NOTICE OF A REGULAR MEETING OF THE CALOPTIMA BOARD OF DIRECTORS

THURSDAY, SEPTEMBER 1, 2016
2:00 P.M.

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

BOARD OF DIRECTORS

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

Supervisor Todd Spitzer, Alternate

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

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

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

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

CALL TO ORDER
Pledge of Allegiance
Establish Quorum

PRESENTATIONS/INTRODUCTIONS

MANAGEMENT REPORTS

1. Chief Executive Officer Report
    a. Health Plan Associations and Advocates
    b. Program of All-Inclusive Care for the Elderly

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

REPORTS

3. Consider Authorization of Contract with a Managed Behavioral Health Organization (MBHO) Effective January 1, 2017 and Contract with Consultant to Assist with MBHO Contract Implementation; Consider Authorization of Extension of Current Behavioral Health Contracts with College Health Independent Practice Association and Windstone Behavioral Health

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

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

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

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

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

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

ADVISORY COMMITTEE UPDATES

10. Member Advisory Committee Update

11. Provider Advisory Committee Update

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

INFORMATION ITEMS

13. July 2016 Financial Summary

14. Compliance Report

15. Federal and State Legislative Advocates Reports

16. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

CLOSED SESSION

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

ADJOURNMENT

NEXT REGULAR MEETING: Thursday, October 6, 2016 at 2:00 p.m.

MEMORANDUM

DATE:	September 1, 2016
TO:	CalOptima Board of Directors
FROM:	Michael Schrader, CEO
SUBJECT:	CEO Report
COPY:	Suzanne Turf, Clerk of the Board; Member Advisory Committee; Provider Advisory Committee; OneCare Connect Member Advisory Committee

Health Plan Associations and Advocates
CalOptima benefits from our active participation in leading health plan associations at the state and national level. Typically, the Centers for Medicare & Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) prefer to work on large initiatives with associations instead of individual health plans. In addition, we maintain productive relationships with federal and state advocates who represent CalOptima in legislative and regulatory matters. Below are brief descriptions of our associations and advocates as well as short summaries of selected recent accomplishments.

STATE ASSOCIATIONS
California Association of Health Plans (CAHP): CAHP includes all 26 public and private health plans in California and has significant influence in Sacramento. Its mission is to create and sustain an environment that permits member plans to maintain or grow their organizations' ability to offer quality health care. In 2015, I was appointed to the CAHP Board of Directors, a position limited to only some CEOs of the member plans.

- Medi-Cal Rates: One of the major benefits of the association is to guide advocacy efforts with regard to Medi-Cal rates. Through its Rates Workgroup, CAHP works closely with DHCS to ensure that health plans receive adequate reimbursement rates to support access for members. While rates advocacy will continue to be a key issue for CalOptima, we are pleased with CAHP's efforts for FY 2016–17 to lessen Medi-Cal Expansion rate cuts and increase Medi-Cal Classic rates.
- Advocacy for Cal MediConnect: In his FY 2015–16 state budget proposal, Gov. Brown indicated that the Coordinated Care Initiative (CCI), which includes Cal MediConnect (OneCare Connect in Orange County), was not meeting financial benchmarks and could be eliminated by January 2017. CAHP took the lead in convening a CCI Workgroup of Cal MediConnect plans, associations and others to develop advocacy strategies and collect data. Reflecting the influence of the workgroup, the governor's FY 2016–17 budget proposal was more positive about the future of CCI, authorizing an extension through 2017. Under CAHP's leadership, the CCI Workgroup continues, and CalOptima actively participates by sharing data, attending meetings and providing information about OneCare Connect's success in Orange County.

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Local Health Plans of California (LHPC): LHPC includes all 16 public, nonprofit plans that serve predominantly low-income individuals with Medi-Cal coverage. CEOs of all member plans are on the LHPC Board.

- CMS Medicaid Managed Care "Mega Reg": In April, CMS released a 1,425-page final rule that updates Medicaid managed care regulations. CMS' major goals in revising the regulations were to enhance beneficiary care and protections, strengthen payment provisions, promote quality of care, and support delivery system reform. LHPC plays a critical role for member organizations by providing analysis regarding the impact of the provisions. LHPC has convened meetings with DHCS to discuss implementation in California and set up a Mega Reg Workgroup, consisting of policy staff from plans.
- California Children's Services (CCS): In 2015, Sen. Ed Hernandez, with the support of the California Children's Hospital Association (CCHA), authored SB 586, a bill aimed at redesigning the CCS program. Funded by the state and administered by counties, CCS provides health care, case management and other services for children with episodic and chronic medical conditions, including cystic fibrosis, hemophilia, cerebral palsy, heart disease, cancer and traumatic injuries. LHPC continues to work closely with members of the Legislature, DHCS, CCHA and other entities to ensure that the bill language is in the best interest of the public plans and their members. LHPC has been involved in amendments to the bill and meetings with health plan CEOs and key influencers.

