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
Michael Schrader

CHIEF COUNSEL
Gary Crockett

CLERK OF THE BOARD
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.
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.
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.
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.
PUBLIC COMMENTS

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)
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 Schoeffer 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.
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)
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.
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

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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
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.
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
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.
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.
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.
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.
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
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.
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.
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*
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.

<table>
<thead>
<tr>
<th>Policy No./Name</th>
<th>Summary of Changes</th>
<th>Reason for Change</th>
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</thead>
</table>
| 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 |
<table>
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<tr>
<th>Policy No./Name</th>
<th>Summary of Changes</th>
<th>Reason for Change</th>
</tr>
</thead>
</table>
| 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  
Authorized Signature  
1/25/2018  
Date

Back to Agenda
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
I. PURPOSE

To develop 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 of managing by results.

II. DEFINITIONS

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>9/80 Work Schedule</td>
<td>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.</td>
</tr>
<tr>
<td>Central Worksite</td>
<td>CalOptima’s primary physical location of business.</td>
</tr>
</tbody>
</table>
HI. 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.

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. 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 position; however, all.

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

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.
G.1 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 his or her 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 before working overtime. Failure...

4.5. An exempt Teleworker who plans to do so will be grounds for disciplinary action to 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' 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.

1A. 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 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. 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: 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 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;

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

4. 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

4.6. 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 who 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 a future date, work spaces at the Central/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 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.

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. 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 Agreement

C. CalOptima Occasional Off-site Work Agreement

D. 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 : 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. REGULATORY AGENCY APPROVALS

Not Applicable None to Date

VIII. 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

IX. REVIEW/REVISION HISTORY

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### IX. GLOSSARY

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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. |
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.
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

<table>
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# CalOptima Teleworking Agreement

**Name**

**Title:**

**Department:**

**Supervisor/Manager:**

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Telework is a workplace arrangement in which eligible 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 will begin a Teleworking work arrangement effective ____/____/______, is between ____________________________ and CalOptima. The parties, intending 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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Back to Agenda
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 as permitted to work at the remote work location on the following days and times:

   Days of week Times
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. Employee agrees to abide by the terms and requirements of the Telework Program policy and all other applicable CalOptima policies. Employee understands and agrees that this telework work arrangement is subject to CalOptima’s Telework Program policy. The policy includes information about:

      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) from 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 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:

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 telecommutingtelework at a remote work site as set forth in this documentby 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:

_____________________________   __________________________

Page 4 of 4     Updated 10 06 15
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.

<table>
<thead>
<tr>
<th>Day</th>
<th>Hours</th>
<th>Location: Remote Work Location (RWL) or Central worksite (C)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuesday</td>
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<tr>
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<td>Thursday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Friday</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ 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

---

Page 4 of 4  Updated 10-06-15
SUBMIT FORM TO HR WITHIN 48 HOURS
CalOptima Teleworking Agreement

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 will begin a Teleworking work arrangement effective on ______________________ pursuant to this 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
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. Employee agrees to abide by the terms and requirements of the Telework Program policy and all other applicable CalOptima policies.
   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.
CalOptima Teleworking Agreement

*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 __________
CalOptima Occasional Off-Site Work Agreement

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<td>Department:</td>
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<tr>
<td>Supervisor/Manager:</td>
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</tbody>
</table>

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 Employee is eligible to work at a Remote Work Location, occasionally, commencing on __________ pursuant to this Occasional Off-site 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
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 11/02/1702/01/18)

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
**VIII. REVIEW/REVISION HISTORY**

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</table>
IX. GLOSSARY

1. Not Applicable
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
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Q. 06/04/15: Regular Meeting of the CalOptima Board of Directors

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

**Effective as of May 1, 2014**

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* 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.
<table>
<thead>
<tr>
<th>Job Title</th>
<th>Pay Grade</th>
<th>Job Code</th>
<th>Min</th>
<th>Mid</th>
<th>Max</th>
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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:

<table>
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<tr>
<th>Title</th>
<th>Old Wage Grade</th>
<th>New Job Code / Wage Grade</th>
<th>Notes / Reason</th>
<th>Salary Adjustment (% Increase)</th>
<th>Month Added/Changed</th>
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<tr>
<td>HR Compensation Specialist Sr</td>
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<td>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.</td>
<td>N/A</td>
<td>February 2018</td>
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<td>Sr Manager Financial Analysis</td>
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<td>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.</td>
<td>N/A</td>
<td>February 2018</td>
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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
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.
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  
   Authorized Signature  
   1/25/2018  
   Date
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.

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.
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 11/30/2017
Authorized Signature Date
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.

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:
§ 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
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
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
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.

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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 11/30/2017
Authorized Signature Date
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.

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:
• § 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,
cluded 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
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.
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
**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.
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:**

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

**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
CalOptima Board Action Agenda Referral
Authorize the Chief Executive Officer to Negotiate Rates for
Certain Fee-for-Service Contracts for Health Care Services
Page 3

Attachments
None

_/s/  Richard Chambers                      5/31/2007
Authorized Signature                    Date
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.
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
Consider Authorizing Amendment to Contract with Liberty Dental Plan of California, Inc. for Dental Services Provided to OneCare and OneCare Connect Members

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
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.
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
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
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.
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

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/s/ Michael Schrader  
Authorized Signature  

11/25/2015  
Date
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.

Back to Agenda
**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
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
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.”
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 07/31/2015
Authorized Signature Date
### 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.

### 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:


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.  
   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.
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. The Contract is terminated or CalOptima reduces its Service Area to exclude such that the Member is no longer within the Service Area;

8. The individual materially misrepresents information to OneCare Connect regarding reimbursement for third party coverage; or

9. 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 for the current Contract 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 to ask any providers to hold their Original Medicare claims for up to one (1) month so that Medicare claims are processed for payment and not denied. Members eligible for passive enrollment who opt out shall be processed, in accordance with CalOptima Policy CMC.4006: Passive Enrollment, as follows:

   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.
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.

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:

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 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 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.

   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 59/61, CalOptima shall disenroll the Member effective at the end of the period of deemed continued eligibility.

   v. No later than three (3) business days following the last day of the deeming period, 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.

   vi. Within three (3) business days following the disenrollment effective date, DHCS shall 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.

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 ConnectCalOptima 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 ConnectCalOptima 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 ConnectCalOptima 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 lastfirst (1st) day of the calendar month following the end of the sixth (6th) month.

c. CalOptima shall accept verbal, or written, certification 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 lastfirst (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.

 filed 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, 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. Generally, such
g. 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. 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. In the case of incarcerated individuals, where CalOptima receives notification of the out-of-
area status via a DTRR, CalOptima shall disenroll the Member on the first (1st) day of the calendar month following confirmation of current incarceration.

j. 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. 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. If CalOptima confirms a Member’s current incarceration, but is unable to confirm the start
date of the incarceration, CalOptima shall disenroll the Member prospectively
effective the first (1st) of the calendar month following the date on which the current
incarceration was confirmed.

m. If CalOptima confirms the Member’s start date of the incarceration, CalOptima
shall disenroll the Member effective the first (1st) day of the calendar month
following the start date of the incarceration.

n. If the disenrollment effective date is outside of the current calendar month transaction
submission timeframe as defined by CMS, CalOptima 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. 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 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优选TRRDTRR, 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优选TRRDTRR 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, Model Notice for Disenrollment due to Loss of Beneficiary Services, Pending Correction of Medicaid Status, Erroneous Medicare Part A and/or Other State Specific Eligibility Status or Out-of-Area Status 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) to two (2) calendar months of deemed continued eligibility.

2. For loss of Medi-Cal Eligibility, DHCS shall notify CalOptima of a loss of Medi-Cal eligibility with an HCP status code 05/41 in the monthly 834 eligibility file.

a. Within ten (10) calendar days of receiving HCP status code 05/41, 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 one (1) to two (2) calendar months of deemed continued eligibility begins the first (1st) day of the calendar month following the month CalOptima receives the code 05/41.

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.

e. 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, 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 code or loss of State-specific eligibility status, move out of Service Area), DHCS shall notify CalOptima of a loss of eligibility with an HCP status code 59/61061 in the monthly 834 eligibility file.

  a. Within ten (10) calendar days of receiving HCP status code 59/61061, 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 one (1) or two (2) calendar months of deemed continued eligibility begins the first day of the calendar month following the month CalOptima receives the code 59/61061.

  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 59/61061, CalOptima shall disenroll 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 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.

  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 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 59/61061 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.
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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.

e-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

4. 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 the date of death specified on the DTRR.

2-l.

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. 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 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, CalOptima shall provide the Member with the disenrollment letter 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 the effective date of disenrollment; and

   c. Explains 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:

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 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. 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.

e. 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

- Exhibit 14: Model Notice to Acknowledge Receipt of Voluntary Disenrollment from the Member
- Exhibit 16: Model Notice to Confirm Voluntary Disenrollment from the Member and Following Receipt of Transaction Reply Report (TRR) (H8016_MM1013)
- Exhibit 17: Model Notice for Denial of Disenrollment (H8016_MM1014)
- Exhibit 18: Model Acknowledgement of Request to Cancel Disenrollment (H8016_MM1015)
- Exhibit 19: Model Notice for Disenrollment due to Out-of-Area Status (No Response to Request for Address Verification)
- Exhibit 20: Model Notice for Disenrollment Due to Confirmation of Out of Area Status (Upon New Address Verification from Member)
- 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)
VI. REFERENCES

A. CalOptima Policy CMC.1001: Glossary of Terms
B. CalOptima Policy CMC.4006: Passive4003: Member Enrollment (Voluntary)
C-B. CalOptima Policy CMC.9002: Member Grievance Process
D. CalOptima Three-Way 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
E. Medicare–Medicaid Plan (MMP) Enrollment and Disenrollment Guidance Updated June 14, 2013 (Revised 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. 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

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Revised 09/07/2017 CMC.4004 Member Disenrollment OneCare Connect
### IX. GLOSSARY

<table>
<thead>
<tr>
<th>Term</th>
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<tr>
<td>Abuse</td>
<td>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.</td>
</tr>
<tr>
<td>Authorized Representative</td>
<td>For the purpose of this policy, an Authorized Representative is the same as Legal Representative. Centers for Medicare &amp; 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.</td>
</tr>
<tr>
<td>Contract</td>
<td>The contract between United States Department of Health &amp; Human Services Centers for Medicare &amp; Medicaid Services, California Department of Health Care Services and Orange County Health Authority</td>
</tr>
<tr>
<td>Designee</td>
<td>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.</td>
</tr>
<tr>
<td>Disenrollment</td>
<td>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.</td>
</tr>
<tr>
<td>Election</td>
<td>Enrollment in, or voluntary disenrollment from, a Medicare Advantage (MA) plan or Original Medicare.</td>
</tr>
<tr>
<td>Election Period</td>
<td>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.</td>
</tr>
<tr>
<td>Functional Status</td>
<td>An individuals’ ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being.</td>
</tr>
<tr>
<td>Grievance</td>
<td>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.</td>
</tr>
<tr>
<td>In-Home Supportive Services (IHSS)</td>
<td>A program that provides in-home care for people who cannot remain in their own homes without assistance.</td>
</tr>
<tr>
<td>Member</td>
<td>An enrollee-beneficiary of the CalOptima OneCare Connect program.</td>
</tr>
<tr>
<td>Multi-Purpose Senior Services Program (MSSP)</td>
<td>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...</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>---------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Opt Out</td>
<td>An individual’s declination of Passive Enrollment received by CalOptima OneCare Connect prior to the Passive Enrollment effective date.</td>
</tr>
<tr>
<td>Original Medicare</td>
<td>The traditional Medicare Fee-for-Service program.</td>
</tr>
<tr>
<td>Passive Enrollment</td>
<td>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.</td>
</tr>
<tr>
<td>Provider</td>
<td>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.</td>
</tr>
<tr>
<td>Share of Cost (SOC)</td>
<td>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.</td>
</tr>
<tr>
<td>Service Area</td>
<td>Orange County, California, and ten (10) air miles of any portion of Orange County, California.</td>
</tr>
<tr>
<td>Special Election Period</td>
<td>Election Period provided to individuals in situations where;</td>
</tr>
<tr>
<td></td>
<td>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 &amp; 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;</td>
</tr>
<tr>
<td></td>
<td>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;</td>
</tr>
<tr>
<td></td>
<td>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;</td>
</tr>
<tr>
<td></td>
<td>4. The individual is entitled to Medicare Part A and Part B and receives any type of assistance from Medi-Cal; or</td>
</tr>
<tr>
<td></td>
<td>5. The individual meets such other exceptional conditions as CMS may provide.</td>
</tr>
</tbody>
</table>
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 (6th) 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 (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, DHCS will submit a disenrollment transaction to CMS, effective the 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 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 (1st) 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.
Policy #: CMC.4004
Title: Member Disenrollment
Revised Date: 09/07/17

1. 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.

2. 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.

3. 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.

4. 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.

5. The notice shall include the disenrollment effective date and the Medicare SEP for which the individual is eligible.

6. 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.

7. 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
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

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Policy Number</th>
<th>Policy Title</th>
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<tr>
<td>Effective</td>
<td>07/01/2015</td>
<td>CMC.4004</td>
<td>Member Disenrollment</td>
<td>OneCare Connect</td>
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### IX. GLOSSARY

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Abuse</td>
<td>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.</td>
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<tr>
<td>Authorized Representative</td>
<td>For the purpose of this policy, an Authorized Representative is the same as Legal Representative. Centers for Medicare &amp; 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.</td>
</tr>
<tr>
<td>Contract</td>
<td>The contract between United States Department of Health &amp; Human Services Centers for Medicare &amp; Medicaid Services, California Department of Health Care Services and Orange County Health Authority</td>
</tr>
<tr>
<td>Designee</td>
<td>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.</td>
</tr>
<tr>
<td>Disenrollment</td>
<td>For the purposes of this policy, disenrollments are actions taken by the Member or plan after the effective date of enrollment.</td>
</tr>
<tr>
<td>Election</td>
<td>Enrollment in, or voluntary disenrollment from, a Medicare Advantage (MA) plan or Original Medicare.</td>
</tr>
<tr>
<td>Election Period</td>
<td>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.</td>
</tr>
<tr>
<td>Functional Status</td>
<td>An individuals’ ability to perform normal daily activities required to meet basic needs, fulfill usual roles, and maintain health and well-being.</td>
</tr>
<tr>
<td>Grievance</td>
<td>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.</td>
</tr>
<tr>
<td>In-Home Supportive Services (IHSS)</td>
<td>A program that provides in-home care for people who cannot remain in their own homes without assistance.</td>
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<td>Member</td>
<td>An enrollee-beneficiary of the CalOptima OneCare Connect program.</td>
</tr>
<tr>
<td>Multi-Purpose Senior Services Program (MSSP)</td>
<td>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.</td>
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<tr>
<td>Original Medicare</td>
<td>The traditional Medicare Fee-for-Service program.</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Provider</td>
<td>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.</td>
</tr>
<tr>
<td>Share of Cost (SOC)</td>
<td>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.</td>
</tr>
<tr>
<td>Service Area</td>
<td>Orange County, California, and ten (10) air miles of any portion of Orange County, California.</td>
</tr>
<tr>
<td>Special Election Period</td>
<td>Election Period provided to individuals in situations where;</td>
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<tr>
<td></td>
<td>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 &amp; 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;</td>
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<td></td>
<td>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;</td>
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<td></td>
<td>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;</td>
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<td></td>
<td>4. The individual is entitled to Medicare Part A and Part B and receives any type of assistance from Medi-Cal; or</td>
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<td></td>
<td>5. The individual meets such other exceptional conditions as CMS may provide.</td>
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</table>
<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

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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.


자세한 정보는 웹사이트 www.caloptima.org/onecareconnect를 방문하십시오. 질문이 있으시면, OneCare Connect 번호 1-855-705-8823으로 주 7일 24시간 전화하십시오. TTY 사용자는 1-800-735-2929로 전화해도 됩니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실 수 있습니다.

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)


Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցություններ: Զանգահարեք 1-855-705-8823 (TTY (հեռախոս)՝ 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。


Punjabi: ਅਧਾਈ ਕਰਨੇ: ਮੀ ਅਪਸਿਂਕ ਬੰਗਲਾ, ਕੁਝ ਬੂਲਵਾਇਆ ਪਾਰੇਂਨ, ਤਾਹਲੀਲ ਨਿਯਮਚਾਰਾਂ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸਿਹਤਕਰ ਉਪਰਾਲੇ ਮੋਸ਼ੇ। ਕਰਨ 1-855-705-8823(TTY: 1-800-735-2929)

Cambodian: លោកករណ: យុវ អេស្ទីន បារា, កូម បឹង បាយ ប៉ោង, ឃាត បំណុល រួម ធាតុស្ថាខា ប្រមូល សំរាប់ សាលាបូ បំរលី ឈើ។ តាម ករណ 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।

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.


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).


Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցություններ: Զանգահարեք 1-855-705-8823 (TTY (համաղեծ)՝ 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。


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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 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.


자세한 정보는 웹사이트 www.caloptima.org/onecareconnect를 방문하십시오. 질문이 있으시면, OneCare Connect 번호 1-855-705-8823으로 주 7일 24시간 전화하십시오. TTY 사용자는 1-800-735-2929로 전화하십시오. 통화는 무료입니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실수 있습니다.

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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).


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)


Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-705-8823 (TTY (հեռախոսով)՝ 1-800-735-2929):


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Punjabi: ਸਮਰਥਨ ਹਿੱਸਾ: ਤੁਹਾਡੀ ਭਾਸ਼ਾ ਹੁੰਦੀ ਨੀਂ ਕੋਲ ਵੇਲੇ, ਉਹ ਵਿਦਵਾਨ ਵਿੱਧ ਵਿਦਵਾਨ ਮੇਹਰ ਤੂਹਾਡੇ ਲਕੀ ਮੁਹਤਾਫ ਵਿਚ ਹਨ। 1-855-705-8823 (TTY: 1-800-735-2929) ਉੱਤੇ ਕਲਾਸ ਵਹੇਲ।

Cambodian: លំបែង ការណ៍: ប្រឈមអេស្តី បាសាគេ, ក្នុងជីវការ ទំនើប, តាមដានការមិនឈរ ជីវិតប្រឈម ស្នាដៃប្រភេទ ឃើញ។ មានការណ៍ 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।
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.

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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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Cambodian: ឡើយ: យើង ចង់ អាច ជាការ និងជាការ រៀបចំ គ្រប់គ្រង តាម រយៈ សឹក សាលាមួយ សុភាព បាន តាមរយៈ ១-៨៥៥-៧០៥-៨៨២៣ (TTY: ១-៨០០-៧៣៥-២៩២៩)

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।

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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Punjabi: ਨਿਹਾਲ ਕਰੋ: ਛੁੱਟ ਜਾਣਵਾਨੀ ਬਣਾਉਂਦੇ ਹਨ, ਉੱਤਰ ਵਿਦਿ਼ੇ ਮਗਿਣਟੀਬਲ ਮੇਲਾ ਉੱਤਰ ਤਰੀ ਭੁਗਤ ਦੌਰਾਨ ਉਥਾ ਹੋਵੇ । 1-855-705-8823 (TTY: 1-800-735-2929) ਨੇ ਕਾਰਲ ਵੇਲ।

Cambodian: លើក ការ៉េ: នូវ អាយ៉ង អំពី យ៉ាម គេ, ក៏ បាន សម្រាប់ អំពី របស់ ជាតិ ជាធម្មតា ជើងក្នុងការ ពីរុបី 1-855-705-8823(TTY: 1-800-735-2929)


Hindi: ठीक हैं; यदि आप बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाओं उपलब्ध हैं। 1-855-705-8823 (TTY: 1-800-735-2929) पर कॉल करें।

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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**).


Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեք անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-705-8823 (TTY (հեռախոս)՝ 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。


Punjabi: ਵੱਖਰੇ ਕਰੋ: ਇਸ ਲਈ ਕਿਸੇ ਬੰਗਲਾ, ਕਰਥ ਬੁੱਲਣਾ ਪਾਰੋਂ, ਜੋਹ ਹਿੰਦੀ ਕਿਨਾਰਾ ਭਾਸਾ ਸਹਾਇਤਾ ਨਿਰੀਖਣ ਉਪਲਬਧ ਹੈ। ਕਿਸੇ ਕਰੋ 1-855-705-8823 (TTY: 1-800-735-2929) ਦੌਰਾਨ ਕਾਲ ਕਰੋ।

Cambodian: លខ្លក្រ របស់ អ្នក ចាប់ ពី សេវាកម្ម អាស៊ី ណាណ ក្នុង ការ រៀបចំ សឹក សរសេរ និង អាស៊ី ណាណ ក្នុង ការ សុវត្ថិភាព តំបន់ (សេវាកម្ម តំបន់) 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।

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 Part B plan. You’ll need to get new prescription drug coverage through a new plan.

H8016_MM17_66 Approved (11/22/16)
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.
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).


**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 (հեռախոս): 1-800-735-2929):

**Farsi:**


**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:**

Back to Agenda
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.

H8016_MM17_73 Approved (11/21/16)
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.

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 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).


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。

Punjabi: ਫਿਰ ਤ੍ਰਿਕੁੰਤ ਟੀਲਾਈ ਸੇਵਾ ਸੇਵਾ ਦੇ ਲਈ ਤ੍ਰਿਕੁੰਤ ਟੀਲਾਈ ਸੇਵਾ ਸੇਵਾ ਦੇ ਲਈ ਤ੍ਰਿਕੁੰਤ ਟੀਲਾਈ ਸੇਵਾ ਦੇ ਲਈ ਤ੍ਰਿਕੁੰਤ ਟੀਲਾਈ ਸੇਵਾ ਦੇ ਲਈ ਤ੍ਰਿਕੁੰਤ ਟੀਲਾਈ 
1-855-705-8823 (TTY: 1-800-735-2929) ਉੱਤੇ ਕੋਲ ਕਰੋ।


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।

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.
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.

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.

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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**)

**Tagalog:** PAUNAWA: Kung nagsasaalita 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.

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**Farsi:** توجه: اگر به زبان فارسی گفتگو می‌کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌شود: توجه باشماره 1-855-705-8823 (TTY: 1-800-735-2929).

**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 أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل على الرقم (الهاتف التنصفي/خط الاناتصال لضعف السمع TTY: 1-800-735-2929)

1-855-705-8823

**Punjabi:** ਇਨਕਲਪੇਡੀਕ ਜਾਂ ਤੱਕਰ ਲੱਕਾ ਪੇਸਟ ਦੇ, ਹਾਲਾਂਕਿ ਰੈਡਰ ਸਿੱਟਾਂ ਸੇਟਾ ਹੋਣਾ ਹੁੰਦਾ ਹੁੰਦਾ ਹੁੰਦਾ ਪ੍ਰਤੀਕਾਲ ਦੇ। 1-855-705-8823 (TTY: 1-800-735-2929) ਇਹ ਬਰਸ ਬਰਸ।

**Cambodian:** လេធ ករនី: គឺ អិស្ធិត បាសាគន កេត បញ្ជាក់ គ្រឿន, បាយ៉េ និយាយចំនួន ប្រសិនបើ សាស្រ្ត ប្រការ និយាយ នូវ សម្រាប់ ការ បរិស្ថាន ករនី 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।

To the Estate of «First1» «Last2»:

Our records show «First1» «Last2» has passed away. Please accept our condolences. Because of this report of death, «First1» «Last2»’s coverage in OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) will end as of «Term_date».

If this information is wrong and you’ve already contacted Social Security, disregard this notice. If this information is wrong and you have not contact Social Security, here’s how to fix this information:

- Call Social Security at toll-free 1-800-772-1213 (Monday to Friday 7am – 7pm) to have the record corrected. TTY users should call 1-800-325-0778. **Ask Social Security to give you a notice that says they’ve fixed your records.**
- Send a copy of Social Security’s letter to your County Social Services Eligibility Worker.

Note: Please keep using OneCare Connect primary care providers for your health services and network pharmacies while your records are being corrected by Social Security.

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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.

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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).


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 شود.


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。

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ملحوظة: إذا كنت تتحدث بلغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجاني. اتصل على الرقم 1-855-705-8823 (الهاتف النصي/خط الاتصال لضعف السمع) TTY 1-800-735-2929.
**Punjabi:** ਪੰਜਾਬੀ ਵਿੱਚ, ਅਸਟੇਟ ਮੁਕਾਬਲਾ ਵੇਲੇ, ਦਾ ਵਾਲਾ ਹਾਲ ਮੁਕਾਬਲਾ ਵੇਲੇ ਵਾਲਾ ਬਣਨ ਵਾਲਾ। 1-855-705-8823 (TTY: 1-800-735-2929) ਵੇਲੇ ਕਾਲ ਕਰੋ।

**Cambodian:** កម្ពុជាទូទៅ: យើងស្វែងយល់ដោយសារបែបនេះ, ប្រការសម្រាប់ប៉ុន្តែ, ប្រការប្រការសម្រាប់ប៉ុន្តែ, តាមតូចកុម្មុយ្យសម្រាប់ប៉ុន្តែ, តាមតូចកុម្មុយ្យសម្រាប់ប៉ុន្តែ, តាមតូចកុម្មុយ្យ 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:** ถ้าคุณต้องการขอความช่วยเหลือภาษาระดับชาติ โปรดโทร 1-855-705-8823 (TTY: 1-800-735-2929).
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**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).


**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-705-8823 (TTY: 1-800-735-2929) 번으로 전화해 주십시오.

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Back to Agenda
<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.

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H8016_MM17_70
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?

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Farsi: گروه: یک شرکت بیمه درمانی برای پولیساتورهای بهره‌برداری از برنامه‌های بهزیستی کشور و کارکنان وسایل انتقالی می‌باشد. شماره تماس 1-855-705-8823 (TTY (بنابراین) ۱-۸۰۰-۷۳۵-۲۹۲۹):
If you speak another language, you may need assistance. Call 1-855-705-8823 (TTY: 1-800-735-2929).

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ملحوظة: إذا كنت تتحدث بلغة أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل على الرقم 1-800-735-2929 (الهاتف النصي/خط الاتصال لضعاف السمع).

**Punjabi:** ਇਹ ਭਾਸ਼ਾ ਵਿਚੋਂ ਨਹੀਂ ਦੀ ਸੌਂਦਰ ਬਾਲਕੀ ਤੇ, ਉਹ ਭਾਸ਼ਾ ਇਕੋਂ ਮਹਾਂ ਮੇਦ ਉੱਠ ਰਹੀ ਚੁੱਕੀ ਭਰਦੁਆਂ ਦੀ ਖੋਜ ਘਾਇਤ ਨਾ। ਹੁੰਦੋ ਦੋ ਆਲੂ 1-855-705-8823 (TTY: 1-800-735-2929) ਹੁੰਦੋ ਆਲੂ।

**Cambodian:** លេខ ការណ៍: បើលេខ ឆាក បាន ថេស ឬ អំពី ការរៀបរាប់, ប្រការ បញ្ឹៀត បាន ធ្វើ ឬ ប្រការ បញ្ជាញ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ជាញ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ជាញ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ជាញ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ជាញ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ជាញ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រការ បញ្ញាលើ ឬ ប្រក�... 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:** ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการข่าวเหตุการณ์ทางอากาศได้ที่ โทร 1-855-705-8823 (TTY: 1-800-735-2929).
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
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.


자세한 정보는 웹사이트 www.caloptima.org/onecareconnect를 방문하십시오. 질문이 있으시면, OneCare Connect 번호 1-855-705-8823으로 주 7일 24시간 전화하십시오. TTY 사용자는 1-800-735-2929로 전화하십시오. 통화는 무료입니다. 큰글자, 점자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실 수 있습니다.

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).


**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):
Cambodian: លេងករណ: វិដាលើខុសបាន, កូនបារមុខមានសុខភាពប្រសើរ និងអាហារមានសុខភាពប្រសើរ ទោះយើងមានអត្ថប្រយោជន៍ ទៀត។ ប៉ុន្តែអាចទុកជាអក្សរអាមេរិកបាន 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।

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.


자세한 정보는 웹사이트 www.caloptima.org/onecareconnect를 방문하십시오. 질문이 있으시면, OneCare Connect 번호 1-855-705-8823으로 주 7일 24시간 전화하십시오. TTY 사용자는 1-800-735-2929로 전화하십시오. 통화는 무료입니다. 큰글자, 정자 및 오디오 같이 다른 형태 및 다른 언어로 된 이 정보를 무료로 받아보실 수 있습니다.

Mراجعه تمامیت. آگر پرسشی دارید، لطفاًTE cynical 24 ساعت شبانه روز، در 7 روز هفته با OneCare Connect تماس 855-705-8823 1 از طریق شماره تماس بگیرید. این تماس رایگان است. شما می‌توانید با شماره بگیرید. TTY می‌توانید با شماره بگیرید. این اطلاعات را بطور رایگان در فرم‌های دیگر، از قبیل پادشاه دشمن، خط بیلی 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**).


**Armenian**: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-855-705-8823 (TTY (հեռախոս)՝ 1-800-735-2929):  

**Farsi**: 

**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 أخرى غير الإنجليزية، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل على الرقم 1-800-735-2929 (الهاتف النصي/خط الاتصال لضعاف السمع 1-855-705-8823).

Punjabi: ਮਹੱਤਵਪੂਰਵਤਾ ਹੈ ਕਿ ਤੁਸੀਂ ਜਾਣਦੇ ਹਨ ਕਿ ਅਜਿਹਾ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਤੋਂ ਆਪਣੀ ਪ੍ਰਾਪਤ ਹੋਣ ਦਿਸਤਾਂ। ਸੰਕੇਤ ਨੂੰ ਕਰੋ 1-855-705-8823 (TTY: 1-800-735-2929) ਅਤੇ ਕਾਲਜ ਕਰੋ।

Cambodian: លុបក្រមុន: បើអ្នកប្រើភាសាអក្សរដែលគ្រប់គ្រងនៅក្នុងសំណុំមិនបានសរសេរឬសម្រាប់អ្នកមិនស្រាប់សភាពភាសាបន្ទាន់ភ្លៅ។ អ្នកអាចរក្សាទូទៅ 1-855-705-8823 (TTY: 1-800-735-2929) ដើម្បីទាញយកសុវត្ថុ។

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।

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
County
State
Zip Code
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
County
State
Zip Code
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.
«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».

H8016_MM17_8 Approve (10/24/16)
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
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.

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.
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.

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).


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)


Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ։ Звоните 1-855-705-8823 (TTY (հեռատիպ)՝ 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:

Punjabi:
ਚੁਣਾ ਕਰੋ: ਸੁੰਦਰ ਅਪੀਲ ਬੰਗਾਲੀ, ਕਥਾ ਬਣਾਏ ਪੈਰਿਆਂ, ਤਾਹਲਣ ਹੁਣਤਾਂ ਵਾਰੀ ਸਹਾਇਤਾ ਨਿਰਦੇਸ਼ਵਰਾਂ ਉਪਲਾਧ ਆਉਂਦੇ ਹਨ। ਕਾਲਜ਼ 1-855-705-8823 (TTY: 1-800-735-2929) ਕਰੀਂ।

Cambodian:
លេខថ្មី: បុរសនេះ គឺជាអោយបានបញ្ហាក្នុងការពារ់ប្រាក់, តើចគ្លែង ជំនួសភាសានិងការស្វែងរកវិធីប្រឈមប្រាក់ អំពីការទទួលបាន 1-855-705-8823 (TTY: 1-800-735-2929).

Hmong:

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।

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.
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

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
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
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

/signature Michael Schrader  11/25/2015
Authorized Signature  Date
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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CalOptima Board Action Agenda Referral
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
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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
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
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.”
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

Back to Agenda
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
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 periodontics 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
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
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.

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
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.
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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<td>7/1/12</td>
<td>125 W. Cerritos Avenue Anaheim, CA 92805</td>
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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
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
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
RFI Respondents/PACE Service Area

Legend
- RFI Respondents
- CalOptima PACE
- PACE Service Area
- Non-Service Area

Back to Agenda
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
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

Legend
- ACS Sites
- CalOptima PACE
- PACE Service Area
- Service Area Expansion

Back to Agenda
Phased Implementation

- Phased implementation supports use of best practices
- Monthly workgroup fosters collaboration from the start

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* Pending CMS approval of service area expansion
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.
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; 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.

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
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
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
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.
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
CalOptima Board Action Agenda Referral
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
Page 3

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
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.

Back to Agenda
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.
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
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 prepayment 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.
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.
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.
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
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
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
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 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:

<table>
<thead>
<tr>
<th>Proficiency</th>
<th>Rate Per Pay Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>$60.00</td>
</tr>
<tr>
<td>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.</td>
<td>$40.00</td>
</tr>
</tbody>
</table>

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:

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

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

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:

<table>
<thead>
<tr>
<th>Enrollments</th>
<th>Incentive per eligible member enrolled</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 25</td>
<td>$0.00</td>
</tr>
</tbody>
</table>


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 of 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

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Policy Number</th>
<th>Policy Title</th>
<th>Line(s) of Business</th>
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<tr>
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<td>01/01/2011</td>
<td>GA.8042</td>
<td>Pay Differentials</td>
<td>Administrative</td>
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<td>GA.8042</td>
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<td>Supplemental Compensation</td>
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## IX. GLOSSARY

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilingual Certified Employee</td>
<td>An employee who has passed CalOptima’s Bilingual Screening Process either upon hire or any time during their employment.</td>
</tr>
<tr>
<td>Bilingual Screening Process:</td>
<td>Prospective staff translators are identified by Cultural and Linguistic (C&amp;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&amp;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.</td>
</tr>
<tr>
<td>Bonus Pay</td>
<td>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.</td>
</tr>
<tr>
<td>CalPERS</td>
<td>California Public Employees Retirement System</td>
</tr>
<tr>
<td>CalPERS Classic Member</td>
<td>A member enrolled in CalPERS prior to January 1, 2013.</td>
</tr>
<tr>
<td>Classic Director</td>
<td>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.</td>
</tr>
<tr>
<td>Classic Executive</td>
<td>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.</td>
</tr>
<tr>
<td>Compensation Earnable</td>
<td>The pay rate and special compensation as defined in Government Code sections 20636 and 20636.1.</td>
</tr>
<tr>
<td>Executive Staff</td>
<td>Staff holding Executive level positions as specifically designated by the Board of Directors.</td>
</tr>
<tr>
<td>Exempt Employee</td>
<td>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.</td>
</tr>
<tr>
<td>Leave of Absence (LOA)</td>
<td>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.</td>
</tr>
<tr>
<td>Management Staff</td>
<td>Staff holding positions at or above Director level.</td>
</tr>
<tr>
<td>Sales Incentive</td>
<td>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.</td>
</tr>
<tr>
<td>Special Compensation</td>
<td>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).</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
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<td>----------------------</td>
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</tr>
<tr>
<td>Threshold Language</td>
<td>For purposes of this policy, a threshold language as defined by the Centers for Medicare &amp; Medicaid Services (CMS) for Medicare programs, or Department of Health Care Services for the Medi-Cal program.</td>
</tr>
</tbody>
</table>
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.
## Request for Proposal Description Allocated

<table>
<thead>
<tr>
<th>#</th>
<th>Request for Proposal</th>
<th>Description</th>
<th>Allocated Amount</th>
<th>Priority Area</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Expand Access to Mental Health Services and Provide Outreach to Promote Awareness of Services</td>
<td>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</td>
<td>$5 million</td>
<td>Adult Mental Health</td>
</tr>
<tr>
<td>2.</td>
<td>Expand Mental Health and Socialization Services for Older Adults</td>
<td>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</td>
<td>$500,000</td>
<td>Adult Mental Health</td>
</tr>
<tr>
<td>3.</td>
<td>Expand Access to Mental Health/Developmental Services for Children Ages 0-5</td>
<td>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</td>
<td>$1 million</td>
<td>Children’s Mental Health</td>
</tr>
<tr>
<td>4.</td>
<td>Nutrition Education and Fitness Program for Children and their Families</td>
<td>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</td>
<td>$1 million</td>
<td>Childhood Obesity</td>
</tr>
<tr>
<td>5.</td>
<td>Medi-Cal Benefits Education and Outreach</td>
<td>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.</td>
<td>$500,000</td>
<td>Strengthening the Safety Net</td>
</tr>
</tbody>
</table>
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.
CalOptima Board Action Agenda Referral
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

Page 4

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
Member Health Needs Assessment

Board of Directors Meeting
February 1, 2018

Cheryl Meronk
Director, Strategic Development
Member Health Needs Assessment

A better study offering deeper insight, leading to a healthier future.
A Better Study

➔ More Comprehensive
➔ More Engaging
➔ More Personal
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)
More Comprehensive (Cont.)

• Gathered responses from all geographic areas of Orange County
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)
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)
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
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)
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
More Personal (Cont.)

• We spoke their language
  - English
  - Spanish
  - Vietnamese
  - Korean
  - Farsi
  - Chinese
  - Arabic
  - Cambodian
  - Marshallese
  - American Sign Language
Offering Deeper Insight

- Barriers to Care
- Lack of Awareness About Benefits and Resources
- Negative Social and Environmental Impacts
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
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
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
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
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
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
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
Leading to a Healthier Future

→ Funding
→ Requests for Proposal
→ Moving Forward
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
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
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
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
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
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
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
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
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
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
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.
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.

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

<table>
<thead>
<tr>
<th>Language</th>
<th>Number of Completed Surveys</th>
<th>Percent of Completed Surveys</th>
<th>Percent of CalOptima Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>658</td>
<td>11.3%</td>
<td>55.5%</td>
</tr>
<tr>
<td>Spanish</td>
<td>715</td>
<td>12.3%</td>
<td>28.6%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>981</td>
<td>16.9%</td>
<td>10.3%</td>
</tr>
<tr>
<td>Korean</td>
<td>940</td>
<td>16.2%</td>
<td>1.4%</td>
</tr>
<tr>
<td>Farsi</td>
<td>743</td>
<td>12.8%</td>
<td>1.1%</td>
</tr>
<tr>
<td>Arabic</td>
<td>648</td>
<td>11.1%</td>
<td>0.6%</td>
</tr>
<tr>
<td>Chinese</td>
<td>731</td>
<td>12.6%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Other</td>
<td>399</td>
<td>6.9%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Region</th>
<th>Number of Completed Surveys</th>
<th>Percent of Completed Surveys</th>
<th>Percent of CalOptima Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central</td>
<td>2,315</td>
<td>39.8%</td>
<td>51.5%</td>
</tr>
<tr>
<td>North</td>
<td>1,947</td>
<td>33.5%</td>
<td>32.4%</td>
</tr>
<tr>
<td>South</td>
<td>1,538</td>
<td>26.4%</td>
<td>15.1%</td>
</tr>
<tr>
<td>Out of County</td>
<td>15</td>
<td>0.3%</td>
<td>1.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of Completed Surveys</th>
<th>Percent of Completed Surveys</th>
<th>Percent of CalOptima Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–18 years old</td>
<td>1,665</td>
<td>28.6%</td>
<td>41.8%</td>
</tr>
<tr>
<td>19–64 years old</td>
<td>2,453</td>
<td>42.2%</td>
<td>47.2%</td>
</tr>
<tr>
<td>65 or older</td>
<td>1,697</td>
<td>29.2%</td>
<td>10.9%</td>
</tr>
</tbody>
</table>
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 HEALTH

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)

- Yes: 44.3%
- No: 55.7%

Exhibit 3: Percent of members who needed help with basic needs in the past six months

- Childcare (n=5,157): 10.5% Sometimes, 4.6% Almost Always
- Transportation (n=5,389): 18.9% Sometimes, 9.9% Almost Always
- Money to buy things need (n=5,447): 30.3% Sometimes, 12.8% Almost Always
- Housing (n=5,353): 11.8% Sometimes, 12.2% Almost Always
- Food for anyone in your household (n=5,456): 22.5% Sometimes, 9.9% Almost Always
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).

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.

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.

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.

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 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)

Exhibit 10: Reasons why members don’t make an appointment to see doctor (n=4,598)
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.

