisory Meeting
12/04/17	• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting
12/05/17	• Collaborative to Assist Motel Families Meeting
12/06/17	• Orange County Aging Services Collaborative Meeting • Anaheim Human Services Network Meeting • Orange County Healthy Aging Initiative Meeting
12/11/17	• Orange County Veterans and Military Families Collaborative Meeting • Fullerton Collaborative Meeting
12/12/17	• 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
12/13/17	• Buena Park Collaborative Meeting
12/14/17	• FOCUS Collaborative Meeting
12/19/17	• Placentia Community Collaborative Meeting
12/20/17	• Covered Orange County Steering Committee Meeting

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- Minnie Street Family Resource Center Professional Roundtable
- Orange County Promotoras Meeting
- La Habra Collaborative — Move More, Eat Healthy Campaign Meeting
- Orange County Communication Workgroup

12/21/17
- Orange County Children's Partnership Committee
- Surf City Senior Providers Network Luncheon
- Orange County Women's Health Project Advisory Board Meeting

12/26/17
- Orange County Senior Roundtable

01/02/18
- Collaborative to Assist Motel Families Meeting

01/04/18
- Refugee Forum Orange County

01/05/18
- Covered Orange County General Meeting

01/08/18
- Fullerton Collaborative Meeting

01/09/18
- 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

01/10/18
- Buena Park Collaborative Meeting
- Anaheim Homeless Collaborative Meeting

01/11/18
- FOCUS Collaborative Meeting
- State Council on Developmental Disabilities Regional Advisory Committee Meeting

01/12/18
- Senior Citizens Advisory Committee Meeting

01/16/18
- North Orange County Senior Collaborative Meeting
- Placentia Community Collaborative Meeting

01/17/18
- Covered Orange County Steering Committee Meeting
- Minnie Street Family Resource Center Professional Roundtable
- Orange County Promotoras Meeting
- La Habra Collaborative — Move More, Eat Healthy Campaign Meeting
- Orange County Communication Workgroup

01/18/18
- Orange County Children's Partnership Committee
- Orange County Women's Health Project Advisory Board Meeting

01/22/18
- Stanton Collaborative Meeting

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01/23/18	• Orange County Senior Roundtable • Santa Ana Building Healthy Community
01/25/18	• Disability Coalition of Orange County • Orange County Care Coordination for Kids

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	# Staff Attended	Events/Meetings
12/16/17	1	• Community Breakfast with Santa hosted by the Cambodian Family Community Center (Registration Fee: $500 included a table for outreach)
1/20/18	1	• Community Health and Wellness Fair hosted by Santa Ana College School of Continuing Education

CalOptima organized or convened the following eight community stakeholder events, meeting and presentations:

TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS

Date	Events/Meetings/Presentations
12/12/17	• CalOptima Health Education Workshop — Topic: Applying Beers Criteria for Potentially Inappropriate Medication Use in Older Adults
12/13/17	• Community Alliances Forum — Topic: Me We Do Be: The Four Cornerstones of Success
01/12/18	• County Community Service Center Health Seminar — Topic: Understanding Cervical Cancer: Prevention and Treatment (Vietnamese)
01/16/18	• CalOptima New Member Orientation for Medi-Cal Members (English and Spanish)
01/19/18	• County Community Service Center Health Seminar — Topic: Understanding Osteoporosis (Vietnamese)
01/24/18	• CalOptima New Member Orientation for Medi-Cal Members (Korean and Farsi) • CalOptima Health Education Workshop at Madison Elementary School — Topic: Nutrition and Body Mass Index
01/25/18	• CalOptima New Member Orientation for Medi-Cal Members (Vietnamese) • CalOptima New Member Orientation for Medi-Cal Members (Chinese and Arabic)

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).

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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.

February

Date and Time	Event Title	Event Type/Audience	Staff/Financial Participation	Location
Friday, 2/2 9-10:30am	++Covered OC General Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Friday, 2/2 10-11am	++Help Me Grow Advisory Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana
Saturday, 2/3 9am-4pm	+OC Heritage Council 2018 OC Black History Cultural Faire	Health/Resource Fair Open to the Public	1 Staff	Downtown Anaheim 205 W. Center Promenade Anaheim
Monday, 2/5 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, 2/6 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, 2/7 9-10:30am	++OC Aging Services Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Wednesday, 2/7 10am-12pm	++Anaheim Human Services Network	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange County Family Justice Center 150 W. Vermont Anaheim