CalPACE: CalPACE is dedicated to the expansion of comprehensive health care for frail elderly and the promotion of PACE through education and advocacy. Members include 11 organizations that operate 30 PACE centers in California. CalOptima Director of Government Affairs Arif Shaikh is on the CalPACE Board of Directors.

- PACE Modernization Act: CalPACE was at the forefront of working with DHCS and the Legislature to draft the PACE Modernization Act, which is currently part of a state budget health trailer bill. The bill makes a variety of changes to improve the regulatory structure for PACE. Most notably, the bill would introduce a new process for calculating PACE reimbursement rates that is more likely to account for geographic rate disparity. First, reimbursement rates would be calculated taking into account actual cost data for each PACE center. Second, the rates would then be analyzed by a workgroup for actuarial soundness. Third, DHCS would be empowered to adjust the rates further to mitigate any remaining disparity. The act is especially important for CalOptima, since our Medi-Cal rates for PACE are among the lowest in the state.
- Enrollment Option in Cal MediConnect Materials: While Cal MediConnect and PACE are different programs, the target population they serve is the same — dual eligibles. When DHCS was developing an enrollment strategy for Cal MediConnect, CalPACE strongly advocated for inclusion of PACE as an option on the Cal MediConnect enrollment materials. During the OneCare Connect passive enrollment process, CalOptima was pleased that Orange County dual eligibles not only had an opportunity to enroll in that program but also in our PACE program. CalPACE's efforts in this initiative align with CalOptima's goal to ensure that members receive the right care for their needs.

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NATIONAL ASSOCIATIONS

Association for Community Affiliated Plans (ACAP): Based in Washington, D.C., ACAP includes 61 community-based health plans in 24 states. ACAP has constructive and positive working relationships with federal legislators and regulators. ACAP conducts legislative advocacy with Congress on behalf of public plans in the Medicaid program and works well with CMS to support the efforts of plans operating Medicare programs. CalOptima is actively involved in ACAP programs, and I have been invited to speak at events on a regular basis.

- Medicare Rate Adjustment: ACAP was instrumental in CMS acknowledging that its risk-adjustment methodology under-predicts costs for dual eligibles in the various plans that provide Medicare benefits under managed care. CMS reviewed ACAP data (including some from CalOptima) that showed the payment methodology for dual eligibles resulted in payments that were too low given duals' medical conditions. Based on the new risk-adjustment methodology, CalOptima received a 7.4 percent Medicare base rate increase, retroactive to January 1, 2016, for OneCare Connect members. Beginning in 2017, the new risk-adjustment methodology will apply to both OneCare and OneCare Connect. In addition, ACAP is also asking CMS to reconsider its methodology for Star quality ratings in order to more fairly recognize the complexities of duals.
- Provider Directory Requirement: ACAP influenced a change related to a proposed CMS requirement regarding provider directories for Medicare plans. In light of findings that such directories were often inaccurate, CMS issued a letter stating that plans had to contact all providers monthly to verify the accuracy of information. CalOptima developed a presentation about the time and expense of that communication, which ACAP took to CMS. This resulted in CMS adjusting the frequency to quarterly — a major win in terms of eliminating a potentially burdensome requirement.

National PACE Association (NPA): Based in Alexandria, Va., NPA advances the efforts of PACE programs nationwide. Its membership includes 120 organizations in 31 states.

- Best Practices/Technical Assistance: On August 15, Peter Fitzgerald, NPA executive vice president of policy and strategy, toured CalOptima PACE and met with me, PACE Director Rena Smith and others. We had the opportunity to ask questions about operational best practices, and Mr. Fitzgerald made useful suggestions to boost efficiency and financial success. We also discussed our plan to use the Alternative Care Setting model to expand PACE, and he shared that a number of NPA members are pursuing this option because it has proven to be more flexible. Overall, we came away with renewed confidence that CalOptima PACE, at three years old, is performing consistent with national trends.
- CMS PACE Proposed Rule: CMS recently published a proposed rule to update PACE regulations. NPA is playing a critical role in helping organizations understand the regulation's impact and coordinating comments to CMS.

FEDERAL AND STATE ADVOCATES

James McConnell: Based in Washington, D.C., Mr. McConnell has represented CalOptima for a number of years, maintaining strong relationships with the Orange County delegation in the U.S. Senate and House of Representatives. He provides regular updates regarding health care topics at the federal level, including the Affordable Care Act and other key legislation.

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- Protection of the County Organized Health System (COHS) Model: As one of only six COHS in the United States, CalOptima is a unique, mission-centered organization focused on providing access to quality, cost-effective care for members. Since the COHS model was established by federal statute, it is critical that members of Congress understand CalOptima and our community commitment. Mr. McConnell provides frequent updates to legislators to ensure they support CalOptima and the COHS model for Medi-Cal in Orange County.

Edelstein Gilbert Robson & Smith: Based in Sacramento, Trent Smith and Don Gilbert, partners at Edelstein, Gilbert Robson & Smith, serve as CalOptima's advocates at the state level. They provide representation on a wide variety of health care issues addressed by the legislators.