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 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)

- More than 12 months: 38.2%
- Within past 12 months: 61.8%

### Exhibit 14: Reasons for not seeing dentist within the past 12 months (n=2,209)

- Cost: 41.0%
- Don’t have/know dentist: 24.9%
- Fear of dentist: 16.8%
- No time: 12.3%
- Don’t know: 9.6%
- No transportation: 6.1%

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**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.
CalOptima Member Survey Analysis:
Unweighted Estimates by Language, Region, and Age

DRAFT
Navigating the Healthcare System

Exhibit 1. Percent who report at least one person as their doctor

**CalOptima language:**

<table>
<thead>
<tr>
<th>Language</th>
<th>Percent Reporting Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>English (n=651)</td>
<td>84.2%</td>
</tr>
<tr>
<td>Spanish (n=710)</td>
<td>92.0%</td>
</tr>
<tr>
<td>Vietnamese (n=954)</td>
<td>47.3%</td>
</tr>
<tr>
<td>Korean (n=931)</td>
<td>90.5%</td>
</tr>
<tr>
<td>Farsi (n=727)</td>
<td>94.5%</td>
</tr>
<tr>
<td>Arabic (n=641)</td>
<td>82.4%</td>
</tr>
<tr>
<td>Chinese (n=721)</td>
<td>88.5%</td>
</tr>
<tr>
<td>Other (n=390)</td>
<td>85.9%</td>
</tr>
</tbody>
</table>

**Age Group:**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Percent Reporting Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (n= 419)</td>
<td>86.6%</td>
</tr>
<tr>
<td>6-18 (n=1,234)</td>
<td>85.3%</td>
</tr>
<tr>
<td>19-64 (n=2,423)</td>
<td>76.8%</td>
</tr>
<tr>
<td>65+ (n=1,649)</td>
<td>85.4%</td>
</tr>
</tbody>
</table>

---

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:**

- North (n=1,922): 85.8%
- South (n=1,512): 89.6%
- Central (n=2,276): 73.5%
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

### Exhibit 2. Where respondents go to see their doctor

#### CalOptima language:

<table>
<thead>
<tr>
<th>CalOptima Language</th>
<th>Doctor’s office</th>
<th>Clinic /health center</th>
<th>Emergency room</th>
<th>Urgent Care</th>
<th>Alternative medicine provider /herbalist</th>
<th>Other</th>
<th>Don’t Know</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>71.8%</td>
<td>11.9%</td>
<td>2.0%</td>
<td>6.6%</td>
<td>0.5%</td>
<td>6.4%</td>
<td>0.8%</td>
<td>653</td>
</tr>
<tr>
<td>Spanish</td>
<td>59.7%</td>
<td>32.3%</td>
<td>3.4%</td>
<td>1.0%</td>
<td>0.3%</td>
<td>3.1%</td>
<td>0.1%</td>
<td>699</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>86.3%</td>
<td>12.0%</td>
<td>0.1%</td>
<td>0.2%</td>
<td>0.0%</td>
<td>1.0%</td>
<td>0.3%</td>
<td>965</td>
</tr>
<tr>
<td>Korean</td>
<td>87.8%</td>
<td>4.3%</td>
<td>0.9%</td>
<td>1.1%</td>
<td>0.7%</td>
<td>4.1%</td>
<td>1.2%</td>
<td>938</td>
</tr>
<tr>
<td>Farsi</td>
<td>84.0%</td>
<td>6.5%</td>
<td>3.0%</td>
<td>0.8%</td>
<td>0.1%</td>
<td>5.0%</td>
<td>0.5%</td>
<td>737</td>
</tr>
<tr>
<td>Arabic</td>
<td>65.3%</td>
<td>15.8%</td>
<td>4.6%</td>
<td>5.4%</td>
<td>0.3%</td>
<td>8.0%</td>
<td>0.5%</td>
<td>625</td>
</tr>
<tr>
<td>Chinese</td>
<td>77.2%</td>
<td>11.4%</td>
<td>0.3%</td>
<td>0.8%</td>
<td>0.4%</td>
<td>6.6%</td>
<td>3.3%</td>
<td>727</td>
</tr>
<tr>
<td>Other</td>
<td>72.2%</td>
<td>12.6%</td>
<td>1.5%</td>
<td>3.0%</td>
<td>0.0%</td>
<td>9.6%</td>
<td>1.0%</td>
<td>396</td>
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</table>

#### Age Category:

<table>
<thead>
<tr>
<th>CalOptima Age Category</th>
<th>Doctor’s office</th>
<th>Clinic /health center</th>
<th>Emergency room</th>
<th>Urgent Care</th>
<th>Alternative medicine provider /herbalist</th>
<th>Other</th>
<th>Don’t Know</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>68.4%</td>
<td>19.1%</td>
<td>1.9%</td>
<td>2.7%</td>
<td>0.2%</td>
<td>7.2%</td>
<td>0.5%</td>
<td>414</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>73.0%</td>
<td>16.5%</td>
<td>1.6%</td>
<td>3.0%</td>
<td>0.4%</td>
<td>4.4%</td>
<td>1.0%</td>
<td>1,224</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>73.1%</td>
<td>14.2%</td>
<td>2.6%</td>
<td>2.7%</td>
<td>0.5%</td>
<td>5.5%</td>
<td>1.4%</td>
<td>2,425</td>
</tr>
<tr>
<td>65+ ( Older Adults)</td>
<td>87.5%</td>
<td>6.8%</td>
<td>0.8%</td>
<td>0.4%</td>
<td>0.1%</td>
<td>4.1%</td>
<td>0.4%</td>
<td>1,677</td>
</tr>
</tbody>
</table>
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Region:**

<table>
<thead>
<tr>
<th>CalOptima Region</th>
<th>Doctor’s office</th>
<th>Clinic /health center</th>
<th>Emergency room</th>
<th>Urgent Care</th>
<th>Alternative medicine provider /herbalist</th>
<th>Other</th>
<th>Don’t Know</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>74.4%</td>
<td>13.8%</td>
<td>1.7%</td>
<td>3.4%</td>
<td>0.4%</td>
<td>5.4%</td>
<td>1.0%</td>
<td>1,920</td>
</tr>
<tr>
<td>South</td>
<td>80.4%</td>
<td>7.9%</td>
<td>2.0%</td>
<td>1.4%</td>
<td>0.5%</td>
<td>6.4%</td>
<td>1.4%</td>
<td>1,521</td>
</tr>
<tr>
<td>Central</td>
<td>76.8%</td>
<td>15.5%</td>
<td>1.8%</td>
<td>1.4%</td>
<td>0.2%</td>
<td>3.6%</td>
<td>0.6%</td>
<td>2,284</td>
</tr>
</tbody>
</table>
Exhibit 3. Reasons why members go somewhere other than their doctor when they need medical attention

CalOptima language:

<table>
<thead>
<tr>
<th>CalOptima Language</th>
<th>I don't have a doctor</th>
<th>It's easier for me to get to the emergency room or urgent care than my doctor's office</th>
<th>It's hard to get an appointment with my doctor</th>
<th>Other</th>
<th>Don't know</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>7.4%</td>
<td>26.5%</td>
<td>21.4%</td>
<td>40.7%</td>
<td>4.0%</td>
<td>570</td>
</tr>
<tr>
<td>Spanish</td>
<td>7.5%</td>
<td>22.2%</td>
<td>20.1%</td>
<td>37.9%</td>
<td>12.4%</td>
<td>523</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>3.1%</td>
<td>31.8%</td>
<td>16.8%</td>
<td>46.2%</td>
<td>2.1%</td>
<td>584</td>
</tr>
<tr>
<td>Korean</td>
<td>11.5%</td>
<td>22.7%</td>
<td>27.8%</td>
<td>37.6%</td>
<td>0.4%</td>
<td>687</td>
</tr>
<tr>
<td>Farsi</td>
<td>3.1%</td>
<td>15.4%</td>
<td>22.7%</td>
<td>58.8%</td>
<td>0.0%</td>
<td>422</td>
</tr>
<tr>
<td>Arabic</td>
<td>5.2%</td>
<td>40.6%</td>
<td>25.5%</td>
<td>28.0%</td>
<td>0.7%</td>
<td>554</td>
</tr>
<tr>
<td>Chinese</td>
<td>9.1%</td>
<td>26.8%</td>
<td>14.6%</td>
<td>47.9%</td>
<td>1.6%</td>
<td>549</td>
</tr>
<tr>
<td>Other</td>
<td>6.0%</td>
<td>24.9%</td>
<td>16.7%</td>
<td>50.8%</td>
<td>1.6%</td>
<td>317</td>
</tr>
</tbody>
</table>
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

### Age Category:

<table>
<thead>
<tr>
<th>Age Category</th>
<th>I don't have a doctor</th>
<th>It is easier for me to get to the emergency room or urgent care than my doctor's office</th>
<th>It's hard to get an appointment with my doctor</th>
<th>Other</th>
<th>Don't know</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>4.5%</td>
<td>34.4%</td>
<td>25.4%</td>
<td>29.3%</td>
<td>6.5%</td>
<td>355</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>5.2%</td>
<td>27.7%</td>
<td>24.0%</td>
<td>36.2%</td>
<td>6.9%</td>
<td>986</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>9.2%</td>
<td>26.0%</td>
<td>23.7%</td>
<td>39.9%</td>
<td>1.3%</td>
<td>1,789</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>4.5%</td>
<td>34.4%</td>
<td>25.4%</td>
<td>29.3%</td>
<td>6.5%</td>
<td>1,076</td>
</tr>
</tbody>
</table>

### Region:

<table>
<thead>
<tr>
<th>Region</th>
<th>I don't have a doctor</th>
<th>It is easier for me to get to the emergency room or urgent care than my doctor's office</th>
<th>It's hard to get an appointment with my doctor</th>
<th>Other</th>
<th>Don't know</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>7.4%</td>
<td>27.1%</td>
<td>25.2%</td>
<td>38.4%</td>
<td>1.9%</td>
<td>1,501</td>
</tr>
<tr>
<td>South</td>
<td>6.7%</td>
<td>23.1%</td>
<td>20.5%</td>
<td>47.2%</td>
<td>2.5%</td>
<td>1,052</td>
</tr>
<tr>
<td>Central</td>
<td>6.3%</td>
<td>28.9%</td>
<td>17.6%</td>
<td>43.2%</td>
<td>4.0%</td>
<td>1,639</td>
</tr>
</tbody>
</table>
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

### Exhibit 4. When do members make an appointment to see doctor^{2}

**CalOptima Language:**

<table>
<thead>
<tr>
<th>CalOptima Language</th>
<th>When Sick %</th>
<th>Check-Up %</th>
<th>Specialist Needed %</th>
<th>Don’t Know %</th>
<th>Other %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>75.8%</td>
<td>77.2%</td>
<td>51.8%</td>
<td>1.1%</td>
<td>4.2%</td>
<td>650</td>
</tr>
<tr>
<td>Spanish</td>
<td>77.7%</td>
<td>76.2%</td>
<td>36.9%</td>
<td>0.8%</td>
<td>4.5%</td>
<td>713</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>76.0%</td>
<td>74.7%</td>
<td>39.7%</td>
<td>0.1%</td>
<td>1.7%</td>
<td>973</td>
</tr>
<tr>
<td>Korean</td>
<td>81.3%</td>
<td>75.2%</td>
<td>47.4%</td>
<td>0.4%</td>
<td>0.6%</td>
<td>938</td>
</tr>
<tr>
<td>Farsi</td>
<td>87.4%</td>
<td>80.0%</td>
<td>65.1%</td>
<td>1.8%</td>
<td>3.7%</td>
<td>736</td>
</tr>
<tr>
<td>Arabic</td>
<td>82.5%</td>
<td>40.4%</td>
<td>30.9%</td>
<td>0.5%</td>
<td>1.4%</td>
<td>644</td>
</tr>
<tr>
<td>Chinese</td>
<td>80.3%</td>
<td>73.6%</td>
<td>48.6%</td>
<td>1.5%</td>
<td>1.2%</td>
<td>727</td>
</tr>
<tr>
<td>Other</td>
<td>70.1%</td>
<td>82.0%</td>
<td>51.1%</td>
<td>1.5%</td>
<td>4.6%</td>
<td>395</td>
</tr>
</tbody>
</table>

**Age Category:**

<table>
<thead>
<tr>
<th>Age Category</th>
<th>When Sick %</th>
<th>Check-Up %</th>
<th>Specialist Needed %</th>
<th>Don’t Know %</th>
<th>Other %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>86.4%</td>
<td>76.9%</td>
<td>41.9%</td>
<td>0.7%</td>
<td>1.2%</td>
<td>420</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>81.8%</td>
<td>73.2%</td>
<td>39.9%</td>
<td>0.5%</td>
<td>2.2%</td>
<td>1,236</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>78.0%</td>
<td>67.9%</td>
<td>47.3%</td>
<td>1.1%</td>
<td>2.3%</td>
<td>2,433</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>77.8%</td>
<td>77.4%</td>
<td>50.0%</td>
<td>0.9%</td>
<td>3.4%</td>
<td>1,687</td>
</tr>
</tbody>
</table>

---

^{2} Members were allowed to choose multiple answers; thus, the total does not equal 100%.
## Region:

<table>
<thead>
<tr>
<th>Region</th>
<th>When Sick</th>
<th>Check-Up</th>
<th>Specialist Needed</th>
<th>Don’t Know</th>
<th>Other</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>78.2%</td>
<td>70.5%</td>
<td>43.6%</td>
<td>0.9%</td>
<td>2.3%</td>
<td>1,938</td>
</tr>
<tr>
<td>South</td>
<td>83.3%</td>
<td>75.9%</td>
<td>55.9%</td>
<td>1.3%</td>
<td>2.8%</td>
<td>1,527</td>
</tr>
<tr>
<td>Central</td>
<td>77.7%</td>
<td>72.0%</td>
<td>41.8%</td>
<td>0.5%</td>
<td>2.5%</td>
<td>2,296</td>
</tr>
</tbody>
</table>
Exhibit 5. Reasons why members don’t make an appointment to see doctor³

CalOptima language:

<table>
<thead>
<tr>
<th>CalOptima Language</th>
<th>No Doctor</th>
<th>No way to get there</th>
<th>Scheduling Conflict</th>
<th>Too long to get appointment</th>
<th>No childcare available</th>
<th>Didn’t think necessary</th>
<th>Don’t Know</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>7.8%</td>
<td>6.7%</td>
<td>28.0%</td>
<td>27.6%</td>
<td>5.2%</td>
<td>54.0%</td>
<td>1.8%</td>
<td>554</td>
</tr>
<tr>
<td>Spanish</td>
<td>6.3%</td>
<td>6.5%</td>
<td>20.8%</td>
<td>27.4%</td>
<td>5.2%</td>
<td>53.2%</td>
<td>0.8%</td>
<td>504</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>2.3%</td>
<td>7.0%</td>
<td>50.9%</td>
<td>24.8%</td>
<td>4.1%</td>
<td>42.8%</td>
<td>0.0%</td>
<td>725</td>
</tr>
<tr>
<td>Korean</td>
<td>11.7%</td>
<td>4.1%</td>
<td>48.4%</td>
<td>39.7%</td>
<td>3.8%</td>
<td>31.5%</td>
<td>0.0%</td>
<td>677</td>
</tr>
<tr>
<td>Farsi</td>
<td>5.7%</td>
<td>19.5%</td>
<td>24.9%</td>
<td>45.1%</td>
<td>6.9%</td>
<td>33.3%</td>
<td>0.0%</td>
<td>406</td>
</tr>
<tr>
<td>Arabic</td>
<td>2.7%</td>
<td>7.0%</td>
<td>28.2%</td>
<td>42.6%</td>
<td>2.1%</td>
<td>37.1%</td>
<td>0.0%</td>
<td>561</td>
</tr>
<tr>
<td>Chinese</td>
<td>7.2%</td>
<td>9.6%</td>
<td>29.8%</td>
<td>24.8%</td>
<td>2.2%</td>
<td>51.0%</td>
<td>0.9%</td>
<td>541</td>
</tr>
<tr>
<td>Other</td>
<td>4.1%</td>
<td>8.8%</td>
<td>25.0%</td>
<td>29.1%</td>
<td>1.7%</td>
<td>56.8%</td>
<td>0.0%</td>
<td>296</td>
</tr>
</tbody>
</table>

³ 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

### Age Category:

<table>
<thead>
<tr>
<th>Age Category</th>
<th>No Doctor</th>
<th>No way to get there</th>
<th>Scheduling Conflict</th>
<th>Too long to get appointment</th>
<th>No childcare available</th>
<th>Didn’t think necessary</th>
<th>Don’t Know</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>4.6%</td>
<td>6.5%</td>
<td>32.8%</td>
<td>35.9%</td>
<td>10.5%</td>
<td>43.7%</td>
<td>0.0%</td>
<td>323</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>4.8%</td>
<td>4.5%</td>
<td>38.2%</td>
<td>32.8%</td>
<td>3.9%</td>
<td>43.4%</td>
<td>0.1%</td>
<td>990</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>7.8%</td>
<td>7.4%</td>
<td>36.3%</td>
<td>34.5%</td>
<td>4.2%</td>
<td>39.5%</td>
<td>0.8%</td>
<td>1,933</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>4.5%</td>
<td>13.3%</td>
<td>26.1%</td>
<td>26.9%</td>
<td>1.3%</td>
<td>53.2%</td>
<td>0.3%</td>
<td>1,018</td>
</tr>
</tbody>
</table>

### Region:

<table>
<thead>
<tr>
<th>Region</th>
<th>No Doctor</th>
<th>No way to get there</th>
<th>Scheduling Conflict</th>
<th>Too long to get appointment</th>
<th>No childcare available</th>
<th>Didn’t think necessary</th>
<th>Don’t Know</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>7.6%</td>
<td>7.7%</td>
<td>36.3%</td>
<td>35.0%</td>
<td>3.3%</td>
<td>40.5%</td>
<td>0.3%</td>
<td>1,521</td>
</tr>
<tr>
<td>South</td>
<td>6.3%</td>
<td>10.5%</td>
<td>27.5%</td>
<td>35.8%</td>
<td>4.8%</td>
<td>45.7%</td>
<td>0.6%</td>
<td>1,019</td>
</tr>
<tr>
<td>Central</td>
<td>4.6%</td>
<td>6.9%</td>
<td>35.9%</td>
<td>28.1%</td>
<td>4.0%</td>
<td>46.1%</td>
<td>0.5%</td>
<td>1,712</td>
</tr>
</tbody>
</table>
### Exhibit 6. When do members make an appointment to see a specialist

<table>
<thead>
<tr>
<th>CalOptima Language</th>
<th>Doctor gave referral</th>
<th>Doctor helped schedule the appointment</th>
<th>Important for health</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>76.0%</td>
<td>26.5%</td>
<td>63.5%</td>
<td>638</td>
</tr>
<tr>
<td>Spanish</td>
<td>71.9%</td>
<td>30.5%</td>
<td>60.7%</td>
<td>679</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>70.3%</td>
<td>24.4%</td>
<td>56.7%</td>
<td>949</td>
</tr>
<tr>
<td>Korean</td>
<td>69.1%</td>
<td>27.1%</td>
<td>45.2%</td>
<td>877</td>
</tr>
<tr>
<td>Farsi</td>
<td>78.6%</td>
<td>31.4%</td>
<td>55.7%</td>
<td>688</td>
</tr>
<tr>
<td>Arabic</td>
<td>68.9%</td>
<td>16.3%</td>
<td>42.5%</td>
<td>631</td>
</tr>
<tr>
<td>Chinese</td>
<td>66.0%</td>
<td>35.6%</td>
<td>45.4%</td>
<td>694</td>
</tr>
<tr>
<td>Other</td>
<td>79.2%</td>
<td>26.8%</td>
<td>59.9%</td>
<td>384</td>
</tr>
</tbody>
</table>

**Age Category:**

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Doctor gave referral</th>
<th>Doctor helped schedule the appointment</th>
<th>Important for health</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>71.1%</td>
<td>28.4%</td>
<td>53.8%</td>
<td>394</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>67.7%</td>
<td>25.7%</td>
<td>52.6%</td>
<td>1,172</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>71.5%</td>
<td>25.2%</td>
<td>54.5%</td>
<td>2,328</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>75.7%</td>
<td>31.3%</td>
<td>51.7%</td>
<td>1,646</td>
</tr>
</tbody>
</table>

4 Members were allowed to choose multiple answers; thus, the total does not equal 100%.
## Region:

<table>
<thead>
<tr>
<th>CalOptima Language</th>
<th>Doctor gave referral %</th>
<th>Doctor helped schedule the appointment %</th>
<th>Important for health %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>69.3%</td>
<td>27.7%</td>
<td>50.6%</td>
<td>1,857</td>
</tr>
<tr>
<td>South</td>
<td>74.3%</td>
<td>28.3%</td>
<td>52.9%</td>
<td>1,453</td>
</tr>
<tr>
<td>Central</td>
<td>72.6%</td>
<td>26.6%</td>
<td>55.5%</td>
<td>2,216</td>
</tr>
</tbody>
</table>
## CalOptima Member Survey Results: *Unweighted Estimates by Language, Region and Age*

### Exhibit 7. Reasons why members don’t make an appointment to see specialist\(^5\)

#### CalOptima Language:

<table>
<thead>
<tr>
<th>CalOptima Language</th>
<th>Too far away</th>
<th>No transportation</th>
<th>Appointments not at times that work with schedule</th>
<th>Takes too long to get an appointment</th>
<th>Didn’t think needed to go</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>19.5%</td>
<td>8.0%</td>
<td>20.4%</td>
<td>27.0%</td>
<td>41.1%</td>
<td>548</td>
</tr>
<tr>
<td>Spanish</td>
<td>7.9%</td>
<td>5.5%</td>
<td>12.0%</td>
<td>20.2%</td>
<td>46.4%</td>
<td>560</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>11.3%</td>
<td>9.3%</td>
<td>37.8%</td>
<td>30.7%</td>
<td>33.4%</td>
<td>724</td>
</tr>
<tr>
<td>Korean</td>
<td>14.2%</td>
<td>12.5%</td>
<td>32.6%</td>
<td>41.5%</td>
<td>27.6%</td>
<td>696</td>
</tr>
<tr>
<td>Farsi</td>
<td>13.9%</td>
<td>14.3%</td>
<td>15.2%</td>
<td>37.6%</td>
<td>24.5%</td>
<td>474</td>
</tr>
<tr>
<td>Arabic</td>
<td>9.9%</td>
<td>6.9%</td>
<td>21.5%</td>
<td>47.1%</td>
<td>25.6%</td>
<td>577</td>
</tr>
<tr>
<td>Chinese</td>
<td>11.9%</td>
<td>14.6%</td>
<td>17.6%</td>
<td>25.4%</td>
<td>42.6%</td>
<td>556</td>
</tr>
<tr>
<td>Other</td>
<td>15.6%</td>
<td>12.6%</td>
<td>16.5%</td>
<td>27.2%</td>
<td>39.2%</td>
<td>334</td>
</tr>
</tbody>
</table>

#### Age Category:

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Too far away</th>
<th>No transportation</th>
<th>Appointments not at times that work with schedule</th>
<th>Takes too long to get an appointment</th>
<th>Didn’t think needed to go</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>10.8%</td>
<td>8.1%</td>
<td>22.8%</td>
<td>33.5%</td>
<td>41.0%</td>
<td>334</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>12.1%</td>
<td>7.9%</td>
<td>27.2%</td>
<td>32.1%</td>
<td>35.9%</td>
<td>1,019</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>13.7%</td>
<td>9.8%</td>
<td>24.9%</td>
<td>35.5%</td>
<td>31.6%</td>
<td>1,953</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>12.6%</td>
<td>13.8%</td>
<td>16.3%</td>
<td>27.6%</td>
<td>37.0%</td>
<td>1,163</td>
</tr>
</tbody>
</table>

\(^5\)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:

<table>
<thead>
<tr>
<th>Region</th>
<th>Too far away</th>
<th>No transportation</th>
<th>Appointments not at times that work with schedule</th>
<th>Takes too long to get an appointment</th>
<th>Didn’t think needed to go</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>14.0%</td>
<td>11.3%</td>
<td>24.8%</td>
<td>35.9%</td>
<td>31.1%</td>
<td>1,567</td>
</tr>
<tr>
<td>South</td>
<td>13.6%</td>
<td>11.3%</td>
<td>17.5%</td>
<td>33.6%</td>
<td>35.9%</td>
<td>1,097</td>
</tr>
<tr>
<td>Central</td>
<td>11.4%</td>
<td>8.8%</td>
<td>24.9%</td>
<td>28.9%</td>
<td>37.2%</td>
<td>1,792</td>
</tr>
</tbody>
</table>
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:

- English (n=569): 12.8%
- Spanish (n=607): 7.9%
- Vietnamese (n=814): 10.1%
- Korean (n=576): 7.8%
- Farsi (n=476): 12.0%
- Arabic (n=508): 5.9%
- Chinese (n=454): 7.0%
- Other (n=354): 23.7%

Age Category:

- 0-5 (n=322): 5.0%
- 6-18 (n=939): 4.4%
- 19-64 (n=1,842): 11.3%
- 65+ (n=1,255): 14.8%

Region:

- North (n=1,437): 9.3%
- South (n=1,041): 10.6%
- Central (n=1,868): 11.1%
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

CalOptima Language:

Need to see a mental health specialist (n=5,723) | Saw a mental health specialist (n=5,716)
---|---
18.3% | 17.1%
5.6% | 5.6%
8.3% | 14.2%
11.3% | 12.9%
18.1% | 45.7%
4.6% | 4.6%
5.7% | 6.7%
13.3% | 14.9%

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.
CalOptima Member Survey Results: Unweighted Estimates by Language, Region and Age

Age Category:

Need to see a mental health specialist (n=5,713)

- 0-5 (Children): 5.1%
- 6-18 (Children): 7.2%
- 19-64 (Adults/MCE): 13.0%
- 65+ (Older Adults): 10.4%

Saw a mental health specialist (n=5,696)

- 0-5 (Children): 5.6%
- 6-18 (Children): 7.9%
- 19-64 (Adults/MCE): 16.7%
- 65+ (Older Adults): 21.0%

Region:

Need to see a mental health specialist (n=5,713)

- North: 9.2%
- South: 12.4%
- Central: 10.2%

Saw a mental health specialist (n=5,696)

- North: 10.9%
- South: 23.9%
- Central: 13.3%
Exhibit 10. Percent of members who needed to see a mental health specialist but didn’t see a mental health specialist

CalOptima Language:

<table>
<thead>
<tr>
<th>Language</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>English (n=119)</td>
<td>22.7%</td>
</tr>
<tr>
<td>Spanish (n=39)</td>
<td>33.3%</td>
</tr>
<tr>
<td>Vietnamese (n=78)</td>
<td>12.8%</td>
</tr>
<tr>
<td>Korean (n=104)</td>
<td>35.6%</td>
</tr>
<tr>
<td>Farsi (n=128)</td>
<td>34.4%</td>
</tr>
<tr>
<td>Arabic (n=29)</td>
<td>34.5%</td>
</tr>
<tr>
<td>Chinese (n=39)</td>
<td>15.4%</td>
</tr>
<tr>
<td>Other (n=52)</td>
<td>7.7%</td>
</tr>
</tbody>
</table>

Age Category:

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children) (n=21)</td>
<td>47.6%</td>
</tr>
<tr>
<td>6-8 (Children) (n=89)</td>
<td>32.6%</td>
</tr>
<tr>
<td>19-64 (Adults/MCE) (n=312)</td>
<td>25.0%</td>
</tr>
<tr>
<td>65+ (Older Adults) (n=166)</td>
<td>20.5%</td>
</tr>
</tbody>
</table>

Region:

<table>
<thead>
<tr>
<th>Region</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>North (n=178)</td>
<td>31.3%</td>
</tr>
<tr>
<td>South (n=182)</td>
<td>28.6%</td>
</tr>
<tr>
<td>Central (n=229)</td>
<td>18.8%</td>
</tr>
</tbody>
</table>
Exhibit 11. Reasons why members didn’t see mental health specialist

Among those who indicated that they needed to see a mental health specialist but did not see one.

- Didn’t know who to call or ask for help (n=175): 39.8%
- Did not feel comfortable talking about personal problems (n=168): 37.5%
- Concerned about what happen if someone found out had a problem (n=176): 26.1%
- Hard time getting an appointment (n=173): 13.0%

---

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:**

- English (n=647): 81.3%
- Spanish (n=692): 88.3%
- Vietnamese (n=929): 75.8%
- Korean (n=931): 82.1%
- Farsi (n=699): 77.0%
- Arabic (n=637): 88.1%
- Chinese (n=704): 80.0%
- Other (n=386): 83.4%

**Age Category:**

- 0-5 (Children) (n=404): 81.9%
- 6-18 (Children) (n=1,214): 87.5%
- 19-64 (Adults/MCE) (n=2,373): 78.0%
- 65+ (Older Adults) (n=1,634): 82.3%

**Region:**

- North (n=1,914): 82.3%
- South (n=1,469): 82.0%
- Central (n=2,227): 80.6%
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:

January 2018
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Housing:**

**CalOptima language:**

![Bar chart showing unweighted estimates by language for housing](chart)

**Age Category:**

![Bar chart showing unweighted estimates by age category for housing](chart)

**Region:**

![Bar chart showing unweighted estimates by region for housing](chart)
Money to buy things need:

CalOptima language:

Age Category:

Region:
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Transportation:**

**CalOptima language:**

<table>
<thead>
<tr>
<th>Language</th>
<th>English (n=629)</th>
<th>Spanish (n=650)</th>
<th>Vietnamese (n=792)</th>
<th>Korean (n=805)</th>
<th>Farsi (n=631)</th>
<th>Arabic (n=589)</th>
<th>Chinese (n=668)</th>
<th>Other (n=376)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sometimes</td>
<td>18.8%</td>
<td>17.8%</td>
<td>20.2%</td>
<td>24.7%</td>
<td>27.7%</td>
<td>21.9%</td>
<td>20.5%</td>
<td>20.5%</td>
</tr>
<tr>
<td>Almost Always</td>
<td>10.5%</td>
<td>6.5%</td>
<td>17.4%</td>
<td>12.7%</td>
<td>17.6%</td>
<td>13.1%</td>
<td>16.0%</td>
<td>23.9%</td>
</tr>
</tbody>
</table>

**Age Category:**

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Sometimes</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children) (n=396)</td>
<td>18.3%</td>
<td>6.6%</td>
</tr>
<tr>
<td>6-18 (Children) (n=1,148)</td>
<td>16.9%</td>
<td>8.5%</td>
</tr>
<tr>
<td>19-64 (Adults/MCE) (n=2,189)</td>
<td>22.2%</td>
<td>12.4%</td>
</tr>
<tr>
<td>65+ (Older Adults) (n=1,436)</td>
<td>25.3%</td>
<td>23.6%</td>
</tr>
</tbody>
</table>

**Region:**

<table>
<thead>
<tr>
<th>Region</th>
<th>Sometimes</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>North (n=1,744)</td>
<td>34.6%</td>
<td>15.4%</td>
</tr>
<tr>
<td>South (n=1,371)</td>
<td>30.5%</td>
<td>13.5%</td>
</tr>
<tr>
<td>Central (n=2,012)</td>
<td>29.0%</td>
<td>17.1%</td>
</tr>
</tbody>
</table>
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Child care:**

**CalOptima language:**

<table>
<thead>
<tr>
<th>Language</th>
<th>Sometimes</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>English (n=605)</td>
<td>11.2%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Spanish (n=625)</td>
<td>8.2%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Vietnamese (n=731)</td>
<td>9.0%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Korean (n=729)</td>
<td>18.2%</td>
<td>6.3%</td>
</tr>
<tr>
<td>Farsi (n=5-2)</td>
<td>11.2%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Arabic (n=521)</td>
<td>12.5%</td>
<td>5.6%</td>
</tr>
<tr>
<td>Chinese (n=610)</td>
<td>12.0%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Other (n=321)</td>
<td>8.1%</td>
<td>5.3%</td>
</tr>
</tbody>
</table>

**Age Category:**

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Sometimes</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children) (n=396)</td>
<td>25.9%</td>
<td>10.1%</td>
</tr>
<tr>
<td>6-18 (Children) (n=1,148)</td>
<td>14.1%</td>
<td>6.1%</td>
</tr>
<tr>
<td>19-64 (Adults/MCE) (n=2,189)</td>
<td>11.1%</td>
<td>5.7%</td>
</tr>
<tr>
<td>65+ (Older Adults) (n=1,436)</td>
<td>5.3%</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

**Region:**

<table>
<thead>
<tr>
<th>Region</th>
<th>Sometimes</th>
<th>Almost Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>North (n=1,213)</td>
<td>13.1%</td>
<td>5.7%</td>
</tr>
<tr>
<td>South (n=1,876)</td>
<td>12.2%</td>
<td>5.2%</td>
</tr>
<tr>
<td>Central (n=1,826)</td>
<td>9.8%</td>
<td>4.9%</td>
</tr>
</tbody>
</table>
### Exhibit 14. Members who received public benefits

Percent of members who receive public benefits:

#### CalOptima language:

<table>
<thead>
<tr>
<th>Language</th>
<th>Percent of Members Receiving Public Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>English (n=575)</td>
<td>55.3%</td>
</tr>
<tr>
<td>Spanish (n=660)</td>
<td>54.4%</td>
</tr>
<tr>
<td>Vietnamese (n=791)</td>
<td>67.0%</td>
</tr>
<tr>
<td>Korean (n=839)</td>
<td>39.3%</td>
</tr>
<tr>
<td>Farsi (n=688)</td>
<td>47.7%</td>
</tr>
<tr>
<td>Arabic (n=572)</td>
<td>71.3%</td>
</tr>
<tr>
<td>Chinese (n=569)</td>
<td>37.3%</td>
</tr>
<tr>
<td>Other (n=348)</td>
<td>65.5%</td>
</tr>
</tbody>
</table>

#### Age Category:

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Percent of Members Receiving Public Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children) (n=378)</td>
<td>71.4%</td>
</tr>
<tr>
<td>6-18 (Children) (n=1,064)</td>
<td>46.8%</td>
</tr>
<tr>
<td>19-64 (Adults/MCE) (n=2,082)</td>
<td>51.2%</td>
</tr>
<tr>
<td>65+ (Older Adults) (n=1,518)</td>
<td>57.9%</td>
</tr>
</tbody>
</table>
CalOptima Member Survey Results: Unweighted Estimates by Language, Region and Age

Region:

- North (n=1,690): 55.2%
- South (n=1,351): 42.6%
- Central (n=1,988): 60.3%
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Type of public benefits that members receive**:  
**Receive CalFresh as a public benefit:**

**CalOptima language:**

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>62.9%</td>
<td>318</td>
</tr>
<tr>
<td>Spanish</td>
<td>65.5%</td>
<td>359</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>57.7%</td>
<td>530</td>
</tr>
<tr>
<td>Korean</td>
<td>42.4%</td>
<td>330</td>
</tr>
<tr>
<td>Farsi</td>
<td>50.6%</td>
<td>328</td>
</tr>
<tr>
<td>Arabic</td>
<td>74.5%</td>
<td>408</td>
</tr>
<tr>
<td>Chinese</td>
<td>25.9%</td>
<td>212</td>
</tr>
<tr>
<td>Other</td>
<td>29.4%</td>
<td>228</td>
</tr>
</tbody>
</table>

**Age Category:**

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Percentage</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>58.9%</td>
<td>270</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>78.3%</td>
<td>498</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>66.6%</td>
<td>1066</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>24.3%</td>
<td>879</td>
</tr>
</tbody>
</table>

**Region:**

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>54.1%</td>
<td>933</td>
</tr>
<tr>
<td>South</td>
<td>48.3%</td>
<td>576</td>
</tr>
<tr>
<td>Central</td>
<td>57.1%</td>
<td>1199</td>
</tr>
</tbody>
</table>

---

*Only reporting those who reported that they received at least one public benefit.*
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Receive TANF or CalWorks as a public benefit:**

**CalOptima language:**

<table>
<thead>
<tr>
<th>Language</th>
<th>Percent</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>6.6%</td>
<td>(n=318)</td>
</tr>
<tr>
<td>Spanish</td>
<td>6.7%</td>
<td>(n=359)</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>3.8%</td>
<td>(n=530)</td>
</tr>
<tr>
<td>Korean</td>
<td>3.0%</td>
<td>(n=330)</td>
</tr>
<tr>
<td>Farsi</td>
<td>7.9%</td>
<td>(n=328)</td>
</tr>
<tr>
<td>Arabic</td>
<td>8.3%</td>
<td>(n=408)</td>
</tr>
<tr>
<td>Chinese</td>
<td>8.5%</td>
<td>(n=212)</td>
</tr>
<tr>
<td>Other</td>
<td>5.3%</td>
<td>(n=228)</td>
</tr>
</tbody>
</table>

**Age Category:**

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Percent</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>6.3%</td>
<td>(n=270)</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>9.2%</td>
<td>(n=498)</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>6.6%</td>
<td>(n=1,066)</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>3.6%</td>
<td>(n=879)</td>
</tr>
</tbody>
</table>

**Region:**

<table>
<thead>
<tr>
<th>Region</th>
<th>Percent</th>
<th>Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>5.4%</td>
<td>(n=933)</td>
</tr>
<tr>
<td>South</td>
<td>6.1%</td>
<td>(n=576)</td>
</tr>
<tr>
<td>Central</td>
<td>6.7%</td>
<td>(n=1,199)</td>
</tr>
</tbody>
</table>
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Receive SSI or SSDI as a public benefit:**

**CalOptima language:**

<table>
<thead>
<tr>
<th>Language</th>
<th>Age Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>0-5 (Children)</td>
<td>28.3%</td>
</tr>
<tr>
<td>Spanish</td>
<td>0-5 (Children)</td>
<td>24.2%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>6-18 (Children)</td>
<td>44.9%</td>
</tr>
<tr>
<td>Korean</td>
<td>19-64 (Adults/MCE)</td>
<td>49.7%</td>
</tr>
<tr>
<td>Farsi</td>
<td>19-64 (Adults/MCE)</td>
<td>49.4%</td>
</tr>
<tr>
<td>Arabic</td>
<td>65+ (Older Adults)</td>
<td>24.0%</td>
</tr>
<tr>
<td>Chinese</td>
<td>65+ (Older Adults)</td>
<td>67.5%</td>
</tr>
<tr>
<td>Other</td>
<td>65+ (Older Adults)</td>
<td>71.9%</td>
</tr>
</tbody>
</table>

**Age Category:**

- 0-5 (Children): 81.0%
- 6-18 (Children): 4.4%
- 19-64 (Adults/MCE): 14.3%
- 65+ (Older Adults): 32.9%

**Region:**

- North: 41.4%
- South: 47.9%
- Central: 40.4%
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Receive WIC as a public benefit:**

**CalOptima language:**

![Language Bar Chart](Image)

**Age Category:**

- 0-5 (Children) (n=270): 72.6%
- 6-18 (Children) (n=498): 25.3%
- 19-64 (Adults/MCE) (n=1,066): 16.1%
- 65+ (Older Adults) (n=879): 2.4%

**Region:**

- North (n=933): 23.0%
- South (n=576): 13.5%
- Central (n=1,199): 18.5%
Exhibit 15. Personal activities participation:

CalOptima language:

<table>
<thead>
<tr>
<th>Care for a family member</th>
<th>English</th>
<th>Spanish</th>
<th>Vietnamese</th>
<th>Korean</th>
<th>Farsi</th>
<th>Arabic</th>
<th>Chinese</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Once a week</td>
<td>41.2%</td>
<td>19.1%</td>
<td>53.5%</td>
<td>35.4%</td>
<td>28.5%</td>
<td>47.2%</td>
<td>16.8%</td>
<td>32.3%</td>
</tr>
<tr>
<td>Once a month</td>
<td>6.4%</td>
<td>4.3%</td>
<td>3.3%</td>
<td>6.3%</td>
<td>3.2%</td>
<td>5.9%</td>
<td>3.8%</td>
<td>4.0%</td>
</tr>
<tr>
<td>Once in the last 6 months</td>
<td>6.4%</td>
<td>3.1%</td>
<td>4.3%</td>
<td>2.3%</td>
<td>3.4%</td>
<td>1.9%</td>
<td>3.1%</td>
<td>5.1%</td>
</tr>
<tr>
<td>Never</td>
<td>45.9%</td>
<td>73.5%</td>
<td>38.9%</td>
<td>56.0%</td>
<td>65.0%</td>
<td>45.0%</td>
<td>76.3%</td>
<td>58.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do fun activities with others</th>
<th>English</th>
<th>Spanish</th>
<th>Vietnamese</th>
<th>Korean</th>
<th>Farsi</th>
<th>Arabic</th>
<th>Chinese</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Once a week</td>
<td>63.3%</td>
<td>61.8%</td>
<td>49.6%</td>
<td>51.9%</td>
<td>39.5%</td>
<td>54.8%</td>
<td>45.4%</td>
<td>46.3%</td>
</tr>
<tr>
<td>Once a month</td>
<td>18.3%</td>
<td>13.0%</td>
<td>19.5%</td>
<td>22.7%</td>
<td>25.0%</td>
<td>20.6%</td>
<td>12.1%</td>
<td>21.6%</td>
</tr>
<tr>
<td>Once in the last 6 months</td>
<td>7.4%</td>
<td>4.0%</td>
<td>9.3%</td>
<td>7.3%</td>
<td>10.2%</td>
<td>6.7%</td>
<td>5.8%</td>
<td>11.6%</td>
</tr>
<tr>
<td>Never</td>
<td>11.0%</td>
<td>21.2%</td>
<td>21.7%</td>
<td>18.0%</td>
<td>25.3%</td>
<td>17.9%</td>
<td>36.7%</td>
<td>20.5%</td>
</tr>
</tbody>
</table>

n: Number of respondents
## CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

### Volunteer or Charity

<table>
<thead>
<tr>
<th>Language</th>
<th>Once a week</th>
<th>Once a month</th>
<th>Once in the last 6 months</th>
<th>Never</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>16.2%</td>
<td>15.8%</td>
<td>19.4%</td>
<td>48.6%</td>
<td>628</td>
</tr>
<tr>
<td>Spanish</td>
<td>15.9%</td>
<td>10.0%</td>
<td>9.9%</td>
<td>64.2%</td>
<td>628</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>15.8%</td>
<td>19.1%</td>
<td>26.7%</td>
<td>38.3%</td>
<td>752</td>
</tr>
<tr>
<td>Korean</td>
<td>21.0%</td>
<td>13.2%</td>
<td>15.6%</td>
<td>50.2%</td>
<td>825</td>
</tr>
<tr>
<td>Farsi</td>
<td>15.4%</td>
<td>13.8%</td>
<td>19.9%</td>
<td>50.9%</td>
<td>578</td>
</tr>
<tr>
<td>Arabic</td>
<td>23.5%</td>
<td>18.1%</td>
<td>14.3%</td>
<td>44.2%</td>
<td>575</td>
</tr>
<tr>
<td>Chinese</td>
<td>16.5%</td>
<td>11.9%</td>
<td>14.0%</td>
<td>57.7%</td>
<td>607</td>
</tr>
<tr>
<td>Other</td>
<td>9.9%</td>
<td>7.0%</td>
<td>12.1%</td>
<td>71.0%</td>
<td>355</td>
</tr>
</tbody>
</table>

### Physical Fitness

<table>
<thead>
<tr>
<th>Language</th>
<th>Once a week</th>
<th>Once a month</th>
<th>Once in the last 6 months</th>
<th>Never</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>68.7%</td>
<td>11.5%</td>
<td>6.0%</td>
<td>13.7%</td>
<td>633</td>
</tr>
<tr>
<td>Spanish</td>
<td>66.0%</td>
<td>8.7%</td>
<td>2.8%</td>
<td>22.5%</td>
<td>644</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>69.6%</td>
<td>6.6%</td>
<td>4.0%</td>
<td>19.8%</td>
<td>807</td>
</tr>
<tr>
<td>Korean</td>
<td>75.1%</td>
<td>10.1%</td>
<td>3.7%</td>
<td>11.2%</td>
<td>874</td>
</tr>
<tr>
<td>Farsi</td>
<td>68.9%</td>
<td>7.7%</td>
<td>5.6%</td>
<td>17.9%</td>
<td>627</td>
</tr>
<tr>
<td>Arabic</td>
<td>59.1%</td>
<td>11.8%</td>
<td>4.4%</td>
<td>24.7%</td>
<td>587</td>
</tr>
<tr>
<td>Chinese</td>
<td>71.9%</td>
<td>7.3%</td>
<td>3.8%</td>
<td>17.1%</td>
<td>661</td>
</tr>
<tr>
<td>Other</td>
<td>57.6%</td>
<td>10.2%</td>
<td>4.7%</td>
<td>27.5%</td>
<td>363</td>
</tr>
</tbody>
</table>
## CalOptima Member Survey Results: Unweighted Estimates by Language, Region and Age