* *CalOptima Hosted*

1 – *Updated 2018-01-08*

\+ *Exhibitor/Attendee*
++ *Meeting Attendee*

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Wednesday, 2/7 10-11am	*New Member Orientation *Presentations in Farsi and Korean*	Community Presentation Open to Members	N/A	CalOptima
Wednesday, 2/7 10:30am-12pm	++OC Healthy Aging Initiative	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Thursday, 2/8 11:30am-12:30pm	++FOCUS Collaborative Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Magnolia Park Family Resource Center 11402 Magnolia St. Garden Grove
Friday, 2/9 9:30am-11am	+Senior Citizen Advisory Council Meeting	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Saturday, 2/10 8:30am-2pm	+Alzheimer's OC OC Strategic Plan for Aging Heart to Heart Conference	Conference and Community Presentation Open to the Public	1 Staff	Lakeview Senior Center 20 Lake Rd. Irvine
Monday, 2/12 2:30-3:30pm	++Fullerton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Fullerton Library 353 W. Commonwealth Ave. Fullerton
Tuesday, 2/13 9-10:30am	++OC Strategic Plan for Aging	Steering Committee Meeting: Open to Collaborative Members	N/A	Alzheimer's OC 2515 McCabe Way Irvine
Tuesday, 2/13 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
Tuesday, 2/13 1-2pm	*New Member Orientation *Presentations in English and Spanish*	Community Presentation Open to Members	N/A	CalOptima
Wednesday, 2/14 10-11:30am	++Buena Park Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Buena Park Library 7150 La Palma Ave. Buena Park

Wednesday, 2/14 12-1:30pm	++Anaheim Homeless Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Anaheim Central Library 500 W. Broadway Anaheim
Thursday, 2/15 8:30-10am	++Orange County Children's Partnership Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	OC Hall of Administration 10 Civic Center Plaza Santa Ana
Thursday, 2/15 8:30-10am	++Surf City Senior Providers Network and Lunch	Steering Committee Meeting: Open to Collaborative Members	N/A	Senior Center at Central Park 18041 Goldenwest St. Huntington Beach
Thursday, 2/15 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
Friday-Sunday 2/16-18 10am-6pm	+CEAVA Foundation Inc. 2018 Tet Festival	Health/Resource Fair Open to the Public	*Requesting Sponsorship* $5,000 16 Staff	Mile Square Park 16801 Euclid St. Fountain Valley
Friday-Sunday 2/16-18 10am-6pm	+Union of Vietnamese Students (UVSA) 2018 Tet Festival	Health/Resource Fair Open to the Public	*Requesting Sponsorship* $5,000 16 Staff	OC Fair & Event Center 88 Fair Dr. Costa Mesa
Tuesday, 2/20 10-11:30am	++Placentia Community Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Placentia Presbyterian Church 849 Bradford Ave. Placentia
Tuesday, 2/20 10-11:30am	++OC Cancer Coalition	Steering Committee Meeting: Open to Collaborative Members	N/A	American Cancer Society 1940 E. Deere Ave. Santa Ana
Wednesday, 2/21 9:15-11am	+Covered OC Steering Committee	Steering Committee Meeting: Open to Collaborative Members	N/A	The Village 1505 E. 17th St. Santa Ana
Wednesday, 2/21 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana

Wednesday, 2/21 1-4pm	++Orange County Promotoras	Steering Committee Meeting: Open to Collaborative Members	N/A	Location varies
Wednesday, 2/21 1:30-3pm	++La Habra Move More Eat Health Plan	Steering Committee Meeting: Open to Collaborative Members	N/A	Friends of Family Community Clinic 501 S. Idaho St. La Habra
Wednesday, 2/21 3:30-4:30pm	++Orange County Communications Workgroup	Steering Committee Meeting: Open to Collaborative Members	N/A	CalOptima
Thursday, 2/22 8:30-10am	++Disability Coalition of Orange County	Steering Committee Meeting: Open to Collaborative Members	N/A	Dayle McIntosh Center 501 N. Brookhurst St. Anaheim
Thursday, 2/22 9:30-10:30am	*New Member Orientation *Presentation in Vietnamese*	Community Presentation Open to Members	N/A	County Community Service Center 15496 Westminster Ave. Westminster
Thursday, 2/22 8:30-10am	++OC Care Coordination for Kids	Steering Committee Meeting: Open to Collaborative Members	N/A	Help Me Grow 2500 Redhill Ave. Santa Ana
Thursday, 2/22 2-3pm	*New Member Orientation *Presentations in Chinese and Arabic*	Community Presentation Open to Members	N/A	CalOptima
Monday, 2/26 12:30-1:10pm	++Community Health and Research Exchange	Steering Committee Meeting: Open to Collaborative Members	N/A	Healthy Smiles for Kids 2101 E. Fourth St. Santa Ana
Monday, 2/26 12:30-1:10pm	++Stanton Collaborative	Steering Committee Meeting: Open to Collaborative Members	N/A	Stanton Civic Center 7800 Katella Ave. Stanton
Monday-Tuesday 2/26-27 8am-5pm	+Family Voices of California Annual Health Summit	Conference and Community Presentation *Registration required.*	Sponsorship $2,400 3 OC Family Members	Courtyard Marriott 1782 Tribute Rd. Sacramento
Tuesday, 2/27 7:30-9am	++OC Senior Roundtable	Steering Committee Meeting: Open to Collaborative Members	N/A	Orange Senior Center 170 S. Olive Orange

Tuesday, 2/27 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, 2/28 10:30-11:30am	++OC Human Trafficking Task Force	Steering Committee Meeting: Open to Collaborative Members	N/A	Community Service Program 1221 E. Dyer Rd. Santa Ana