- Defeat of SB 260: Last year, Sen. Bill Monning, with the support of Western Center on Law & Poverty, authored a bill that would have required COHS plans to obtain a Knox-Keene license from the California Department of Managed Health Care. Knox-Keene licenses are for private health plans competing in a commercial marketplace. COHS plans are public entities and do not compete for Medi-Cal members. CalOptima and other COHS plans opposed SB 260, and Mr. Smith was extremely effective in lobbying against the bill. First, he set up multiple meetings between the COHS plans and Sen. Monning and his staff to ensure they understood the COHS model and clarify any misconceptions. However, once it was clear that Sen. Monning was moving forward with his bill, our advocates worked diligently to educate other legislators about the negative impacts of the bill, resulting in a defeat on the Assembly floor.
- Defeat of SB 1308: Introduced earlier this year, SB 1308 would have imposed financial restrictions on COHS plans, limiting spending on promotional giveaways, staff retreats, lobbying activities, certain media campaigns and other areas. COHS plans opposed SB 1308 because it undermined local control for the respective governing bodies of the health plans and oddly focused on spending when, in fact, COHS have among the lowest administrative costs of any Medi-Cal managed care model. Our advocates met with the bill's author, Sen. Ed Hernandez, chair of the Senate Health Committee, and other committee members to address concerns regarding the bill. As a result of this sustained lobbying effort, the author decided to drop the bill.

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

CalOptima PACE may soon be impacted by new legislation and regulation pending at the state and federal levels. A California budget health trailer bill contains the PACE Modernization Act. The act would make an adjustment to the PACE reimbursement process that is likely to significantly benefit our program by better accounting for geographic rate disparities. At the federal level, CMS published a proposed rule to update PACE regulations and build on the program's success. In releasing the rule, CMS stated that PACE programs have grown significantly in recent years yet the rules governing the programs have not changed in a decade. Therefore, CMS' proposal is designed to revise the requirements for PACE, aiming to provide organizations with more administrative and operational flexibility while strengthening protections and improving care for participants.

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MINUTES

REGULAR MEETING
OF THE
CALOPTIMA BOARD OF DIRECTORS

August 4, 2016

A Regular Meeting of the CalOptima Board of Directors was held on August 4, 2016, at CalOptima, 505 City Parkway West, Orange, California. Chair Mark Refowitz called the meeting to order at 2:03 p.m. Supervisor Do led the Invocation, and Supervisor Bartlett led the Pledge of Allegiance. Chair Refowitz administered the Oath of Office to the Board.

ROLL CALL

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

Members Absent: All members present

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

Chair Refowitz announced the following change to the agenda: Item 14, Consider Authorizing Policy Modifications to Eliminate Specialist Physician Aggregate Reimbursement Rate Requirement for Health Networks, was continued to a future Board meeting.

MANAGEMENT REPORTS

1. Chief Executive Officer (CEO) Report

CEO Michael Schrader reported that CalOptima received the final report from the annual Department of Health Care Services (DHCS) audit of our Medi-Cal plan conducted in February 2016. The audit covered CalOptima and our health networks, and reviewed six categories: utilization management, continuity of care, access and availability, members' rights, quality management, and administrative and organizational capacity. DHCS auditors noted significant improvements compared with the prior year.

Mr. Schrader provided an update on OneCare Connect (OCC), CalOptima's Cal MediConnect plan authorized by California's Coordinated Care Initiative, which marked its one-year anniversary in July 2016. It was noted that the passive enrollment process has been completed. As of August 2016, OCC is the second largest Cal MediConnect plan in California with more than 19,000 members.

PUBLIC COMMENTS

There were no requests for public comment.

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CONSENT CALENDAR

2. Minutes
   a. Approve Minutes of the June 2, 2016 Regular Meeting of the CalOptima Board of Directors; and
   b. Receive and File Minutes of the May 12, 2016 Meeting of the CalOptima Board of Directors' Member Advisory Committee; the May 12, 2016 Meeting of the CalOptima Board of Directors' Provider Advisory Committee; the May 26, 2016 and April 28, 2016 Meetings of the CalOptima Board of Directors' OneCare Connect Plan (Medicare-Medicaid Plan) Member Advisory Committee

3. Consider Adoption of Resolution Adding Vice Chair Positions to the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee and Provider Advisory Committee

4. Ratify Agreement 16-93274 with the California Department of Health Care Services

5. Consider Revising the Membership of the CalOptima Board of Directors' Finance and Audit Committee and the Board of Directors' Quality Assurance Committee

6. Consider Revising the Membership of the CalOptima Board of Directors' Finance and Audit Committee and the Board of Directors' Quality Assurance Committee

7. Appoint Directors to the CalOptima Foundation Board of Directors

Supervisor Bartlett pulled Consent Calendar Item 3 for discussion.

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

Consider Adoption of Resolution Adding Vice Chair Positions to the CalOptima Board of Directors' Member Advisory Committee, OneCare Connect Member Advisory Committee and Provider Advisory Committee

Supervisor Bartlett commented in support of adding vice chair positions to the Member Advisory Committee (MAC), OneCare Connect Member Advisory Committee (OCC MAC), and Provider Advisory Committee (PAC), and directed the advisory committees to revisit their nominations for chair and vice chair to ensure proper coverage in both positions before presenting to the Board for approval.

Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors adopted Resolution No. 16-0804-01, adding Vice Chair positions to the Board of Directors' Member Advisory Committee (MAC), OneCare Connect Cal MediConnect (Medicare-Medicaid Plan) Member Advisory Committee (OCC MAC) and Provider Advisory Committee (PAC), effective upon Board approval. (Motion carried 9-0-0)***

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REPORTS

Chair Refowitz noted the following for the record: 1) With the exception of items 10 and 13, Supervisor Bartlett did not participate in the discussion and vote on agenda items 8 through 30 due to potential conflicts of interest based on campaign contributions under the Levine Act; 2) Supervisor Do did not participate in the discussion and vote on agenda items 8 through 30 due to potential conflicts of interest based on campaign contributions under the Levine Act; and 3) Director Schoeffel did not participate on agenda items 8 through 30, and item 36, due to potential conflicts of interest based on campaign contributions under the Levine Act and other potential conflicts of interest and left the room during the discussion and vote on these items.

8. Consider Ratification of Medi-Cal Expansion (MCE) Member Rate Change for CalOptima Community Network Specialist Physicians and Contract Amendments Implementing the Rate Change and Aligning Contract Expiration Dates with CalOptima's Fiscal Year End

Due to his provider affiliations with St. Joseph Health, Vice Chair Penrose left the room during the discussion and vote on this item.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors ratified change of the reimbursement rates for CalOptima Community Network Specialists for services rendered to Medi-Cal Expansion (MCE) member to 156% of the CalOptima Medi-Cal fee schedule, effective July 1, 2016; and ratified contact amendments with existing Community Network Specialists and contracts with new Community Network Specialists to implement the rate change and align contract expiration dates with CalOptima's fiscal year end. (Motion carried 5-0-0; Supervisors Bartlett and Do recused; Vice Chair Penrose and Director Schoeffel absent)***

9. Consider Authorizing Rate Increase for CalOptima Community Network Primary Care Physicians (PCPs), except for St. Joseph Health Entities and Affiliates, for Services Provided to Medi-Cal Members and Contract Amendments Implementing the Rate Increase and Aligning Contract Expiration Dates with CalOptima's Fiscal Year End

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors authorized an increase of the reimbursement rates for CalOptima Community Network Primary Care Physicians (PCPs) except for St. Joseph Health entities and affiliates, for services rendered to Medi-Cal Members to 129% of the CalOptima Medi-Cal fee schedule, effective July 1, 2016; and authorized contract amendments with existing Community Network PCPs, except for St. Joseph Health entities and affiliates, and contracts with new Community Network PCPs to implement the rate increase and align contract expiration dates with CalOptima's fiscal year end. (Motion carried 5-0-0; Supervisors Bartlett and Do recused; Vice Chair Penrose and Director Schoeffel absent)***

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10. Consider Authorizing Rate Increase for CalOptima Community Network St. Joseph Health Entities and Affiliates, Primary Care Physicians (PCPs), for Services Provided to Medi-Cal Members and Contract Amendments Implementing the Rate Increase and Aligning Contract Expiration Dates with CalOptima's Fiscal Year End

Due to his affiliation with St. Joseph Health, Vice Chair Penrose did not participate in this item and left the room during the discussion and vote. Director DiLuigi did not participate in the discussion and vote on this item due to his service on the St. Jude Clinic Board of Directors.

Action: ***On motion of Director Yost, seconded and carried, the Board of Directors authorized an increase of the reimbursement rates for CalOptima Community Network St. Joseph Health entities and affiliates Primary Care Physicians (PCPs) for services rendered to Medi-Cal Members to 129% of the CalOptima Medi-Cal fee schedule, effective July 1, 2016; and authorized contract amendments with existing Community Network St. Joseph Health entities and affiliates PCPs, and contracts with new Community Network PCPs to implement the rate increase and align contract expiration dates with CalOptima's fiscal year end. (Motion carried 5-0-0; Supervisor Do and Director DiLuigi recused; Vice Chair Penrose and Director Schoeffel absent)***

11. Consider Ratification of Rate Adjustments to Medi-Cal Fee-For-Service Hospital Inpatient Rates, Except for the Entities and Affiliates of Kindred Hospitals, St. Joseph Health, and UC Irvine Medical Center, for Classic (Non-Expansion) Medi-Cal Members; Rate Adjustments for Hospitals Reimbursed using the All Patient Refined Diagnosis Related Group (APR-DRG) Methodology for Medi-Cal Expansion Members; and Contract Amendments Implementing these Rate Changes

Based on his provider affiliation with St. Joseph Health, Director Yost did not participate in the discussion and vote on this item.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors ratified: 1) an increase of 4% to the inpatient rates for hospital fee-for-service Classic (non-Expansion) Medi-Cal member rates except for the entities and affiliates of Kindred Hospitals, St. Joseph Health, and UC Irvine Medical Center, effective July 1, 2016; 2) effective July 1, 2016, revision of Medi-Cal Expansion rates to hospitals reimbursed based using the APR-DRG methodology to 2% above their pre-July 1, 2016 levels; and 3) contract amendments to implement these rate changes. (Motion carried 5-0-0; Supervisors Bartlett and Do, and Director Yost recused; Director Schoeffel absent)***