### Get enough sleep

<table>
<thead>
<tr>
<th>Language</th>
<th>Once a week (%)</th>
<th>Once a month (%)</th>
<th>Once in the last 6 months (%)</th>
<th>Never (%)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>83.3%</td>
<td>6.0%</td>
<td>1.0%</td>
<td>9.6%</td>
<td>612</td>
</tr>
<tr>
<td>Spanish</td>
<td>85.1%</td>
<td>5.3%</td>
<td>1.0%</td>
<td>8.6%</td>
<td>590</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>78.0%</td>
<td>5.1%</td>
<td>1.5%</td>
<td>15.4%</td>
<td>740</td>
</tr>
<tr>
<td>Korean</td>
<td>88.2%</td>
<td>6.3%</td>
<td>1.0%</td>
<td>4.5%</td>
<td>842</td>
</tr>
<tr>
<td>Farsi</td>
<td>84.3%</td>
<td>4.8%</td>
<td>1.9%</td>
<td>8.9%</td>
<td>516</td>
</tr>
<tr>
<td>Arabic</td>
<td>83.2%</td>
<td>5.5%</td>
<td>1.5%</td>
<td>9.8%</td>
<td>531</td>
</tr>
<tr>
<td>Chinese</td>
<td>86.9%</td>
<td>5.2%</td>
<td>1.1%</td>
<td>6.7%</td>
<td>610</td>
</tr>
<tr>
<td>Other</td>
<td>80.3%</td>
<td>6.7%</td>
<td>3.5%</td>
<td>9.5%</td>
<td>315</td>
</tr>
</tbody>
</table>

### Have enough time for self

<table>
<thead>
<tr>
<th>Language</th>
<th>Once a week (%)</th>
<th>Once a month (%)</th>
<th>Once in the last 6 months (%)</th>
<th>Never (%)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>76.7%</td>
<td>12.2%</td>
<td>2.9%</td>
<td>8.2%</td>
<td>621</td>
</tr>
<tr>
<td>Spanish</td>
<td>80.1%</td>
<td>7.7%</td>
<td>2.9%</td>
<td>9.3%</td>
<td>613</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>78.2%</td>
<td>7.7%</td>
<td>1.9%</td>
<td>12.1%</td>
<td>725</td>
</tr>
<tr>
<td>Korean</td>
<td>73.6%</td>
<td>13.8%</td>
<td>4.6%</td>
<td>8.0%</td>
<td>864</td>
</tr>
<tr>
<td>Farsi</td>
<td>78.4%</td>
<td>9.9%</td>
<td>3.7%</td>
<td>8.0%</td>
<td>538</td>
</tr>
<tr>
<td>Arabic</td>
<td>74.5%</td>
<td>11.4%</td>
<td>2.7%</td>
<td>11.4%</td>
<td>553</td>
</tr>
<tr>
<td>Chinese</td>
<td>85.9%</td>
<td>5.3%</td>
<td>2.4%</td>
<td>6.3%</td>
<td>618</td>
</tr>
<tr>
<td>Other</td>
<td>82.9%</td>
<td>9.2%</td>
<td>3.5%</td>
<td>4.4%</td>
<td>315</td>
</tr>
<tr>
<td>Visit a casino or gamble on the internet</td>
<td>Once a week (%)</td>
<td>Once a month (%)</td>
<td>Once in the last 6 months (%)</td>
<td>Never (%)</td>
<td>n</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------</td>
<td>-----------------</td>
<td>-------------------------------</td>
<td>-----------</td>
<td>---</td>
</tr>
<tr>
<td>English</td>
<td>0.8%</td>
<td>1.1%</td>
<td>6.2%</td>
<td>91.9%</td>
<td>632</td>
</tr>
<tr>
<td>Spanish</td>
<td>0.2%</td>
<td>0.3%</td>
<td>2.5%</td>
<td>97.1%</td>
<td>651</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>2.6%</td>
<td>0.6%</td>
<td>3.1%</td>
<td>93.7%</td>
<td>772</td>
</tr>
<tr>
<td>Korean</td>
<td>0.8%</td>
<td>0.8%</td>
<td>6.5%</td>
<td>91.8%</td>
<td>846</td>
</tr>
<tr>
<td>Farsi</td>
<td>1.3%</td>
<td>1.0%</td>
<td>2.9%</td>
<td>94.8%</td>
<td>594</td>
</tr>
<tr>
<td>Arabic</td>
<td>5.0%</td>
<td>2.4%</td>
<td>1.0%</td>
<td>91.6%</td>
<td>582</td>
</tr>
<tr>
<td>Chinese</td>
<td>7.5%</td>
<td>2.3%</td>
<td>3.3%</td>
<td>86.8%</td>
<td>598</td>
</tr>
<tr>
<td>Other</td>
<td>2.2%</td>
<td>2.0%</td>
<td>8.1%</td>
<td>87.7%</td>
<td>358</td>
</tr>
</tbody>
</table>
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Age Category:**

| Age Category                  | Care for a family member | | |  |  |  |  |  |  |
|-------------------------------|--------------------------|--|--|--|--|--|--|---|
|                               | **%**  | **%**  | **%**  | **%**  | **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 | | | | |

| Age Category                  | Do fun activities with others | | |  |  |  |  |  |  |
|-------------------------------|-------------------------------|--|--|--|--|--|--|---|
|                               | **%**  | **%**  | **%**  | **%**  | **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 | | | | |

| Age Category                  | Volunteer or charity | | |  |  |  |  |  |  |
|-------------------------------|-----------------------|--|--|--|--|--|--|---|
|                               | **%**  | **%**  | **%**  | **%**  | **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 | | | | |
### CalOptima Member Survey Results: Unweighted Estimates by Language, Region and Age

#### Physical Fitness

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Once a Week (%)</th>
<th>Once a Month (%)</th>
<th>Once in the Last 6 Months (%)</th>
<th>Never (%)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>69.2%</td>
<td>7.0%</td>
<td>1.9%</td>
<td>21.9%</td>
<td>370</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>77.9%</td>
<td>8.4%</td>
<td>3.2%</td>
<td>10.5%</td>
<td>1,148</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>62.2%</td>
<td>12.6%</td>
<td>5.7%</td>
<td>19.5%</td>
<td>2,211</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>69.3%</td>
<td>4.9%</td>
<td>3.6%</td>
<td>22.2%</td>
<td>1,467</td>
</tr>
</tbody>
</table>

#### Get Enough Sleep

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Once a Week (%)</th>
<th>Once a Month (%)</th>
<th>Once in the Last 6 Months (%)</th>
<th>Never (%)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>89.8%</td>
<td>3.6%</td>
<td>0.6%</td>
<td>6.1%</td>
<td>362</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>90.2%</td>
<td>4.5%</td>
<td>0.9%</td>
<td>4.3%</td>
<td>1,084</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>80.5%</td>
<td>6.7%</td>
<td>1.7%</td>
<td>11.0%</td>
<td>2,061</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>82.4%</td>
<td>5.2%</td>
<td>1.6%</td>
<td>10.8%</td>
<td>1,249</td>
</tr>
</tbody>
</table>

#### Have Enough Time for Self

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Once a Week (%)</th>
<th>Once a Month (%)</th>
<th>Once in the Last 6 Months (%)</th>
<th>Never (%)</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>79.0%</td>
<td>6.4%</td>
<td>3.6%</td>
<td>11.0%</td>
<td>362</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>83.2%</td>
<td>7.7%</td>
<td>2.4%</td>
<td>6.7%</td>
<td>1,110</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>70.7%</td>
<td>14.3%</td>
<td>4.3%</td>
<td>10.8%</td>
<td>2,105</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>86.5%</td>
<td>5.3%</td>
<td>1.7%</td>
<td>6.5%</td>
<td>1,270</td>
</tr>
</tbody>
</table>
## CalOptima Member Survey Results: Unweighted Estimates by Language, Region and Age

<table>
<thead>
<tr>
<th>Visit a casino or gamble on the internet</th>
<th>Once a week</th>
<th>Once a month</th>
<th>Once in the last 6 months</th>
<th>Never</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>3.0%</td>
<td>0.5%</td>
<td>1.6%</td>
<td>94.8%</td>
<td>368</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>2.3%</td>
<td>0.6%</td>
<td>1.8%</td>
<td>95.3%</td>
<td>1,134</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>1.9%</td>
<td>1.0%</td>
<td>5.4%</td>
<td>91.7%</td>
<td>2,171</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>3.2%</td>
<td>2.3%</td>
<td>4.6%</td>
<td>89.9%</td>
<td>1,360</td>
</tr>
</tbody>
</table>
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Region:**

<table>
<thead>
<tr>
<th>Care for a family member</th>
<th>Once a week %</th>
<th>Once a month %</th>
<th>Once in the last 6 months %</th>
<th>Never %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>35.3%</td>
<td>5.4%</td>
<td>3.7%</td>
<td>55.6%</td>
<td>1,639</td>
</tr>
<tr>
<td>South</td>
<td>28.8%</td>
<td>4.2%</td>
<td>4.0%</td>
<td>62.9%</td>
<td>1,252</td>
</tr>
<tr>
<td>Central</td>
<td>38.8%</td>
<td>4.4%</td>
<td>3.4%</td>
<td>53.4%</td>
<td>1,910</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Do fun activities with others</th>
<th>Once a week %</th>
<th>Once a month %</th>
<th>Once in the last 6 months %</th>
<th>Never %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>51.8%</td>
<td>20.1%</td>
<td>8.0%</td>
<td>20.0%</td>
<td>1,757</td>
</tr>
<tr>
<td>South</td>
<td>47.7%</td>
<td>21.1%</td>
<td>8.0%</td>
<td>23.2%</td>
<td>1,345</td>
</tr>
<tr>
<td>Central</td>
<td>55.0%</td>
<td>16.6%</td>
<td>6.9%</td>
<td>21.5%</td>
<td>1,989</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Volunteer or charity</th>
<th>Once a week %</th>
<th>Once a month %</th>
<th>Once in the last 6 months %</th>
<th>Never %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>17.7%</td>
<td>13.8%</td>
<td>16.0%</td>
<td>52.5%</td>
<td>1,702</td>
</tr>
<tr>
<td>South</td>
<td>16.8%</td>
<td>13.2%</td>
<td>16.8%</td>
<td>53.3%</td>
<td>1,307</td>
</tr>
<tr>
<td>Central</td>
<td>17.1%</td>
<td>14.9%</td>
<td>17.9%</td>
<td>50.1%</td>
<td>1,927</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical fitness</th>
<th>Once a week %</th>
<th>Once a month %</th>
<th>Once in the last 6 months %</th>
<th>Never %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>67.4%</td>
<td>10.2%</td>
<td>4.9%</td>
<td>17.5%</td>
<td>1,780</td>
</tr>
<tr>
<td>South</td>
<td>69.4%</td>
<td>8.8%</td>
<td>4.4%</td>
<td>17.4%</td>
<td>1,387</td>
</tr>
<tr>
<td>Central</td>
<td>67.9%</td>
<td>8.3%</td>
<td>3.7%</td>
<td>20.1%</td>
<td>2,017</td>
</tr>
</tbody>
</table>
## CalOptima Member Survey Results: Unweighted Estimates by Language, Region and Age

### Get enough sleep

<table>
<thead>
<tr>
<th></th>
<th>Once a week</th>
<th>Once a month</th>
<th>Once in the last 6 months</th>
<th>Never</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>86.8%</td>
<td>4.7%</td>
<td>0.8%</td>
<td>7.7%</td>
<td>1,668</td>
</tr>
<tr>
<td>South</td>
<td>86.0%</td>
<td>5.3%</td>
<td>1.8%</td>
<td>6.9%</td>
<td>1,230</td>
</tr>
<tr>
<td>Central</td>
<td>79.9%</td>
<td>6.6%</td>
<td>1.7%</td>
<td>11.8%</td>
<td>1,848</td>
</tr>
</tbody>
</table>

### Have enough time for self

<table>
<thead>
<tr>
<th></th>
<th>Once a week</th>
<th>Once a month</th>
<th>Once in the last 6 months</th>
<th>Never</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>76.2%</td>
<td>10.9%</td>
<td>3.8%</td>
<td>9.1%</td>
<td>1,694</td>
</tr>
<tr>
<td>South</td>
<td>81.0%</td>
<td>9.2%</td>
<td>3.3%</td>
<td>6.5%</td>
<td>1,263</td>
</tr>
<tr>
<td>Central</td>
<td>78.5%</td>
<td>9.2%</td>
<td>2.3%</td>
<td>9.9%</td>
<td>1,880</td>
</tr>
</tbody>
</table>

### Visit a casino or gamble on the internet

<table>
<thead>
<tr>
<th></th>
<th>Once a week</th>
<th>Once a month</th>
<th>Once in the last 6 months</th>
<th>Never</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>1.5%</td>
<td>0.9%</td>
<td>4.5%</td>
<td>93.2%</td>
<td>1,726</td>
</tr>
<tr>
<td>South</td>
<td>4.0%</td>
<td>1.1%</td>
<td>3.7%</td>
<td>91.3%</td>
<td>1,327</td>
</tr>
<tr>
<td>Central</td>
<td>2.2%</td>
<td>1.7%</td>
<td>4.0%</td>
<td>92.1%</td>
<td>1,969</td>
</tr>
</tbody>
</table>
Exhibit 16.   Feelings towards community and home environment:

Feeling lonely and isolated:

**CalOptima language:**

<table>
<thead>
<tr>
<th>Language</th>
<th>Agree</th>
<th>Disagree</th>
<th>Does not apply to me</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>13.5%</td>
<td>56.0%</td>
<td>26.0%</td>
<td>4.4%</td>
</tr>
<tr>
<td>Spanish</td>
<td>4.1%</td>
<td>35.8%</td>
<td>56.5%</td>
<td>3.5%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>3.6%</td>
<td>66.6%</td>
<td>15.6%</td>
<td>14.1%</td>
</tr>
<tr>
<td>Korean</td>
<td>12.2%</td>
<td>46.0%</td>
<td>35.8%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Farsi</td>
<td>18.2%</td>
<td>51.0%</td>
<td>15.9%</td>
<td>14.8%</td>
</tr>
<tr>
<td>Arabic</td>
<td>9.3%</td>
<td>33.1%</td>
<td>51.5%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Chinese</td>
<td>7.1%</td>
<td>58.5%</td>
<td>26.5%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Other</td>
<td>10.1%</td>
<td>48.1%</td>
<td>35.7%</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

**Age Category:**

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Agree</th>
<th>Disagree</th>
<th>Does not apply to me</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children) (n=374)</td>
<td>3.2%</td>
<td>48.7%</td>
<td>42.5%</td>
<td>5.6%</td>
</tr>
<tr>
<td>6-18 (Children) (n=1,136)</td>
<td>4.6%</td>
<td>52.9%</td>
<td>37.9%</td>
<td>4.7%</td>
</tr>
<tr>
<td>19-64 (Adults/MCE) (n=2,231)</td>
<td>12.1%</td>
<td>50.7%</td>
<td>27.3%</td>
<td>9.8%</td>
</tr>
<tr>
<td>65+ (Older Adults) (n=1,487)</td>
<td>11.4%</td>
<td>46.9%</td>
<td>33.0%</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

**Region:**

<table>
<thead>
<tr>
<th>Region</th>
<th>Agree</th>
<th>Disagree</th>
<th>Does not apply to me</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>North (n=1,810)</td>
<td>9.9%</td>
<td>46.7%</td>
<td>36.5%</td>
<td>7.0%</td>
</tr>
<tr>
<td>South (n=1,382)</td>
<td>12.2%</td>
<td>52.5%</td>
<td>26.8%</td>
<td>8.5%</td>
</tr>
<tr>
<td>Central (n=2,022)</td>
<td>7.6%</td>
<td>51.2%</td>
<td>32.5%</td>
<td>8.8%</td>
</tr>
</tbody>
</table>
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Feel not treated equally because of ethnic and cultural backgrounds:**

**CalOptima language:**

<table>
<thead>
<tr>
<th>Language</th>
<th>Agree</th>
<th>Disagree</th>
<th>Does not apply to me</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>English (n=627)</td>
<td>7.7%</td>
<td>59.5%</td>
<td>27.9%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Spanish (n=642)</td>
<td>5.9%</td>
<td>36.4%</td>
<td>52.2%</td>
<td>5.5%</td>
</tr>
<tr>
<td>Vietnamese (n=786)</td>
<td>3.7%</td>
<td>67.2%</td>
<td>13.6%</td>
<td>15.5%</td>
</tr>
<tr>
<td>Korean (n=890)</td>
<td>17.5%</td>
<td>43.3%</td>
<td>26.4%</td>
<td>12.8%</td>
</tr>
<tr>
<td>Farsi (n=614)</td>
<td>7.8%</td>
<td>66.1%</td>
<td>14.3%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Arabic (n=586)</td>
<td>3.4%</td>
<td>39.1%</td>
<td>51.4%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Chinese (n=663)</td>
<td>7.5%</td>
<td>56.4%</td>
<td>22.6%</td>
<td>13.4%</td>
</tr>
<tr>
<td>Other (n=376)</td>
<td>6.4%</td>
<td>49.7%</td>
<td>36.4%</td>
<td>7.4%</td>
</tr>
</tbody>
</table>

**Age Category:**

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Agree</th>
<th>Disagree</th>
<th>Does not apply to me</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children) (n=379)</td>
<td>6.9%</td>
<td>47.8%</td>
<td>39.6%</td>
<td>5.8%</td>
</tr>
<tr>
<td>6-18 (Children) (n=1,131)</td>
<td>7.1%</td>
<td>52.6%</td>
<td>33.2%</td>
<td>7.1%</td>
</tr>
<tr>
<td>19-64 (Adults/MCE) (n=2,220)</td>
<td>10.5%</td>
<td>52.8%</td>
<td>25.2%</td>
<td>11.5%</td>
</tr>
<tr>
<td>65+ (Older Adults) (n=1,454)</td>
<td>5.1%</td>
<td>52.8%</td>
<td>30.4%</td>
<td>11.7%</td>
</tr>
</tbody>
</table>

**Region:**

<table>
<thead>
<tr>
<th>Region</th>
<th>Agree</th>
<th>Disagree</th>
<th>Does not apply to me</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>North (n=1,802)</td>
<td>9.9%</td>
<td>46.6%</td>
<td>33.4%</td>
<td>10.2%</td>
</tr>
<tr>
<td>South (n=1,366)</td>
<td>7.8%</td>
<td>58.8%</td>
<td>24.7%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Central (n=2,003)</td>
<td>6.3%</td>
<td>53.3%</td>
<td>29.3%</td>
<td>11.1%</td>
</tr>
</tbody>
</table>
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Feel child respects them as a parent**:  

**CalOptima language:**

<table>
<thead>
<tr>
<th>Language</th>
<th>Agree (n=417)</th>
<th>Disagree (n=249)</th>
<th>Does not apply to me (n=684)</th>
<th>Don't know (n=510)</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>46.0%</td>
<td>6.5%</td>
<td>44.4%</td>
<td>3.1%</td>
</tr>
<tr>
<td>Spanish</td>
<td>63.9%</td>
<td>6.0%</td>
<td>27.3%</td>
<td>2.8%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>78.4%</td>
<td>5.3%</td>
<td>9.6%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Korean</td>
<td>71.3%</td>
<td>5.1%</td>
<td>12.9%</td>
<td>10.8%</td>
</tr>
<tr>
<td>Farsi</td>
<td>71.9%</td>
<td>11.3%</td>
<td>12.0%</td>
<td>4.7%</td>
</tr>
<tr>
<td>Arabic</td>
<td>67.5%</td>
<td>2.4%</td>
<td>28.2%</td>
<td>1.9%</td>
</tr>
<tr>
<td>Chinese</td>
<td>73.9%</td>
<td>8.0%</td>
<td>16.1%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Other</td>
<td>57.4%</td>
<td>3.9%</td>
<td>36.1%</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

**Age Category:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Agree (n=2,216)</th>
<th>Disagree (n=1,522)</th>
<th>Does not apply to me (n=1,431)</th>
<th>Don't know (n=1,056)</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>61.3%</td>
<td>6.7%</td>
<td>26.3%</td>
<td>5.8%</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>78.3%</td>
<td>5.7%</td>
<td>12.2%</td>
<td>3.9%</td>
</tr>
</tbody>
</table>

**Region:**

<table>
<thead>
<tr>
<th>Region</th>
<th>Agree (n=1,242)</th>
<th>Disagree (n=1,056)</th>
<th>Does not apply to me (n=1,431)</th>
<th>Don't know (n=1,056)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>66.7%</td>
<td>5.1%</td>
<td>22.7%</td>
<td>5.6%</td>
</tr>
<tr>
<td>South</td>
<td>68.0%</td>
<td>8.8%</td>
<td>19.8%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Central</td>
<td>69.6%</td>
<td>5.5%</td>
<td>19.2%</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

* Only reported those who are over 18 years old.
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Feel child’s attitudes and behavior conflict with cultural values**:  
**CalOptima language:**

<table>
<thead>
<tr>
<th>Language</th>
<th>Agree</th>
<th>Disagree</th>
<th>Does not apply to me</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>English (n=413)</td>
<td>7.0%</td>
<td>36.3%</td>
<td>53.0%</td>
<td>3.6%</td>
</tr>
<tr>
<td>Spanish (n=241)</td>
<td>11.6%</td>
<td>32.4%</td>
<td>51.5%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Vietnamese (n=620)</td>
<td>9.5%</td>
<td>62.7%</td>
<td>14.8%</td>
<td>12.9%</td>
</tr>
<tr>
<td>Korean (n=638)</td>
<td>23.0%</td>
<td>38.6%</td>
<td>29.5%</td>
<td>8.9%</td>
</tr>
<tr>
<td>Farsi (n=518)</td>
<td>15.6%</td>
<td>60.4%</td>
<td>15.3%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Arabic (n=368)</td>
<td>5.4%</td>
<td>41.6%</td>
<td>50.3%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Chinese (n=499)</td>
<td>15.2%</td>
<td>53.9%</td>
<td>22.2%</td>
<td>8.6%</td>
</tr>
<tr>
<td>Other (n=301)</td>
<td>7.0%</td>
<td>35.5%</td>
<td>51.8%</td>
<td>5.6%</td>
</tr>
</tbody>
</table>

**Age Category:**

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Agree</th>
<th>Disagree</th>
<th>Does not apply to me</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-64 (Adults/MCE) (n=2,162)</td>
<td>12.2%</td>
<td>43.4%</td>
<td>37.1%</td>
<td>7.3%</td>
</tr>
<tr>
<td>65+ (Older Adults) (n=1,436)</td>
<td>13.8%</td>
<td>53.4%</td>
<td>24.4%</td>
<td>8.4%</td>
</tr>
</tbody>
</table>

**Region:**

<table>
<thead>
<tr>
<th>Region</th>
<th>Agree</th>
<th>Disagree</th>
<th>Does not apply to me</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>North (n=1,201)</td>
<td>13.7%</td>
<td>41.2%</td>
<td>37.1%</td>
<td>8.1%</td>
</tr>
<tr>
<td>South (n=1,027)</td>
<td>13.3%</td>
<td>53.4%</td>
<td>27.3%</td>
<td>6.0%</td>
</tr>
<tr>
<td>Central (n=1,362)</td>
<td>11.6%</td>
<td>48.5%</td>
<td>31.3%</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

---

10 Only reported those who are over 18 years old.
Exhibit 17. Members who reported that they speak English “not well”:

CalOptima language:

<table>
<thead>
<tr>
<th>Language</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>7.8%</td>
</tr>
<tr>
<td>Spanish</td>
<td>39.5%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>65.4%</td>
</tr>
<tr>
<td>Korean</td>
<td>63.3%</td>
</tr>
<tr>
<td>Farsi</td>
<td>50.9%</td>
</tr>
<tr>
<td>Arabic</td>
<td>32.0%</td>
</tr>
<tr>
<td>Chinese</td>
<td>64.1%</td>
</tr>
<tr>
<td>Other</td>
<td>35.8%</td>
</tr>
</tbody>
</table>

Age Category:

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>34.3%</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>21.8%</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>49.1%</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>67.4%</td>
</tr>
</tbody>
</table>

Region:

<table>
<thead>
<tr>
<th>Region</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>46.5%</td>
</tr>
<tr>
<td>South</td>
<td>47.9%</td>
</tr>
<tr>
<td>Central</td>
<td>48.2%</td>
</tr>
</tbody>
</table>
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

Exhibit 18. **Employment status**\(^{11,12}\)

**CalOptima language:**

<table>
<thead>
<tr>
<th>CalOptima language</th>
<th>Employed %</th>
<th>Self-employed %</th>
<th>Homemaker %</th>
<th>Student %</th>
<th>Retired %</th>
<th>Out of work %</th>
<th>Unable to work %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>36.7%</td>
<td>9.8%</td>
<td>7.2%</td>
<td>9.4%</td>
<td>13.4%</td>
<td>15.8%</td>
<td>20.4%</td>
<td>417</td>
</tr>
<tr>
<td>Spanish</td>
<td>21.7%</td>
<td>7.8%</td>
<td>11.6%</td>
<td>4.7%</td>
<td>21.3%</td>
<td>17.1%</td>
<td>28.3%</td>
<td>258</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>32.1%</td>
<td>1.8%</td>
<td>12.1%</td>
<td>6.6%</td>
<td>24.4%</td>
<td>17.0%</td>
<td>20.0%</td>
<td>761</td>
</tr>
<tr>
<td>Korean</td>
<td>18.2%</td>
<td>11.6%</td>
<td>21.3%</td>
<td>6.9%</td>
<td>24.5%</td>
<td>10.0%</td>
<td>16.5%</td>
<td>638</td>
</tr>
<tr>
<td>Farsi</td>
<td>18.0%</td>
<td>4.4%</td>
<td>15.3%</td>
<td>7.6%</td>
<td>19.5%</td>
<td>26.5%</td>
<td>29.9%</td>
<td>616</td>
</tr>
<tr>
<td>Arabic</td>
<td>25.5%</td>
<td>4.2%</td>
<td>21.1%</td>
<td>9.4%</td>
<td>15.7%</td>
<td>11.9%</td>
<td>22.0%</td>
<td>427</td>
</tr>
<tr>
<td>Chinese</td>
<td>14.0%</td>
<td>3.8%</td>
<td>14.2%</td>
<td>4.9%</td>
<td>45.0%</td>
<td>6.8%</td>
<td>19.5%</td>
<td>529</td>
</tr>
<tr>
<td>Other</td>
<td>15.7%</td>
<td>3.4%</td>
<td>8.9%</td>
<td>3.7%</td>
<td>37.5%</td>
<td>10.2%</td>
<td>30.8%</td>
<td>325</td>
</tr>
</tbody>
</table>

**Age Category:**

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Employed %</th>
<th>Self-employed %</th>
<th>Homemaker %</th>
<th>Student %</th>
<th>Retired %</th>
<th>Out of work %</th>
<th>Unable to work %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>35.8%</td>
<td>8.3%</td>
<td>17.5%</td>
<td>10.9%</td>
<td>5.9%</td>
<td>17.6%</td>
<td>15.3%</td>
<td>2,370</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>4.1%</td>
<td>1.7%</td>
<td>10.1%</td>
<td>0.7%</td>
<td>53.7%</td>
<td>10.5%</td>
<td>33.3%</td>
<td>1,601</td>
</tr>
</tbody>
</table>

**Region:**

<table>
<thead>
<tr>
<th>Region</th>
<th>Employed %</th>
<th>Self-employed %</th>
<th>Homemaker %</th>
<th>Student %</th>
<th>Retired %</th>
<th>Out of work %</th>
<th>Unable to work %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>24.0%</td>
<td>6.7%</td>
<td>15.9%</td>
<td>6.7%</td>
<td>23.6%</td>
<td>12.7%</td>
<td>22.5%</td>
<td>1,269</td>
</tr>
<tr>
<td>South</td>
<td>17.3%</td>
<td>6.6%</td>
<td>16.7%</td>
<td>7.3%</td>
<td>26.6%</td>
<td>17.3%</td>
<td>22.1%</td>
<td>1,129</td>
</tr>
<tr>
<td>Central</td>
<td>26.1%</td>
<td>4.0%</td>
<td>11.7%</td>
<td>6.5%</td>
<td>25.6%</td>
<td>14.7%</td>
<td>23.2%</td>
<td>1,561</td>
</tr>
</tbody>
</table>

\(^{11}\) 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)\textsuperscript{13}

<table>
<thead>
<tr>
<th>Number of jobs members have</th>
<th>Number of hours that members work each week</th>
</tr>
</thead>
<tbody>
<tr>
<td>One, 85.7%</td>
<td>0-20 hours, 50.7%</td>
</tr>
<tr>
<td>Two or more, 14.3%</td>
<td>21-40 hours, 39.0%</td>
</tr>
<tr>
<td></td>
<td>More than 40 hours, 10.3%</td>
</tr>
</tbody>
</table>

\textsuperscript{13} Only reported those that indicated that they are “Employed” or “Self-employed” (n=1,802).
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Exhibit 20. Members’ living situation**

### Age Category:

<table>
<thead>
<tr>
<th>Category</th>
<th>Own or rent</th>
<th>Live with a friend or family member</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>73.2%</td>
<td>22.9%</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>75.0%</td>
<td>20.3%</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>68.2%</td>
<td>26.4%</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>53.0%</td>
<td>39.3%</td>
</tr>
</tbody>
</table>

### Region:

<table>
<thead>
<tr>
<th>Region</th>
<th>Own or rent</th>
<th>Live with a friend or family member</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>67.3%</td>
<td>28.3%</td>
</tr>
<tr>
<td>South</td>
<td>64.9%</td>
<td>31.2%</td>
</tr>
<tr>
<td>Central</td>
<td>64.7%</td>
<td>26.9%</td>
</tr>
</tbody>
</table>

---

14 Shelter, hotel or motel, homeless, and other are not shown due to low response rates.
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Exhibit 21. Marital status of members**\(^{15,16}\)

**CalOptima language:**

<table>
<thead>
<tr>
<th>Language</th>
<th>Married (%)</th>
<th>Single (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>English (n=417)</td>
<td>47.0%</td>
<td>24.9%</td>
</tr>
<tr>
<td>Spanish (n=271)</td>
<td>46.5%</td>
<td>27.7%</td>
</tr>
<tr>
<td>Vietnamese (n=750)</td>
<td>60.3%</td>
<td>20.3%</td>
</tr>
<tr>
<td>Korean (n=655)</td>
<td>65.0%</td>
<td>8.4%</td>
</tr>
<tr>
<td>Farsi (n=609)</td>
<td>62.1%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Arabic (n=426)</td>
<td>66.4%</td>
<td>13.1%</td>
</tr>
<tr>
<td>Chinese (n=539)</td>
<td>60.7%</td>
<td>12.6%</td>
</tr>
<tr>
<td>Other (n=332)</td>
<td>38.6%</td>
<td>32.5%</td>
</tr>
</tbody>
</table>

**Age Category:**

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Married (%)</th>
<th>Single (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-64 (Adults/MCE) (n=2,380)</td>
<td>54.0%</td>
<td>28.7%</td>
</tr>
<tr>
<td>65+ (Older Adults) (n=1,603)</td>
<td>57.9%</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

**Region:**

<table>
<thead>
<tr>
<th>Region</th>
<th>Married (%)</th>
<th>Single (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>North (n=1,287)</td>
<td>56.3%</td>
<td>17.9%</td>
</tr>
<tr>
<td>South (n=1,135)</td>
<td>57.3%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Central (n=1,565)</td>
<td>54.0%</td>
<td>23.8%</td>
</tr>
</tbody>
</table>

\(^{15}\) Living with a partner, Widowed, and Divorced or separated 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:

<table>
<thead>
<tr>
<th>Language</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>74.4%</td>
</tr>
<tr>
<td>Spanish</td>
<td>49.0%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>12.7%</td>
</tr>
<tr>
<td>Korean</td>
<td>14.4%</td>
</tr>
<tr>
<td>Farsi</td>
<td>1.8%</td>
</tr>
<tr>
<td>Arabic</td>
<td>9.5%</td>
</tr>
<tr>
<td>Chinese</td>
<td>13.3%</td>
</tr>
<tr>
<td>Other</td>
<td>29.1%</td>
</tr>
</tbody>
</table>

Age Category:

<table>
<thead>
<tr>
<th>Category</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>65.1%</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>50.8%</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>18.1%</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>2.6%</td>
</tr>
</tbody>
</table>

Region:

<table>
<thead>
<tr>
<th>Region</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>25.8%</td>
</tr>
<tr>
<td>South</td>
<td>16.2%</td>
</tr>
<tr>
<td>Central</td>
<td>27.5%</td>
</tr>
</tbody>
</table>
Exhibit 23. Length of time lived in the United States of those not born in the United States

CalOptima language:

<table>
<thead>
<tr>
<th>Language</th>
<th>Less than one year</th>
<th>Two-Five years</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>3.1%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Spanish</td>
<td>2.5%</td>
<td>2.9%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>3.6%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Korean</td>
<td>0.5%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Farsi</td>
<td>8.9%</td>
<td>35.7%</td>
</tr>
<tr>
<td>Arabic</td>
<td>14.3%</td>
<td>49.0%</td>
</tr>
<tr>
<td>Chinese</td>
<td>1.4%</td>
<td>24.7%</td>
</tr>
<tr>
<td>Other</td>
<td>3.4%</td>
<td>17.9%</td>
</tr>
</tbody>
</table>

Age Category:

<table>
<thead>
<tr>
<th>Age Category</th>
<th>Less than one year</th>
<th>Two-Five years</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>22.1%</td>
<td>11.5%</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>6.8%</td>
<td>37.2%</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>5.8%</td>
<td>23.2%</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>1.5%</td>
<td>13.4%</td>
</tr>
</tbody>
</table>

Region:

<table>
<thead>
<tr>
<th>Region</th>
<th>Less than one year</th>
<th>Two-Five years</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>2.4%</td>
<td>11.5%</td>
</tr>
<tr>
<td>South</td>
<td>5.2%</td>
<td>31.5%</td>
</tr>
<tr>
<td>Central</td>
<td>6.7%</td>
<td>17.3%</td>
</tr>
</tbody>
</table>
Health Behaviors

Exhibit 24. Percent of members who have not seen a dentist within the past 12 months

CalOptima language:

Age Category:
Region:

- North (n=1,912): 44.4%
- South (n=1,506): 41.3%
- Central (n=2,243): 38.7%
Exhibit 25. Reasons for not seeing dentist within the past 12 months\textsuperscript{17,18}

CalOptima Language:

<table>
<thead>
<tr>
<th>CalOptima Language</th>
<th>Cost</th>
<th>Don’t have/know dentist</th>
<th>No transportation</th>
<th>Don’t know</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>43.8%</td>
<td>28.3%</td>
<td>6.6%</td>
<td>8.1%</td>
<td>258</td>
</tr>
<tr>
<td>Spanish</td>
<td>39.5%</td>
<td>17.6%</td>
<td>4.9%</td>
<td>12.2%</td>
<td>205</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>26.6%</td>
<td>15.7%</td>
<td>5.0%</td>
<td>13.0%</td>
<td>338</td>
</tr>
<tr>
<td>Korean</td>
<td>64.2%</td>
<td>35.3%</td>
<td>4.1%</td>
<td>5.1%</td>
<td>391</td>
</tr>
<tr>
<td>Farsi</td>
<td>53.1%</td>
<td>23.8%</td>
<td>5.1%</td>
<td>8.1%</td>
<td>273</td>
</tr>
<tr>
<td>Arabic</td>
<td>62.9%</td>
<td>16.3%</td>
<td>1.8%</td>
<td>11.8%</td>
<td>221</td>
</tr>
<tr>
<td>Chinese</td>
<td>40.6%</td>
<td>21.1%</td>
<td>7.7%</td>
<td>14.1%</td>
<td>298</td>
</tr>
<tr>
<td>Other</td>
<td>33.1%</td>
<td>23.2%</td>
<td>5.5%</td>
<td>12.7%</td>
<td>181</td>
</tr>
</tbody>
</table>

Age Category:

<table>
<thead>
<tr>
<th>CalOptima Age Category</th>
<th>Cost</th>
<th>Don’t have/know dentist</th>
<th>No transportation</th>
<th>Don’t know</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 (Children)</td>
<td>19.5%</td>
<td>23.7%</td>
<td>3.4%</td>
<td>14.4%</td>
<td>118</td>
</tr>
<tr>
<td>6-18 (Children)</td>
<td>34.7%</td>
<td>25.6%</td>
<td>1.8%</td>
<td>15.1%</td>
<td>219</td>
</tr>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>52.7%</td>
<td>27.3%</td>
<td>4.1%</td>
<td>9.0%</td>
<td>1,062</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>19.5%</td>
<td>23.7%</td>
<td>3.4%</td>
<td>14.4%</td>
<td>766</td>
</tr>
</tbody>
</table>

\textsuperscript{17} Members were allowed to choose multiple answers; thus, the total does not equal 100%.

\textsuperscript{18} Only reported those who have not seen a dentist within the past 12 months.
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Region:**

<table>
<thead>
<tr>
<th>CalOptima Region</th>
<th>Cost</th>
<th>Don’t have/know dentist</th>
<th>No transportation</th>
<th>Don’t know</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>48.9%</td>
<td>22.3%</td>
<td>5.5%</td>
<td>9.9%</td>
<td>798</td>
</tr>
<tr>
<td>South</td>
<td>51.6%</td>
<td>28.2%</td>
<td>4.6%</td>
<td>9.4%</td>
<td>585</td>
</tr>
<tr>
<td>Central</td>
<td>39.2%</td>
<td>20.9%</td>
<td>5.2%</td>
<td>11.3%</td>
<td>776</td>
</tr>
</tbody>
</table>
CalOptima Member Survey Results: **Unweighted Estimates by Language, Region and Age**

**Exhibit 26. Days per week member had at least one drink of alcoholic beverage during the past 30 days** ¹⁹

**CalOptima language:**

<table>
<thead>
<tr>
<th>CalOptima Language</th>
<th>No drinks in past 30 days %</th>
<th>1-2 days per week %</th>
<th>3-4 days per week %</th>
<th>5-7 days per week %</th>
<th>Don't know %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>71.7%</td>
<td>19.6%</td>
<td>4.0%</td>
<td>2.0%</td>
<td>2.7%</td>
<td>403</td>
</tr>
<tr>
<td>Spanish</td>
<td>83.5%</td>
<td>10.4%</td>
<td>1.3%</td>
<td>0.9%</td>
<td>3.9%</td>
<td>230</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>81.3%</td>
<td>10.7%</td>
<td>1.9%</td>
<td>1.8%</td>
<td>4.3%</td>
<td>738</td>
</tr>
<tr>
<td>Korean</td>
<td>77.1%</td>
<td>15.5%</td>
<td>3.0%</td>
<td>1.5%</td>
<td>2.9%</td>
<td>593</td>
</tr>
<tr>
<td>Farsi</td>
<td>74.8%</td>
<td>19.3%</td>
<td>1.2%</td>
<td>0.2%</td>
<td>4.4%</td>
<td>497</td>
</tr>
<tr>
<td>Arabic</td>
<td>87.6%</td>
<td>4.5%</td>
<td>0.6%</td>
<td>0.8%</td>
<td>6.5%</td>
<td>355</td>
</tr>
<tr>
<td>Chinese</td>
<td>84.9%</td>
<td>8.0%</td>
<td>1.2%</td>
<td>0.6%</td>
<td>5.4%</td>
<td>503</td>
</tr>
<tr>
<td>Other</td>
<td>83.7%</td>
<td>7.7%</td>
<td>1.6%</td>
<td>1.3%</td>
<td>5.8%</td>
<td>312</td>
</tr>
</tbody>
</table>

**Age Category:**

<table>
<thead>
<tr>
<th>CalOptima Age Category</th>
<th>No drinks in past 30 days %</th>
<th>1-2 days per week %</th>
<th>3-4 days per week %</th>
<th>5-7 days per week %</th>
<th>Don't know %</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>19-64 (Adults/MCE)</td>
<td>78.7%</td>
<td>13.0%</td>
<td>2.3%</td>
<td>1.0%</td>
<td>4.9%</td>
<td>2,163</td>
</tr>
<tr>
<td>65+ (Older Adults)</td>
<td>82.2%</td>
<td>11.4%</td>
<td>1.4%</td>
<td>1.4%</td>
<td>3.5%</td>
<td>1,468</td>
</tr>
</tbody>
</table>

¹⁹ Only reported those who are 18 years or older.
### Region:

<table>
<thead>
<tr>
<th>CalOptima Region</th>
<th>No drinks in past 30 days</th>
<th>1-2 days per week</th>
<th>3-4 days per week</th>
<th>5-7 days per week</th>
<th>Don’t know</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>81.1%</td>
<td>11.9%</td>
<td>1.2%</td>
<td>1.5%</td>
<td>4.3%</td>
<td>1,156</td>
</tr>
<tr>
<td>South</td>
<td>79.5%</td>
<td>14.5%</td>
<td>1.8%</td>
<td>0.7%</td>
<td>3.5%</td>
<td>1,000</td>
</tr>
<tr>
<td>Central</td>
<td>79.7%</td>
<td>11.4%</td>
<td>2.5%</td>
<td>1.3%</td>
<td>5.1%</td>
<td>1,465</td>
</tr>
</tbody>
</table>
January 2018

CalOptima Member Survey Data Book: Weighted Population Estimates
Navigating the Healthcare System

Exhibit 27. Percent who report at least one person as their doctor (n=5,749)

- Yes, 82.6%
- No, 14.7%
- Don’t know, 2.6%

Exhibit 28. Where respondents go to see their doctor (n=5,743)

- Doctor's office: 69.2%
- Clinic/health center: 18.1%
- Other: 5.2%
- Urgent Care: 4.3%
- Emergency room: 2.3%
- Don't know: 0.6%
- Alternative medicine provider/herbalist: 0.4%
Exhibit 29. Reasons why members go somewhere other than their doctor when they need medical attention (n=4,657)

- Other: 40.2%
- It is easier for me to get to the emergency room or urgent care than my doctor's office: 25.6%
- It's hard to get an appointment with my doctor: 21.0%
- I don't have a doctor: 7.0%
- Don't know: 6.2%
Exhibit 30. When do members make an appointment to see doctor (n=5,764)²⁰

- When Sick: 77.0%
- Check-Up: 76.3%
- Specialist Needed: 46.1%
- Don’t Know: 1.0%
- Other: 3.8%

Exhibit 31. Reasons why members don’t make an appointment to see doctor (n=4,598)²¹

- Didn’t think necessary: 51.6%
- Scheduling Conflict: 28.8%
- Too long to get appointment: 27.8%
- No Doctor: 7.1%
- No way to get there: 6.8%
- No childcare available: 5.2%
- Don’t Know: 1.2%

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)\textsuperscript{22}

- Important for health: 61.4%
- Doctor helped schedule the appointment: 27.2%
- Doctor gave referral: 25.9%
- Easy to get office: 12.3%
- Doctor and specialist in the same location: 8.5%

Exhibit 33. Reasons why members don’t make an appointment to see a specialist (n=4,713)\textsuperscript{23}

- Didn’t think needed to go: 41.4%
- Takes too long to get an appointment: 26.3%
- Appointments not at times that work with schedule: 20.1%
- Too far away: 14.9%
- No transportation: 7.6%

\textsuperscript{22} Members were allowed to choose multiple answers; thus, the total does not equal 100%.
\textsuperscript{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)

- No, 83.1%
- Yes, 10.9%
- Don’t know, 6.0%
Social and Emotional Well-Being

Exhibit 35. Percent of members who indicated they needed to see a mental health specialist (n=5,723)

- Yes, needed to see a mental health specialist, 13.5%
- No, did not need to see a mental health specialist, 85.1%
- Don't Know, 1.4%

Exhibit 36. Percent of members who indicated they needed to see a mental health specialist and didn’t see one (n=771)

- Saw a mental health specialist, 73.3%
- Didn't see one, 24.8%
- Don't know, 1.9%
Exhibit 37. Reasons why members didn’t see mental health specialist

- Didn't know who to call or ask for help (n=175): 39.8%
- Did not feel comfortable talking about personal problems (n=168): 37.5%
- Concerned about what happen if someone found out had a problem (n=176): 26.1%
- Hard time getting an appointment (n=173): 13.0%

Exhibit 38. Percent of members who can share their worries with family members (n=5,670)

- Yes, 82.8%
- No, 11.4%
- Don't know, 5.8%

24 Among those who indicated that they needed to see a mental health specialist but did not see one.
Exhibit 39. Percent of members who needed help with basic needs in the past 6 months:

- Food for anyone in your household (n=5,456): 4.6% Sometimes, 10.5% Almost Always, 9.9% Sometimes, 22.5% Almost Always
- Transportation (n=5,389): 9.9% Sometimes, 18.9% Almost Always
- Money to buy things need (n=5,447): 12.2% Sometimes, 30.3% Almost Always
- Housing (n=5,353): 12.2% Sometimes, 11.8% Almost Always
- Child care (n=5,157): 9.9% Sometimes, 12.8% Almost Always
Exhibit 41. Percent of members who receive public benefits (n=5,117):

Yes, 55.7%

No, 44.3%

---

Exhibit 42. Type of public benefits that members receive (n=2,849)\textsuperscript{25}:

- CalFresh: 63.4%
- SSI or SSDI: 28.2%
- WIC: 28.1%
- TANF or CalWorks: 6.4%

\textsuperscript{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:**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Once a week</th>
<th>Once a month</th>
<th>Once in the last 6 months</th>
<th>Never</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care for a family member</td>
<td>36.2%</td>
<td>5.6%</td>
<td>5.1%</td>
<td>53.1%</td>
<td>5,209</td>
</tr>
<tr>
<td>Fun with others</td>
<td>61.9%</td>
<td>17.0%</td>
<td>6.6%</td>
<td>14.6%</td>
<td>5,396</td>
</tr>
<tr>
<td>Volunteer or Charity</td>
<td>16.4%</td>
<td>14.2%</td>
<td>17.3%</td>
<td>52.1%</td>
<td>5,288</td>
</tr>
<tr>
<td>Physical fitness</td>
<td>68.4%</td>
<td>10.2%</td>
<td>4.8%</td>
<td>16.7%</td>
<td>5,393</td>
</tr>
<tr>
<td>Attend religious centers</td>
<td>48.7%</td>
<td>11.1%</td>
<td>10.8%</td>
<td>29.4%</td>
<td>5,470</td>
</tr>
<tr>
<td>Get enough sleep</td>
<td>83.5%</td>
<td>5.8%</td>
<td>1.1%</td>
<td>9.6%</td>
<td>5,119</td>
</tr>
<tr>
<td>Enough time for self</td>
<td>77.4%</td>
<td>10.6%</td>
<td>3.1%</td>
<td>8.8%</td>
<td>5,209</td>
</tr>
<tr>
<td>Enough time for family</td>
<td>81.5%</td>
<td>8.5%</td>
<td>3.1%</td>
<td>6.9%</td>
<td>5,274</td>
</tr>
<tr>
<td>Gambling activities</td>
<td>0.9%</td>
<td>0.8%</td>
<td>4.8%</td>
<td>93.5%</td>
<td>5,378</td>
</tr>
</tbody>
</table>

**Exhibit 44. Feelings towards community and home enviroment\(^{26}\):**

<table>
<thead>
<tr>
<th>Feeling</th>
<th>Agree</th>
<th>Disagree</th>
<th>Does not apply to me</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lonely and isolated (n=5,399)</td>
<td>9.7%</td>
<td>51.2%</td>
<td>33.7%</td>
<td>5.4%</td>
</tr>
<tr>
<td>Not treated equally because of ethnic and cultural backgrounds (n=5,357)</td>
<td>7.0%</td>
<td>53.5%</td>
<td>33.4%</td>
<td>6.2%</td>
</tr>
<tr>
<td>Child respects parent (n=3,167)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child’s attitudes and behavior conflict with cultural values (n=3,087)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^{26}\) 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)

- Very well: 51.9%
- Well: 18.6%
- Not well: 23.6%
- Don't know: 5.8%
CalOptima Member Survey Results: Weighted Population Estimates

Exhibit 46. Employment status for members over 18 (n=3,244)\textsuperscript{27,28}

<table>
<thead>
<tr>
<th>Employment Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td>34.5%</td>
</tr>
<tr>
<td>Unable to work</td>
<td>21.3%</td>
</tr>
<tr>
<td>Out of work</td>
<td>16.6%</td>
</tr>
<tr>
<td>Homemaker</td>
<td>9.5%</td>
</tr>
<tr>
<td>Retired</td>
<td>13.9%</td>
</tr>
<tr>
<td>Student</td>
<td>8.6%</td>
</tr>
<tr>
<td>Self-employed</td>
<td>8.3%</td>
</tr>
</tbody>
</table>

Only reported those that indicated that they are “Employed” or “Self-employed” (n=1,802).

Exhibit 47. Number of jobs (n=1,523) and hours worked (n=1,756)\textsuperscript{29}

<table>
<thead>
<tr>
<th>Number of jobs members have</th>
<th>Number of hours that members work each week</th>
</tr>
</thead>
<tbody>
<tr>
<td>One, 85.7%</td>
<td>0-20 hours, 50.7%</td>
</tr>
<tr>
<td>Two or more, 14.3%</td>
<td>More than 40 hours, 10.3%</td>
</tr>
<tr>
<td></td>
<td>21-40 hours, 39.0%</td>
</tr>
</tbody>
</table>

Members were allowed to choose multiple answers; thus, the total does not equal 100%.

\textsuperscript{27} Only reported the members who are over 18 years old.

\textsuperscript{28} Only reported those that indicated that they are “Employed” or “Self-employed” (n=1,802).
CalOptima Member Survey Results: **Weighted Population Estimates**

**Exhibit 48.  Members’ living situation (n=5,590)**

- Own or rent: 59.8%
- Live with a friend, family member: 32.7%
- Other: 5.8%
- Homeless: 0.9%
- Shelter: 0.7%

Only reported those who are over 18 years old.

**Exhibit 49.  Marital status of members (n=3,271)**

- Single: 39.8%
- Married: 35.3%
- Divorced or separated: 12.7%
- Widowed: 7.5%
- Living with a partner: 4.4%

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)\(^3\)

---
\(^3\) Of those who were born outside of the U.S.
Health Behaviors

Exhibit 52. When members last saw a dentist (n=5,685)

- Within past 12 months, 61.8%
- More than 12 months, 38.2%

Exhibit 53. Reasons for not seeing dentist within the past 12 months (n=2,209)

- Cost: 41.0%
- Do not have/know a dentist: 24.9%
- Fear of dentist: 16.8%
- No time: 12.3%
- Don’t know: 9.6%
- No transportation: 6.1%

---

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)\textsuperscript{34}

\begin{center}
\begin{tikzpicture}

\begin{axis}[
    ybar,bar width=20pt, bar shift=0pt,xtick=data, x tick label style={align=center},
    xticklabels={No drinks in past 30 days, 1-2 days per week, 3-4 days per week, 5-7 days per week, Don't know},
    ymin=0,ymax=100
]

\addplot coordinates {(1,75.4) (2,16.4) (3,3.2) (4,1.6) (5,3.4)}; \node at (axis cs:1,90) {75.4\%};
\end{axis}
\end{tikzpicture}
\end{center}

\textsuperscript{34} Only reported those who are 18 years or older.
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.
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.
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
2018
HỘI CHỢ
TẾT MÂU TUẤT
KỶ NIỆM 1080 NĂM CHIẾN THẮNG BẠCH ĐĂNG GIANG
MILE SQUARE PARK
FEBRUARY 16-18, 2018

Bạch Đằng Giang
(938 - 2018)

VÀO CỬA MIỄN PHÍ
ĐẦU XE MIỄN PHÍ
XỔ SỐ MIỄN PHÍ LÃY HÈN ĐẦU NĂM
CA NHẠC - MƯA LÀN - ĐỢT PHÁO
FREE PICK UP AND DROP OFF POINTS

MỌI CHI TIẾT ĐẶT MUA GIẢN HÀNG, QUẢNG CÁO, BẢO TRỌ, XIN LIÊN LẠC:
(714) 962-8669  www.tetfestivalmilesquarepark.com
info@tetfestivalmilesquarepark.com
TET FESTIVAL

FEBRUARY 16-18, 2018

YEAR OF THE DOG
2018 SPONSORSHIP PROPOSAL

OC FAIR & EVENT CENTER, COSTA MESA, CA
DEAR PROSPECTIVE SPONSOR,

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
Sponsorship Director
thaochi.pham@uvsa.org
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

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
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.
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
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-CI (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
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 6' 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 — $4,000 (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 — $1,000
- Prize Donations — Varies

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UNION OF VIETNAMESE STUDENT ASSOCIATIONS SOUTHERN CALIFORNIA
12831 WESTERN AVE., UNIT B
GARDEN GROVE, CA 92841

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P.O. BOX 2069
WESTMINSTER, CA 92684

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CONTACT@UVSA.ORG

TEL
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WWW.UVSA.ORG | WWW.TETFESTIVAL.ORG

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Back to Agenda
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.
SPONSOR PLEDGE FORM

Organization: ____________________________________________

Contact Person: __________________________________ Phone: (   ) __________________________

Address: ____________________________________________________________

Fax: (   ) __________________________ Email: ________________________________

Sponsorship Levels:

☐ Title Sponsor $15,000 – As a Title Sponsor, your Organization will be offered a 10-Minute Speaking Role at the Event. Your Logo will be prominently featured on Event Advertising as “Title Sponsor”. You will also receive Verbal Recognition and be presented a Special Award from Supervisor Bartlett at the Summit; Full-Page advertising space in the Event Program; Premier Booth Location; Two Large Banners prominently displayed at the Summit; Product/Service Information in the Event Bag; Recognition about Title Sponsorship in the Supervisor’s Newsletter; and a Certificate of Recognition from Supervisor Bartlett.

☐ Diamond Sponsor $10,000 – As a Diamond Sponsor, your Organization will be offered a 5-Minute Speaking Role at the Event. Your Logo will be featured on Event Advertising as a “Diamond Sponsor”. You will receive Verbal Recognition and be presented a Special Award from Supervisor Bartlett at the Summit; Half-Page advertising in Event Program; One Large Banner displayed at Summit; Premium Booth Location; Product/Service Information in the Event Bag; Recognition about Diamond Sponsorship in the Supervisor’s Newsletter; and a Certificate of Recognition from Supervisor Bartlett.

☐ Platinum Sponsor $5,000 – As a Platinum Sponsor, your Organization will receive Verbal Recognition and a Special Award from Supervisor Bartlett at the Summit; Quarter-Page advertising in the Event Program; Preferred Booth Location; Product/Service Information in the Event Bag; Recognition about your Platinum Sponsorship in the Supervisor’s Newsletter; and a Certificate of Recognition from Supervisor Bartlett.

☐ Gold Sponsor $2,500 – As a Gold Sponsor, you will receive Verbal Recognition and a Special Award from Supervisor Bartlett at the Summit; Individual Booth Location; Special Recognition in the Event Program; and a Certificate of Recognition from Supervisor Bartlett.

☐ Silver Sponsor $1,000 – Silver Sponsors will receive Verbal Recognition from Supervisor Bartlett at the Summit; Special Recognition in the Event Program; Individual Booth Space; and a Certificate of Recognition from Supervisor Bartlett.

☐ Bronze Sponsor $500 – Recognition in the Event Program; Booth Space; Certificate of Recognition from Supervisor Bartlett.

☐ Non-Profit Sponsor $250 – Recognition in the Event Program; Booth Space; Certificate of Recognition from Supervisor Bartlett.

To ensure your Sponsorship Level is properly recognized on Event Advertising, return this form by March 23 with your tax-deductible check (Tax ID # 93-1163563) made payable to Age Well Senior Services and note “Senior Summit” in the memo line. You may also email your completed Sponsor Pledge Form and high resolution logo file to Beth Apodaca at bapodaca@myagewell.org. Please mail your sponsor check to:

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

Back to Agenda
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
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.
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  1/25/2018
Authorized Signature  Date
All firms were evaluated on a five point scale, 0-5.

**Townsend Public Affairs**

<table>
<thead>
<tr>
<th>Firm Presentation (25% of Overall Score)</th>
<th>Question 1 re: Medi-Cal (25%)</th>
<th>Question 2 re: Medicaid (25%)</th>
<th>Question 3 re: COHS (25%)</th>
<th>Total (Out of 5.0)</th>
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<td>4.25 x 0.25 = 1.0625</td>
<td>3.0 x 0.25 = 0.75</td>
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**Edelstein**

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<th>Total (Out of 5.0)</th>
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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

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<tr>
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<th>Technical Capabilities (20% of overall score)</th>
<th>Qualifications (25%)</th>
<th>Proposal (10%)</th>
<th>Pricing (20%)</th>
<th>COHS Experience (25%)</th>
<th>Total (Out of 5.0)</th>
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<td>4.25 x 0.1 = 0.43</td>
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Edelstein

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<th></th>
<th>Technical Capabilities (20% of overall score)</th>
<th>Qualifications (25%)</th>
<th>Proposal (10%)</th>
<th>Pricing (20%)</th>
<th>COHS Experience (25%)</th>
<th>Total (Out of 5.0)</th>
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<td>Average Score of Evaluation Committee</td>
<td>4.75 x 0.20 = .95</td>
<td>5.0 x 0.25 = 1.25</td>
<td>2.75 x 0.10 = 0.28</td>
<td>4.25 x 0.20 = 0.85</td>
<td>5.0 x 0.25 = 1.25</td>
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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.
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.
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).
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.
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.
Financial Summary
December 2017

Board of Directors Meeting
February 1, 2018

Greg Hamblin
Chief Financial Officer
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 members 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
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

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<thead>
<tr>
<th>Month-to-Date</th>
<th>Year-to-Date</th>
</tr>
</thead>
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<td>Actual</td>
<td>Budget</td>
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<td>63,796</td>
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<td>617</td>
<td>618</td>
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<tr>
<td>47,140</td>
<td>48,790</td>
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<td>324,940</td>
<td>329,355</td>
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<td>95,221</td>
<td>103,659</td>
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<tr>
<td>3,470</td>
<td>3,268</td>
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<td>240,355</td>
<td>236,702</td>
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<td><strong>774,646</strong></td>
<td><strong>786,194</strong></td>
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<td>15,223</td>
<td>15,558</td>
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<td>235</td>
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<td>1,372</td>
<td>1,363</td>
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<tr>
<td><strong>791,475</strong></td>
<td><strong>803,356</strong></td>
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</table>

CalOptima Total

---

[Back to Agenda]
## Financial Highlights: December 2017

<table>
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<tr>
<th>Month-to-Date</th>
<th>( \text{Actua} )</th>
<th>( \text{Budget} )</th>
<th>( \text{Variances} )</th>
<th>( % \text{ Variance} )</th>
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</thead>
<tbody>
<tr>
<td>Actual</td>
<td>791,476</td>
<td>803,356</td>
<td>(11,880)</td>
<td>(1.5%)</td>
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<tr>
<td>Budget</td>
<td>283,343,384</td>
<td>275,693,125</td>
<td>7,650,259</td>
<td>2.8%</td>
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<tr>
<td>Actual</td>
<td>264,819,397</td>
<td>266,593,714</td>
<td>1,774,317</td>
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<tr>
<td>Budget</td>
<td>9,888,144</td>
<td>12,531,002</td>
<td>2,662,858</td>
<td>21.3%</td>
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<tr>
<td>Total</td>
<td>8,655,843</td>
<td>(3,431,591)</td>
<td>12,087,434</td>
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<tr>
<td>Actual</td>
<td>1,753,228</td>
<td>231,157</td>
<td>1,522,071</td>
<td>658.5%</td>
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</table>

<table>
<thead>
<tr>
<th>Year-to-Date</th>
<th>( \text{Actual} )</th>
<th>( \text{Budget} )</th>
<th>( \text{Variances} )</th>
<th>( % \text{ Variance} )</th>
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</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>4,738,924</td>
<td>4,815,220</td>
<td>(76,296)</td>
<td>(1.6%)</td>
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<tr>
<td>Revenues</td>
<td>1,707,910,458</td>
<td>1,652,163,156</td>
<td>55,747,302</td>
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<tr>
<td>Medical Expenses</td>
<td>1,637,889,772</td>
<td>1,574,189,765</td>
<td>63,700,007</td>
<td>(4.0%</td>
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<tr>
<td>Administrative Expenses</td>
<td>57,484,517</td>
<td>73,447,504</td>
<td>15,962,987</td>
<td>21.7%</td>
</tr>
<tr>
<td>Operating Margin</td>
<td>12,536,170</td>
<td>4,525,887</td>
<td>8,010,282</td>
<td>177.0%</td>
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<tr>
<td>Non Operating Income (Loss)</td>
<td>10,463,272</td>
<td>1,429,716</td>
<td>9,033,556</td>
<td>631.8%</td>
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<tr>
<td>Change in Net Assets</td>
<td>22,999,442</td>
<td>5,955,603</td>
<td>17,043,839</td>
<td>286.2%</td>
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### Ratios

<table>
<thead>
<tr>
<th>Medical Loss Ratio</th>
<th>( \text{Actual} )</th>
<th>( \text{Budget} )</th>
<th>( % \text{ Variance} )</th>
</tr>
</thead>
<tbody>
<tr>
<td>95.9%</td>
<td>95.3%</td>
<td>(0.6%)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Administrative Loss Ratio</th>
<th>( \text{Actual} )</th>
<th>( \text{Budget} )</th>
<th>( % \text{ Variance} )</th>
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</thead>
<tbody>
<tr>
<td>3.4%</td>
<td>4.4%</td>
<td>1.1%</td>
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<table>
<thead>
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<th>Operating Margin Ratio</th>
<th>( \text{Actual} )</th>
<th>( \text{Budget} )</th>
<th>( % \text{ Variance} )</th>
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<td>0.7%</td>
<td>0.3%</td>
<td>0.5%</td>
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<table>
<thead>
<tr>
<th>Total Operating</th>
<th>( \text{Actual} )</th>
<th>( \text{Budget} )</th>
<th>( % \text{ Variance} )</th>
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<tbody>
<tr>
<td>100.0%</td>
<td>100.0%</td>
<td>0.0%</td>
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</table>

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## Consolidated Performance Actual vs. Budget: December (in millions)

<table>
<thead>
<tr>
<th>MONTH-TO-DATE</th>
<th>YEAR-TO-DATE</th>
</tr>
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<tbody>
<tr>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>8.6</td>
<td>(3.4)</td>
</tr>
<tr>
<td>0.9</td>
<td>0.1</td>
</tr>
<tr>
<td>(0.9)</td>
<td>(0.1)</td>
</tr>
<tr>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>8.7</td>
<td>(3.4)</td>
</tr>
<tr>
<td>1.8</td>
<td>0.2</td>
</tr>
<tr>
<td>1.8</td>
<td>0.2</td>
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<tr>
<td><strong>10.4</strong></td>
<td><strong>(3.2)</strong></td>
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</table>
## Consolidated Revenue & Expense:
### December 2017 MTD

<table>
<thead>
<tr>
<th>Member Months</th>
<th>Medi-Cal Classic</th>
<th>Medi-Cal Expansion</th>
<th>Total Medi-Cal</th>
<th>OneCare Connect</th>
<th>OneCare PACE</th>
<th>Consolidated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>534,291</td>
<td>240,355</td>
<td>774,646</td>
<td>15,223</td>
<td>1,372</td>
<td>235</td>
</tr>
</tbody>
</table>

### REVENUES
- **Capitation Revenue**: $149,550,891
- **Other Income**: -
- **Total Operating Revenues**: $149,550,891

### MEDICAL EXPENSES
- **Provider Capitation**: 36,303,674
- **Facilities**: 23,672,453
- **Ancillary**: 616,537
- **Skilled Nursing**: -
- **Professional Claims**: 7,131,177
- **Prescription Drugs**: 17,569,103
- **Quality Incentives**: -
- **MLTSS Facility Payments**: 52,418,742
- **Medical Management**: 1,433,200
- **Reinsurance & Other**: 514,736
- **Total Medical Expenses**: $130,243,086

### Medical Loss Ratio: 93.1%

### GROSS MARGIN
- **Administrative Expenses**: 10,307,805
- **Salaries, Wages & Benefits**: 5,940,204
- **Professional fees**: (12,300)
- **Purchased services**: 574,731
- **Printing and Postage**: 168,884
- **Depreciation and Amortization**: 363,827
- **Other expenses**: 1,005,091
- **Indirect cost allocation, Occupancy expense**: (486,594)
- **Total Administrative Expenses**: $7,619,437

### Admin Loss Ratio: 3.0%

### INCOME (LOSS) FROM OPERATIONS
- **INVESTMENT INCOME**: -
- **NET RENTAL INCOME**: -
- **NET GRANT INCOME**: 1,202
- **OTHER INCOME**: 9

### CHANGE IN NET ASSETS
- **BUDGETED CHANGE IN ASSETS**: (3,159,402)
- **VARIANCE TO BUDGET - FAV (UNFAV)**: 11,980,788

### Consolidated Revenue & Expense: December 2017 MTD

**Consolidated**: 791,476

**Capitation Revenue**: $149,550,891

**Other Income**: -

**Total Operating Revenues**: $149,550,891

**Medical Loss Ratio**: 93.1%

**GROSS MARGIN**: 10,307,805

**Administrative Expenses**: 5,940,204

**Salaries, Wages & Benefits**: 31,110

**Professional fees**: 13,333

**Purchased services**: 20,680

**Printing and Postage**: 16,234

**Depreciation and Amortization**: 2,168

**Other expenses**: 2,730

**Indirect cost allocation, Occupancy expense**: 359,770

**Total Administrative Expenses**: $7,619,437

**Admin Loss Ratio**: 3.0%

**INCOME (LOSS) FROM OPERATIONS**: 8,620,175

**INVESTMENT INCOME**: -

**NET RENTAL INCOME**: -

**NET GRANT INCOME**: 1,202

**OTHER INCOME**: 9

**CHANGE IN NET ASSETS**: $8,612,386

**BUDGETED CHANGE IN ASSETS**: (893,581)

**VARIANCE TO BUDGET - FAV (UNFAV)**: 72,398

**Consolidated**: 10,409,072

**Medi-Cal Classic**: 534,291

**Medi-Cal Expansion**: 240,355

**Total Medi-Cal**: 774,646

**OneCare Connect**: 15,223

**OneCare PACE**: 1,372

**Consolidated**: 235

**Consolidated**: 791,476

**Capitation Revenue**: $149,550,891

**Other Income**: -

**Total Operating Revenues**: $149,550,891

**Medical Loss Ratio**: 93.1%

**GROSS MARGIN**: 10,307,805

**Administrative Expenses**: 5,940,204

**Salaries, Wages & Benefits**: 31,110

**Professional fees**: 13,333

**Purchased services**: 20,680

**Printing and Postage**: 16,234

**Depreciation and Amortization**: 2,168

**Other expenses**: 2,730

**Indirect cost allocation, Occupancy expense**: 359,770

**Total Administrative Expenses**: $7,619,437

**Admin Loss Ratio**: 3.0%

**INCOME (LOSS) FROM OPERATIONS**: 8,620,175

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**NET RENTAL INCOME**: -

**NET GRANT INCOME**: 1,202

**OTHER INCOME**: 9

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**BUDGETED CHANGE IN ASSETS**: (893,581)

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**Consolidated**: 10,409,072

**Medi-Cal Classic**: 534,291

**Medi-Cal Expansion**: 240,355

**Total Medi-Cal**: 774,646

**OneCare Connect**: 15,223

**OneCare PACE**: 1,372

**Consolidated**: 235

**Consolidated**: 791,476

**Capitation Revenue**: $149,550,891

**Other Income**: -

**Total Operating Revenues**: $149,550,891

**Medical Loss Ratio**: 93.1%

**GROSS MARGIN**: 10,307,805

**Administrative Expenses**: 5,940,204

**Salaries, Wages & Benefits**: 31,110

**Professional fees**: 13,333

**Purchased services**: 20,680

**Printing and Postage**: 16,234

**Depreciation and Amortization**: 2,168

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**Indirect cost allocation, Occupancy expense**: 359,770

**Total Administrative Expenses**: $7,619,437

**Admin Loss Ratio**: 3.0%

**INCOME (LOSS) FROM OPERATIONS**: 8,620,175

**INVESTMENT INCOME**: -

**NET RENTAL INCOME**: -

**NET GRANT INCOME**: 1,202

**OTHER INCOME**: 9

**CHANGE IN NET ASSETS**: $8,612,386

**BUDGETED CHANGE IN ASSETS**: (893,581)

**VARIANCE TO BUDGET - FAV (UNFAV)**: 72,398

**Consolidated**: 10,409,072
## Consolidated Revenue & Expense:
December 2017 YTD

<table>
<thead>
<tr>
<th>Member Months</th>
<th>Medi-Cal Classic</th>
<th>Medi-Cal Expansion</th>
<th>Total Medi-Cal</th>
<th>OneCare Connect</th>
<th>OneCare</th>
<th>PACE</th>
<th>Consolidated</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>3,205,704</td>
<td>1,431,978</td>
<td>4,637,682</td>
<td>91,579</td>
<td>8,313</td>
<td>1,359</td>
<td>4,738,924</td>
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<tr>
<td><strong>REVENUES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitation Revenue</td>
<td>$896,748,544</td>
<td>$621,909,649</td>
<td>$1,518,658,193</td>
<td>$172,821,540</td>
<td>$6,827,021</td>
<td>$9,603,105</td>
<td>$1,707,910,458</td>
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<tr>
<td>Other Income</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Operating Revenues</strong></td>
<td>$896,748,544</td>
<td>$621,909,649</td>
<td>$1,518,658,193</td>
<td>$172,821,540</td>
<td>$6,827,021</td>
<td>$9,603,105</td>
<td>$1,707,910,458</td>
</tr>
<tr>
<td><strong>MEDICAL EXPENSES</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provider Capitation</td>
<td>232,526,166</td>
<td>301,737,891</td>
<td>534,264,057</td>
<td>66,950,450</td>
<td>(8,082)</td>
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<td>114,544,752</td>
<td>265,484,329</td>
<td>60,958,305</td>
<td>2,493,220</td>
<td>1,669,718</td>
<td>286,065,573</td>
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<td>Ancillary</td>
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<td>3,971,943</td>
<td>259,231</td>
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<td>3,900,174</td>
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<td>Skilled Nursing</td>
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<td>Professional Claims</td>
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<td>50,012,643</td>
<td>95,203,046</td>
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<td>97,295,516</td>
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<td>Prescription Drugs</td>
<td>186,667,583</td>
<td>107,258,732</td>
<td>293,926,314</td>
<td>30,570,996</td>
<td>2,694,590</td>
<td>686,870</td>
<td>247,278,778</td>
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<td>MLTSS Facility Payments</td>
<td>322,052,369</td>
<td>15,262,844</td>
<td>337,315,213</td>
<td>31,955,995</td>
<td>(17,511)</td>
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<td>369,308,718</td>
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<td>Medical Management</td>
<td>11,564,805</td>
<td>4,414,375</td>
<td>15,979,180</td>
<td>5,936,423</td>
<td>313,662</td>
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<td>25,374,005</td>
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<td>Reinsurance &amp; Other</td>
<td>3,960,590</td>
<td>1,769,334</td>
<td>5,729,924</td>
<td>1,025,048</td>
<td>44,691</td>
<td>591,838</td>
<td>6,818,107</td>
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<tr>
<td><strong>Total Medical Expenses</strong></td>
<td>871,707,498</td>
<td>590,040,572</td>
<td>1,461,748,070</td>
<td>557,077,802</td>
<td>5,860,953</td>
<td>8,202,947</td>
<td>1,637,886,772</td>
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<tr>
<td>Medical Loss Ratio</td>
<td>97.2%</td>
<td>95.7%</td>
<td>96.6%</td>
<td>90.9%</td>
<td>85.8%</td>
<td>86.4%</td>
<td>96.9%</td>
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<td>GROSS MARGIN</td>
<td>26,041,045</td>
<td>26,869,078</td>
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<td>16,743,679</td>
<td>966,628</td>
<td>1,400,267</td>
<td>70,020,687</td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Salaries, Wages &amp; Benefits</td>
<td>32,115,166</td>
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<td>147,105</td>
<td>445,768</td>
<td>37,322,124</td>
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<td>Professional fees</td>
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<td>92,340</td>
<td>16,672</td>
<td>1,120,849</td>
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<td>Purchased services</td>
<td>4,142,909</td>
<td>913,306</td>
<td>116,036</td>
<td>30,413</td>
<td>5,202,664</td>
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<td>Printing and Postage</td>
<td>1,061,480</td>
<td>461,190</td>
<td>56,758</td>
<td>21,410</td>
<td>2,170,844</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and Amortization</td>
<td>2,473,970</td>
<td>12,936</td>
<td>24,969,900</td>
<td>7,079,154</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other expenses</td>
<td>6,748,013</td>
<td>241,492</td>
<td>(32)</td>
<td>89,710</td>
<td>2,101,976</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indirect cost allocation, Occupancy expense</td>
<td>(2,173,902)</td>
<td>4,070,948</td>
<td>160,030</td>
<td>44,100</td>
<td>2,101,976</td>
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<td></td>
</tr>
<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td>45,847,925</td>
<td>10,402,510</td>
<td>573,046</td>
<td>661,036</td>
<td>1,548,517</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin Loss Ratio</td>
<td>3.0%</td>
<td>6.0%</td>
<td>8.4%</td>
<td>6.9%</td>
<td>3.4%</td>
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<td></td>
</tr>
<tr>
<td><strong>INCOME (LOSS) FROM OPERATIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6,062,198</td>
<td>5,341,169</td>
<td>393,582</td>
<td>739,222</td>
<td>12,536,170</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>INVESTMENT INCOME</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10,480,161</td>
<td></td>
<td></td>
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<tr>
<td><strong>NET RENTAL INCOME</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>54,103</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NET GRANT INCOME</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(71,525)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(71,525)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER INCOME</strong></td>
<td>533</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>533</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHANGE IN NET ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$6,991,207</td>
<td>$6,341,169</td>
<td>$393,582</td>
<td>$739,222</td>
<td>$22,999,442</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>BUDGETED CHANGE IN ASSETS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4,922,764</td>
<td>717,666</td>
<td>(835,563)</td>
<td>(278,979)</td>
<td>5,955,603</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>VARIANCE TO BUDGET - FAV (UNFAV)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1,068,443</td>
<td>4,623,503</td>
<td>1,229,145</td>
<td>1,018,201</td>
<td>17,043,839</td>
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<td></td>
<td></td>
</tr>
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</table>
## Balance Sheet:
**As of December 2017**

### ASSETS

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Assets</strong></td>
<td></td>
</tr>
<tr>
<td>Operating Cash</td>
<td>$481,885,979</td>
</tr>
<tr>
<td>Investments</td>
<td>633,329,387</td>
</tr>
<tr>
<td>Capitation receivable</td>
<td>383,482,587</td>
</tr>
<tr>
<td>Receivables - Other</td>
<td>17,374,740</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>4,966,816</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>$1,721,099,509</td>
</tr>
<tr>
<td><strong>Capital Assets</strong></td>
<td></td>
</tr>
<tr>
<td>Furniture and equipment</td>
<td>34,039,043</td>
</tr>
<tr>
<td>Building/Leasehold improvements</td>
<td>6,226,243</td>
</tr>
<tr>
<td>505 City Parkway West</td>
<td>49,433,337</td>
</tr>
<tr>
<td><strong>Less: accumulated depreciation</strong></td>
<td></td>
</tr>
<tr>
<td>89,700,629</td>
<td></td>
</tr>
<tr>
<td><strong>Capital assets, net</strong></td>
<td>(38,197,224)</td>
</tr>
<tr>
<td><strong>Total Capital Assets</strong></td>
<td>$51,503,404</td>
</tr>
<tr>
<td><strong>Other Assets</strong></td>
<td></td>
</tr>
<tr>
<td>Restricted deposit &amp; Other</td>
<td>300,000</td>
</tr>
<tr>
<td>Board-designated assets</td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>30,352,757</td>
</tr>
<tr>
<td>Long term investments</td>
<td>506,544,015</td>
</tr>
<tr>
<td><strong>Total Board-designated Assets</strong></td>
<td>$536,896,783</td>
</tr>
<tr>
<td><strong>Total Other Assets</strong></td>
<td>$537,196,783</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS &amp; OUTFLOWS</strong></td>
<td>$2,321,336,835</td>
</tr>
</tbody>
</table>

### LIABILITIES & FUND BALANCES

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Current Liabilities</strong></td>
<td></td>
</tr>
<tr>
<td>Accounts payable</td>
<td>$13,807,781</td>
</tr>
<tr>
<td>Medical claims liability</td>
<td>964,354,976</td>
</tr>
<tr>
<td>Accrued payroll liabilities</td>
<td>9,341,768</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>167,061,116</td>
</tr>
<tr>
<td>Deferred lease obligations</td>
<td>158,970</td>
</tr>
<tr>
<td>Capitation and withhelds</td>
<td>382,720,721</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td>$1,537,455,331</td>
</tr>
<tr>
<td><strong>Other Liabilities</strong></td>
<td></td>
</tr>
<tr>
<td>Other employment benefits liability</td>
<td>29,618,397</td>
</tr>
<tr>
<td>Net Pension Liabilities</td>
<td>16,365,263</td>
</tr>
<tr>
<td>Long Term Liabilities</td>
<td>100,000</td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES</strong></td>
<td>$1,583,538,991</td>
</tr>
<tr>
<td><strong>Deferred inflows of Resources - Excess Earnings</strong></td>
<td>-</td>
</tr>
<tr>
<td><strong>Deferred inflows of Resources - Changes in Assumptions</strong></td>
<td>1,340,010</td>
</tr>
<tr>
<td><strong>Tangible net equity (TNE)</strong></td>
<td>88,937,308</td>
</tr>
<tr>
<td><strong>Funds in excess of TNE</strong></td>
<td>647,520,526</td>
</tr>
<tr>
<td><strong>Total Liabilities, Inflows &amp; Fund Balances</strong></td>
<td>$2,321,336,835</td>
</tr>
<tr>
<td><strong>Net Assets</strong></td>
<td>$736,457,834</td>
</tr>
</tbody>
</table>

[Back to Agenda]
### Board Designated Reserve and TNE Analysis

**As of December 2017**

<table>
<thead>
<tr>
<th>Type</th>
<th>Reserve Name</th>
<th>Market Value</th>
<th>Benchmark</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>High</td>
<td>Mkt - Low</td>
</tr>
<tr>
<td>Board-designated Reserve</td>
<td>Tier 1 - Payden &amp; Rygel</td>
<td>439,653,712</td>
<td>301,731,893</td>
<td>137,921,819</td>
</tr>
<tr>
<td></td>
<td>Tier 1 - Logan Circle</td>
<td>469,161,551</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 1 - Wells Capital</td>
<td>146,736,596</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 1 - Logan Circle</td>
<td>146,622,040</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 1 - Wells Capital</td>
<td>146,295,076</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TNE Requirement</td>
<td>Tier 2 - Logan Circle</td>
<td>536,896,783</td>
<td>390,669,201</td>
<td>146,227,581</td>
</tr>
<tr>
<td></td>
<td></td>
<td>558,098,859</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Consolidated:**

| Current reserve level | 1.92 | 1.40 | 2.00 |

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UNAUDITED FINANCIAL STATEMENTS

December 2017
CalOptima - Consolidated
Financial Highlights
For the Six Months Ended December 31, 2017

<table>
<thead>
<tr>
<th>Month-to-Date</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Mem.</td>
<td>791,476</td>
<td>803,356</td>
</tr>
<tr>
<td>Budget Mem.</td>
<td>283,343,384</td>
<td>275,693,125</td>
</tr>
<tr>
<td>Actual Mem.</td>
<td>264,819,397</td>
<td>266,593,714</td>
</tr>
<tr>
<td>Budget Mem.</td>
<td>9,868,144</td>
<td>12,531,002</td>
</tr>
<tr>
<td>Actual Mem.</td>
<td>8,655,843</td>
<td>(3,431,591)</td>
</tr>
<tr>
<td>Budget Mem.</td>
<td>1,753,228</td>
<td>231,157</td>
</tr>
<tr>
<td>Actual Mem.</td>
<td>10,409,072</td>
<td>(3,200,434)</td>
</tr>
<tr>
<td>Budget Mem.</td>
<td>93.5%</td>
<td>96.7%</td>
</tr>
<tr>
<td>Actual Mem.</td>
<td>3.5%</td>
<td>4.5%</td>
</tr>
<tr>
<td>Budget Mem.</td>
<td>3.1%</td>
<td>(1.2%)</td>
</tr>
<tr>
<td>Actual Mem.</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year-to-Date</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual Mem.</td>
<td>4,738,924</td>
<td>4,815,220</td>
</tr>
<tr>
<td>Budget Mem.</td>
<td>1,707,910,458</td>
<td>1,652,163,156</td>
</tr>
<tr>
<td>Actual Mem.</td>
<td>1,637,889,772</td>
<td>1,574,189,765</td>
</tr>
<tr>
<td>Budget Mem.</td>
<td>57,484,517</td>
<td>73,447,504</td>
</tr>
<tr>
<td>Actual Mem.</td>
<td>12,536,170</td>
<td>4,525,887</td>
</tr>
<tr>
<td>Budget Mem.</td>
<td>10,463,272</td>
<td>1,429,716</td>
</tr>
<tr>
<td>Actual Mem.</td>
<td>22,999,442</td>
<td>5,955,603</td>
</tr>
</tbody>
</table>

| Medical Loss Ratio | 95.9% | 95.3% | (0.6%) |
| Administrative Loss Ratio | 3.4% | 4.4% | 1.1% |
| Operating Margin Ratio | 0.7% | 0.3% | 0.5% |
| Total Operating | 100.0% | 100.0% |
# CalOptima Financial Dashboard

**For the Six Months Ended December 31, 2017**

## Enrollment

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Fav / (Unfav)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>774,646</td>
<td>766,194</td>
<td>(11,454) (1.5%)</td>
</tr>
<tr>
<td>OneCare Count</td>
<td>15,223</td>
<td>15,558</td>
<td>(-335) (2.2%)</td>
</tr>
<tr>
<td>OneCare</td>
<td>1,372</td>
<td>1,363</td>
<td>9  0.7%</td>
</tr>
<tr>
<td>PACE</td>
<td>235</td>
<td>241</td>
<td>(-6)  (2.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>791,476</td>
<td>803,356</td>
<td>(11,880) (1.5%)</td>
</tr>
</tbody>
</table>

## Change in Net Assets (000)

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Fav / (Unfav)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>$8,621</td>
<td>$3,359</td>
<td>$11,981 356.6%</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>857</td>
<td>85</td>
<td>772 911.7%</td>
</tr>
<tr>
<td>OneCare</td>
<td>794</td>
<td>137</td>
<td>756 (551.3%)</td>
</tr>
<tr>
<td>PACE</td>
<td>72</td>
<td>20</td>
<td>92  467.7%</td>
</tr>
<tr>
<td>505 Bldg.</td>
<td>11</td>
<td>19</td>
<td>29 156.4%</td>
</tr>
<tr>
<td>Investment Income &amp; Other</td>
<td>1,741</td>
<td>250</td>
<td>1,491 425.2%</td>
</tr>
<tr>
<td>Total</td>
<td>$10,409</td>
<td>$3,200</td>
<td>$13,610 425.2%</td>
</tr>
</tbody>
</table>

## MLR

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>% Point Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>93.5%</td>
<td>97.1%</td>
<td>3.6</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>90.2%</td>
<td>90.6%</td>
<td>0.4</td>
</tr>
<tr>
<td>OneCare</td>
<td>146.2%</td>
<td>102.9%</td>
<td>(-43.4)</td>
</tr>
</tbody>
</table>