12. Consider Ratification of Rate Adjustments to Medi-Cal Fee-For-Service Hospital Inpatient Rates for UC Irvine Medical Center, for Classic (Non-Expansion) Medi-Cal Members; Rate Adjustments for Hospitals Reimbursed using the All Patient Refined Diagnosis Related Group (APR-DRG) Methodology for Medi-Cal Expansion Members as applicable; and Contract Amendments Implementing These Rate Changes

Director Nguyen did not participate in this item due to his spouse's affiliation with UCI as a resident physician, and left the room during the discussion and vote.

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Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors ratified: 1) an increase of 4% to the inpatient rates for hospital fee-for-service Classic (non-Expansion) Medi-Cal member rates for UC Irvine Medical Center, effective July 1, 2016; 2) effective July 1, 2016, revision of Medi-Cal Expansion rates to hospitals reimbursed based using the APR-DRG methodology to 2% above their pre-July 1, 2016 levels; and 3) contract amendments to implement these rate changes. (Motion carried 5-0-0; Supervisors Bartlett and Do recused; Directors Nguyen and Schoeffel absent)***

13. Consider Ratification of Rate Adjustments to Medi-Cal Fee-For-Service Hospital Inpatient Rates for St. Joseph Health Entities and Affiliates, for Classic (Non-Expansion) Medi-Cal Members; Rate Adjustments for Hospitals Reimbursed using the All Patient Refined Diagnosis Related Group (APR-DRG) Methodology for Medi-Cal Expansion Members; and Contract Amendments Implementing These Rate Changes

Based on their provider affiliations with St. Joseph Health, Vice Chair Penrose and Director Yost did not participate in the discussion and vote on this item.

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors ratified: 1) an increase of 4% to the inpatient rates for hospital fee-for-service Classic (non-Expansion) Medi-Cal member rates for St. Joseph Health entities and affiliates, effective July 1, 2016; 2) effective July 1, 2016, revision of Medi-Cal Expansion rates to hospitals reimbursed based using the APR-DRG methodology to 2% above their pre-July 1, 2016 levels; and 3) contract amendments to implement these rate changes. (Motion carried 5-0-0; Supervisor Do, Vice Chair Penrose and Director Yost recused; Director Schoeffel absent)***

14. Consider Authorizing Policy Modifications to Eliminate Specialist Physician Aggregate Reimbursement Rate Requirement for Health Networks

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

15. Consider Ratification of the Rate Increase for the Professional component of Capitation Rates for Contracted Medi-Cal Shared Risk Group AltaMed Health Services Corporation, for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors ratified a 4% increase for the professional component of capitation rates for contracted Medi-Cal Shared Risk Group AltaMed Health Services Corporation, for Classic (non-Expansion) Medi-Cal members effective July 1, 2016; ratified contract amendment to implement the rate increase, and authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the health network contract to remove specialist physician***

reimbursement requirement effective July 1, 2016. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)

16. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, AMVI Health Network for Classic (Non-Expansion) Medi-Cal members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors ratified a 4% increase for the professional component of capitation rates for contracted Medi-Cal Physician-Hospital Consortia AMVI Health Network for Classic (non-Expansion) Medi-Cal members effective July 1, 2016; ratified contract amendment to implement the rate increase, and authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

17. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Arta Western Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors ratified a 4% increase for the professional component of capitation rates for contracted Medi-Cal Shared Risk Group Arta Western Medical Group, Inc., for Classic (non-Expansion) Medi-Cal members effective July 1, 2016; ratified contract amendment to implement the rate increase, and authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

18. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, CHOC Physicians Network for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Based on his provider affiliation with CHOC Health Alliance, Director Yost did not participate in the discussion and vote on this item.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors ratified a 4% increase for the professional component of capitation rates for contracted Medi-Cal Physician-Hospital Consortia CHOC Physicians***

Network for Classic (non-Expansion) Medi-Cal members effective July 1, 2016; ratified contract amendment to implement the rate increase, and authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016. (Motion carried 5-0-0; Supervisors Bartlett and Do, and Director Yost recused; Director Schoeffel absent)

19. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, Family Choice Medical Group, Inc. for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors ratified a 4% increase for the professional component of capitation rates for contracted Medi-Cal Physician-Hospital Consortia Family Choice Medical Group, Inc., for Classic (non-Expansion) Medi-Cal members effective July 1, 2016; ratified contract amendment to implement the rate increase, and authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

20. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Health Maintenance Organization, Heritage Provider Network, Inc. for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors ratified a 4% increase for the professional component of capitation rates for contracted Medi-Cal Health Maintenance Organization Heritage Provider Network, for Classic (non-Expansion) Medi-Cal members effective July 1, 2016; ratified contract amendment to implement the rate increase, and authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

21. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Monarch HealthCare, A Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

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22. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Orange County Physicians IPA Medical Group, Inc., dba Noble Community Medical Associates, Inc. of Mid-Orange County for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors ratified a 4% increase for the professional component of capitation rates for contracted Medi-Cal Shared Risk Groups Monarch HealthCare, A Medical Group, Inc., and Orange County Physicians IPA Medical Group, Inc., dba Noble Community Medical Associates, Inc. of Mid-Orange County, for Classic (non-Expansion) Medi-Cal members effective July 1, 2016; ratified contract amendments to implement the rate increase, and authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the health network contracts to remove specialist physician reimbursement requirements effective July 1, 2016. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

23. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, Orange County Advantage Medical Group, Inc. for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Action: ***On motion of Director Nguyen, seconded and carried, the Board of Directors ratified a 4% increase for the professional component of capitation rates for contracted Medi-Cal Physician-Hospital Consortia Orange County Advantage Medical Group, Inc., for Classic (non-Expansion) Medi-Cal members effective July 1, 2016; ratified contract amendment to implement the rate increase, and authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the health network contract to remove specialist physician reimbursement requirement effective July 1, 2016. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

24. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Prospect Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

25. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, Talbert Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize

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Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

26. Consider Ratification of the Rate Increase for the Professional Component of Capitation Rates for Contracted Medi-Cal Shared Risk Group, United Care Medical Group, Inc., for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase; Authorize Contract Amendment to Implement Changes to Board Policy, if any, Regarding Specialist Physician Aggregate Reimbursement Requirements

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors ratified a 4% increase for the professional component of capitation rates for contracted Medi-Cal Shared Risk Groups Prospect Medical Group, Inc., Talbert Medical Group, Inc., and United Care Medical Group, Inc., for Classic (non-Expansion) Medi-Cal members effective July 1, 2016; ratified contract amendments to implement the rate increase, and authorized the Chief Executive Officer, with the assistance of legal counsel, to amend the health network contracts to remove specialist physician reimbursement requirements effective July 1, 2016. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

27. Consider Ratification of Rate Increase for Facility Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, Children's Hospital of Orange County for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase
Director Yost did not participate in the discussion and vote on this item due to his provider affiliation with CHOC Health Alliance.

Action: ***On motion of Director DiLuigi, seconded and carried, the Board of Directors ratified a 4% increase for the facility component of capitation rates for contracted Medi-Cal Physician-Hospital Consortia Children's Hospital of Orange County for Classic (non-Expansion) Medi-Cal members effective July 1, 2016; and ratified contract amendment to implement the rate increase. (Motion carried 5-0-0; Supervisors Bartlett and Do, and Director Yost recused; Director Schoeffel absent)***

28. Consider Ratification of Rate Increase for Facility Component of Capitation Rates for Contracted Medi-Cal Physician-Hospital Consortia, Fountain Valley Regional Hospital and Medical Center, for Classic (Non-Expansion) Medi-Cal Members and Contract Amendments Implementing the Rate Increase

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors ratified a 4% increase for the facility component of capitation rates for contracted Medi-Cal Physician-Hospital Consortia Fountain Valley Regional Hospital and Medical Center for Classic (non-Expansion) Medi-Cal members effective July 1, 2016; and ratified contract amendment to implement the rate increase. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

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29. Consider Ratification of Rate Increase for Facility Component of Capitation Rates for Contracted Medi-Cal Health Maintenance Organization, Heritage Provider Network, Inc. for Classic (Non-Expansion) Medi-Cal Members and Contract Amendment Implementing the Rate Increase

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors ratified a 4% increase for the facility component of capitation rates for contracted Medi-Cal Health Maintenance Organization Heritage Provider Network, Inc., for Classic (non-Expansion) Medi-Cal members effective July 1, 2016; and ratified contract amendment to implement the rate increase. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

30. Consider Approval of Rate Increase for Contracted Community Based Adult Services (CBAS) Centers Serving Medi-Cal and OneCare Connect Members; Authorize Contract Amendments to Implement the Increase

Action: ***On motion of Director Khatibi, seconded and carried, the Board of Directors authorized a 4% increase for CalOptima CBAS centers for Medi-Cal and OneCare Connect members effective July 1, 2016; and authorized the Chief Executive Officer, with the assistance of legal counsel, to amend CBAS contracts to implement the rate increase. (Motion carried 6-0-0; Supervisors Bartlett and Do recused; Director Schoeffel absent)***

31. Consider Proposed Changes to Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment Requirements

Vice Chair Penrose abstained from the discussion and vote on this item, stating that St. Joseph Health System is in the process of becoming a network and would be subject to the minimum requirements presented for consideration.