## Administrative Cost (000)

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Fav / (Unfav)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>$7,619</td>
<td>$10,354</td>
<td>$2,735 26.4%</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>1,931</td>
<td>1,931</td>
<td>0 0.0%</td>
</tr>
<tr>
<td>OneCare</td>
<td>184</td>
<td>97</td>
<td>(87) (90.3%)</td>
</tr>
<tr>
<td>PACE</td>
<td>134</td>
<td>149</td>
<td>15 10.1%</td>
</tr>
<tr>
<td>Total</td>
<td>$9,868</td>
<td>$12,531</td>
<td>$2,663 21.3%</td>
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</tbody>
</table>

## Total FTE's Month

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Fav / (Unfav)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>912</td>
<td>900</td>
<td>(11)</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>217</td>
<td>237</td>
<td>20</td>
</tr>
<tr>
<td>OneCare</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>PACE</td>
<td>57</td>
<td>64</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>1,189</td>
<td>1,205</td>
<td>16</td>
</tr>
</tbody>
</table>

## MM per FTE

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Fav / (Unfav)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>850</td>
<td>873</td>
<td>(23)</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>70</td>
<td>66</td>
<td>4</td>
</tr>
<tr>
<td>OneCare</td>
<td>460</td>
<td>454</td>
<td>5</td>
</tr>
<tr>
<td>PACE</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>1,384</td>
<td>1,397</td>
<td>(13)</td>
</tr>
</tbody>
</table>

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**Back to Agenda**
### CalOptima - Consolidated Statement of Revenue and Expenses

**For the One Month Ended December 31, 2017**

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>PMPM*</th>
<th>Month Budget</th>
<th>PMPM*</th>
<th>Variance</th>
<th>PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Months</strong>**</td>
<td>791,476</td>
<td>$</td>
<td>803,356</td>
<td></td>
<td>(11,880)</td>
<td></td>
</tr>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>251,686,124</td>
<td>$ 324.90</td>
<td>245,405,770</td>
<td>$ 312.14</td>
<td>6,280,354</td>
<td>$ 12.76</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>28,448,503</td>
<td>1,188.77</td>
<td>27,285,160</td>
<td>1,038.19</td>
<td>1,163,343</td>
<td>115.01</td>
</tr>
<tr>
<td>OneCare</td>
<td>1,534,959</td>
<td>1,118.77</td>
<td>1,415,050</td>
<td>1,083.15</td>
<td>119,909</td>
<td>80.59</td>
</tr>
<tr>
<td>PACE</td>
<td>1,673,799</td>
<td>1,122.55</td>
<td>1,587,145</td>
<td>6,585.66</td>
<td>86,654</td>
<td>536.88</td>
</tr>
<tr>
<td><strong>Total Operating Revenue</strong></td>
<td>283,343,384</td>
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<td>275,693,125</td>
<td>343.18</td>
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<td>Medi-Cal</td>
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<td>238,411,015</td>
<td>303.25</td>
<td>2,964,503</td>
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<td>OneCare Connect</td>
<td>25,660,741</td>
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<td>25,269,108</td>
<td>1,624.19</td>
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<td>(61.47)</td>
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<td>2,196,942</td>
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<td>1,467,669</td>
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<td>1,458,064</td>
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<td>(195.34)</td>
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<td>266,593,714</td>
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<td><strong>Gross Margin</strong></td>
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<td>9,424,577</td>
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<td><strong>Administrative Expenses</strong></td>
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<td>Salaries and Benefits</td>
<td>7,013,574</td>
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<td>(38,837)</td>
<td>(0.05)</td>
<td>384,191</td>
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<td>463,298</td>
<td>0.56</td>
<td>97,303</td>
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<td>1,549,471</td>
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<td>(3,431,591)</td>
<td>(4.27)</td>
<td>12,087,434</td>
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<td><strong>Investment income</strong></td>
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<td>Interest income</td>
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<td>Unrealized gain/(loss) on investments</td>
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<td>(330,957)</td>
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<td><strong>Total Net Grant Income</strong></td>
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<td>-</td>
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<td><strong>Other Income</strong></td>
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<td>0.00</td>
<td>-</td>
<td>-</td>
<td>9</td>
<td>0.00</td>
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<td><strong>Change In Net Assets</strong></td>
<td>10,409,072</td>
<td>13.15</td>
<td>(3,200,434)</td>
<td>(3.98)</td>
<td>13,609,506</td>
<td>17.14</td>
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<td><strong>Medical Loss Ratio</strong></td>
<td>93.5%</td>
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<td><strong>Administrative Loss Ratio</strong></td>
<td>3.5%</td>
<td>4.5%</td>
<td>-</td>
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<td>-</td>
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</tbody>
</table>

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP
# CalOptima - Consolidated Statement of Revenue and Expenses
For the Six Months Ended December 31, 2017

<table>
<thead>
<tr>
<th></th>
<th>Actual $</th>
<th>PMPM*</th>
<th>Budget $</th>
<th>PMPM*</th>
<th>Variance $</th>
<th>PMPM*</th>
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<td><strong>Member Months</strong>**</td>
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<td><strong>Revenues</strong></td>
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<td>Medi-Cal</td>
<td>$ 1,518,658,193</td>
<td>$ 327.46</td>
<td>$ 1,470,580,910</td>
<td>$ 312.05</td>
<td>$ 48,077,283</td>
<td>$ 15.41</td>
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<td>OneCare Connect</td>
<td>172,821,540</td>
<td>1,887.32</td>
<td>164,281,426</td>
<td>1,763.83</td>
<td>(8,540,114)</td>
<td>123.49</td>
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<td>OneCare</td>
<td>6,827,621</td>
<td>821.32</td>
<td>8,279,090</td>
<td>1,030.51</td>
<td>(4,451,469)</td>
<td>(209.19)</td>
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<td>9,603,105</td>
<td>7,066.30</td>
<td>9,021,730</td>
<td>6,580.40</td>
<td>581,375</td>
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<td><strong>Total Operating Revenue</strong></td>
<td>1,707,910,458</td>
<td>360.40</td>
<td>1,657,163,156</td>
<td>343.11</td>
<td>55,747,302</td>
<td>17.29</td>
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<td><strong>Medical Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>1,466,748,070</td>
<td>316.27</td>
<td>1,405,248,630</td>
<td>298.18</td>
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<td>(18.06)</td>
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<td>157,077,862</td>
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<td>152,010,381</td>
<td>1,632.08</td>
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<td>(83.30)</td>
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<td>OneCare</td>
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<td>705.04</td>
<td>8,279,090</td>
<td>1,030.51</td>
<td>(2,418,097)</td>
<td>(356.05)</td>
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<td>6,035.94</td>
<td>8,405,926</td>
<td>6,131.24</td>
<td>203,079</td>
<td>95.29</td>
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<tr>
<td><strong>Total Medical Expenses</strong></td>
<td>1,637,889,772</td>
<td>345.62</td>
<td>1,574,169,765</td>
<td>326.92</td>
<td>(63,700,007)</td>
<td>(18.71)</td>
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<td><strong>Gross Margin</strong></td>
<td>70,020,687</td>
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<td>77,973,391</td>
<td>16.19</td>
<td>(7,952,704)</td>
<td>(1.42)</td>
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<td><strong>Administrative Expenses</strong></td>
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<td></td>
</tr>
<tr>
<td>Salaries and Benefits</td>
<td>37,322,124</td>
<td>7.88</td>
<td>41,931,512</td>
<td>8.71</td>
<td>4,609,388</td>
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<td>2,321,637</td>
<td>0.48</td>
<td>1,200,788</td>
<td>0.25</td>
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<td>Purchased services</td>
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<td>12,022,550</td>
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<td>6,819,886</td>
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<td>0.66</td>
<td>1,027,894</td>
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<td>Depreciation and Amortization</td>
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<td>2,779,788</td>
<td>0.56</td>
<td>292,882</td>
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<td>9,150,777</td>
<td>1.90</td>
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<td>Indirect cost allocation, Occupancy expense</td>
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<td>2,042,502</td>
<td>0.42</td>
<td>(59,474)</td>
<td>(0.02)</td>
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<tr>
<td><strong>Total Administrative Expenses</strong></td>
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<td>15,962,987</td>
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<tr>
<td><strong>Income (Loss) From Operations</strong></td>
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<td>4,525,887</td>
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<td>8,010,282</td>
<td>1.71</td>
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<tr>
<td><strong>Investment income</strong></td>
<td></td>
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<td>Interest income</td>
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<td>11,915,192</td>
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<tr>
<td>Realized gain/(loss) on investments</td>
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<td>(0.17)</td>
<td>-</td>
<td>-</td>
<td>(805,065)</td>
<td>(0.17)</td>
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<tr>
<td>Unrealized gain/(loss) on investments</td>
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<td>-</td>
<td>(2,129,966)</td>
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<tr>
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<tr>
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<td>(70,284)</td>
<td>(0.01)</td>
<td>124,387</td>
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<td><strong>Total Net Operating Tax</strong></td>
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<tr>
<td><strong>Total Net Grant Income</strong></td>
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<td>(71,525)</td>
<td>(0.02)</td>
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<tr>
<td><strong>QAF/IGT</strong></td>
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<td><strong>Other Income</strong></td>
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<td>0.00</td>
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<td>4.4%</td>
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<td>1.1%</td>
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* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

Back to Agenda
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<th></th>
<th>Medi-Cal Classic</th>
<th>Medi-Cal Expansion</th>
<th>Total Medi-Cal</th>
<th>OneCare Connect</th>
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<tr>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>0</td>
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<tr>
<td><strong>Total Operating Revenues</strong></td>
<td>149,550,891</td>
<td>102,135,233</td>
<td>251,686,124</td>
<td>28,448,503</td>
<td>1,534,959</td>
<td>1,673,799</td>
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<td>244,777</td>
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<td>1,078,367</td>
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<td><strong>Total Medical Expenses</strong></td>
<td>139,243,086</td>
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<td>235,446,512</td>
<td>25,660,741</td>
<td>1,467,669</td>
<td>264,819,397</td>
<td></td>
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<tr>
<td>Medical Loss Ratio</td>
<td>93.1%</td>
<td>94.2%</td>
<td>93.5%</td>
<td>90.2%</td>
<td>-</td>
<td>-</td>
<td>93.5%</td>
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<td>16,239,612</td>
<td>2,787,762</td>
<td>(709,515)</td>
<td>206,129</td>
<td>18,523,988</td>
</tr>
<tr>
<td>ADMINISTRATIVE EXPENSES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries, Wages &amp; Benefits</td>
<td>5,946,204</td>
<td>942,919</td>
<td>31,110</td>
<td>93,341</td>
<td>7,013,574</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional fees</td>
<td>(12,396)</td>
<td>(41,108)</td>
<td>13,333</td>
<td>1,333</td>
<td>(38,837)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchased services</td>
<td>574,731</td>
<td>157,754</td>
<td>20,880</td>
<td>5,269</td>
<td>758,635</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Printing and Postage</td>
<td>168,884</td>
<td>113,562</td>
<td>25,677</td>
<td>16,238</td>
<td>324,361</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and Amortization</td>
<td>363,827</td>
<td>-</td>
<td>2,168</td>
<td>365,995</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other expenses</td>
<td>1,065,091</td>
<td>10,826</td>
<td>0</td>
<td>8,730</td>
<td>1,084,647</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indirect cost allocation, Occupancy expense</td>
<td>486,904</td>
<td>746,957</td>
<td>93,065</td>
<td>6,652</td>
<td>359,770</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td>7,619,437</td>
<td>1,930,910</td>
<td>184,066</td>
<td>133,732</td>
<td>9,668,144</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admin Loss Ratio</td>
<td>3.0%</td>
<td>6.8%</td>
<td>12.0%</td>
<td>8.0%</td>
<td>3.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INCOME (LOSS) FROM OPERATIONS</td>
<td>8,620,175</td>
<td>856,852</td>
<td>(893,581)</td>
<td>72,398</td>
<td>8,655,843</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INVESTMENT INCOME</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,741,395</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NET RENTAL INCOME</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>10,623</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NET GRANT INCOME</td>
<td>1,202</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1,202</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER INCOME</td>
<td>9</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CHANGE IN NET ASSETS</strong></td>
<td>$8,621,386</td>
<td>$856,852</td>
<td>$893,581</td>
<td>$72,398</td>
<td>$10,409,072</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BUDGETED CHANGE IN ASSETS</td>
<td>(3,359,402)</td>
<td>84,693</td>
<td>(137,190)</td>
<td>(19,692)</td>
<td>(3,200,434)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VARIANCE TO BUDGET - FAV (UNFAV)</td>
<td>11,980,788</td>
<td>772,159</td>
<td>(756,391)</td>
<td>92,090</td>
<td>13,609,505</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## CalOptima - Consolidated - Year to Date
### Statement of Revenues and Expenses by LOB
#### For the Six Months Ended December 31, 2017

<table>
<thead>
<tr>
<th></th>
<th>Medi-Cal Classic</th>
<th>Medi-Cal Expansion</th>
<th>Total Medi-Cal</th>
<th>OneCare Connect</th>
<th>OneCare</th>
<th>PACE</th>
<th>Consolidated</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Months</strong></td>
<td>3,205,704</td>
<td>1,431,978</td>
<td>4,637,682</td>
<td>91,570</td>
<td>8,313</td>
<td>1,359</td>
<td>4,738,924</td>
</tr>
<tr>
<td><strong>REVENUES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitation Revenue</td>
<td>$ 896,748,544</td>
<td>$ 621,909,649</td>
<td>$ 1,518,658,193</td>
<td>$ 172,821,540</td>
<td>$ 6,827,621</td>
<td></td>
<td>$ 1,707,910,458</td>
</tr>
<tr>
<td>Other Income</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total Operating Revenues</strong></td>
<td>$ 896,748,544</td>
<td>$ 621,909,649</td>
<td>$ 1,518,658,193</td>
<td>$ 172,821,540</td>
<td>$ 6,827,621</td>
<td>9,603,105</td>
<td>$ 1,707,910,458</td>
</tr>
</tbody>
</table>

**MEDICAL EXPENSES**

|                      |                  |                    |                |                 |         |      |             |
| Provider Capitation  | 232,526,166      | 301,737,891        | 534,264,057    | 16,958,305      | 2,493,220 |         | 601,141,425 |
| Facilities           | 150,939,577      | 114,544,752        | 265,484,329    | 16,958,305      | 2,493,220 |         | 286,605,573 |
| Ancillary            | 3,671,043        | 259,231            | 3,671,043      |                 |         |      |             |
| Skilled Nursing      |                  | 137,375            |                 |                 |         |      | 137,375 |
| Professional Claims  | 45,190,403       | 50,012,643         | 95,203,046     |                 |         |      | 97,295,116 |
| Prescription Drugs   | 106,067,583      | 107,258,732        | 213,326,314    | 30,570,998      | 2,694,595 | 16,958,305 | 247,278,778 |
| MLTSS Facility Payments | 322,052,369     | 15,282,844         | 337,335,213    | 31,955,995      | 2,344,440 |         | 369,308,718 |
| Medical Management   | 11,564,805       | 4,414,375          | 15,979,180     |                 |         |      | 25,374,005 |
| Reinsurance & Other  | 3,366,596        | 1,789,334          | 5,155,930      |                 |         |      | 6,181,107  |
| **Total Medical Expenses** | $ 871,707,498 | $ 595,040,572 | $ 1,466,748,070 | $ 157,077,862 | $ 5,860,993 | 9,603,105 | $ 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          | 4,614,066      | 147,105         | 445,788 |         | 37,322,124 |
| Professional fees     | 910,290          | 101,538            | 101,538        | 92,349          | 16,762  | 92,349 | 1,120,849 |
| Purchased services    | 1,634,190        | 451,936            | 451,936        | 92,349          | 16,762  | 92,349 | 1,120,849 |
| Depreciation and Amortization | 2,473,970 | 12,936              | 12,936         | 12,936          | 2,486,906 |         | 2,486,906 |
| Other expenses        | 6,748,013        | 241,462            | 241,462        | (32)            | 89,710  | 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%  6.9%  3.4%

**INCOME (LOSS) FROM OPERATIONS**

6,062,198  5,341,169  393,582  739,222  12,536,170

**INVESTMENT INCOME**

-  -  -  -  -

**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

**VARIENCE TO BUDGET - FAV (UNFAV)**

1,068,443  4,623,503  1,229,145  1,018,201  17,043,839
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)

<table>
<thead>
<tr>
<th>MONTH-TO-DATE</th>
<th>YEAR-TO-DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>8.6</td>
<td>(3.4)</td>
</tr>
<tr>
<td>0.9</td>
<td>0.1</td>
</tr>
<tr>
<td>(0.9)</td>
<td>(0.1)</td>
</tr>
<tr>
<td>0.1</td>
<td>0.0</td>
</tr>
<tr>
<td>8.7</td>
<td>(3.4)</td>
</tr>
<tr>
<td>1.8</td>
<td>0.2</td>
</tr>
<tr>
<td>1.8</td>
<td>0.2</td>
</tr>
<tr>
<td>10.4</td>
<td>(3.2)</td>
</tr>
</tbody>
</table>
# CalOptima

## Enrollment Summary

For the Six Months Ended December 31, 2017

<table>
<thead>
<tr>
<th>Month-to-Date</th>
<th>Year-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td>Aged</td>
<td>62,897</td>
</tr>
<tr>
<td>BCCTP</td>
<td>47,146</td>
</tr>
<tr>
<td>TANF Child</td>
<td>324,940</td>
</tr>
<tr>
<td>TANF Adult</td>
<td>95,221</td>
</tr>
<tr>
<td>LTC</td>
<td>3,470</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>774,646</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>15,223</td>
</tr>
<tr>
<td>PACE</td>
<td>235</td>
</tr>
<tr>
<td>OneCare</td>
<td>1,372</td>
</tr>
<tr>
<td>CalOptima Total</td>
<td>791,476</td>
</tr>
</tbody>
</table>

## Enrollment (By Network)

<table>
<thead>
<tr>
<th>Network</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>170,698</td>
<td>174,384</td>
<td>(3,686)</td>
<td>(2.1%)</td>
</tr>
<tr>
<td>PHC</td>
<td>222,780</td>
<td>225,829</td>
<td>(3,049)</td>
<td>(1.4%)</td>
</tr>
<tr>
<td>Shared Risk Group</td>
<td>198,753</td>
<td>209,052</td>
<td>(10,299)</td>
<td>(4.9%)</td>
</tr>
<tr>
<td>Fee for Service</td>
<td>182,415</td>
<td>176,929</td>
<td>5,486</td>
<td>3.1%</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>774,646</td>
<td>786,194</td>
<td>(11,548)</td>
<td>(1.5%)</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>15,223</td>
<td>15,558</td>
<td>(335)</td>
<td>(2.2%)</td>
</tr>
<tr>
<td>PACE</td>
<td>235</td>
<td>241</td>
<td>(6)</td>
<td>(2.5%)</td>
</tr>
<tr>
<td>OneCare</td>
<td>1,372</td>
<td>1,363</td>
<td>9</td>
<td>0.7%</td>
</tr>
<tr>
<td>CalOptima Total</td>
<td>791,476</td>
<td>803,356</td>
<td>(11,880)</td>
<td>(1.5%)</td>
</tr>
</tbody>
</table>

Back to Agenda
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

3,980

-

-

-

-

-

-

1

1

1

5

1

5

-

-

-

-

-

-

14

6,749

4,058

6,740

6,729

6,703

6,733

6,743

-

-

-

-

-

-

40,397

BCCTP
Disabled

4,045

4,051

3,864

4,020

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

3

4

6

4

4

3

-

-

-

-

-

-

24

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

1,480

1,493

1,530

1,401

1,561

LTC
MCE

-

-

-

-

-

24,018

PHC
1,581

-

-

-

-

-

-

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

Aged

9,046

12,312

-

-

-

-

-

-

LTC

-

-

1

1

-

-

-

-

-

-

-

-

2

MCE

38,398

38,821

39,088

38,681

39,261

39,620

-

-

-

-

-

-

233,869

74,564

222,601

224,125

223,489

221,721

222,392

222,780

-

-

-

-

-

-

1,337,108

3,029

3,765

3,641

-

-

-

-

-

-

21,831

-

-

-

-

-

-

-

-

1

7,978

7,887

-

-

-

-

-

-

48,017

Shared Risk Group
Aged

3,809

3,756

3,831

BCCTP

-

-

-

Disabled

8,108

8,058

8,035

1
7,951

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

1

2

-

-

2

-

-

-

-

-

-

5

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

48,036

48,599

48,846

48,863

49,108

293,030

LTC

-

MCE

-

-

-

-

-

Fee for Service (Dual)
Aged
BCCTP
Disabled

49,578

-

-

-

-

-

-

25

22

25

23

22

23

-

-

-

-

-

-

140

20,343

20,528

20,516

20,448

20,494

20,691

-

-

-

-

-

-

123,020

TANF Child

3

3

2

2

1

1

-

-

-

-

-

-

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

12

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

3,580

3,855

4,031

3,714

4,250

4,117

-

-

-

-

-

-

23,547

601

602

599

523

598

589

-

-

-

-

-

-

Fee for Service (Non-Dual)
Aged
BCCTP
Disabled

3,512

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

372

364

379

194

363

353

-

-

-

-

-

-

LTC
MCE

2,025

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

60,963

61,748

62,289

60,871

62,704

371,472

MEDI-CAL TOTAL
Aged

62,897

-

-

-

-

-

-

627

625

625

552

621

617

-

-

-

-

-

-

3,667

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

3,377

3,493

3,514

3,267

3,504

3,470

-

-

-

-

-

-

20,625

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

215

221

228

227

233

235

-

-

-

-

-

-

1,359

BCCTP
Disabled

LTC
MCE

PACE
OneCare
OneCare Connect
TOTAL

Page 11

1,367

1,386

1,404

1,406

1,378

1,372

-

-

-

-

-

-

8,313

15,365

15,229

15,265

15,234

15,254

15,223

-

-

-

-

-

-

91,570

787,686

797,991

796,181

780,645

784,945

791,476

-

-

-

-

-

-

4,738,924

Back to Agenda


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

<table>
<thead>
<tr>
<th>Month</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>774,646</td>
<td>786,194</td>
<td>(11,548)</td>
<td>(1.5%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year - To - Date</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>4,637,682</td>
<td>4,712,676</td>
<td>(74,994)</td>
<td>(1.6%)</td>
</tr>
</tbody>
</table>

#### Revenues

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>251,686,124</td>
<td>245,405,770</td>
<td>6,280,354</td>
<td>2.6%</td>
</tr>
<tr>
<td>Capitation revenue</td>
<td>1,518,658,193</td>
<td>1,470,580,910</td>
<td>48,077,283</td>
<td>3.3%</td>
</tr>
<tr>
<td>Total Operating Revenues</td>
<td>1,518,658,193</td>
<td>1,470,580,910</td>
<td>48,077,283</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

#### Medical Expenses

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider capitation</td>
<td>87,162,322</td>
<td>86,932,521</td>
<td>229,801</td>
<td>(0.3%)</td>
</tr>
<tr>
<td>Facilities</td>
<td>15,140,675</td>
<td>14,659,256</td>
<td>481,419</td>
<td>(3.3%)</td>
</tr>
<tr>
<td>MLTSS</td>
<td>54,926,188</td>
<td>51,568,950</td>
<td>3,357,238</td>
<td>(6.5%)</td>
</tr>
<tr>
<td>Medical Management</td>
<td>2,140,898</td>
<td>3,270,989</td>
<td>1,130,091</td>
<td>(34.5%)</td>
</tr>
<tr>
<td>Reinsurance &amp; other</td>
<td>821,524</td>
<td>315,017</td>
<td>506,507</td>
<td>(160.8%)</td>
</tr>
<tr>
<td>Total Medical Expenses</td>
<td>235,446,512</td>
<td>238,411,015</td>
<td>2,964,503</td>
<td>(1.2%)</td>
</tr>
</tbody>
</table>

#### Gross Margin

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Operating Expenses</td>
<td>1,466,748,070</td>
<td>1,405,248,630</td>
<td>61,499,440</td>
<td>(4.4%)</td>
</tr>
<tr>
<td>Gross Margin</td>
<td>51,910,123</td>
<td>65,332,280</td>
<td>13,422,157</td>
<td>(20.5%)</td>
</tr>
</tbody>
</table>

#### Administrative Expenses

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries, wages &amp; employee benefits</td>
<td>5,946,204</td>
<td>6,016,614</td>
<td>70,410</td>
<td>(1.2%)</td>
</tr>
<tr>
<td>Professional fees</td>
<td>18,184,075</td>
<td>18,293,024</td>
<td>109,954</td>
<td>(0.6%)</td>
</tr>
<tr>
<td>Purchased services</td>
<td>168,884</td>
<td>1,094,584</td>
<td>927,700</td>
<td>(84.6%)</td>
</tr>
<tr>
<td>Printing and postage</td>
<td>363,827</td>
<td>254,475</td>
<td>109,352</td>
<td>(43.3%)</td>
</tr>
<tr>
<td>Depreciation &amp; amortization</td>
<td>1,065,091</td>
<td>1,136,574</td>
<td>71,483</td>
<td>(6.2%)</td>
</tr>
<tr>
<td>Indirect cost allocation</td>
<td>2,137,008</td>
<td>906,824</td>
<td>1,230,184</td>
<td>(136.2%)</td>
</tr>
<tr>
<td>Total Administrative Expenses</td>
<td>7,619,437</td>
<td>10,354,157</td>
<td>2,734,720</td>
<td>(26.4%)</td>
</tr>
</tbody>
</table>

#### Operating Tax

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Revenue</td>
<td>10,093,118</td>
<td>0</td>
<td>10,093,118</td>
<td>100.0%</td>
</tr>
<tr>
<td>Premium tax expense</td>
<td>10,190,882</td>
<td>0</td>
<td>10,190,882</td>
<td>100.0%</td>
</tr>
<tr>
<td>Sales tax expense</td>
<td>(97,764)</td>
<td>0</td>
<td>97,764</td>
<td>100.0%</td>
</tr>
<tr>
<td>Total Net Operating Tax</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

#### Grant Income

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant Revenue</td>
<td>96,516</td>
<td>291,249</td>
<td>(194,733)</td>
<td>(66.9%)</td>
</tr>
<tr>
<td>Grant expense - Service Partner</td>
<td>84,703</td>
<td>258,276</td>
<td>173,573</td>
<td>67.2%</td>
</tr>
<tr>
<td>Grant expense - Administrative</td>
<td>10,810</td>
<td>32,973</td>
<td>22,163</td>
<td>67.8%</td>
</tr>
<tr>
<td>Total Grant Income</td>
<td>1,202</td>
<td>0</td>
<td>1,202</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other income</td>
<td>9</td>
<td>0</td>
<td>9</td>
<td>0.0%</td>
</tr>
<tr>
<td>Change in Net Assets</td>
<td>8,621,386</td>
<td>(3,359,402)</td>
<td>11,980,788</td>
<td>356.6%</td>
</tr>
<tr>
<td>93.5% 97.1% 3.6% 3.7%</td>
<td>3.0% 4.2% 1.2% 28.2%</td>
<td>Medical Loss Ratio</td>
<td>96.6% 95.6% -1.0% -1.1%</td>
<td></td>
</tr>
<tr>
<td>Admin Loss Ratio</td>
<td>3%</td>
<td>4.1%</td>
<td>1.1%</td>
<td>26.5%</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15,223</td>
<td>$15,558</td>
<td>$(335)</td>
<td>(2.2%)</td>
</tr>
<tr>
<td>$7,192,713</td>
<td>$7,495,752</td>
<td>$(303,039)</td>
<td>(4.0%)</td>
</tr>
<tr>
<td>$16,219,508</td>
<td>$14,663,334</td>
<td>$1,556,174</td>
<td>10.6%</td>
</tr>
<tr>
<td>$5,036,281</td>
<td>$5,126,074</td>
<td>$(89,793)</td>
<td>(1.8%)</td>
</tr>
<tr>
<td><strong>$28,448,503</strong></td>
<td><strong>$27,285,160</strong></td>
<td><strong>$1,163,343</strong></td>
<td><strong>4.3%</strong></td>
</tr>
</tbody>
</table>

### Year - To - Date

<table>
<thead>
<tr>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>$91,570</td>
<td>$93,139</td>
<td>$(1,569)</td>
<td>(1.7%)</td>
</tr>
<tr>
<td>$43,510,574</td>
<td>$45,021,155</td>
<td>$(1,510,581)</td>
<td>(3.4%)</td>
</tr>
<tr>
<td>$96,588,174</td>
<td>$87,529,360</td>
<td>$9,058,814</td>
<td>10.3%</td>
</tr>
<tr>
<td>$32,722,792</td>
<td>$31,730,911</td>
<td>$991,881</td>
<td>3.1%</td>
</tr>
<tr>
<td><strong>$172,821,540</strong></td>
<td><strong>$164,281,426</strong></td>
<td><strong>$8,540,114</strong></td>
<td><strong>5.2%</strong></td>
</tr>
</tbody>
</table>

### Revenues

<table>
<thead>
<tr>
<th>Type</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>$15,223</td>
<td>$15,558</td>
<td>$(335)</td>
<td>(2.2%)</td>
</tr>
<tr>
<td>Medi-Cal Capitation revenue</td>
<td>$7,192,713</td>
<td>$7,495,752</td>
<td>$(303,039)</td>
<td>(4.0%)</td>
</tr>
<tr>
<td>Medicare Capitation revenue part C</td>
<td>$16,219,508</td>
<td>$14,663,334</td>
<td>$1,556,174</td>
<td>10.6%</td>
</tr>
<tr>
<td>Medicare Capitation revenue part D</td>
<td>$5,036,281</td>
<td>$5,126,074</td>
<td>$(89,793)</td>
<td>(1.8%)</td>
</tr>
<tr>
<td><strong>Total Operating Revenue</strong></td>
<td><strong>$28,448,503</strong></td>
<td><strong>$27,285,160</strong></td>
<td><strong>$1,163,343</strong></td>
<td><strong>4.3%</strong></td>
</tr>
</tbody>
</table>

### Medical Expenses

<table>
<thead>
<tr>
<th>Type</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider capitation</td>
<td>$11,235,554</td>
<td>$8,510,479</td>
<td>$(2,725,075)</td>
<td>(32.0%)</td>
</tr>
<tr>
<td>Facilities</td>
<td>$3,210,266</td>
<td>$1,956,247</td>
<td>$(1,254,019)</td>
<td>(64.2%)</td>
</tr>
<tr>
<td>Ancillary</td>
<td>$616,337</td>
<td>$822,127</td>
<td>$(205,790)</td>
<td>(25.0%)</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>$5,128,691</td>
<td>$4,273,142</td>
<td>$(855,549)</td>
<td>(20.0%)</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>$4,664,471</td>
<td>$4,273,142</td>
<td>$(391,329)</td>
<td>(9.1%)</td>
</tr>
<tr>
<td>Medical management</td>
<td>$656,180</td>
<td>$909,446</td>
<td>$(253,266)</td>
<td>(27.9%)</td>
</tr>
<tr>
<td>Other medical expenses</td>
<td>$149,243</td>
<td>$106,878</td>
<td>$(42,365)</td>
<td>(39.6%)</td>
</tr>
<tr>
<td><strong>Total Medical Expenses</strong></td>
<td><strong>$25,660,741</strong></td>
<td><strong>$25,269,108</strong></td>
<td><strong>$391,633</strong></td>
<td><strong>1.5%</strong></td>
</tr>
</tbody>
</table>

### Gross Margin

<table>
<thead>
<tr>
<th>Type</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Operating Revenue</td>
<td>$172,821,540</td>
<td>$164,281,426</td>
<td>$8,540,114</td>
<td>5.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Expenses</td>
<td>$25,660,741</td>
<td>$25,269,108</td>
<td>$391,633</td>
<td>1.5%</td>
</tr>
<tr>
<td><strong>Gross Margin</strong></td>
<td><strong>$157,160,800</strong></td>
<td><strong>$139,012,318</strong></td>
<td><strong>$28,148,482</strong></td>
<td><strong>16.8%</strong></td>
</tr>
</tbody>
</table>

### Administrative Expenses

<table>
<thead>
<tr>
<th>Type</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries, wages &amp; employee benefits</td>
<td>$942,919</td>
<td>$914,507</td>
<td>$(28,412)</td>
<td>(3.1%)</td>
</tr>
<tr>
<td>Professional fees</td>
<td>$321,266</td>
<td>$1,956,247</td>
<td>$(1,634,981)</td>
<td>(84.0%)</td>
</tr>
<tr>
<td>Purchased services</td>
<td>$616,337</td>
<td>$822,127</td>
<td>$(205,790)</td>
<td>(25.0%)</td>
</tr>
<tr>
<td>Long Term Care</td>
<td>$5,128,691</td>
<td>$4,273,142</td>
<td>$(855,549)</td>
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</tr>
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<td>Prescription drugs</td>
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<td>$4,273,142</td>
<td>$(391,329)</td>
<td>(9.1%)</td>
</tr>
<tr>
<td>Medical management</td>
<td>$656,180</td>
<td>$909,446</td>
<td>$(253,266)</td>
<td>(27.9%)</td>
</tr>
<tr>
<td>Other medical expenses</td>
<td>$149,243</td>
<td>$106,878</td>
<td>$(42,365)</td>
<td>(39.6%)</td>
</tr>
<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td><strong>$10,402,510</strong></td>
<td><strong>$10,532,379</strong></td>
<td><strong>$(129,869)</strong></td>
<td><strong>1.2%</strong></td>
</tr>
</tbody>
</table>

### Operating Tax

<table>
<thead>
<tr>
<th>Type</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Administrative Expenses</td>
<td>$10,402,510</td>
<td>$10,532,379</td>
<td>$(129,869)</td>
<td>1.2%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Loss Ratio</td>
<td>$90.2%</td>
<td>$92.6%</td>
<td>2.4%</td>
<td>2.6%</td>
</tr>
<tr>
<td>Admin Loss Ratio</td>
<td>6.8%</td>
<td>7.1%</td>
<td>0.3%</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

### Change in Net Assets

<table>
<thead>
<tr>
<th>Type</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>856,852</td>
<td>84,693</td>
<td>772,159</td>
<td>911.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Net Operating Tax</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in Net Assets</td>
<td>5,341,169</td>
<td>717,666</td>
<td>4,623,503</td>
<td>644.2%</td>
</tr>
</tbody>
</table>

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[Back to Agenda]
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

<table>
<thead>
<tr>
<th>Month</th>
<th>$</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Actual</strong></td>
<td><strong>Budget</strong></td>
<td><strong>Variance</strong></td>
</tr>
<tr>
<td>1,372</td>
<td>1,363</td>
<td>9</td>
</tr>
</tbody>
</table>

**Revenues**

<table>
<thead>
<tr>
<th></th>
<th><strong>Actual</strong></th>
<th><strong>Budget</strong></th>
<th><strong>Variance</strong></th>
<th><strong>% Variance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>8,313</td>
<td>8,034</td>
<td>279</td>
<td>3.5%</td>
</tr>
</tbody>
</table>

**Medical Expenses**

<table>
<thead>
<tr>
<th></th>
<th><strong>Actual</strong></th>
<th><strong>Budget</strong></th>
<th><strong>Variance</strong></th>
<th><strong>% Variance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Med-Cal Capitation revenue</td>
<td>420,887</td>
<td>279,129</td>
<td>141,758</td>
<td>50.8%</td>
</tr>
<tr>
<td>Medicare Part C Revenue</td>
<td>4,144,068</td>
<td>5,154,339</td>
<td>(1,010,271)</td>
<td>(19.6%)</td>
</tr>
<tr>
<td>Medicare Part D Revenue</td>
<td>2,622,666</td>
<td>2,845,622</td>
<td>(222,956)</td>
<td>(7.8%)</td>
</tr>
<tr>
<td>Total Operating Revenue</td>
<td>6,827,621</td>
<td>8,279,090</td>
<td>(1,451,469)</td>
<td>(17.5%)</td>
</tr>
</tbody>
</table>

**Administrative Expenses**

<table>
<thead>
<tr>
<th></th>
<th><strong>Actual</strong></th>
<th><strong>Budget</strong></th>
<th><strong>Variance</strong></th>
<th><strong>% Variance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Medical Expenses</td>
<td>5,860,993</td>
<td>8,524,828</td>
<td>2,663,835</td>
<td>31.2%</td>
</tr>
<tr>
<td>Gross Margin</td>
<td>966,628</td>
<td>(245,738)</td>
<td>1,212,366</td>
<td>493.4%</td>
</tr>
</tbody>
</table>

**Change in Net Assets**

<table>
<thead>
<tr>
<th></th>
<th><strong>Actual</strong></th>
<th><strong>Budget</strong></th>
<th><strong>Variance</strong></th>
<th><strong>% Variance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>(709,515)</td>
<td>(40,477)</td>
<td>(669,038)</td>
<td>(1,652.9%)</td>
<td></td>
</tr>
</tbody>
</table>

**Administrative Expenses**

<table>
<thead>
<tr>
<th></th>
<th><strong>Actual</strong></th>
<th><strong>Budget</strong></th>
<th><strong>Variance</strong></th>
<th><strong>% Variance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries, wages &amp; employee benefits</td>
<td>147,105</td>
<td>122,071</td>
<td>(25,034)</td>
<td>(20.5%)</td>
</tr>
<tr>
<td>Professional fees</td>
<td>92,349</td>
<td>79,998</td>
<td>(12,351)</td>
<td>(15.4%)</td>
</tr>
<tr>
<td>Purchased services</td>
<td>116,036</td>
<td>71,990</td>
<td>(44,046)</td>
<td>(61.2%)</td>
</tr>
<tr>
<td>Prin ing and postage</td>
<td>56,758</td>
<td>123,228</td>
<td>66,470</td>
<td>53.9%</td>
</tr>
<tr>
<td>Other operating expenses</td>
<td>32</td>
<td>1,078</td>
<td>1,046</td>
<td>(102.9%)</td>
</tr>
<tr>
<td>Indirect cost allocation, Occupancy Expense</td>
<td>160,630</td>
<td>191,460</td>
<td>30,830</td>
<td>16.0%</td>
</tr>
<tr>
<td>Total Administrative Expenses</td>
<td>573,046</td>
<td>589,825</td>
<td>16,779</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

**Medical Loss Ratio**

<table>
<thead>
<tr>
<th></th>
<th><strong>Actual</strong></th>
<th><strong>Budget</strong></th>
<th><strong>Variance</strong></th>
<th><strong>% Variance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>146.2%</td>
<td>102.9%</td>
<td>-43.4%</td>
<td>-42.2%</td>
<td>Medical Loss Ra io</td>
</tr>
</tbody>
</table>
CalOptima - PACE
Statement of Revenues and Expenses
For the Six Months Ended December 31, 2017

<table>
<thead>
<tr>
<th>Month</th>
<th>$ Actual</th>
<th>$ Budget</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>235</td>
<td>241</td>
<td>(6)</td>
<td>(2.5%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year - To - Date</th>
<th>$ Actual</th>
<th>$ Budget</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1,359</td>
<td>1,371</td>
<td>(12)</td>
<td>(0.9%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revenues</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>MedCal capitation revenue</td>
<td>7,081,861</td>
<td>6,933,016</td>
</tr>
<tr>
<td>Medicare part C revenue</td>
<td>2,023,170</td>
<td>1,642,480</td>
</tr>
<tr>
<td>Medicare part D revenue</td>
<td>498,074</td>
<td>446,234</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Expenses</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Management</td>
<td>3,144,440</td>
<td>3,499,036</td>
</tr>
<tr>
<td>Claims payments to hospitals</td>
<td>1,669,718</td>
<td>1,659,162</td>
</tr>
<tr>
<td>Professional Claims</td>
<td>2,952,469</td>
<td>1,617,095</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>686,870</td>
<td>680,323</td>
</tr>
<tr>
<td>Long-term care facility payments</td>
<td>17,511</td>
<td>70,084</td>
</tr>
<tr>
<td>Professional Claims</td>
<td>2,599,838</td>
<td>560,226</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other Expenses</td>
<td>32,000</td>
<td>20,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Administrative Expenses</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries, wages &amp; employee benefits</td>
<td>445,788</td>
<td>564,159</td>
</tr>
<tr>
<td>Professional fees</td>
<td>16,672</td>
<td>30,000</td>
</tr>
<tr>
<td>Purchased services</td>
<td>30,413</td>
<td>126,816</td>
</tr>
<tr>
<td>Printing and postage</td>
<td>21,416</td>
<td>33,282</td>
</tr>
<tr>
<td>Depreciation &amp; amortization</td>
<td>12,936</td>
<td>12,312</td>
</tr>
<tr>
<td>Other operating expenses</td>
<td>89,710</td>
<td>111,030</td>
</tr>
<tr>
<td>Indirect cost allocation, Occupancy Expense</td>
<td>44,100</td>
<td>17,184</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operating Tax</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tax Revenue</td>
<td>34,660</td>
<td>0</td>
</tr>
<tr>
<td>Premium tax expense</td>
<td>34,660</td>
<td>0</td>
</tr>
</tbody>
</table>

| Medical Loss Ratio | 85.4% | 93.2% | 7.8% | 8.3% |
| Admin Loss Ratio | 6.9% | 9.9% | 3.0% | 30.6% |
### Statement of Revenues and Expenses

**For the Six Months Ended December 31, 2017**

#### Month

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues</td>
<td>10,598</td>
<td>0</td>
<td>10,598</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

#### Year - To - Date

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revenues</td>
<td>155,426</td>
<td>42,774</td>
<td>112,652</td>
<td>263.4%</td>
</tr>
</tbody>
</table>

#### Administrative Expenses

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purchase services</td>
<td>29,467</td>
<td>23,186</td>
<td>(6,282)</td>
<td>(27.1%)</td>
</tr>
<tr>
<td>Depreciation &amp; amortization</td>
<td>159,543</td>
<td>161,474</td>
<td>1,930</td>
<td>1.2%</td>
</tr>
<tr>
<td>Insurance expense</td>
<td>14,913</td>
<td>9,117</td>
<td>(5,797)</td>
<td>(63.6%)</td>
</tr>
<tr>
<td>Repair and maintenance</td>
<td>134,044</td>
<td>158,122</td>
<td>24,078</td>
<td>15.2%</td>
</tr>
<tr>
<td>Other Operating Expense</td>
<td>28,560</td>
<td>0</td>
<td>(28,560)</td>
<td>0.0%</td>
</tr>
<tr>
<td>Indirect allocation, Occupancy Expense</td>
<td>(336,553)</td>
<td>(333,055)</td>
<td>33,498</td>
<td>10.1%</td>
</tr>
</tbody>
</table>

|                      | (25)   | 18,843 | 18,868   | 100.1%     |

#### Total Administrative Expenses

|                      | 101,324| 113,058| 11,734   | 10.4%      |

#### Change in Net Assets

|                      | 10,623 | (18,843) | 29,466   | 156.4%     |

|                      | 54,103 | (70,284) | 124,387  | 177.0%     |
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
<table>
<thead>
<tr>
<th>ASSETS</th>
<th>LIABILITIES &amp; FUND BALANCES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Current Assets</td>
<td>Current Liabilities</td>
</tr>
<tr>
<td>Operating Cash</td>
<td>$481,885,979</td>
</tr>
<tr>
<td>Investments</td>
<td>833,329,387</td>
</tr>
<tr>
<td>Capitation receivable</td>
<td>383,482,587</td>
</tr>
<tr>
<td>Receivables - Other</td>
<td>17,374,740</td>
</tr>
<tr>
<td>Prepaid Expenses</td>
<td>4,986,816</td>
</tr>
<tr>
<td>Capitation and withholds</td>
<td>382,720,721</td>
</tr>
<tr>
<td>Total Current Assets</td>
<td><strong>1,721,059,509</strong></td>
</tr>
<tr>
<td>Capital Assets</td>
<td>Other employment benefits liability</td>
</tr>
<tr>
<td>Furniture and equipment</td>
<td>34,039,048</td>
</tr>
<tr>
<td>Building/Leasehold improvements</td>
<td>6,228,243</td>
</tr>
<tr>
<td>505 City Parkway West</td>
<td>49,433,337</td>
</tr>
<tr>
<td>Less: accumulated depreciation</td>
<td>(38,197,224)</td>
</tr>
<tr>
<td>Capital assets, net</td>
<td><strong>51,503,404</strong></td>
</tr>
<tr>
<td>Other Assets</td>
<td>Deferred inflows of Resources - Excess Earnings</td>
</tr>
<tr>
<td>Restricted deposit &amp; Other</td>
<td>300,000</td>
</tr>
<tr>
<td>Board-designated assets</td>
<td></td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>30,352,767</td>
</tr>
<tr>
<td>Long term investments</td>
<td>506,544,015</td>
</tr>
<tr>
<td>Total Board-designated Assets</td>
<td>536,896,783</td>
</tr>
<tr>
<td>Total Other Assets</td>
<td><strong>537,196,783</strong></td>
</tr>
<tr>
<td>Deferred outflows of Resources - Pension Contributions</td>
<td>5,234,198</td>
</tr>
<tr>
<td>Deferred outflows of Resources - Difference in Experience</td>
<td>1,072,771</td>
</tr>
<tr>
<td>Deferred outflows of Resources - Excess Earnings</td>
<td>5,270,171</td>
</tr>
<tr>
<td>TOTAL ASSETS &amp; OUTFLOWS</td>
<td><strong>2,321,336,835</strong></td>
</tr>
</tbody>
</table>
## CalOptima
### Board Designated Reserve and TNE Analysis
#### as of December 31, 2017

<table>
<thead>
<tr>
<th>Type</th>
<th>Reserve Name</th>
<th>Market Value</th>
<th>Benchmark</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>High</td>
<td>Mkt - Low</td>
</tr>
<tr>
<td>Board-designated Reserve</td>
<td>Tier 1 - Payden &amp; Rygel</td>
<td>146,736,596</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 1 - Logan Circle</td>
<td>146,622,040</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tier 1 - Wells Capital</td>
<td>146,295,076</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Consolidated:</strong></td>
<td><strong>439,653,712</strong></td>
<td><strong>301,731,893</strong></td>
<td><strong>469,161,551</strong></td>
</tr>
<tr>
<td>TNE Requirement</td>
<td>Tier 2 - Logan Circle</td>
<td>97,243,070</td>
<td>88,937,308</td>
<td>88,937,308</td>
</tr>
<tr>
<td></td>
<td><strong>Consolidated:</strong></td>
<td><strong>536,896,783</strong></td>
<td><strong>390,669,201</strong></td>
<td><strong>558,098,859</strong></td>
</tr>
<tr>
<td>Current reserve level</td>
<td></td>
<td>1.92</td>
<td>1.40</td>
<td>2.00</td>
</tr>
</tbody>
</table>
### Cash Flows from Operating Activities:

<table>
<thead>
<tr>
<th>Description</th>
<th>Month Ended</th>
<th>Year-To-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in net assets</td>
<td>10,409,072</td>
<td>22,999,442</td>
</tr>
<tr>
<td>Adjustments to reconcile change in net assets to net cash provided by operating activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>525,539</td>
<td>3,444,837</td>
</tr>
<tr>
<td>Changes in assets and liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepaid expenses and other</td>
<td>(81,418)</td>
<td>667,830</td>
</tr>
<tr>
<td>Catastrophic reserves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitation receivable</td>
<td>(13,520,961)</td>
<td>142,691,408</td>
</tr>
<tr>
<td>Medical claims liability</td>
<td>(54,629,776)</td>
<td>(282,061,044)</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>2,901,424</td>
<td>63,087,991</td>
</tr>
<tr>
<td>Payable to providers</td>
<td>(62,126,110)</td>
<td>(198,118,990)</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>(25,008,390)</td>
<td>(26,614,827)</td>
</tr>
<tr>
<td>Other accrued liabilities</td>
<td>456,865</td>
<td>1,928,744</td>
</tr>
<tr>
<td><strong>Net cash provided by/(used in) operating activities</strong></td>
<td>(141,073,756)</td>
<td>(271,974,607)</td>
</tr>
</tbody>
</table>

GASB 68 CalPERS Adjustments

<table>
<thead>
<tr>
<th>Description</th>
<th>Month Ended</th>
<th>Year-To-Date</th>
</tr>
</thead>
</table>

### Cash Flows from Investing Activities

<table>
<thead>
<tr>
<th>Description</th>
<th>Month Ended</th>
<th>Year-To-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in Investments</td>
<td>174,386,193</td>
<td>249,096,365</td>
</tr>
<tr>
<td>Change in property and equipment</td>
<td>(192,801)</td>
<td>(647,215)</td>
</tr>
<tr>
<td>Change in Board designated reserves</td>
<td>(323,992)</td>
<td>(1,758,409)</td>
</tr>
<tr>
<td><strong>Net cash provided by/(used in) investing activities</strong></td>
<td>173,869,400</td>
<td>246,690,742</td>
</tr>
</tbody>
</table>

NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS

<table>
<thead>
<tr>
<th>Description</th>
<th>Month Ended</th>
<th>Year-To-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Net cash provided by/(used in) operating activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Net increase/(decrease) in cash &amp; cash equivalents</strong></td>
<td>32,795,643</td>
<td>(25,283,866)</td>
</tr>
</tbody>
</table>

CASH AND CASH EQUIVALENTS, beginning of period

<table>
<thead>
<tr>
<th>Description</th>
<th>Month Ended</th>
<th>Year-To-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CASH AND CASH EQUIVALENTS, end of period</strong></td>
<td>$ 481,885,979</td>
<td>$ 481,885,979</td>
</tr>
</tbody>
</table>
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  
\textit{Consolidated}  

<table>
<thead>
<tr>
<th>Month</th>
<th>Year - To - Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Actual</td>
<td>Actual</td>
</tr>
<tr>
<td>Budget</td>
<td>Budget</td>
</tr>
<tr>
<td>Variance</td>
<td>Variance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month</th>
<th>Year - To - Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Actual</td>
<td>Actual</td>
</tr>
<tr>
<td>Budget</td>
<td>Budget</td>
</tr>
<tr>
<td>Variance</td>
<td>Variance</td>
</tr>
</tbody>
</table>

### Revenues

<table>
<thead>
<tr>
<th>Month</th>
<th>Year - To - Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Actual</td>
<td>Actual</td>
</tr>
<tr>
<td>Budget</td>
<td>Budget</td>
</tr>
<tr>
<td>Variance</td>
<td>Variance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month</th>
<th>Year - To - Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Actual</td>
<td>Actual</td>
</tr>
<tr>
<td>Budget</td>
<td>Budget</td>
</tr>
<tr>
<td>Variance</td>
<td>Variance</td>
</tr>
</tbody>
</table>

### Operating Expenditures

<table>
<thead>
<tr>
<th>Month</th>
<th>Year - To - Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Actual</td>
<td>Actual</td>
</tr>
<tr>
<td>Budget</td>
<td>Budget</td>
</tr>
<tr>
<td>Variance</td>
<td>Variance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Month</th>
<th>Year - To - Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>Actual</td>
<td>Actual</td>
</tr>
<tr>
<td>Budget</td>
<td>Budget</td>
</tr>
<tr>
<td>Variance</td>
<td>Variance</td>
</tr>
</tbody>
</table>

- **Total Operating Revenue**: 0 0 0 0.0%
- **Personnel**: 0 37,105 37,105 100.0%
- **Taxes and Benefits**: 0 17,909 17,909 100.0%
- **Travel**: 0 0 0 0.0%
- **Supplies**: 0 0 0 0.0%
- **Contractual**: 0 0 0 0.0%
- **Other**: 12,498 1,391,538 1,379,040 99.1%
- **Total Operating Expenditures**: 12,498 1,446,552 1,434,054 99.1%
- **Investment Income**: 0 0 0 0.0%
- **Program Income**: (12,498) (1,446,552) (1,434,054) (99.1%)
<table>
<thead>
<tr>
<th>Assets</th>
<th></th>
<th>Liabilities &amp; Net Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating cash</td>
<td>2,868,139</td>
<td>Accounts payable-Current 12,498</td>
</tr>
<tr>
<td>Grants receivable</td>
<td>0</td>
<td>Deferred Revenue 0</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>0</td>
<td>Payable to CalOptima 0</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td><strong>2,868,139</strong></td>
<td>Grants-Foundation 0</td>
</tr>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td><strong>12,498</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Assets</td>
<td>2,855,641</td>
<td></td>
</tr>
</tbody>
</table>

**Total Assets** 2,868,139  **Total Liabilities & Net Assets** 2,868,139
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

<table>
<thead>
<tr>
<th>Transfer Month</th>
<th>Line of Business</th>
<th>From Description</th>
<th>To Description</th>
<th>Amount</th>
<th>Expense Description</th>
<th>Fiscal Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>Medi-Cal</td>
<td>IS - Infrastructure - Professional Fee (Virtualization Architecture Assessment)</td>
<td>IS - Infrastructure - Professional Fee (On-Site Staff for the Phone System)</td>
<td>$48,600</td>
<td>Re-Purpose $48,600 from Professional Fees (Virtualization Architecture Assessment) to pay for an on-site staff for the phone system</td>
<td>2018</td>
</tr>
<tr>
<td>July</td>
<td>Medi-Cal</td>
<td>Facilities - Purchased Services (Restacking Services)</td>
<td>Facilities - Purchased Services (Reconfiguration Services)</td>
<td>$15,000</td>
<td>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</td>
<td>2018</td>
</tr>
<tr>
<td>August</td>
<td>Medi-Cal</td>
<td>Health Education &amp; Disease Mgmt. - Purchased Services (Adult Weight Management Vendor)</td>
<td>Health Education &amp; Disease Mgmt. - Purchased Services (Ansafone)</td>
<td>$30,000</td>
<td>Re-Purpose $30,000 from Purchased Services (Adult Weight Management Vendor) to pay for Ansafone services</td>
<td>2018</td>
</tr>
<tr>
<td>August</td>
<td>Medi-Cal</td>
<td>Health Education &amp; Disease Mgmt. - Purchased Services (Pediatric Weight Management Vendor)</td>
<td>Health Education &amp; Disease Mgmt. - Purchased Services (Captivate Contract and other initiatives)</td>
<td>$25,000</td>
<td>Re-Purpose $25,000 from Purchased Services (Pediatric Weight Management Vendor) to pay for Captivate contract and other initiatives</td>
<td>2018</td>
</tr>
<tr>
<td>August</td>
<td>PACE</td>
<td>PACE Administrative - Purchased Services (Encounter Reporting &amp; Translation Services)</td>
<td>PACE Administrative - Purchased Services (Satisfaction Survey)</td>
<td>$12,208</td>
<td>Re-Purpose $12,208 from Purchased Services (Encounter Reporting &amp; Translation Services) to pay for Satisfaction Survey</td>
<td>2018</td>
</tr>
<tr>
<td>August</td>
<td>Medi-Cal</td>
<td>Facilities - Capital Project (Upgrade CalOptima and Building Access System)</td>
<td>Facilities - Capital Project (Mail Room/Basement/Property Management Office)</td>
<td>$15,000</td>
<td>Reallocate $15,000 from Capital Project (Upgrade CalOptima and Building Access System) to Capital Project (Mail Room/Basement/Property Management Office)</td>
<td>2018</td>
</tr>
<tr>
<td>September</td>
<td>Medi-Cal</td>
<td>Other G&amp;A - Other Operating Expenses</td>
<td>Facilities - Building Repair and Maintenance</td>
<td>$65,000</td>
<td>Reallocate $65,000 from Other G&amp;A (other operating expenses) to cover cost to conduct a review/study from soil engineer and necessary repairs of the east entry sinkhole.</td>
<td>2018</td>
</tr>
<tr>
<td>September</td>
<td>OCC</td>
<td>Health Education &amp; Disease Management - Member Communications</td>
<td>Health Education &amp; Disease Management - Purchased Services</td>
<td>$12,000</td>
<td>Reallocate $12,000 within medical management activities budget for additional funding needed on CareNet in OneCare Connect.</td>
<td>2018</td>
</tr>
<tr>
<td>November</td>
<td>Medi-Cal</td>
<td>Human Resources - Purchased Services - Temporary Outsource Service</td>
<td>Human Resources - Purchased Services - General</td>
<td>$10,000</td>
<td>Re-Purpose $10,000 from Purchased Services (Temporary Outsource Service) to fund for training module design and other department initiatives in Purchased Services</td>
<td>2018</td>
</tr>
</tbody>
</table>
Financial Summary
November 2017

Board of Directors Meeting
February 1, 2018

Greg Hamblin
Chief Financial Officer
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%
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**

<table>
<thead>
<tr>
<th>Enrollment (By Aid Category)</th>
<th>Month-to-Date</th>
<th>Year-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Aged</td>
<td>62,704</td>
<td>63,406</td>
</tr>
<tr>
<td>BCCTP</td>
<td>621</td>
<td>618</td>
</tr>
<tr>
<td>Disabled</td>
<td>47,137</td>
<td>48,785</td>
</tr>
<tr>
<td>TANF Child</td>
<td>322,288</td>
<td>329,502</td>
</tr>
<tr>
<td>TANF Adult</td>
<td>94,261</td>
<td>103,749</td>
</tr>
<tr>
<td>LTC</td>
<td>3,504</td>
<td>3,268</td>
</tr>
<tr>
<td>MCE</td>
<td>237,565</td>
<td>236,567</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>768,080</strong></td>
<td><strong>785,895</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medi-Cal</th>
<th>OneCare Connect</th>
<th>PACE</th>
<th>OneCare</th>
<th>CalOptima Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>15,254</td>
<td>15,543</td>
<td>(289)</td>
<td>(1.9%)</td>
</tr>
<tr>
<td>Year-to-Date</td>
<td>233</td>
<td>236</td>
<td>(3)</td>
<td>(1.3%)</td>
</tr>
<tr>
<td></td>
<td>1,378</td>
<td>1,353</td>
<td>25</td>
<td>1.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>784,945</strong></td>
<td><strong>803,027</strong></td>
<td><strong>(18,082)</strong></td>
<td><strong>(2.3%)</strong></td>
</tr>
</tbody>
</table>
# Financial Highlights: November 2017

### Month-to-Date

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>784,945</td>
<td>803,027</td>
<td>(18,082)</td>
<td>(2.3%)</td>
</tr>
<tr>
<td>Revenues</td>
<td>285,485,855</td>
<td>275,462,239</td>
<td>10,023,616</td>
<td>3.6%</td>
</tr>
<tr>
<td>Medical Expenses</td>
<td>276,911,087</td>
<td>260,936,827</td>
<td>(15,974,260)</td>
<td>(6.1%)</td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>10,228,511</td>
<td>12,733,080</td>
<td>2,504,569</td>
<td>19.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(1,651,743)</td>
<td>1,792,332</td>
<td>(3,444,075)</td>
<td>(192.2%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Margin</td>
<td>423,148</td>
<td>231,157</td>
<td>191,991</td>
<td>83.1%</td>
</tr>
<tr>
<td>Non Operating Income (Loss)</td>
<td>3,880,326</td>
<td>7,957,478</td>
<td>(4,077,152)</td>
<td>(51.2%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(1,228,595)</td>
<td>2,023,489</td>
<td>(3,252,084)</td>
<td>(160.7%)</td>
</tr>
</tbody>
</table>

### Year-to-Date

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>3,947,448</td>
<td>4,011,864</td>
<td>(64,416)</td>
<td>(1.6%)</td>
</tr>
<tr>
<td>Revenues</td>
<td>1,424,567,074</td>
<td>1,376,470,031</td>
<td>48,097,043</td>
<td>3.5%</td>
</tr>
<tr>
<td>Medical Expenses</td>
<td>1,373,070,375</td>
<td>1,307,596,051</td>
<td>(65,474,324)</td>
<td>(5.0%)</td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>47,616,373</td>
<td>60,916,502</td>
<td>13,300,129</td>
<td>21.8%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3,880,326</td>
<td>7,957,478</td>
<td>(4,077,152)</td>
<td>(51.2%)</td>
</tr>
</tbody>
</table>

### Change in Net Assets

<table>
<thead>
<tr>
<th></th>
<th>Medical Loss Ratio</th>
<th>Administrative Loss Ratio</th>
<th>Operating Margin Ratio</th>
<th>Total Operating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>96.4%</td>
<td>3.3%</td>
<td>0.3%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Budget</td>
<td>95.0%</td>
<td>4.4%</td>
<td>0.6%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

### Notes
- All percentages are rounded to two decimal places.
- Variance calculations are based on actual versus budgeted amounts.
Consolidated Performance Actual vs. Budget: November (in millions)

<table>
<thead>
<tr>
<th>MONTH-TO-DATE</th>
<th>YEAR-TO-DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>Actual</td>
</tr>
<tr>
<td>(2.6)</td>
<td>(2.6)</td>
</tr>
<tr>
<td>0.7</td>
<td>4.5</td>
</tr>
<tr>
<td>0.3</td>
<td>1.3</td>
</tr>
<tr>
<td>(0.1)</td>
<td>0.7</td>
</tr>
<tr>
<td>(1.7)</td>
<td>Operating</td>
</tr>
<tr>
<td>0.4</td>
<td>Inv./Rental Inc, MCO tax</td>
</tr>
<tr>
<td>0.4</td>
<td>Non-Operating</td>
</tr>
<tr>
<td>(1.2)</td>
<td>TOTAL</td>
</tr>
</tbody>
</table>
# Consolidated Revenue & Expense: November 2017 MTD

<table>
<thead>
<tr>
<th>Member Months</th>
<th>Medi-Cal Classic</th>
<th>Medi-Cal Expansion</th>
<th>Total Medi-Cal</th>
<th>OneCare Connect</th>
<th>OneCare</th>
<th>PACE</th>
<th>Consolidated</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>530,515</td>
<td>237,565</td>
<td>768,080</td>
<td>15,254</td>
<td>1,378</td>
<td>233</td>
<td>784,945</td>
</tr>
</tbody>
</table>

## REVENUES
- Capitation Revenue: $151,985,935
- Other Income: -
- **Total Operating Revenues**: $253,602,284

## MEDICAL EXPENSES

<table>
<thead>
<tr>
<th>Item</th>
<th>Medi-Cal Classic</th>
<th>Medi-Cal Expansion</th>
<th>Total Medi-Cal</th>
<th>OneCare Connect</th>
<th>OneCare</th>
<th>PACE</th>
<th>Consolidated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Capitalation</td>
<td>39,609,588</td>
<td>49,693,262</td>
<td>89,302,850</td>
<td>10,364,079</td>
<td>378,428</td>
<td>-</td>
<td>100,045,357</td>
</tr>
<tr>
<td>Facilities</td>
<td>27,980,269</td>
<td>17,261,143</td>
<td>45,241,412</td>
<td>2,460,173</td>
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<td>Skilled Nursing</td>
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<td>1,209</td>
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<td>1,847,971</td>
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<td>2,735,657</td>
<td>1,078,869</td>
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<td>564,797</td>
<td>4,376,323</td>
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<td>Reimbursement &amp; Other</td>
<td>481,235</td>
<td>335,970</td>
<td>817,206</td>
<td>150,000</td>
<td>7,100</td>
<td>101,204</td>
<td>1,075,500</td>
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<tr>
<td><strong>Total Medical Expenses</strong></td>
<td>150,593,115</td>
<td>97,749,333</td>
<td>248,342,448</td>
<td>25,907,587</td>
<td>1,107,067</td>
<td>1,553,386</td>
<td>276,911,087</td>
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</table>

**Medical Loss Ratio**: 99.1% 96.2% 97.9% 90.4% 68.4% 97.7% 97.0%

## GROSS MARGIN
- Total: 5,299,836
- OneCare: 2,765,127
- PACE: 512,488
- Consolidated: 37,318
- Total: 8,574,768

## ADMINISTRATIVE EXPENSES

<table>
<thead>
<tr>
<th>Item</th>
<th>Medi-Cal Classic</th>
<th>Medi-Cal Expansion</th>
<th>Total Medi-Cal</th>
<th>OneCare Connect</th>
<th>OneCare</th>
<th>PACE</th>
<th>Consolidated</th>
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<tbody>
<tr>
<td>Salaries, Wages &amp; Benefits</td>
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<td>663,318</td>
<td>20,139</td>
<td>74,618</td>
<td>6,168,224</td>
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<td>Purchased services</td>
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<td>Depreciation and Amortization</td>
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<td>Other expenses</td>
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<td>Indirect cost allocation, Occupancy expense</td>
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<td>664,798</td>
<td>13,553</td>
<td>3,052</td>
<td>318,891</td>
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<td><strong>Total Administrative Expenses</strong></td>
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<td>2,066,938</td>
<td>168,896</td>
<td>102,330</td>
<td>10,226,511</td>
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</table>

**Admin Loss Ratio**: 3.1% 7.2% 10.4% 6.4% 3.6%

## INCOME (LOSS) FROM OPERATIONS
- Total: (2,628,510)
- OneCare: 698,189
- Consolidated: 343,592 (65,013)
- Total: (1,651,743)

## INVESTMENT INCOME
- Total: 415,351

## NET RENTAL INCOME
- Total: 23,099

## NET GRANT INCOME
- Total: (15,408)

## OTHER INCOME
- Total: 106

## CHANGE IN NET ASSETS
- Total: (2,643,813)
- OneCare: 698,189
- Consolidated: 343,592 (65,013)
- Total: (1,228,556)

## BUDGETED CHANGE IN ASSETS
- Total: 1,567,139
- OneCare: 366,020
- Consolidated: (115,076) (25,951)
- Total: 2,023,489

## VARIANCE TO BUDGET - FAV (UNFAV)
- Total: (4,210,952)
- OneCare: 331,369
- Consolidated: 459,268 (39,062)
- Total: (3,252,084)
# Consolidated Revenue & Expense: November 2017 YTD

<table>
<thead>
<tr>
<th></th>
<th>Medi-Cal Classic</th>
<th>Medi-Cal Expansion</th>
<th>Total Medi-Cal</th>
<th>OneCare Connect</th>
<th>OneCare</th>
<th>PACE</th>
<th>Consolidated</th>
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<td></td>
<td>2,671,413</td>
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<td><strong>REVENUES</strong></td>
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<tr>
<td>Capitation Revenue</td>
<td>$ 747,252,854</td>
<td>$ 519,719,215</td>
<td>$ 1,266,972,069</td>
<td>$ 144,373,037</td>
<td>5,292,062</td>
<td>$ 7,929,306</td>
<td>$ 1,426,567,074</td>
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<tr>
<td>Total Operating Revenues</td>
<td>$ 747,252,854</td>
<td>$ 519,719,215</td>
<td>$ 1,266,972,069</td>
<td>$ 144,373,037</td>
<td>5,292,062</td>
<td>7,929,306</td>
<td>1,426,567,074</td>
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<td><strong>MEDICAL EXPENSES</strong></td>
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<td>Provider Capitation</td>
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<td>55,725,806</td>
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<td>3,276,676</td>
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<td>$ 131,417,121</td>
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<td><strong>Medical Loss Ratio</strong></td>
<td>98.0%</td>
<td>96.0%</td>
<td>97.2%</td>
<td>91.0%</td>
<td>68.3%</td>
<td>84.9%</td>
<td>96.4%</td>
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<td><strong>GROSS MARGIN</strong></td>
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<td>51,496,699</td>
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<td><strong>ADMINISTRATIVE EXPENSES</strong></td>
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<td>Salaries, Wages &amp; Benefits</td>
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<td>352,446</td>
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<td>7.3%</td>
<td>6.7%</td>
<td>3.3%</td>
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<td><strong>INCOME (LOSS) FROM OPERATIONS</strong></td>
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<td>666,824</td>
<td>3,880,326</td>
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<td><strong>NET GRANT INCOME</strong></td>
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<td>(72,727)</td>
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<tr>
<td><strong>CHANGE IN NET ASSETS</strong></td>
<td><strong>(2,630,179)</strong></td>
<td><strong>4,484,317</strong></td>
<td><strong>1,287,163</strong></td>
<td><strong>666,824</strong></td>
<td><strong>3,880,326</strong></td>
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<tr>
<td><strong>BUDGETED CHANGE IN ASSETS</strong></td>
<td>6,282,165</td>
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<td>(698,373)</td>
<td>(259,287)</td>
<td>9,156,037</td>
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<td><strong>VARIANCE TO BUDGET - FAV (UNFAV)</strong></td>
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<td>1,985,536</td>
<td>926,111</td>
<td>3,434,333</td>
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Back to Agenda
## Balance Sheet: As of November 2017

<table>
<thead>
<tr>
<th>ASSETS</th>
<th>LIABILITIES &amp; FUND BALANCES</th>
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<tbody>
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<td><strong>Current Assets</strong></td>
<td><strong>Current Liabilities</strong></td>
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<tr>
<td>Operating Cash</td>
<td>Accounts payable</td>
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<td>Investments</td>
<td>Medical claims liability</td>
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<td>Capitation receivable</td>
<td>Accrued payroll liabilities</td>
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<td>Receivables - Other</td>
<td>Deferred revenue</td>
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<td>Prepaid Expenses</td>
<td>Deferred lease obligations</td>
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<td><strong>Total Current Assets</strong></td>
<td>Capitation and withhold</td>
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<td>1,849,047,680</td>
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<tr>
<th>Capital Assets</th>
<th>Other employment benefits liability</th>
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<tr>
<td>Furniture and equipment</td>
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<tr>
<td>Building/Leasehold improvements</td>
<td>5,983,412</td>
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<td>505 City Parkway West</td>
<td>49,433,337</td>
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<td><strong>Less: accumulated depreciation</strong></td>
<td>Net Pension Liabilities</td>
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<td>(37,619,667)</td>
<td>Long Term Liabilities</td>
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<td><strong>Capital assets, net</strong></td>
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<tr>
<td>51,836,141</td>
<td>TOTAL LIABILITIES</td>
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<td><strong>Total Other Assets</strong></td>
<td>1,721,944,880</td>
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<tr>
<td>536,872,791</td>
<td><strong>Net Assets</strong></td>
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<td><strong>Deferred outflows of Resources - Pension Contributions</strong></td>
<td>726,048,762</td>
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<tr>
<td><strong>Deferred outflows of Resources - Difference in Experience</strong></td>
<td>5,234,199</td>
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<td><strong>Deferred outflows of Resources - Excess Earnings</strong></td>
<td>1,072,771</td>
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<tr>
<td><strong>Total ASSETS &amp; OUTFLOWS</strong></td>
<td><strong>TOTAL LIABILITIES, INFLows &amp; FUND BALANCES</strong></td>
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<tr>
<td>2,449,333,752</td>
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# Board Designated Reserve and TNE Analysis

As of November 2017

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<th>Reserve Name</th>
<th>Market Value</th>
<th>Benchmark</th>
<th>Variance</th>
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<td></td>
<td></td>
<td></td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td>Tier 1 - Payden &amp; Rygel</td>
<td>146,641,999</td>
<td></td>
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<tr>
<td></td>
<td>Tier 1 - Logan Circle</td>
<td>146,498,235</td>
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<tr>
<td></td>
<td>Tier 1 - Wells Capital</td>
<td>146,246,368</td>
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<td>Board-designated Reserve</td>
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<td>439,386,601</td>
<td>309,435,704</td>
<td>480,447,597</td>
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<td>TNE Requirement</td>
<td>97,186,190</td>
<td>89,592,046</td>
<td>89,592,046</td>
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<td></td>
<td>Tier 2 - Logan Circle</td>
<td>536,572,791</td>
<td>399,027,750</td>
<td>570,039,643</td>
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<td><strong>Consolidated:</strong></td>
<td><strong>536,572,791</strong></td>
<td><strong>399,027,750</strong></td>
<td><strong>570,039,643</strong></td>
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<tr>
<td></td>
<td><strong>Current reserve level</strong></td>
<td><strong>1.88</strong></td>
<td><strong>1.40</strong></td>
<td><strong>2.00</strong></td>
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</table>
UNAUDITED FINANCIAL STATEMENTS

November 2017
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### CalOptima - Consolidated

**Financial Highlights**

For the Five Months Ended November 30, 2017

<table>
<thead>
<tr>
<th></th>
<th>Month-to-Date</th>
<th>Year-to-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
</tr>
<tr>
<td><strong>Member Months</strong></td>
<td>784,945</td>
<td>803,027</td>
</tr>
<tr>
<td><strong>Revenues</strong></td>
<td>285,485,855</td>
<td>275,462,239</td>
</tr>
<tr>
<td><strong>Medical Expenses</strong></td>
<td>276,911,087</td>
<td>260,936,827</td>
</tr>
<tr>
<td><strong>Administrative Expenses</strong></td>
<td>10,226,511</td>
<td>12,733,080</td>
</tr>
<tr>
<td><strong>Operating Margin</strong></td>
<td>(1,651,743)</td>
<td>1,792,332</td>
</tr>
<tr>
<td><strong>Non Operating Income (Loss)</strong></td>
<td>423,148</td>
<td>231,157</td>
</tr>
<tr>
<td><strong>Change in Net Assets</strong></td>
<td>(1,228,595)</td>
<td>2,023,489</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Loss Ratio</strong></td>
<td>97.0%</td>
<td>94.7%</td>
</tr>
<tr>
<td><strong>Administrative Loss Ratio</strong></td>
<td>3.6%</td>
<td>4.6%</td>
</tr>
<tr>
<td><strong>Operating Margin Ratio</strong></td>
<td>(0.6%)</td>
<td>9.7%</td>
</tr>
<tr>
<td><strong>Total Operating</strong></td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
## Financial Dashboard
**For the Five Months Ended November 30, 2017**

### Enrollment

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Favor / (Unfavor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>766,080</td>
<td>785,895</td>
<td>(17,815) (2.3%)</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>15,254</td>
<td>15,543</td>
<td>(289) (1.9%)</td>
</tr>
<tr>
<td>OneCare</td>
<td>1,378</td>
<td>1,353</td>
<td>25 1.8%</td>
</tr>
<tr>
<td>PACE</td>
<td>233</td>
<td>236</td>
<td>(3) (1.3%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>784,945</td>
<td>803,027</td>
<td>(18,082) (2.3%)</td>
</tr>
</tbody>
</table>

### Change in Net Assets (000)

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Favor / (Unfavor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>$2,644</td>
<td>$1,567</td>
<td>$4,211 (268.7%)</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>698</td>
<td>367</td>
<td>331 90.3%</td>
</tr>
<tr>
<td>OneCare</td>
<td>344</td>
<td>(116)</td>
<td>459 397.0%</td>
</tr>
<tr>
<td>PACE</td>
<td>(65)</td>
<td>(26)</td>
<td>(39) (150.5%)</td>
</tr>
<tr>
<td>505 Bldg.</td>
<td>23</td>
<td>9</td>
<td>14 222.6%</td>
</tr>
<tr>
<td>Investment Income &amp; Other</td>
<td>415</td>
<td>250</td>
<td>165 66.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$(1,229)</td>
<td>$2,023</td>
<td>$(3,252) (160.7%)</td>
</tr>
</tbody>
</table>

### MLR

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>% Point Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>97.9%</td>
<td>95.1%</td>
<td>(2.8)</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>90.4%</td>
<td>91.5%</td>
<td>1.1</td>
</tr>
<tr>
<td>OneCare</td>
<td>68.4%</td>
<td>101.3%</td>
<td>33.0</td>
</tr>
</tbody>
</table>

### Administrative Cost (000)

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Favor / (Unfavor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>$7,888</td>
<td>$10,526</td>
<td>$2,637 25.1%</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>2,067</td>
<td>1,958</td>
<td>(109) (5.6%)</td>
</tr>
<tr>
<td>OneCare</td>
<td>169</td>
<td>97</td>
<td>(72) (73.7%)</td>
</tr>
<tr>
<td>PACE</td>
<td>102</td>
<td>152</td>
<td>50 32.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>10,227</td>
<td>12,733</td>
<td>2,507 19.7%</td>
</tr>
</tbody>
</table>

### Administrative Cost (000)

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Favor / (Unfavor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>881</td>
<td>872</td>
<td>(9)</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>71</td>
<td>66</td>
<td>5</td>
</tr>
<tr>
<td>OneCare</td>
<td>461</td>
<td>451</td>
<td>10</td>
</tr>
<tr>
<td>PACE</td>
<td>4</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,394</td>
<td>1,393</td>
<td>1</td>
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</tbody>
</table>

### MLR

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>% Point Var</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>97.2%</td>
<td>96.2%</td>
<td>(1.0)</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>91.0%</td>
<td>92.5%</td>
<td>1.5</td>
</tr>
<tr>
<td>OneCare</td>
<td>68.3%</td>
<td>103.0%</td>
<td>34.7</td>
</tr>
</tbody>
</table>

### Administrative Cost (000)

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Budget</th>
<th>Favor / (Unfavor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>39,228</td>
<td>50,055</td>
<td>$10,827 21.8%</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>8,472</td>
<td>9,622</td>
<td>$1,150 12.0%</td>
</tr>
<tr>
<td>OneCare</td>
<td>389</td>
<td>493</td>
<td>104 21.1%</td>
</tr>
<tr>
<td>PACE</td>
<td>527</td>
<td>746</td>
<td>219 29.3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>47,816</td>
<td>60,917</td>
<td>$13,101 21.8%</td>
</tr>
</tbody>
</table>

### MM per FTE

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>Favor / (Unfavor)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td>859</td>
<td>873 (14)</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>71</td>
<td>66 5</td>
</tr>
<tr>
<td>OneCare</td>
<td>461</td>
<td>451 10</td>
</tr>
<tr>
<td>PACE</td>
<td>4</td>
<td>4 1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1,394</td>
<td>1,393 1</td>
</tr>
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</table>
CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended November 30, 2017

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>PMPM*</th>
<th>Budget</th>
<th>PMPM*</th>
<th>Variance</th>
<th>PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Months</strong>**</td>
<td>784,945</td>
<td></td>
<td>803,027</td>
<td></td>
<td>(18,082)</td>
<td></td>
</tr>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>253,602,284</td>
<td>330.18</td>
<td>245,282,587</td>
<td>312.11</td>
<td>$8,319,697</td>
<td>18.07</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>28,672,713</td>
<td>1,879.68</td>
<td>27,229,316</td>
<td>1,751.87</td>
<td>1,443,397</td>
<td>127.81</td>
</tr>
<tr>
<td>OneCare</td>
<td>1,620,154</td>
<td>1,751.87</td>
<td>1,397,670</td>
<td>1,033.02</td>
<td>222,484</td>
<td>142.71</td>
</tr>
<tr>
<td>PACE</td>
<td>1,590,703</td>
<td>6,827.05</td>
<td>1,552,666</td>
<td>6,579.09</td>
<td>38,037</td>
<td>247.96</td>
</tr>
<tr>
<td><strong>Total Operating Revenue</strong></td>
<td>285,485,855</td>
<td>363.70</td>
<td>275,462,239</td>
<td>343.03</td>
<td>(10,023,616)</td>
<td>20.67</td>
</tr>
<tr>
<td><strong>Medical Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>248,342,448</td>
<td>323.33</td>
<td>233,189,629</td>
<td>296.72</td>
<td>(15,152,819)</td>
<td>(26.61)</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>25,907,587</td>
<td>1,698.41</td>
<td>24,904,512</td>
<td>1,602.30</td>
<td>(1,003,075)</td>
<td>(96.12)</td>
</tr>
<tr>
<td>OneCare</td>
<td>1,107,667</td>
<td>803.82</td>
<td>1,416,123</td>
<td>1,046.65</td>
<td>308,456</td>
<td>242.83</td>
</tr>
<tr>
<td>PACE</td>
<td>1,553,386</td>
<td>6,666.89</td>
<td>1,426,563</td>
<td>6,043.76</td>
<td>(126,823)</td>
<td>(62.13)</td>
</tr>
<tr>
<td><strong>Total Medical Expenses</strong></td>
<td>276,911,087</td>
<td>352.78</td>
<td>260,936,827</td>
<td>324.94</td>
<td>(15,974,260)</td>
<td>(27.84)</td>
</tr>
<tr>
<td><strong>Gross Margin</strong></td>
<td>8,574,768</td>
<td>10.92</td>
<td>14,525,412</td>
<td>18.09</td>
<td>(5,950,644)</td>
<td>(7.16)</td>
</tr>
<tr>
<td><strong>Administrative Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries and Benefits</td>
<td>6,168,224</td>
<td>7.86</td>
<td>7,271,987</td>
<td>9.06</td>
<td>1,103,763</td>
<td>1.20</td>
</tr>
<tr>
<td>Professional fees</td>
<td>426,477</td>
<td>0.54</td>
<td>376,191</td>
<td>0.47</td>
<td>(50,286)</td>
<td>(0.07)</td>
</tr>
<tr>
<td>Purchased services</td>
<td>1,254,207</td>
<td>1.60</td>
<td>2,204,941</td>
<td>2.75</td>
<td>950,734</td>
<td>1.15</td>
</tr>
<tr>
<td>Printing and Postage</td>
<td>474,220</td>
<td>0.80</td>
<td>528,874</td>
<td>0.66</td>
<td>55,054</td>
<td>0.06</td>
</tr>
<tr>
<td>Depreciation and Amortization</td>
<td>368,728</td>
<td>0.47</td>
<td>463,298</td>
<td>0.56</td>
<td>94,570</td>
<td>0.11</td>
</tr>
<tr>
<td>Other</td>
<td>1,215,765</td>
<td>1.55</td>
<td>1,546,372</td>
<td>1.93</td>
<td>330,607</td>
<td>0.38</td>
</tr>
<tr>
<td>Indirect cost allocation, Occupancy expense</td>
<td>318,891</td>
<td>0.41</td>
<td>340,417</td>
<td>0.42</td>
<td>21,526</td>
<td>0.02</td>
</tr>
<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td>10,226,511</td>
<td>13.03</td>
<td>12,733,080</td>
<td>15.86</td>
<td>2,506,569</td>
<td>2.63</td>
</tr>
<tr>
<td><strong>Income (Loss) From Operations</strong></td>
<td>(1,651,743)</td>
<td>(2.10)</td>
<td>1,792,332</td>
<td>2.23</td>
<td>(3,444,075)</td>
<td>(4.34)</td>
</tr>
<tr>
<td>Investment income</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest income</td>
<td>2,337,088</td>
<td>2.98</td>
<td>250,000</td>
<td>0.31</td>
<td>2,087,088</td>
<td>2.67</td>
</tr>
<tr>
<td>Realized gain/(loss) on investments</td>
<td>(91,087)</td>
<td>(0.12)</td>
<td>-</td>
<td>-</td>
<td>(91,087)</td>
<td>(0.12)</td>
</tr>
<tr>
<td>Unrealized gain/(loss) on investments</td>
<td>(1,830,649)</td>
<td>(2.33)</td>
<td>-</td>
<td>-</td>
<td>(1,830,649)</td>
<td>(2.33)</td>
</tr>
<tr>
<td><strong>Total Investment Income</strong></td>
<td>415,351</td>
<td>0.53</td>
<td>250,000</td>
<td>0.31</td>
<td>165,351</td>
<td>0.22</td>
</tr>
<tr>
<td><strong>Net Rental Income</strong></td>
<td>23,099</td>
<td>0.03</td>
<td>(18,843)</td>
<td>(0.02)</td>
<td>41,942</td>
<td>0.05</td>
</tr>
<tr>
<td><strong>Total Net Operating Tax</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Net Grant Income</strong></td>
<td>(15,408)</td>
<td>(0.02)</td>
<td>-</td>
<td>-</td>
<td>(15,408)</td>
<td>(0.02)</td>
</tr>
<tr>
<td>QAF/IGT</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Other Income</strong></td>
<td>106</td>
<td>0.00</td>
<td>-</td>
<td>-</td>
<td>106</td>
<td>0.00</td>
</tr>
<tr>
<td><strong>Change In Net Assets</strong></td>
<td>(1,228,595)</td>
<td>(1.57)</td>
<td>2,023,489</td>
<td>2.52</td>
<td>(3,252,084)</td>
<td>(4.09)</td>
</tr>
<tr>
<td><strong>Medical Loss Ratio</strong></td>
<td>97.0%</td>
<td></td>
<td>94.7%</td>
<td></td>
<td>(2.3%)</td>
<td></td>
</tr>
<tr>
<td><strong>Administrative Loss Ratio</strong></td>
<td>3.6%</td>
<td></td>
<td>4.6%</td>
<td></td>
<td>1.0%</td>
<td></td>
</tr>
</tbody>
</table>