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

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized proposed modifications to Policy EE.1106, Health Network and CalOptima Community Network Minimum and Maximum Member Enrollment, to extend the timeframe for health networks to meet the minimum member enrollment requirement from 12 months to a maximum of 36 months. (Motion carried 8-0-1; Vice Chair Penrose abstained)***

32. Consider Extension of Contract with National Committee for Quality Assurance (NCQA)-Certified Vendor Inovalon which Provides Healthcare Effectiveness Data and Information Set (HEDIS) Reporting Support

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors authorized the Chief Executive Officer to extend the Inovalon contract through October 31, 2019, and authorized payment of maintenance and support fees under the Inovalon contract through October 31, 2019. (Motion carried 9-0-0)***

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33. Authorize Submission of Proposal to the U.S. Department of Health and Human Services for a Quality Improvement Technical Assistance Grant

Len Rosignoli, Chief Information Officer, provided a brief overview of the Quality Improvement Technical Assistance Grant and reported that CalOptima staff continues to gather details on this program grant as they are developed, including the requirement that applicants commit to assisting an entire contiguous state rather than by county. CalOptima will move forward with the submittal of the grant application should this requirement change.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the Chief Executive Officer to submit an application for a direct technical assistance grant to the Department of Health and Human Services Centers for Medicare & Medicaid Services under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and directed staff to return to the Board with specific deliverables and a proposed spending plan. (Motion carried 9-0-0)***

34. Authorize Extension of Contract with Healthcare Insight, a Division of Verisk Health, Inc.

Action: ***On motion of Director Berger, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to negotiate an amendment to extend the existing Amended and Restated Contract with Verisk Health Inc., through December 31, 2017. (Motion carried 9-0-0)***

35. Consider Authorizing Contract with a Real Estate Consultant to Assist in the Evaluation of Options Related to CalOptima's Development Rights and Approve Budget Allocation

Mr. Schrader presented the recommended action to authorize a contract with a real estate consultant to assist in the providing market research, evaluating development feasibility and financial feasibility, and provide recommended options based on CalOptima's development rights, and approve the allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017. As proposed, the evaluation will take into consideration options of new leased space for CalOptima, costs, compliance with internal policies and procedures, requirements of Public Works projects, and possible public-private partnerships.

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 authorized the Chief Executive Officer to enter into a contract with a real estate consultant to assist in providing market research, evaluating development feasibility and financial feasibility, and recommend options based on CalOptima's development rights in accordance with the Board approved procurement process; and approved the allocation of $22,602 from existing reserves to fund the contract with the selected real estate consultant through June 30, 2017. (Motion carried 9-0-0)***

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36. Consider Authorization of License Agreement with the County of Orange for Usage of Space at the County Community Service Center

As previously noted, Director Schoeffel did not participate in this item and left the room during the discussion and vote.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized the Chief Executive Officer, with the assistance of legal counsel, to enter into a one-year license agreement with the County of Orange for non-exclusive use of approximately 362 square feet of space at the County Community Service Center located at 15496 Magnolia Street, Westminster, California, 92683; and approved the allocation of $22,538 from existing reserves to fund the license agreement through June 30, 2017. (Motion carried 8-0-0; Director Schoeffel absent)***

37. Consider Authorization of Expenditures in Support of CalOptima's Participation in Community Activities

Director Yost did not participate in the discussion and vote on this item due to his recent election to serve as the Secretary-Treasurer of the Orange County Medical Association (OCMA). Director Khatibi did not participate in the discussion and vote on this item due to his association with the OCMA.

Action: ***On motion of Supervisor Do, seconded and carried, the Board of Directors authorized expenditures in support of CalOptima's participation in the following community activities: 1) up to $5,250 and staff participation at the Vietnamese Cultural Center 2016 Mid-Autumn Festival in Fountain Valley, and 2) up to $5,000 and staff participation for Preferred Community Partner membership with the Orange County Medical Association; made a finding that such expenditures are for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and authorized the Chief Executive Officer to execute agreements as necessary for the events and expenditures. (Motion carried 7-0-0; Directors Khatibi and Yost recusing)***

38. Consider Authorization of Expenditures for Full Board Membership in the National Association of Corporate Directors

Action: ***On motion of Supervisor Bartlett, seconded and carried, the Board of Directors authorized expenditures of $11,050 for full Board membership in the National Association of Corporate Directors. (Motion carried 9-0-0)***

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

Action: ***On motion of Vice Chair Penrose, seconded and carried, the Board of Directors adopted Resolution No. 16-0804-02, approving updated Human Resources Policy GA.8058: Salary Schedule, and approved proposed market adjustments for various positions. (Motion carried 9-0-0)***

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ADVISORY COMMITTEE UPDATES

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

Christine Chow, OCC MAC Member Advocate Representative, presented a brief review of activities at the June 23, 2016 OCC MAC meeting. The Committee received updates on OCC member enrollment, proposed supplemental transportation benefits for OCC members, and an overview of the Orange County Social Services Agency Adult Services programs.

42. Provider Advisory Committee (PAC) Update

Jenna Jensen, PAC Chair, reported that the PAC received updates at their June 9, 2016 meeting on the following topics: Health Network Minimum and Maximum Enrollment policy, the upcoming CalOptima managed behavioral healthcare organization Request for Proposal, and information on the Group Needs Assessment to be conducted during the third quarter of 2016.