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP
CalOptima - Consolidated Statement of Revenue and Expenses
For the Five Months Ended November 30, 2017

<table>
<thead>
<tr>
<th></th>
<th>Actual</th>
<th>PMPM*</th>
<th>Month Budget</th>
<th>PMPM*</th>
<th>Variance</th>
<th>PMPM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Months</strong>**</td>
<td>3,947,448</td>
<td></td>
<td>4,011,864</td>
<td>(64,416)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Revenues</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>$1,266,972,069</td>
<td>327.97</td>
<td>$1,225,175,140</td>
<td>312.03</td>
<td>$41,796,929</td>
<td>15.94</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>144,373,037</td>
<td>1,891.01</td>
<td>136,996,266</td>
<td>1,765.85</td>
<td>7,376,771</td>
<td>475.26</td>
</tr>
<tr>
<td>OneCare</td>
<td>5,292,662</td>
<td>762.52</td>
<td>6,864,040</td>
<td>1,028.94</td>
<td>(1,571,378)</td>
<td>266.42</td>
</tr>
<tr>
<td>PACE</td>
<td>7,929,306</td>
<td>7,054.54</td>
<td>7,434,585</td>
<td>6,579.28</td>
<td>494,721</td>
<td>475.26</td>
</tr>
<tr>
<td><strong>Total Operating Revenue</strong></td>
<td>1,424,567,074</td>
<td>360.88</td>
<td>1,376,470,031</td>
<td>343.10</td>
<td>48,097,043</td>
<td>17.78</td>
</tr>
<tr>
<td><strong>Medical Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>$1,231,301,558</td>
<td>318.74</td>
<td>1,166,837,615</td>
<td>297.17</td>
<td>(64,463,943)</td>
<td>(21.57)</td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>131,417,121</td>
<td>1,721.31</td>
<td>126,741,273</td>
<td>1,633.66</td>
<td>(6,675,848)</td>
<td>(87.65)</td>
</tr>
<tr>
<td>OneCare</td>
<td>3,616,519</td>
<td>521.04</td>
<td>7,069,301</td>
<td>1,059.71</td>
<td>3,452,782</td>
<td>538.67</td>
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<td>PACE</td>
<td>6,735,178</td>
<td>5,992.15</td>
<td>6,947,862</td>
<td>6,148.55</td>
<td>212,684</td>
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<td><strong>Total Medical Expenses</strong></td>
<td>1,373,070,375</td>
<td>347.84</td>
<td>1,307,596,051</td>
<td>325.93</td>
<td>(65,474,324)</td>
<td>(21.91)</td>
</tr>
<tr>
<td><strong>Gross Margin</strong></td>
<td>51,496,699</td>
<td>13.05</td>
<td>68,873,980</td>
<td>17.17</td>
<td>(17,377,281)</td>
<td>(4.12)</td>
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<tr>
<td><strong>Administrative Expenses</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Salaries and Benefits</td>
<td>30,308,550</td>
<td>7.68</td>
<td>34,886,703</td>
<td>8.70</td>
<td>4,578,153</td>
<td>1.02</td>
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<td>Professional fees</td>
<td>1,159,686</td>
<td>0.29</td>
<td>1,937,446</td>
<td>0.48</td>
<td>777,760</td>
<td>0.19</td>
</tr>
<tr>
<td>Purchased services</td>
<td>4,444,029</td>
<td>1.13</td>
<td>9,825,609</td>
<td>2.45</td>
<td>5,381,579</td>
<td>1.32</td>
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<tr>
<td>Printing and Postage</td>
<td>1,846,483</td>
<td>0.47</td>
<td>2,846,844</td>
<td>0.66</td>
<td>500,361</td>
<td>0.19</td>
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<td>Depreciation and Amortization</td>
<td>2,120,911</td>
<td>0.54</td>
<td>2,316,490</td>
<td>0.55</td>
<td>195,579</td>
<td>0.04</td>
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<tr>
<td>Other</td>
<td>5,994,506</td>
<td>1.52</td>
<td>7,601,306</td>
<td>1.89</td>
<td>1,606,799</td>
<td>0.38</td>
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<tr>
<td>Indirect cost allocation, Occupancy expense</td>
<td>1,742,206</td>
<td>0.44</td>
<td>1,702,085</td>
<td>0.42</td>
<td>(40,121)</td>
<td>(0.02)</td>
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<tr>
<td><strong>Total Administrative Expenses</strong></td>
<td>47,616,373</td>
<td>12.06</td>
<td>60,916,902</td>
<td>15.18</td>
<td>13,300,529</td>
<td>3.12</td>
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<tr>
<td><strong>Income (Loss) From Operations</strong></td>
<td>3,880,326</td>
<td>0.98</td>
<td>7,957,478</td>
<td>1.98</td>
<td>(4,077,152)</td>
<td>(1.00)</td>
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<td><strong>Investment income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest income</td>
<td>11,038,986</td>
<td>2.80</td>
<td>1,250,000</td>
<td>0.31</td>
<td>9,788,986</td>
<td>2.48</td>
</tr>
<tr>
<td>Realized gain/(loss) on investments</td>
<td>(501,211)</td>
<td>(0.13)</td>
<td>-</td>
<td>-</td>
<td>(501,211)</td>
<td>(0.13)</td>
</tr>
<tr>
<td>Unrealized gain/(loss) on investments</td>
<td>(1,799,009)</td>
<td>(0.46)</td>
<td>-</td>
<td>-</td>
<td>(1,799,009)</td>
<td>(0.46)</td>
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<tr>
<td><strong>Total Investment Income</strong></td>
<td>8,738,768</td>
<td>2.21</td>
<td>1,250,000</td>
<td>0.31</td>
<td>7,488,768</td>
<td>1.99</td>
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<td><strong>Net Rental Income</strong></td>
<td>43,480</td>
<td>0.01</td>
<td>(51,441)</td>
<td>(0.01)</td>
<td>94,921</td>
<td>0.02</td>
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<td><strong>Total Net Operating Tax</strong></td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
<td><strong>Total Net Grant Income</strong></td>
<td>(72,727)</td>
<td>(0.02)</td>
<td>-</td>
<td>-</td>
<td>(72,727)</td>
<td>(0.02)</td>
</tr>
<tr>
<td><strong>Other Income</strong></td>
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<td>0.00</td>
<td>-</td>
<td>-</td>
<td>525</td>
<td>0.00</td>
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<td><strong>Change In Net Assets</strong></td>
<td>12,590,370</td>
<td>3.19</td>
<td>9,156,037</td>
<td>2.28</td>
<td>3,434,333</td>
<td>0.91</td>
</tr>
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</table>

| **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
<table>
<thead>
<tr>
<th></th>
<th>Medi-Cal Classic</th>
<th>Medi-Cal Expansion</th>
<th>Total Medi-Cal</th>
<th>OneCare Connect</th>
<th>OneCare PACE</th>
<th>PACE</th>
<th>Consolidated</th>
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<td>237,565</td>
<td>768,080</td>
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<td>1,378</td>
<td>233</td>
<td>784,945</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Capitation Revenue</td>
<td>$ 151,985,935</td>
<td>$ 101,616,349</td>
<td>$ 253,602,284</td>
<td>$ 28,672,713</td>
<td>$ 1,620,154</td>
<td></td>
<td>$ 285,485,855</td>
</tr>
<tr>
<td>Other Income</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total Operating Revenues</td>
<td>151,985,935</td>
<td>101,616,349</td>
<td>253,602,284</td>
<td>28,672,713</td>
<td>1,620,154</td>
<td></td>
<td>285,485,855</td>
</tr>
<tr>
<td>MEDICAL EXPENSES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
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<td>Provider Capitation</td>
<td>39,609,588</td>
<td>49,693,262</td>
<td>89,302,850</td>
<td>10,364,079</td>
<td>378,428</td>
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<td>100,045,357</td>
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<td>Facilities</td>
<td>27,986,269</td>
<td>17,261,143</td>
<td>45,247,412</td>
<td>2,460,173</td>
<td>229,417</td>
<td>370,440</td>
<td>48,307,442</td>
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<td>Ancillary</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>658,020</td>
<td>69,269</td>
<td></td>
<td>727,289</td>
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<td>Skilled Nursing</td>
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<td>-</td>
<td>-</td>
<td>5,418</td>
<td>-</td>
<td>5,418</td>
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<td>Professional Claims</td>
<td>7,817,321</td>
<td>8,925,403</td>
<td>16,742,724</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>17,129,831</td>
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<td>Prescription Drugs</td>
<td>16,965,570</td>
<td>17,785,115</td>
<td>34,750,685</td>
<td>-</td>
<td>387,108</td>
<td>-</td>
<td>40,550,954</td>
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<td>Quality Incentives</td>
<td>-</td>
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<td>-</td>
<td>658,020</td>
<td>-</td>
<td>-</td>
<td></td>
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<td>MLTSS Facility Payments</td>
<td>55,885,162</td>
<td>2,860,753</td>
<td>58,745,914</td>
<td>5,942,841</td>
<td>-</td>
<td>1,209</td>
<td>64,689,965</td>
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<tr>
<td>Medical Management</td>
<td>1,847,971</td>
<td>887,687</td>
<td>2,735,657</td>
<td>1,078,869</td>
<td>-</td>
<td>564,797</td>
<td>4,379,323</td>
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<td>Reinsurance &amp; Other</td>
<td>481,235</td>
<td>335,970</td>
<td>817,206</td>
<td>150,000</td>
<td>7,100</td>
<td>101,204</td>
<td>1,075,509</td>
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<td>Total Medical Expenses</td>
<td>150,593,115</td>
<td>97,749,333</td>
<td>248,342,448</td>
<td>25,907,587</td>
<td>1,107,667</td>
<td>1,553,386</td>
<td>276,911,087</td>
</tr>
<tr>
<td>Medical Loss Ratio</td>
<td>99.1%</td>
<td>96.2%</td>
<td>97.9%</td>
<td>90.4%</td>
<td>68.4%</td>
<td>97.7%</td>
<td>97.0%</td>
</tr>
<tr>
<td>GROSS MARGIN</td>
<td>1,392,821</td>
<td>3,867,016</td>
<td>5,259,836</td>
<td>2,765,127</td>
<td>512,488</td>
<td>37,318</td>
<td>8,574,768</td>
</tr>
<tr>
<td>ADMINISTRATIVE EXPENSES</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Salaries, Wages &amp; Benefits</td>
<td>5,410,150</td>
<td>663,318</td>
<td>20,139</td>
<td>74,618</td>
<td>97,416</td>
<td>4,085</td>
<td>6,168,224</td>
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<tr>
<td>Professional fees</td>
<td>235,343</td>
<td>108,033</td>
<td>79,016</td>
<td>4,085</td>
<td>426,477</td>
<td>0</td>
<td>426,477</td>
</tr>
<tr>
<td>Purchased services</td>
<td>697,604</td>
<td>502,279</td>
<td>45,904</td>
<td>8,730</td>
<td>1,254,207</td>
<td>0</td>
<td>1,254,207</td>
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<td>Printing and Postage</td>
<td>373,219</td>
<td>90,406</td>
<td>10,595</td>
<td>0</td>
<td>474,220</td>
<td>0</td>
<td>474,220</td>
</tr>
<tr>
<td>Depreciation and Amortization</td>
<td>366,560</td>
<td>-</td>
<td>368,728</td>
<td>0</td>
<td>368,728</td>
<td>1,208</td>
<td>368,728</td>
</tr>
<tr>
<td>Other expenses</td>
<td>1,167,984</td>
<td>38,103</td>
<td>0</td>
<td>9,677</td>
<td>1,215,765</td>
<td>0</td>
<td>1,215,765</td>
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<tr>
<td>Indirect cost allocation, Occupancy expense</td>
<td>(362,512)</td>
<td>(664,798)</td>
<td>(13,553)</td>
<td>3,052</td>
<td>318,891</td>
<td></td>
<td></td>
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<tr>
<td>Total Administrative Expenses</td>
<td>7,888,347</td>
<td>2,066,938</td>
<td>168,896</td>
<td>102,330</td>
<td>10,226,511</td>
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<td></td>
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<tr>
<td>Admin Loss Ratio</td>
<td>3.1%</td>
<td>7.2%</td>
<td>10.4%</td>
<td>6.4%</td>
<td>3.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INCOME (LOSS) FROM OPERATIONS</td>
<td>(2,628,510)</td>
<td>698,189</td>
<td>343,592</td>
<td>(65,013)</td>
<td>(1,651,743)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>INVESTMENT INCOME</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>415,351</td>
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<tr>
<td>NET RENTAL INCOME</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>23,099</td>
</tr>
<tr>
<td>NET GRANT INCOME</td>
<td>(15,408)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>(15,408)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER INCOME</td>
<td>106</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>106</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CHANGE IN NET ASSETS</td>
<td>$ (2,643,813)</td>
<td>$ 698,189</td>
<td>$ 343,592</td>
<td>$ (65,013)</td>
<td>$ (1,228,595)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BUDGETED CHANGE IN ASSETS</td>
<td>1,567,139</td>
<td>366,820</td>
<td>(115,676)</td>
<td>(25,951)</td>
<td>2,023,489</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VARIANCE TO BUDGET - FAV (UNFAV)</td>
<td>(4,210,952)</td>
<td>331,369</td>
<td>459,268</td>
<td>(39,062)</td>
<td>(3,252,084)</td>
<td></td>
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</tr>
</tbody>
</table>
### Medi-Cal Classic Medi-Cal Expansion Total Medi-Cal OneCare Connect OneCare PACE Consolidated

<table>
<thead>
<tr>
<th>Member Months</th>
<th>2,671,413</th>
<th>1,191,623</th>
<th>3,863,036</th>
<th>76,347</th>
<th>6,941</th>
<th>1,124</th>
<th>3,947,448</th>
</tr>
</thead>
</table>

#### REVENUES

| | Capitation Revenue | Other Income | 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 | Facilities | Ancillary | Skilled Nursing | Prescription Drugs | MLTSS Facility Payments | Medical Management | Reinsurance & Other | Total Medical Expenses |
| | $196,222,492 | $127,067,124 | $38,059,226 | $3,568,178 | $88,498,480 | $269,633,627 | $10,131,604 | $2,689,222 | $732,301,775 |
| | $250,879,244 | $95,888,299 | $42,003,145 | $755,552 | $180,600,315 | $282,409,025 | $13,838,282 | $1,645,185 | $498,999,783 |
| | $447,101,735 | $222,955,423 | $80,062,372 | $25,906,527 | $282,409,025 | $26,827,304 | $5,280,243 | $4,334,407 | $1,231,301,558 |
| | | | | | | | | | |

#### 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 | Professional fees | Purchased services | Printing and Postage | Depreciation and Amortization | Other expenses | Indirect cost allocation, Occupancy expense | Total Administrative Expenses |
| | 26,168,962 | 922,685 | 3,568,178 | 1,462,596 | 2,110,143 | 5,682,922 | (1,686,998) | 38,228,488 |
| | 3,671,147 | 142,646 | 755,552 | 347,628 | 10,768 | 230,636 | 3,323,991 | 8,471,600 |
| | 115,994 | 79,016 | 95,156 | 31,081 | 10,766 | 3,206,363 | 67,765 | 388,980 |
| | | | 79,016 | 31,081 | 10,766 | 3,206,363 | 67,765 | 388,980 |
| | | | | | | | | |

#### 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 |
**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)**

<table>
<thead>
<tr>
<th></th>
<th>MONTH-TO-DATE</th>
<th></th>
<th></th>
<th>YEAR-TO-DATE</th>
<th></th>
</tr>
</thead>
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<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
<td></td>
<td>Actual</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>(2.6)</td>
<td>1.6</td>
<td>(4.2)</td>
<td></td>
<td>(2.6)</td>
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<tr>
<td>OCC</td>
<td>0.7</td>
<td>0.4</td>
<td>0.3</td>
<td></td>
<td>4.5</td>
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<tr>
<td>OneCare</td>
<td>0.3</td>
<td>(0.1)</td>
<td>0.5</td>
<td></td>
<td>1.3</td>
</tr>
<tr>
<td>PACE</td>
<td>(0.1)</td>
<td>0.0</td>
<td>0.0</td>
<td></td>
<td>0.7</td>
</tr>
<tr>
<td>Total</td>
<td>(1.7)</td>
<td>1.9</td>
<td>(3.4)</td>
<td></td>
<td>3.9</td>
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<td>Inv./Rental Inc, MCO tax</td>
<td>0.4</td>
<td>0.2</td>
<td>0.2</td>
<td>Operating</td>
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<tr>
<td>Non-Operating</td>
<td>0.4</td>
<td>0.2</td>
<td>0.2</td>
<td></td>
<td>8.8</td>
</tr>
</tbody>
</table>

|                      | (1.2)  | 2.0    | (3.3)    |                  | 12.6   | 9.2    | 3.4      |
## CalOptima Enrollment Summary

**For the Five Months Ended November 30, 2017**

### Actual Budget Variance % Enrollment (By Aid Category) Actual Budget Variance %

<table>
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<tr>
<th>Category</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>%</th>
<th>Enrollments</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged</td>
<td>62,704</td>
<td>63,406</td>
<td>(702)</td>
<td>1.1%</td>
<td>308,575</td>
<td>313,147</td>
<td>(4,572)</td>
<td>1.5%</td>
<td></td>
</tr>
<tr>
<td>BCCTP</td>
<td>47,137</td>
<td>48,785</td>
<td>(1,648)</td>
<td>3.4%</td>
<td>235,088</td>
<td>243,824</td>
<td>(8,736)</td>
<td>3.6%</td>
<td></td>
</tr>
<tr>
<td>Disabled</td>
<td>322,288</td>
<td>329,502</td>
<td>(7,214)</td>
<td>2.2%</td>
<td>1,629,913</td>
<td>1,648,931</td>
<td>(19,018)</td>
<td>1.2%</td>
<td></td>
</tr>
<tr>
<td>TANF Child</td>
<td>94,261</td>
<td>103,749</td>
<td>(9,488)</td>
<td>9.1%</td>
<td>477,632</td>
<td>519,652</td>
<td>(42,020)</td>
<td>8.1%</td>
<td></td>
</tr>
<tr>
<td>LTC</td>
<td>3,504</td>
<td>3,268</td>
<td>236</td>
<td>7.2%</td>
<td>17,155</td>
<td>16,340</td>
<td>815</td>
<td>5.0%</td>
<td></td>
</tr>
<tr>
<td>MCE</td>
<td>237,565</td>
<td>236,567</td>
<td>998</td>
<td>0.4%</td>
<td>1,191,623</td>
<td>1,181,498</td>
<td>10,125</td>
<td>0.9%</td>
<td></td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>768,080</td>
<td>785,895</td>
<td>(17,815)</td>
<td>2.3%</td>
<td>3,863,036</td>
<td>3,926,482</td>
<td>(63,446)</td>
<td>1.6%</td>
<td></td>
</tr>
<tr>
<td>OneCare Connect</td>
<td>15,254</td>
<td>15,543</td>
<td>(289)</td>
<td>1.9%</td>
<td>76,347</td>
<td>77,581</td>
<td>(1,234)</td>
<td>1.6%</td>
<td></td>
</tr>
<tr>
<td>PACE</td>
<td>233</td>
<td>236</td>
<td>(3)</td>
<td>1.3%</td>
<td>1,124</td>
<td>1,130</td>
<td>(6)</td>
<td>0.5%</td>
<td></td>
</tr>
<tr>
<td>OneCare</td>
<td>1,378</td>
<td>1,353</td>
<td>25</td>
<td>1.8%</td>
<td>6,941</td>
<td>6,671</td>
<td>270</td>
<td>4.0%</td>
<td></td>
</tr>
<tr>
<td>CalOptima Total</td>
<td>784,945</td>
<td>803,027</td>
<td>(18,082)</td>
<td>2.3%</td>
<td>3,947,448</td>
<td>4,011,864</td>
<td>(64,416)</td>
<td>1.6%</td>
<td></td>
</tr>
</tbody>
</table>

### Enrollment (By Network)

<table>
<thead>
<tr>
<th>Network</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>%</th>
<th>Enrollments</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO</td>
<td>170,025</td>
<td>174,301</td>
<td>(4,276)</td>
<td>2.5%</td>
<td>854,162</td>
<td>870,668</td>
<td>(16,506)</td>
<td>1.9%</td>
<td></td>
</tr>
<tr>
<td>PHC</td>
<td>222,392</td>
<td>226,114</td>
<td>(3,722)</td>
<td>1.6%</td>
<td>1,114,328</td>
<td>1,133,372</td>
<td>(19,044)</td>
<td>1.7%</td>
<td></td>
</tr>
<tr>
<td>Shared Risk Group</td>
<td>199,692</td>
<td>209,369</td>
<td>(9,677)</td>
<td>4.6%</td>
<td>1,004,652</td>
<td>1,050,043</td>
<td>(45,391)</td>
<td>4.3%</td>
<td></td>
</tr>
<tr>
<td>Fee for Service</td>
<td>175,971</td>
<td>176,111</td>
<td>(140)</td>
<td>0.1%</td>
<td>889,894</td>
<td>872,399</td>
<td>17,495</td>
<td>2.0%</td>
<td></td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>768,080</td>
<td>785,895</td>
<td>(17,815)</td>
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<td>OneCare Connect</td>
<td>15,254</td>
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<tr>
<td>CalOptima Total</td>
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<td>803,027</td>
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<td>3,947,448</td>
<td>4,011,864</td>
<td>(64,416)</td>
<td>1.6%</td>
<td></td>
</tr>
</tbody>
</table>
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

BCCTP

4,045

4,051

3,864

4,020

-

-

-

-

-

-

-

20,038

1

1

1

5

1

-

-

-

-

-

-

-

9

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

3

4

6

4

4

-

-

-

-

-

-

-

21

68,020

68,792

69,169

68,294

68,764

-

-

-

-

-

-

-

343,039

170,752

171,735

171,630

170,020

170,025

-

-

-

-

-

-

-

854,162

1,530

1,401

1,561

-

Disabled

LTC
MCE

-

-

-

-

-

-

PHC
Aged

1,480

1,493

-

-

-

-

-

-

7,465

BCCTP

-

-

-

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-

-

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-

-

-

-

-

-

Disabled

7,318

7,264

7,258

7,236

7,229

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-

36,305

162,801

163,976

163,202

162,046

162,030

-

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-

814,055

12,356

12,311

TANF Child

-

-

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-

-

-

-

LTC

-

-

1

1

-

-

-

-

-

-

-

-

2

MCE

TANF Adult

38,398

12,604

38,821

12,571

39,088

12,410

38,681

39,261

-

-

-

-

-

-

-

194,249

62,252

222,601

224,125

223,489

221,721

222,392

-

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-

1,114,328

3,029

3,765

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-

18,190

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-

-

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-

-

1

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-

-

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-

40,130

Shared Risk Group
3,809

3,756

3,831

BCCTP

Aged

-

-

-

Disabled

8,108

8,058

8,035

7,951

7,978

1

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

1

2

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3

85,799

86,330

86,191

81,677

85,025

-

-

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-

-

425,022

203,214

203,743

202,477

195,526

199,692

-

-

-

-

-

-

-

1,004,652

LTC

-

MCE

-

-

-

-

-

-

Fee for Service (Dual)
Aged
BCCTP
Disabled
TANF Child

49,108

-

-

-

-

-

-

-

25

22

25

23

22

-

-

-

-

-

-

-

117

20,343

48,036

20,528

20,516

20,448

20,494

-

-

-

-

-

-

-

102,329

3

48,599

3

48,846

2

48,863

2

1

-

-

-

-

-

-

-

243,452

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

3,580

3,855

4,031

3,714

4,250

-

-

-

-

-

-

-

19,430

601

602

599

523

598

-

-

-

-

-

-

-

Fee for Service (Non-Dual)
Aged
BCCTP
Disabled

2,923

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

372

364

379

194

363

-

-

-

-

-

-

-

LTC
MCE

1,672

43,457

44,664

44,438

40,986

42,402

-

-

-

-

-

-

-

215,947

98,742

105,202

105,231

100,120

99,978

-

-

-

-

-

-

-

509,273

60,871

308,575

MEDI-CAL TOTAL
Aged

62,704

-

-

-

-

-

-

-

627

625

625

552

621

-

-

-

-

-

-

-

3,050

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

3,377

3,493

3,514

3,267

3,504

-

-

-

-

-

-

-

17,155

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

215

221

228

227

233

-

-

-

-

-

-

-

1,124

BCCTP
Disabled

LTC
MCE

PACE
OneCare
OneCare Connect
TOTAL

Page 11

60,963

61,748

62,289

-

-

-

-

-

-

1,367

1,386

1,404

1,406

1,378

-

-

-

-

-

-

-

6,941

15,365

15,229

15,265

15,234

15,254

-

-

-

-

-

-

-

76,347

787,686

797,991

796,181

780,645

784,945

-

-

-

-

-

-

-

3,947,448

Back to Agenda


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

<table>
<thead>
<tr>
<th>Month</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>768,080</td>
<td>785,895</td>
<td>(17,815)</td>
<td>(2.3%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year - To - Date</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>3,863,036</td>
<td>3,926,482</td>
<td>(63,446)</td>
<td>(1.6%)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,452,827</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>98,302,850</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reimbursement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,266,972,069</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gross Margin</th>
</tr>
</thead>
<tbody>
<tr>
<td>35,670,511</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Administrative Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>5,410,150</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Administrative Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>2,452,827</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operating Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>10,021,418</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operating Expenses (Loss)</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>7,388,347</td>
<td>5,055,360</td>
<td>2,337,472</td>
<td>25.1%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operating Expenses (Loss)</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>10,021,418</td>
<td>0</td>
<td>(10,021,418)</td>
<td>0.0%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grant Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>127,951</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Net Operating Tax</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Change in Net Assets</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2,643,813)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Loss Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>97.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Admin Loss Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1%</td>
</tr>
</tbody>
</table>

---

Back to Agenda
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

<table>
<thead>
<tr>
<th>Month</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
<th>Year - To - Date</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Actual Budget</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Variance</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
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</tr>
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<td>15,543</td>
<td>(289)</td>
<td>(1.9%)</td>
<td></td>
<td>76,347</td>
<td>77,581</td>
<td>(1,234)</td>
<td>(1.6%)</td>
<td></td>
</tr>
<tr>
<td>7,163,459</td>
<td>7,496,395</td>
<td>(332,936)</td>
<td>(4.4%)</td>
<td></td>
<td>36,317,861</td>
<td>37,525,403</td>
<td>(1,207,542)</td>
<td>(3.2%)</td>
<td></td>
</tr>
<tr>
<td>15,973,937</td>
<td>14,754,867</td>
<td>1,219,070</td>
<td>8.3%</td>
<td></td>
<td>80,368,666</td>
<td>72,866,026</td>
<td>7,502,640</td>
<td>10.3%</td>
<td></td>
</tr>
<tr>
<td>5,535,317</td>
<td>4,978,054</td>
<td>557,263</td>
<td>11.2%</td>
<td></td>
<td>27,686,111</td>
<td>26,604,837</td>
<td>1,081,274</td>
<td>4.1%</td>
<td></td>
</tr>
<tr>
<td>28,672,713</td>
<td>27,229,316</td>
<td>1,443,397</td>
<td>5.3%</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Revenues</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10,364,079</td>
<td>8,565,608</td>
<td>(1,798,471)</td>
<td>(21.0%)</td>
<td></td>
<td>55,723,896</td>
<td>42,254,387</td>
<td>(13,469,519)</td>
<td>(31.9%)</td>
<td></td>
</tr>
<tr>
<td>2,460,173</td>
<td>4,981,076</td>
<td>2,520,903</td>
<td>50.6%</td>
<td></td>
<td>13,748,039</td>
<td>25,261,569</td>
<td>11,513,530</td>
<td>45.6%</td>
<td></td>
</tr>
<tr>
<td>658,020</td>
<td>613,016</td>
<td>(45,004)</td>
<td>(7.3%)</td>
<td></td>
<td>3,054,706</td>
<td>3,105,319</td>
<td>50,613</td>
<td>1.6%</td>
<td></td>
</tr>
<tr>
<td>5,942,841</td>
<td>4,190,544</td>
<td>(1,752,297)</td>
<td>(41.8%)</td>
<td></td>
<td>26,827,304</td>
<td>21,146,541</td>
<td>(5,680,763)</td>
<td>(26.9%)</td>
<td></td>
</tr>
<tr>
<td>2,460,173</td>
<td>5,241,959</td>
<td>(2,781,786)</td>
<td>(55.0%)</td>
<td></td>
<td>25,906,527</td>
<td>28,327,860</td>
<td>2,421,333</td>
<td>8.5%</td>
<td></td>
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<tr>
<td>1,078,869</td>
<td>1,203,372</td>
<td>124,503</td>
<td>10.3%</td>
<td></td>
<td>5,280,243</td>
<td>6,080,274</td>
<td>800,031</td>
<td>13.2%</td>
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</tr>
<tr>
<td>150,000</td>
<td>108,937</td>
<td>(41,063)</td>
<td>(37.7%)</td>
<td></td>
<td>876,405</td>
<td>565,323</td>
<td>311,082</td>
<td>55.0%</td>
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<tr>
<td>25,907,587</td>
<td>24,904,512</td>
<td>(1,003,075)</td>
<td>(4.0%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Expenses</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2,765,127</td>
<td>2,324,804</td>
<td>440,323</td>
<td>18.9%</td>
<td></td>
<td>12,955,917</td>
<td>10,254,993</td>
<td>2,700,924</td>
<td>26.3%</td>
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</tr>
<tr>
<td>663,318</td>
<td>941,404</td>
<td>278,086</td>
<td>29.5%</td>
<td></td>
<td>3,671,147</td>
<td>4,537,755</td>
<td>866,608</td>
<td>19.1%</td>
<td></td>
</tr>
<tr>
<td>108,033</td>
<td>38,334</td>
<td>(69,699)</td>
<td>(181.8%)</td>
<td></td>
<td>142,646</td>
<td>191,667</td>
<td>49,020</td>
<td>25.6%</td>
<td></td>
</tr>
<tr>
<td>502,279</td>
<td>239,868</td>
<td>(262,411)</td>
<td>(104.4%)</td>
<td></td>
<td>755,552</td>
<td>1,199,440</td>
<td>443,888</td>
<td>37.0%</td>
<td></td>
</tr>
<tr>
<td>90,605</td>
<td>105,921</td>
<td>15,316</td>
<td>12.5%</td>
<td></td>
<td>347,828</td>
<td>519,005</td>
<td>171,177</td>
<td>33.0%</td>
<td></td>
</tr>
<tr>
<td>38,103</td>
<td>50,149</td>
<td>12,046</td>
<td>24.0%</td>
<td></td>
<td>230,636</td>
<td>252,014</td>
<td>21,378</td>
<td>8.5%</td>
<td></td>
</tr>
<tr>
<td>664,798</td>
<td>584,428</td>
<td>(80,370)</td>
<td>(13.8%)</td>
<td></td>
<td>3,323,991</td>
<td>2,922,140</td>
<td>(401,851)</td>
<td>(13.8%)</td>
<td></td>
</tr>
<tr>
<td>2,066,936</td>
<td>1,957,984</td>
<td>(108,954)</td>
<td>(5.6%)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Tax</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Net Operating Tax</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change in Net Assets</td>
<td>4,484,317</td>
<td>632,973</td>
<td>3,851,344</td>
<td>608.5%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>% Loss Ratio</th>
<th>% Admin Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>90.4%</td>
<td>91.5%</td>
</tr>
<tr>
<td>7.2%</td>
<td>7.2%</td>
</tr>
<tr>
<td>0.0%</td>
<td>-0.3%</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>Month</th>
<th>Actual</th>
<th>Budget</th>
<th>$</th>
<th>%</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>1,378</td>
<td>1,353</td>
<td>25</td>
<td>1.8%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>69,768</td>
<td>47,017</td>
<td>22,751</td>
<td>48.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1,042,016</td>
<td>831,110</td>
<td>210,906</td>
<td>18.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>508,370</td>
<td>469,543</td>
<td>38,827</td>
<td>8.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>1,620,154</td>
<td>1,397,670</td>
<td>222,484</td>
<td>15.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year - To - Date</th>
<th>Actual</th>
<th>Budget</th>
<th>$</th>
<th>%</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td>6,941</td>
<td>6,671</td>
<td>270</td>
<td>4.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revenues</th>
<th>Actual</th>
<th>Budget</th>
<th>$</th>
<th>%</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal Capitation revenue</td>
<td>351,423</td>
<td>231,782</td>
<td>199,641</td>
<td>51.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Part C Revenue</td>
<td>3,025,923</td>
<td>4,274,493</td>
<td>(1,248,570)</td>
<td>(29.2%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare Part D Revenue</td>
<td>1,915,316</td>
<td>2,357,765</td>
<td>(442,449)</td>
<td>(18.8%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Operating Revenue</td>
<td>5,292,662</td>
<td>6,864,040</td>
<td>(1,571,378)</td>
<td>(22.9%)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Expenses</th>
<th>Actual</th>
<th>Budget</th>
<th>$</th>
<th>%</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider capitation</td>
<td>(529,739)</td>
<td>1,883,896</td>
<td>1,354,157</td>
<td>71.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>1,388,737</td>
<td>2,207,179</td>
<td>818,442</td>
<td>37.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ancillary</td>
<td>221,969</td>
<td>238,701</td>
<td>16,732</td>
<td>7.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing facilities</td>
<td>100,101</td>
<td>206,329</td>
<td>106,228</td>
<td>51.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>2,328,120</td>
<td>2,382,617</td>
<td>54,497</td>
<td>2.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical management</td>
<td>69,195</td>
<td>112,691</td>
<td>43,496</td>
<td>38.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other medical expenses</td>
<td>38,135</td>
<td>37,888</td>
<td>247</td>
<td>0.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Medical Expenses</td>
<td>3,616,519</td>
<td>7,069,301</td>
<td>3,452,782</td>
<td>48.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Gross Margin | 1,676,143 | (205,261) | 1,881,404 | 916.6% |

<table>
<thead>
<tr>
<th>Administrative Expenses</th>
<th>Actual</th>
<th>Budget</th>
<th>$</th>
<th>%</th>
<th>Variance</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Salaries, wages &amp; employee benefits</td>
<td>115,994</td>
<td>102,051</td>
<td>(13,943)</td>
<td>(13.7%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional fees</td>
<td>79,016</td>
<td>66,665</td>
<td>(12,351)</td>
<td>(18.5%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Purchased services</td>
<td>95,156</td>
<td>60,000</td>
<td>(35,156)</td>
<td>(58.6%)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Printing and postage</td>
<td>31,081</td>
<td>103,940</td>
<td>72,859</td>
<td>70.1%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other operating expenses</td>
<td>(32)</td>
<td>906</td>
<td>938</td>
<td>103.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indirect cost allocation, Occupancy Expense</td>
<td>67,765</td>
<td>159,550</td>
<td>91,785</td>
<td>57.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Administrative Expenses</td>
<td>388,980</td>
<td>493,112</td>
<td>104,132</td>
<td>21.1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Change in Net Assets | 1,287,163 | (698,373) | 1,985,536 | 284.3% |

| Medical Loss Ratio | 68.3% | 103.0% | 34.7% | 33.7% |
## Statement of Revenues and Expenses

### For the Five Months Ended November 30, 2017

<table>
<thead>
<tr>
<th>Month</th>
<th>$ Actual</th>
<th>$ Budget</th>
<th>% Variance</th>
<th>$ Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Months</td>
<td></td>
<td></td>
<td></td>
<td>233</td>
<td>236</td>
</tr>
<tr>
<td>Revenues</td>
<td></td>
<td></td>
<td></td>
<td>1,190,325</td>
<td>1,191,984</td>
</tr>
<tr>
<td>Medi-Cal capitation revenue</td>
<td>5,915,684</td>
<td>5,713,984</td>
<td>201,700</td>
<td>3.5%</td>
<td></td>
</tr>
<tr>
<td>Medicare part C revenue</td>
<td>1,704,812</td>
<td>1,353,344</td>
<td>351,468</td>
<td>26.0%</td>
<td></td>
</tr>
<tr>
<td>Medicare part D revenue</td>
<td>309,010</td>
<td>367,257</td>
<td>(58,247)</td>
<td>(15.9%)</td>
<td></td>
</tr>
<tr>
<td>Total Operating Revenues</td>
<td>7,929,306</td>
<td>7,434,585</td>
<td>494,721</td>
<td>6.7%</td>
<td></td>
</tr>
<tr>
<td>Medical Expenses</td>
<td></td>
<td></td>
<td></td>
<td>564,797</td>
<td>593,315</td>
</tr>
<tr>
<td>Medical Management</td>
<td>2,619,513</td>
<td>2,917,843</td>
<td>298,330</td>
<td>10.2%</td>
<td></td>
</tr>
<tr>
<td>Claims payments to hospitals</td>
<td>1,307,622</td>
<td>1,611,196</td>
<td>303,574</td>
<td>18.8%</td>
<td></td>
</tr>
<tr>
<td>Professional Claims</td>
<td>1,728,334</td>
<td>1,329,873</td>
<td>(398,461)</td>
<td>(30.0%)</td>
<td></td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>571,405</td>
<td>559,551</td>
<td>(11,854)</td>
<td>(2.1%)</td>
<td></td>
</tr>
<tr>
<td>Long-term care facility payments</td>
<td>17,511</td>
<td>58,734</td>
<td>41,223</td>
<td>70.2%</td>
<td></td>
</tr>
<tr>
<td>Professional Claims</td>
<td>3,052</td>
<td>2,864</td>
<td>(188)</td>
<td>(6.6%)</td>
<td></td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>10,000</td>
<td>2,000</td>
<td>8,000</td>
<td>20.0%</td>
<td></td>
</tr>
<tr>
<td>Total Medical Expenses</td>
<td>6,735,178</td>
<td>6,947,862</td>
<td>212,684</td>
<td>3.1%</td>
<td></td>
</tr>
<tr>
<td>Gross Margin</td>
<td>1,194,128</td>
<td>486,723</td>
<td>707,405</td>
<td>145.3%</td>
<td></td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td></td>
<td></td>
<td></td>
<td>74,618</td>
<td>96,949</td>
</tr>
<tr>
<td>Salaries, wages &amp; employee benefits</td>
<td>352,446</td>
<td>470,491</td>
<td>118,045</td>
<td>25.1%</td>
<td></td>
</tr>
<tr>
<td>Professional fees</td>
<td>15,339</td>
<td>25,000</td>
<td>9,661</td>
<td>38.6%</td>
<td></td>
</tr>
<tr>
<td>Purchased services</td>
<td>25,144</td>
<td>105,680</td>
<td>80,536</td>
<td>78.2%</td>
<td></td>
</tr>
<tr>
<td>Depreciation &amp; amortization</td>
<td>5,178</td>
<td>27,735</td>
<td>22,557</td>
<td>81.3%</td>
<td></td>
</tr>
<tr>
<td>Other operating expenses</td>
<td>80,980</td>
<td>92,524</td>
<td>11,544</td>
<td>12.5%</td>
<td></td>
</tr>
<tr>
<td>Indirect cost allocation, Occupancy Expense</td>
<td>37,448</td>
<td>14,320</td>
<td>(23,128)</td>
<td>(161.5%)</td>
<td></td>
</tr>
<tr>
<td>Total Administrative Expenses</td>
<td>527,304</td>
<td>746,010</td>
<td>218,706</td>
<td>29.3%</td>
<td></td>
</tr>
<tr>
<td>Operating Tax</td>
<td></td>
<td></td>
<td></td>
<td>3,253</td>
<td>0</td>
</tr>
<tr>
<td>Tax Revenue</td>
<td>31,379</td>
<td>0</td>
<td>31,379</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Premium tax expense</td>
<td>31,379</td>
<td>0</td>
<td>(31,379)</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Total Net Operating Tax</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td>Change in Net Assets</td>
<td>666,824</td>
<td>(259,287)</td>
<td>926,111</td>
<td>357.2%</td>
<td></td>
</tr>
<tr>
<td>Medical Loss Ratio</td>
<td>84.9%</td>
<td>93.5%</td>
<td>8.5%</td>
<td>9.1%</td>
<td></td>
</tr>
<tr>
<td>Admin Loss Ratio</td>
<td>6.7%</td>
<td>10.0%</td>
<td>3.4%</td>
<td>33.7%</td>
<td></td>
</tr>
</tbody>
</table>
## CalOptima - Building 505 City Parkway
### Statement of Revenues and Expenses
#### For the Five Months Ended November 30, 2017

<table>
<thead>
<tr>
<th>Month</th>
<th>$</th>
<th>% Variance</th>
<th>Year - To - Date</th>
<th>$</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Actual</td>
<td>Budget</td>
<td>Variance</td>
<td></td>
<td>Actual</td>
</tr>
<tr>
<td></td>
<td>41,066</td>
<td>0</td>
<td>41,066</td>
<td>0.0%</td>
<td>144,829</td>
</tr>
<tr>
<td></td>
<td>41,066</td>
<td>0</td>
<td>41,066</td>
<td>0.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>17,967</td>
<td>18,843</td>
<td>876</td>
<td>4.6%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>23,099</td>
<td>(18,843)</td>
<td>41,942</td>
<td>222.6%</td>
<td></td>
</tr>
<tr>
<td>Revenues</td>
<td>Rental income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Total Operating Revenue</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrative Expenses</td>
<td>Purchase services</td>
<td>162,032</td>
<td>115,930</td>
<td>(46,102)</td>
<td>(39.8%)</td>
</tr>
<tr>
<td></td>
<td>Depreciation &amp; amortization</td>
<td>798,388</td>
<td>807,369</td>
<td>8,981</td>
<td>1.1%</td>
</tr>
<tr>
<td></td>
<td>Insurance expense</td>
<td>74,567</td>
<td>45,584</td>
<td>(28,983)</td>
<td>(63.6%)</td>
</tr>
<tr>
<td></td>
<td>Repair and maintenance</td>
<td>553,694</td>
<td>790,608</td>
<td>236,914</td>
<td>30.0%</td>
</tr>
<tr>
<td></td>
<td>Other Operating Expense</td>
<td>256,924</td>
<td>0</td>
<td>(256,924)</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Indirect allocation, Occupancy Expense</td>
<td>(1,744,255)</td>
<td>(1,665,275)</td>
<td>78,981</td>
<td>4.7%</td>
</tr>
<tr>
<td></td>
<td>Total Administrative Expenses</td>
<td>101,348</td>
<td>94,215</td>
<td>(7,133)</td>
<td>(7.6%)</td>
</tr>
<tr>
<td>Change in Net Assets</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>43,480</td>
</tr>
</tbody>
</table>

---

*Back to Agenda*
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
### ASSETS

**Current Assets**
- Operating Cash: $449,090,336
- Investments: 1,007,715,579
- Capitation receivable: 372,373,146
- Receivables - Other: 14,963,220
- Prepaid Expenses: 4,905,399

**Capital Assets**
- Furniture and equipment: 34,039,048
- Building/Leasehold improvements: 5,983,412
- 505 City Parkway West: 49,433,337

**Other Assets**
- Restricted deposit & Other: 300,000
- Board-designated assets: 536,572,791

**Deferred outflows of Resources**
- Pension Contributions: 5,234,198
- Difference in Experience: 1,072,771
- Excess Earnings: 5,270,171

**Total Current Assets**: $1,849,047,680

**Capital assets, net**: 51,836,141

**Total Other Assets**: 536,872,791

**Deferred outflows of Resources**
- Excess Earnings: 5,270,171

**Total Assets & Outflows**: $2,449,333,752

### LIABILITIES & FUND BALANCES

**Current Liabilities**
- Accounts payable: $36,494,046
- Medical claims liability: 1,018,994,753
- Accrued payroll liabilities: 11,663,892
- Deferred revenue: 164,159,692
- Deferred lease obligations: 165,329
- Capitation and withholds: 444,846,831

**Total Current Liabilities**: $1,676,324,543

**Deferred inflows of Resources**
- Excess Earnings: 1,340,010
- Changes in Assumptions: 1,340,010
- Pension Contributions: 5,234,198

**Total Liabilities**: $1,721,944,980

**Deferred inflows of Resources - Excess Earnings**: 1,340,010

**Deferred inflows of Resources - Changes in Assumptions**: 1,340,010

**Deferred inflows 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

**Net Assets**: 726,048,762

**Total Liabilities, Inflows & Fund Balances**: $2,449,333,752
### CalOptima

**Board Designated Reserve and TNE Analysis**

as of November 30, 2017

<table>
<thead>
<tr>
<th>Type</th>
<th>Reserve Name</th>
<th>Market Value</th>
<th>Benchmark</th>
<th>Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Low</td>
<td>High</td>
<td>Mkt - Low</td>
</tr>
<tr>
<td>Tier 1 - Payden &amp; Rygel</td>
<td>146,641,999</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 - Logan Circle</td>
<td>146,498,235</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 - Wells Capital</td>
<td>146,246,368</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Board-designated Reserve</strong></td>
<td></td>
<td>439,386,601</td>
<td>309,435,704</td>
<td>480,447,597</td>
</tr>
<tr>
<td>TNE Requirement</td>
<td>Tier 2 - Logan Circle</td>
<td>97,186,190</td>
<td>89,592,046</td>
<td>89,592,046</td>
</tr>
<tr>
<td><strong>Consolidated:</strong></td>
<td></td>
<td>536,572,791</td>
<td>399,027,750</td>
<td>570,039,643</td>
</tr>
<tr>
<td><strong>Current reserve level</strong></td>
<td></td>
<td>1.88</td>
<td>1.40</td>
<td>2.00</td>
</tr>
</tbody>
</table>

Back to Agenda
### CASH FLOWS FROM OPERATING ACTIVITIES:

<table>
<thead>
<tr>
<th>Description</th>
<th>Month Ended</th>
<th>Year-To-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in net assets</td>
<td>(1,228,594)</td>
<td>12,590,371</td>
</tr>
<tr>
<td>Adjustments to reconcile change in net assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>to net cash provided by operating activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depreciation and amortization</td>
<td>528,271</td>
<td>2,919,299</td>
</tr>
<tr>
<td>Changes in assets and liabilities:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prepaid expenses and other</td>
<td>(579,027)</td>
<td>749,248</td>
</tr>
<tr>
<td>Catastrophic reserves</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capitation receivable</td>
<td>(14,505,056)</td>
<td>156,212,369</td>
</tr>
<tr>
<td>Medical claims liability</td>
<td>(33,932,674)</td>
<td>(227,431,267)</td>
</tr>
<tr>
<td>Deferred revenue</td>
<td>7,535,195</td>
<td>60,186,567</td>
</tr>
<tr>
<td>Payable to providers</td>
<td>(577,159)</td>
<td>(135,992,879)</td>
</tr>
<tr>
<td>Accounts payable</td>
<td>9,109,544</td>
<td>(1,606,437)</td>
</tr>
<tr>
<td>Other accrued liabilities</td>
<td>(53,086)</td>
<td>1,471,879</td>
</tr>
<tr>
<td>Net cash provided by/(used in) operating activities</td>
<td>(33,702,586)</td>
<td>(130,900,850)</td>
</tr>
</tbody>
</table>

GASB 68 CalPERS Adjustments -

### CASH FLOWS FROM INVESTING ACTIVITIES

<table>
<thead>
<tr>
<th>Description</th>
<th>Month Ended</th>
<th>Year-To-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in Investments</td>
<td>(113,758,385)</td>
<td>74,710,173</td>
</tr>
<tr>
<td>Change in property and equipment</td>
<td>(47,718)</td>
<td>(454,414)</td>
</tr>
<tr>
<td>Change in Board designated reserves</td>
<td>723,761</td>
<td>(1,434,417)</td>
</tr>
<tr>
<td>Net cash provided by/(used in) investing activities</td>
<td>(113,082,342)</td>
<td>72,821,342</td>
</tr>
</tbody>
</table>

### NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS

<table>
<thead>
<tr>
<th>Description</th>
<th>Month Ended</th>
<th>Year-To-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>(146,784,929)</td>
<td></td>
<td>(58,079,509)</td>
</tr>
</tbody>
</table>

### CASH AND CASH EQUIVALENTS, beginning of period

<table>
<thead>
<tr>
<th>Description</th>
<th>Month Ended</th>
<th>Year-To-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$595,875,265</td>
<td></td>
<td>507,169,844</td>
</tr>
</tbody>
</table>

### CASH AND CASH EQUIVALENTS, end of period

<table>
<thead>
<tr>
<th>Description</th>
<th>Month Ended</th>
<th>Year-To-Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>$449,090,336</td>
<td></td>
<td>$449,090,336</td>
</tr>
</tbody>
</table>
**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*

<table>
<thead>
<tr>
<th>Month $</th>
<th>Year - To - Date $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Actual</td>
<td>Budget Variance</td>
</tr>
<tr>
<td>---------</td>
<td>--------------------</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Revenues**

<table>
<thead>
<tr>
<th></th>
<th>Month $</th>
<th>Year - To - Date $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Operating Revenue</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Operating Expenditures**

<table>
<thead>
<tr>
<th>Category</th>
<th>Month $</th>
<th>Year - To - Date $</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personnel</td>
<td>0</td>
<td>30,921</td>
</tr>
<tr>
<td>Taxes and Benefits</td>
<td>0</td>
<td>14,924</td>
</tr>
<tr>
<td>Travel</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Supplies</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Contractual</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>10,415</td>
<td>1,205,460</td>
</tr>
</tbody>
</table>

**Total Operating Expenditures**

<table>
<thead>
<tr>
<th></th>
<th>Month $</th>
<th>Year - To - Date $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2,083</td>
<td>241,092</td>
</tr>
</tbody>
</table>

**Investment Income**

<table>
<thead>
<tr>
<th></th>
<th>Month $</th>
<th>Year - To - Date $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(2,083)</td>
<td>(241,092)</td>
</tr>
</tbody>
</table>

**Program Income**

<table>
<thead>
<tr>
<th></th>
<th>Month $</th>
<th>Year - To - Date $</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(10,415)</td>
<td>(1,205,460)</td>
</tr>
</tbody>
</table>

CalOptima Foundation
Statement of Revenues and Expenses
For the Five Months Ended November 30, 2017
*Consolidated*
## Balance Sheet

**CalOptima Foundation**  
**Balance Sheet**  
**November 30, 2017**

<table>
<thead>
<tr>
<th><strong>ASSETS</strong></th>
<th><strong>LIABILITIES &amp; NET ASSETS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating cash</td>
<td>Accounts payable-Current</td>
</tr>
<tr>
<td>2,868,139</td>
<td>10,415</td>
</tr>
<tr>
<td>Grants receivable</td>
<td>Deferred Revenue</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prepaid expenses</td>
<td>Payable to CalOptima</td>
</tr>
<tr>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Current Assets</strong></td>
<td>Grants-Foundation</td>
</tr>
<tr>
<td><strong>2,868,139</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Liabilities</strong></th>
<th><strong>Net Assets</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Current Liabilities</strong></td>
<td><strong>10,415</strong></td>
</tr>
<tr>
<td><strong>Total Liabilities</strong></td>
<td><strong>10,415</strong></td>
</tr>
<tr>
<td><strong>Net Assets</strong></td>
<td><strong>2,857,724</strong></td>
</tr>
</tbody>
</table>

**TOTAL ASSETS**  
**2,868,139**  

**TOTAL LIABILITIES & NET ASSETS**  
**2,868,139**
CALOPTIMA FOUNDATION - NOVEMBER MONTH

INCOME STATEMENT:

OPERATING REVENUE
  o  No activity

OPERATING EXPENSES
  o  Audit Fees $2.0 thousand

BALANCE SHEET:

ASSETS
  o  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
  o  Accrued Payables--$10.4 thousand for Audit fees

NET INCOME is ($10.4) thousand
## Budget Allocation Changes
### Reporting Changes for November 2017

<table>
<thead>
<tr>
<th>Transfer Month</th>
<th>Line of Business</th>
<th>From Description</th>
<th>To Description</th>
<th>Amount</th>
<th>Expense Description</th>
<th>Fiscal Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>Medi-Cal</td>
<td>IS - Infrastructure - Professional Fee (Virtualization Architecture Assessment)</td>
<td>IS - Infrastructure - Professional Fee (On-Site Staff for the Phone System)</td>
<td>$48,600</td>
<td>Re-Purpose $48,600 from Professional Fees (Virtualization Architecture Assessment) to pay for an on-site staff for the phone system</td>
<td>2018</td>
</tr>
<tr>
<td>July</td>
<td>Medi-Cal</td>
<td>Facilities - Purchased Services (Restacking Services)</td>
<td>Facilities - Purchased Services (Reconfiguration Services)</td>
<td>$15,000</td>
<td>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</td>
<td>2018</td>
</tr>
<tr>
<td>August</td>
<td>Medi-Cal</td>
<td>Health Educaion &amp; Disease Mgmt. - Purchased Services (Adult Weight Management Vendor)</td>
<td>Health Education &amp; Disease Mgmt. - Purchased Services (Ansafone)</td>
<td>$30,000</td>
<td>Re-Purpose $30,000 from Purchased Services (Adult Weight Management Vendor) to pay for Ansafone services</td>
<td>2018</td>
</tr>
<tr>
<td>August</td>
<td>Medi-Cal</td>
<td>Health Educaion &amp; Disease Mgmt. - Purchased Services (Pediatric Weight Management Vendor)</td>
<td>Health Education &amp; Disease Mgmt. - Purchased Services (Captivate contract and other initiatives)</td>
<td>$25,000</td>
<td>Re-Purpose $25,000 from Purchased Services (Pediatric Weight Management Vendor) to pay for Captivate contract and other initiatives</td>
<td>2018</td>
</tr>
<tr>
<td>August</td>
<td>PACE</td>
<td>PACE Administrative - Purchased Services (Encounter Reporting &amp; Translation Services)</td>
<td>PACE Administrative - Purchased Services (Satisfaction Survey)</td>
<td>$12,208</td>
<td>Re-Purpose $12,208 from Purchased Services (Encounter Reporting &amp; Translation Services) to pay for Satisfaction Survey</td>
<td>2018</td>
</tr>
<tr>
<td>August</td>
<td>Medi-Cal</td>
<td>Facilities - Capital Project (Upgrade CalOptima and Building Access System)</td>
<td>Facilities - Capital Project (Mail Room/Basement/Property Management Office)</td>
<td>$15,000</td>
<td>Reallocate $15,000 from Capital Project (Upgrade CalOptima and Building Access System) to Capital Project (Mail Room/Basement/Property Management Office)</td>
<td>2018</td>
</tr>
<tr>
<td>September</td>
<td>Medi-Cal</td>
<td>Other G&amp;A - Other Operating Expenses</td>
<td>Facilities - Building Repair and Maintenance</td>
<td>$65,000</td>
<td>Reallocate $65,000 from Other G&amp;A (other operating expenses) to cover cost to conduct a review/study from soil engineer and necessary repairs of the east entry sinkhole.</td>
<td>2018</td>
</tr>
<tr>
<td>September</td>
<td>OCC</td>
<td>Health Educaion &amp; Disease Management - Member Communications</td>
<td>Health Education &amp; Disease Management - Purchased Services</td>
<td>$12,000</td>
<td>Reallocate $12,000 within medical management activities budget for additional funding needed on CareNet in OneCare Connect.</td>
<td>2018</td>
</tr>
<tr>
<td>November</td>
<td>Medi-Cal</td>
<td>Human Resources - Purchased Services - Temporary Outsource Service</td>
<td>Human Resources - Purchased Services - General</td>
<td>$10,000</td>
<td>Re-Purpose $10,000 from Purchased Services (Temporary Outsource Service) to fund for training module design and other department initiatives in Purchased Services</td>
<td>2018</td>
</tr>
</tbody>
</table>
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.
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.

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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.
• **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\(^1\)

   - **Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests**

<table>
<thead>
<tr>
<th>Month</th>
<th>Timeliness for Urgents</th>
<th>Clinical Decision Making (CDM) for Urgents</th>
<th>Letter Score for Urgents</th>
<th>Timeliness for Routine</th>
<th>Timeliness for Denials</th>
<th>CDM for Denials</th>
<th>Letter Score for Denials</th>
<th>Timeliness for Modified</th>
<th>CDM for Modified</th>
<th>Letter Score for Modified</th>
<th>Timeliness for Denials</th>
<th>CDM for Deferrals</th>
<th>Letter Score for Deferrals</th>
</tr>
</thead>
<tbody>
<tr>
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<td>N/A</td>
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<td>73%</td>
<td>90%</td>
<td>70%</td>
<td>90%</td>
<td>93%</td>
<td>0%</td>
<td>67%</td>
<td>76%</td>
</tr>
<tr>
<td>September 2017</td>
<td>40%</td>
<td>73%</td>
<td>78%</td>
<td>80%</td>
<td>60%</td>
<td>90%</td>
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<td>88%</td>
<td>100%</td>
<td>67%</td>
<td>84%</td>
</tr>
<tr>
<td>October 2017</td>
<td>0%</td>
<td>100%</td>
<td>90%</td>
<td>10%</td>
<td>90%</td>
<td>77%</td>
<td>84%</td>
<td>40%</td>
<td>100%</td>
<td>87%</td>
<td>0%</td>
<td>60%</td>
<td>51%</td>
</tr>
</tbody>
</table>

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\(^{a}\) “N/A” indicates that the category is not applicable to that file type. “Nothing to Report” indicates that there were no files submitted for review for that file type.

[Back to Agenda]
The lower scores for 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

<table>
<thead>
<tr>
<th>Month</th>
<th>Paid Claims Timeliness</th>
<th>Paid Claims Accuracy</th>
<th>Denied Claims Timeliness</th>
<th>Denied Claims Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>September 2017</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>October 2017</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

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.
• **Medi-Cal Claims**: Provider Dispute Resolutions (PDRs)

<table>
<thead>
<tr>
<th>Month</th>
<th>Accuracy</th>
<th>Determination Timeliness</th>
<th>Acknowledgement Timeliness</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>100%</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>September 2017</td>
<td>100%</td>
<td>90%</td>
<td>100%</td>
</tr>
<tr>
<td>October 2017</td>
<td>100%</td>
<td>80%</td>
<td>100%</td>
</tr>
</tbody>
</table>

➤ 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.

<table>
<thead>
<tr>
<th>Month</th>
<th>Medi-Cal Call Center</th>
<th>Member Liaison Call Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>September 2017</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>October 2017</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

➤ No significant trends to report.

2. **Internal Audits**: OneCare

• **OneCare Pharmacy**: Formulary Rejected Claims Review

<table>
<thead>
<tr>
<th>Month</th>
<th>% Claims Rejected in Error (Member Impact)</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>0%</td>
</tr>
<tr>
<td>September 2017</td>
<td>0%</td>
</tr>
<tr>
<td>October 2017</td>
<td>0%</td>
</tr>
</tbody>
</table>

➤ No claims were rejected in error due to formulary restrictions from August through October 2017.
• **OneCare Pharmacy**: Coverage determination timeliness is reviewed on a monthly basis to ensure that coverage determinations are processed in the appropriate timeframe.

<table>
<thead>
<tr>
<th>Month</th>
<th>% Compliant with Timeliness</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>100%</td>
</tr>
<tr>
<td>September 2017</td>
<td>100%</td>
</tr>
<tr>
<td>October 2017</td>
<td>100%</td>
</tr>
</tbody>
</table>

- The compliance rate for coverage determination timeliness remains consistent at 100% from August through October 2017.

- **OneCare Utilization Management**

- 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

\*\*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.
• OneCare Claims: Professional and Hospital Claims

<table>
<thead>
<tr>
<th>Month</th>
<th>Paid Claims Timeliness</th>
<th>Paid Claims Accuracy</th>
<th>Denied Claims Timeliness</th>
<th>Denied Claims Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>90%</td>
<td>90%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>September 2017</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>October 2017</td>
<td>70%</td>
<td>100%</td>
<td>100%</td>
<td>60%</td>
</tr>
</tbody>
</table>

➢ 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)

<table>
<thead>
<tr>
<th>Month</th>
<th>Determination Timeliness</th>
<th>Payment Accuracy</th>
<th>Letter Accuracy</th>
<th>Check Lag</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>September 2017</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>October 2017</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

➢ No significant trends to report.

• OneCare Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

<table>
<thead>
<tr>
<th>Month</th>
<th>OneCare Customer Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>100%</td>
</tr>
<tr>
<td>September 2017</td>
<td>100%</td>
</tr>
<tr>
<td>October 2017</td>
<td>100%</td>
</tr>
</tbody>
</table>

➢ No significant trends to report.
3. **Internal Audits: OneCare Connect**

   - **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.**

<table>
<thead>
<tr>
<th>Month</th>
<th>% Compliant with Timeliness</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>100%</td>
</tr>
<tr>
<td>September 2017</td>
<td>99.69%</td>
</tr>
<tr>
<td>October 2017</td>
<td>100%</td>
</tr>
</tbody>
</table>

   - No significant trends to report.

   - **OneCare Connect Utilization Management: Prior Authorization (PA) Requests**

     |-------|------------------------|---------------------------------------------|--------------------------|-----------------------|-------------------------|------------------------|----------------|--------------------------|------------------------|----------------|---------------------------|------------------------|----------------|--------------------------|
     | September 2017 | 100% | 100% | 89% | 80% | 60% | 100% | 100% | 88% | Nothing to Report | Nothing to Report | No hing to Report | Nothing to Report | Nothing to Report | No hing 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

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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

<table>
<thead>
<tr>
<th>Month</th>
<th>Paid Claims Timeliness</th>
<th>Paid Claims Accuracy</th>
<th>Denied Claims Timeliness</th>
<th>Denied Claims Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>90%</td>
</tr>
<tr>
<td>September 2017</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>October 2017</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

➢ No significant trends to report.

• OneCare Connect Claims: Provider Dispute Resolutions (PDRs)

<table>
<thead>
<tr>
<th>Month</th>
<th>Determination Timeliness</th>
<th>Payment Accuracy</th>
<th>Letter Accuracy</th>
<th>Check Lag</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>September 2017</td>
<td>100%</td>
<td>92%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>October 2017</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

➢ No significant trends to report.

• OneCare Connect Customer Service: Call center activity is reviewed for appropriate classification, routing, and privacy handling.

<table>
<thead>
<tr>
<th>Month</th>
<th>OneCare Connect Customer Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
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<tr>
<td>September 2017</td>
<td>100%</td>
</tr>
<tr>
<td>October 2017</td>
<td>100%</td>
</tr>
</tbody>
</table>

➢ No significant trends to report.
4. **Internal Audits: PACE**

- **PACE Claims: Professional Claims**

  - No significant trends to report.

- **PACE Claims: Provider Dispute Resolutions (PDRs)**

  - No significant trends to report.

5. **Health Network Audits: Medi-Cal**

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.

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• Medi-Cal Utilization Management (UM): Prior Authorization (PA) Requests

<table>
<thead>
<tr>
<th>Month</th>
<th>Timeliness for Urgent</th>
<th>Clinical Decision Making (CDM) for Urgent</th>
<th>Letter Score for Urgent</th>
<th>Timeliness for Routine</th>
<th>Timeliness for Denials</th>
<th>CDM for Denials</th>
<th>Letter Score for Denials</th>
<th>Timeliness for Modified</th>
<th>CDM for Modified</th>
<th>Letter Score for Modified</th>
<th>Timeliness for Deferrals</th>
<th>CDM for Deferrals</th>
<th>Letter Score for Deferrals</th>
</tr>
</thead>
<tbody>
<tr>
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<td>79%</td>
<td>85%</td>
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<td>55%</td>
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<td>81%</td>
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<tr>
<td>September 2017</td>
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<td>75%</td>
<td>63%</td>
<td>67%</td>
<td>57%</td>
<td>83%</td>
<td>82%</td>
<td>54%</td>
<td>83%</td>
<td>70%</td>
<td>67%</td>
<td>59%</td>
</tr>
<tr>
<td>October 2017</td>
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<td>Exempt</td>
<td>Exempt</td>
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<td>Exempt</td>
<td>Exempt</td>
<td>Exempt</td>
<td>Exempt</td>
<td>Exempt</td>
</tr>
</tbody>
</table>

• Medi-Cal Claims: Professional Claims

<table>
<thead>
<tr>
<th>Month</th>
<th>Paid Claims Timeliness</th>
<th>Paid Claims Accuracy</th>
<th>Denied Claims Timeliness</th>
<th>Denied Claims Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>97%</td>
<td>99%</td>
<td>99%</td>
<td>87%</td>
</tr>
<tr>
<td>September 2017</td>
<td>96%</td>
<td>99%</td>
<td>98%</td>
<td>95%</td>
</tr>
<tr>
<td>October 2017</td>
<td>Exempt</td>
<td>Exempt</td>
<td>Exempt</td>
<td>Exempt</td>
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</tbody>
</table>

• Medi-Cal Claims: Misclassified Hospital Claims

<table>
<thead>
<tr>
<th>Month</th>
<th>Misclassified Paid Claims</th>
<th>Misclassified Denied Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>September 2017</td>
<td>100%</td>
<td>98%</td>
</tr>
<tr>
<td>October 2017</td>
<td>Exempt</td>
<td>Exempt</td>
</tr>
</tbody>
</table>

a\“N/A” indicates that the category is not applicable to that file type. “Nothing to Report” indicates that there were no files submitted for review for that file type.

Back to Agenda
• **Medi-Cal Claims: Hospital Claims**

<table>
<thead>
<tr>
<th>Month</th>
<th>Paid Claims Timeliness</th>
<th>Paid Claims Accuracy</th>
<th>Denied Claims Timeliness</th>
<th>Denied Claims Accuracy</th>
</tr>
</thead>
<tbody>
<tr>
<td>August 2017</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>September 2017</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>October 2017</td>
<td>Exempt</td>
<td>Exempt</td>
<td>Exempt</td>
<td>Exempt</td>
</tr>
</tbody>
</table>

6. **Health Network Audits: OneCare**

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**

<table>
<thead>
<tr>
<th>Month</th>
<th>Timeliness for Expedited Initial Organization Determination (EIOD)</th>
<th>Clinical Decision Making (CDM) for EIOD</th>
<th>Letter Score for EIOD</th>
<th>Timeliness for Standard Organization Determination (SOD)</th>
<th>Letter Score for SOD</th>
<th>Timeliness for Denials</th>
<th>CDM for Denials</th>
<th>Letter Score for Denials</th>
</tr>
</thead>
<tbody>
<tr>
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<td>86%</td>
<td>100%</td>
<td>72%</td>
<td>87%</td>
<td>76%</td>
<td>67%</td>
<td>56%</td>
<td>88%</td>
</tr>
<tr>
<td>September 2017</td>
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<td>33%</td>
<td>59%</td>
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<tr>
<td>October 2017</td>
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• **OneCare Claims: Misclassified Claims**

<table>
<thead>
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<th>Month</th>
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<th>Misclassified Denied Claims</th>
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<tr>
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• **OneCare Claims: Professional Claims**

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7. **Health Network Audits: OneCare Connect**

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**

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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.
• **OneCare Connect Claims: Misclassified Claims**

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• **OneCare Connect Claims: Professional Claims**

<table>
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<th>Denied Claims Timeliness</th>
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D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations

**Types of FWA Cases:** (Received in November and December 2017)

<table>
<thead>
<tr>
<th>Category</th>
<th>November - December 2017</th>
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<tbody>
<tr>
<td>Using Covered Service for Other Than Prescribed</td>
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<tr>
<td>Using Other's Identity to Obtain Services</td>
<td>6</td>
</tr>
<tr>
<td>Submission of Claims in Excess of Actually Provided</td>
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<tr>
<td>False Minimum Standards/Credentialing Info</td>
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<tr>
<td>Submission of Claims for Services Not Provided</td>
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</tr>
<tr>
<td>Receiving/Soliciting Kickback, Bribes or Rebate</td>
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</tr>
<tr>
<td>Provider Prescription Utilization</td>
<td>3</td>
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<tr>
<td>Member Prescription Utilization</td>
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<tr>
<td>Unsubstantiated Declaration of Eligibility</td>
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<tr>
<td>Failure to Disclose Conflict of Interest</td>
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<tr>
<td>Altered Prescriptions</td>
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<tr>
<td>Billing Medi-Cal Members for Services</td>
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<tr>
<td>Doctor Shopping</td>
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</table>

**November - December 2017 Referrals Received**

- Reportable Referrals: 43
- Non-Reportable Referrals: 0

**November - December 2017 Impact of Reported FWA Cases**

- High: 2
- Medium: 21
- Low: 16

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.
E. Privacy Update (November and December 2017)

**HIPAA Privacy November/December 2017 - Referrals Received**

- **Reportable Referrals**: 8
- **Non-Reportable Referrals**: 21

**HIPAA Privacy November/December 2017 - Responsible Party for Reported Referrals**

- CalOptima Employee: 8
- Business Associate(s): 9
- Other (e.g., SSA, Third Party Vendor, Law Firm, etc.): 2
- Pharmacy: 1
- Physician/Provider: 9

**HIPAA Privacy November/December 2017 - Impact of Reported Referrals**

- Impact Level: Low, High, Medium
- Number of Impact: 29

**PRIVACY STATISTICS**

<table>
<thead>
<tr>
<th>Statistic</th>
<th>Number</th>
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<tr>
<td>Total Number of Referrals Reported to DHCS (State)</td>
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<tr>
<td>Total Number of Referrals / Breaches Reported to DHCS and Office for Civil Rights (OCR)</td>
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</tr>
<tr>
<td>Total Number of Referrals Reported</td>
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*“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.*
Federal & State Legislative Advocate Reports

Board of Directors Meeting
February 1, 2018

Akin Gump Strauss Hauer & Feld / Edelstein Gilbert Robson & Smith
MEMORANDUM

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.
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.
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 primary focus 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.
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.
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.
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.
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 tkaaiaakamanu@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**

<table>
<thead>
<tr>
<th>Date</th>
<th>Events/Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/01/17</td>
<td>• Covered Orange County General Meeting</td>
</tr>
<tr>
<td></td>
<td>• Help Me Grow Advisory Meeting</td>
</tr>
<tr>
<td>12/04/17</td>
<td>• Orange County Health Care Agency Mental Health Services Act Steering Committee Meeting</td>
</tr>
<tr>
<td>12/05/17</td>
<td>• Collaborative to Assist Motel Families Meeting</td>
</tr>
<tr>
<td>12/06/17</td>
<td>• Orange County Aging Services Collaborative Meeting</td>
</tr>
<tr>
<td></td>
<td>• Anaheim Human Services Network Meeting</td>
</tr>
<tr>
<td></td>
<td>• Orange County Healthy Aging Initiative Meeting</td>
</tr>
<tr>
<td>12/11/17</td>
<td>• Orange County Veterans and Military Families Collaborative Meeting</td>
</tr>
<tr>
<td></td>
<td>• Fullerton Collaborative Meeting</td>
</tr>
<tr>
<td>12/12/17</td>
<td>• Orange County Strategic Plan for Aging — Social Engagement Committee Meeting</td>
</tr>
<tr>
<td></td>
<td>• Buena Clinton Neighborhood Coalition Meeting</td>
</tr>
<tr>
<td></td>
<td>• Susan G. Komen Orange County — Unidos Contra el Cancer del Seno Coalition Meeting</td>
</tr>
<tr>
<td></td>
<td>• San Clemente Youth Wellness and Prevention Coalition Meeting</td>
</tr>
<tr>
<td>12/13/17</td>
<td>• Buena Park Collaborative Meeting</td>
</tr>
<tr>
<td>12/14/17</td>
<td>• FOCUS Collaborative Meeting</td>
</tr>
<tr>
<td>12/19/17</td>
<td>• Placentia Community Collaborative Meeting</td>
</tr>
<tr>
<td>12/20/17</td>
<td>• Covered Orange County Steering Committee Meeting</td>
</tr>
</tbody>
</table>
• 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
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**

<table>
<thead>
<tr>
<th>Date</th>
<th># Staff Attended</th>
<th>Events/Meetings</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/16/17</td>
<td>1</td>
<td>• Community Breakfast with Santa hosted by the Cambodian Family Community Center (Registration Fee: $500 included a table for outreach)</td>
</tr>
<tr>
<td>1/20/18</td>
<td>1</td>
<td>• Community Health and Wellness Fair hosted by Santa Ana College School of Continuing Education</td>
</tr>
</tbody>
</table>

CalOptima organized or convened the following eight community stakeholder events, meeting and presentations:

**TARGET AUDIENCE: MEMBERS/POTENTIAL MEMBERS**

<table>
<thead>
<tr>
<th>Date</th>
<th>Events/Meetings/Presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/12/17</td>
<td>• CalOptima Health Education Workshop — Topic: Applying Beers Criteria for Potentially Inappropriate Medication Use in Older Adults</td>
</tr>
<tr>
<td>12/13/17</td>
<td>• Community Alliances Forum — Topic: Me We Do Be: The Four Cornerstones of Success</td>
</tr>
<tr>
<td>01/12/18</td>
<td>• County Community Service Center Health Seminar — Topic: Understanding Cervical Cancer: Prevention and Treatment (Vietnamese)</td>
</tr>
<tr>
<td>01/16/18</td>
<td>• CalOptima New Member Orientation for Medi-Cal Members (English and Spanish)</td>
</tr>
<tr>
<td>01/19/18</td>
<td>• County Community Service Center Health Seminar — Topic: Understanding Osteoporosis (Vietnamese)</td>
</tr>
<tr>
<td>01/24/18</td>
<td>• CalOptima New Member Orientation for Medi-Cal Members (Korean and Farsi)</td>
</tr>
<tr>
<td></td>
<td>• CalOptima Health Education Workshop at Madison Elementary School — Topic: Nutrition and Body Mass Index</td>
</tr>
<tr>
<td>01/25/18</td>
<td>• CalOptima New Member Orientation for Medi-Cal Members (Vietnamese)</td>
</tr>
<tr>
<td></td>
<td>• CalOptima New Member Orientation for Medi-Cal Members (Chinese and Arabic)</td>
</tr>
</tbody>
</table>

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).
CalOptima Board of Directors
Community Activities

For more information on the listed items, contact Tiffany Kaaiaakamanu, Manager of Community Relations, at 657-235-6872 or by email at tkaaiakamanu@caloptima.org.

### February

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Event Title</th>
<th>Event Type/Audience</th>
<th>Staff/Financial Participation</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Friday, 2/2 9-10:30am</td>
<td>++Covered OC General Meeting</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>N/A</td>
<td>The Village 1505 E. 17th St. Santa Ana</td>
</tr>
<tr>
<td>Friday, 2/2 10-11am</td>
<td>++Help Me Grow Advisory Meeting</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>N/A</td>
<td>Help Me Grow 2500 Redhill Ave. Santa Ana</td>
</tr>
<tr>
<td>Saturday, 2/3 9am-4pm</td>
<td>+OC Heritage Council 2018 OC Black History Cultural Faire</td>
<td>Health/Resource Fair Open to the Public</td>
<td>1 Staff</td>
<td>Downtown Anaheim 205 W. Center Promenade Anaheim</td>
</tr>
<tr>
<td>Monday, 2/5 1-4pm</td>
<td>++OCHCA Mental Health Services Act Steering Committee</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>N/A</td>
<td>Delhi Center 505 E. Central Ave. Santa Ana</td>
</tr>
<tr>
<td>Tuesday, 2/6 9:30-11am</td>
<td>++Collaborative to Assist Motel Families</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>N/A</td>
<td>Anaheim Downtown Community Center 250 E. Center St. Anaheim</td>
</tr>
<tr>
<td>Wednesday, 2/7 9-10:30am</td>
<td>++OC Aging Services Collaborative</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>N/A</td>
<td>Alzheimer’s OC 2515 McCabe Way Irvine</td>
</tr>
<tr>
<td>Wednesday, 2/7 10am-12pm</td>
<td>++Anaheim Human Services Network</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>N/A</td>
<td>Orange County Family Justice Center 150 W. Vermont Anaheim</td>
</tr>
</tbody>
</table>

* CalOptima Hosted

+ Exhibitor/Attendee
++ Meeting Attendee

Back to Agenda
<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday, 2/7</td>
<td>10-11am</td>
<td>*New Member Orientation Presentations in Farsi and Korean</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>10:30am-12pm</td>
<td>++OC Healthy Aging Initiative</td>
<td>Alzheimer’s OC 2515 McCabe Way Irvine</td>
</tr>
<tr>
<td>Thursday, 2/8</td>
<td>11:30am-12:30pm</td>
<td>++FOCUS Collaborative Meeting</td>
<td>Magnolia Park Family Resource Center 11402 Magnolia St. Garden Grove</td>
</tr>
<tr>
<td>Friday, 2/9</td>
<td>9:30am-11am</td>
<td>+Senior Citizen Advisory Council Meeting</td>
<td>Location varies</td>
</tr>
<tr>
<td>Saturday, 2/10</td>
<td>8:30am-2pm</td>
<td>+Alzheimer’s OC OC Strategic Plan for Aging Heart to Heart Conference</td>
<td>Lakeview Senior Center 20 Lake Rd. Irvine</td>
</tr>
<tr>
<td>Monday, 2/12</td>
<td>2:30-3:30pm</td>
<td>++Fullerton Collaborative</td>
<td>Fullerton Library 353 W. Commonwealth Ave. Fullerton</td>
</tr>
<tr>
<td>Tuesday, 2/13</td>
<td>9-10:30am</td>
<td>++OC Strategic Plan for Aging</td>
<td>Alzheimer’s OC 2515 McCabe Way Irvine</td>
</tr>
<tr>
<td>Tuesday, 2/13</td>
<td>11:30am-12:30pm</td>
<td>++Buena Clinton Neighborhood Coalition</td>
<td>Buena Clinton Youth and Family Center 12661 Sunswept Ave. Garden Grove</td>
</tr>
<tr>
<td>Tuesday, 2/13</td>
<td>1-2pm</td>
<td>*New Member Orientation Presentations in English and Spanish</td>
<td>N/A</td>
</tr>
<tr>
<td>Wednesday, 2/14</td>
<td>10-11:30am</td>
<td>++Buena Park Collaborative</td>
<td>Buena Park Library 7150 La Palma Ave. Buena Park</td>
</tr>
<tr>
<td>Date/Time</td>
<td>Event Description</td>
<td>Location/Details</td>
<td></td>
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<td></td>
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<tr>
<td>Wednesday, 2/14 12-1:30pm</td>
<td>++Anaheim Homeless Collaborative</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
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<tr>
<td></td>
<td></td>
<td>N/A</td>
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<tr>
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<td></td>
<td>Anaheim Central Library 500 W. Broadway Anaheim</td>
<td></td>
</tr>
<tr>
<td>Thursday, 2/15 8:30-10am</td>
<td>++Orange County Children’s Partnership Committee</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
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<tr>
<td></td>
<td></td>
<td>N/A</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>OC Hall of Administration 10 Civic Center Plaza Santa Ana</td>
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</tr>
<tr>
<td>Thursday, 2/15 8:30-10am</td>
<td>++Surf City Senior Providers Network and Lunch</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
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<tr>
<td></td>
<td></td>
<td>N/A</td>
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<tr>
<td></td>
<td></td>
<td>Senior Center at Central Park 18041 Goldenwest St. Huntington Beach</td>
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</tr>
<tr>
<td>Thursday, 2/15 2:30-4:30pm</td>
<td>++Orange County Women’s Health Project Advisory Board Meeting</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
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<tr>
<td></td>
<td></td>
<td>N/A</td>
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<tr>
<td></td>
<td></td>
<td>The Village 1505 E. 17th St. Santa Ana</td>
<td></td>
</tr>
<tr>
<td>Friday-Sunday 2/16-18</td>
<td>+CEAVA Foundation Inc. 2018 Tet Festival</td>
<td>Health/Resource Fair Open to the Public</td>
<td></td>
</tr>
<tr>
<td>10am-6pm</td>
<td></td>
<td>Requesting Sponsorship $5,000 16 Staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mile Square Park 16801 Euclid St. Fountain Valley</td>
<td></td>
</tr>
<tr>
<td>Friday-Sunday 2/16-18</td>
<td>+Union of Vietnamese Students (UVSA) 2018 Tet Festival</td>
<td>Health/Resource Fair Open to the Public</td>
<td></td>
</tr>
<tr>
<td>10am-6pm</td>
<td></td>
<td>Requesting Sponsorship $5,000 16 Staff</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>OC Fair &amp; Event Center 88 Fair Dr. Costa Mesa</td>
<td></td>
</tr>
<tr>
<td>Tuesday, 2/20 10-11:30am</td>
<td>++Placentia Community Collaborative</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
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<tr>
<td></td>
<td></td>
<td>N/A</td>
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<tr>
<td></td>
<td></td>
<td>Placentia Presbyterian Church 849 Bradford Ave. Placentia</td>
<td></td>
</tr>
<tr>
<td>Tuesday, 2/20 10-11:30am</td>
<td>++OC Cancer Coalition</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
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<tr>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>American Cancer Society 1940 E. Deere Ave. Santa Ana</td>
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<tr>
<td>Wednesday, 2/21 9:15-11am</td>
<td>+Covered OC Steering Committee</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Village 1505 E. 17th St. Santa Ana</td>
<td></td>
</tr>
<tr>
<td>Wednesday, 2/21 11am-1pm</td>
<td>++Minnie Street Family Resource Center Professional Roundtable</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>N/A</td>
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<tr>
<td></td>
<td></td>
<td>Minnie Street Family Resource Center 1300 McFadden Ave. Santa Ana</td>
<td></td>
</tr>
</tbody>
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* CalOptima Hosted
+ Exhibitor/Attendee
++ Meeting Attendee
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<tr>
<th>Date</th>
<th>Time</th>
<th>Event</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wednesday, 2/21</td>
<td>1-4pm</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>Location varies</td>
</tr>
<tr>
<td>Wednesday, 2/21</td>
<td>1:30-3pm</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>Friends of Family Community Clinic 501 S. Idaho St. La Habra</td>
</tr>
<tr>
<td>Wednesday, 2/21</td>
<td>3:30-4:30pm</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>CalOptima</td>
</tr>
<tr>
<td>Thursday, 2/22</td>
<td>8:30-10am</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>Disability Coalition of Orange County</td>
</tr>
<tr>
<td>Thursday, 2/22</td>
<td>9:30-10:30am</td>
<td>Community Presentation Open to Members</td>
<td>County Community Service Center 15496 Westminster Ave. Westminster</td>
</tr>
<tr>
<td>Thursday, 2/22</td>
<td>8:30-10am</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>Help Me Grow 2500 Redhill Ave. Santa Ana</td>
</tr>
<tr>
<td>Thursday, 2/22</td>
<td>2-3pm</td>
<td>Community Presentation Open to Members</td>
<td>CalOptima</td>
</tr>
<tr>
<td>Monday, 2/26</td>
<td>12:30-1:10pm</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>Healthy Smiles for Kids 2101 E. Fourth St. Santa Ana</td>
</tr>
<tr>
<td>Monday, 2/26</td>
<td>12:30-1:10pm</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>Stanton Civic Center 7800 Katella Ave. Stanton</td>
</tr>
<tr>
<td>Monday-Tuesday</td>
<td>2/26-27</td>
<td>Conference and Community Presentation Registration required.</td>
<td>Family Voices of California Annual Health Summit 1782 Tribute Rd. Sacramento</td>
</tr>
<tr>
<td>Tuesday, 2/27</td>
<td>7:30-9am</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>Orange Senior Center 170 S. Olive Orange</td>
</tr>
</tbody>
</table>

* CalOptima Hosted
+ Exhibitor/Attendee
++ Meeting Attendee
<table>
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<tr>
<th>Date</th>
<th>Event Description</th>
<th>Meeting Details</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuesday, 2/27</td>
<td>++Santa Ana Building Healthy Communities</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>N/A KidWorks 1902 W. Chestnut Ave. Santa Ana</td>
</tr>
<tr>
<td>3:30-4:30pm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wednesday, 2/28</td>
<td>++OC Human Trafficking Task Force</td>
<td>Steering Committee Meeting: Open to Collaborative Members</td>
<td>N/A Community Service Program 1221 E. Dyer Rd. Santa Ana</td>
</tr>
<tr>
<td>10:30-11:30am</td>
<td></td>
<td></td>
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