43. Member Advisory Committee (MAC) Update

Mallory Vega, MAC Chair, reported that at the July 14, 2016 meeting, the Committee received updates on the Health Network minimum enrollment requirement, the Health Education and Cultural and Linguistic Group Needs Assessment, and a program overview from Easter Seals of Southern California.

INFORMATION ITEMS

The following Information Items were accepted as presented:
44. June 2016 Financial Summary
45. Compliance Report
46. Federal and State Legislative Advocates Reports
47. CalOptima Community Outreach and Program Summary

BOARD MEMBER COMMENTS AND BOARD COMMITTEE REPORTS

Chair Refowitz welcomed the new members of the CalOptima Board of Directors, and announced the following appointments to the two Standing Committees of the Board: 1) Directors DiLuigi, Penrose, and Schoeffel were appointed to the Finance and Audit Committee (FAC), and Vice Chair Penrose to serve as FAC Chair; and 2) Directors Berger, Khatibi, Nguyen, and Yost were appointed to the Quality Assurance Committee (QAC), and Director Yost to serve as QAC Chair.

ADJOURN TO CLOSED SESSION

The Board of Directors adjourned to closed session at 3:58 p.m. pursuant to Government Code Section 54956.87, subdivision (b), Health Plan Trade Secrets – OneCare Connect Program.

The Board reconvened to open session at 4:27 p.m. to consider the following Report item.

40. Consider Ratification of Supplemental Benefit Recommendations to the Centers for Medicare & Medicaid Services and the California Department of Health Care Services for the OneCare Connect Program

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Action: ***On motion of Director Yost, seconded and carried, the Board of Directors ratified the submittal of the calendar year 2017 OneCare Connect Plan Benefit Package (PBP), and authorized the Chief Executive Officer to make any required changes to address regulatory feedback, execute or amend provider contracts, as necessary, to be consistent with the PBP, and update the FY 2016-17 Budget accordingly. (Motion carried 7-0-0; Vice Chair Penrose and Supervisor Do absent)***

ADJOURNMENT

Hearing no further business, the meeting was adjourned at 4:29 p.m.

/s/ Suzanne Turf
Suzanne Turf
Clerk of the Board

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MINUTES

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

June 9, 2016

A Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee (PAC) was held on Thursday, June 9, 2016 at the CalOptima offices located at 505 City Parkway West, Orange, California.

CALL TO ORDER

Teri Miranti, Acting PAC Chair, called the meeting to order at 8:05 a.m., and Member Caliendo led the Pledge of Allegiance.

ESTABLISH QUORUM

Members Present:	Theodore Caliendo, M.D.; Camille Fitzpatrick, MSN, ANP-BC, GNP-BC; Stephen N. Flood; Teri Miranti; George Orras, Ph.D.; FAAP; Cheryl Petterson; Mary Pham, Pharm.D, CHC ; Pamela Pimentel, R.N.; Suzanne Richards, RN, MBA, FACHE; Jacob Sweidan, M.D.
Members Absent:	Alan Edwards, M.D.; Jena Jensen; Pamela Kahn, R.N.; Barry Ross, R.N., MPH, MBA; Joseph M. Ruggio, M.D., FACP, FACC, FSCAI
Others Present:	Michael Schrader, Chief Executive Officer; Chet Uma, Chief Financial Officer; Gary Crockett, Chief Counsel; Richard Helmer, M.D., Chief Medical Officer; Ladan Khamseh, Chief Operating Officer; Phil Tsunoda, Executive Director, Public Affairs; Edwin Poon, Ph.D., Director, Behavioral Health; Lizeth Granados, Director Provider Network Management; Pshyra Jones, Director, Health Education and Disease Management; Cheryl Simmons, Staff to the PAC

MINUTES

Approve the Minutes of the May 12, 2016 Regular Meeting of the CalOptima Board of Directors' Provider Advisory Committee

Action: ***On motion of Member Caliendo seconded and carried, the Committee approved the minutes of the May 12, 2016 meeting. (Motion carried 10-0-0; Members Edwards, Jensen, Kahn, Ross and Ruggio absent.)***

PUBLIC COMMENTS

No requests for public comments were received.

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REPORTS

Consider Recommending Board of Directors' Change to the Health Network Minimum Medi-Cal Enrollment Requirements

As a follow up to the April 14, 2016 PAC Meeting, Ladan Khamseh, Chief Operating Officer, provided an update on the Health Network Minimum and Maximum Enrollment. Ms. Khamseh discussed CalOptima Medi-Cal Policy EE.1106, Health Network (HN) and CalOptima Community Network (CCN) Minimum and Maximum Enrollment, which applies to Medi-Cal members only and requires the Health Networks and CCN to maintain an enrollment of at least 5,000 members following the first 12 months after initial member enrollment. After a robust discussion on the allowance of additional time to grow their memberships, PAC members recommended that the Board consider allowing flexibility to staff/CEO to extend the timeframe by providing an additional 18 months to achieve that goal. The additional months are contingent on the new health networks continuing to be in good standing operationally.

Action: ***On motion of Member Richards seconded and carried, the Committee recommended Board consideration of an extension up to 18-month for the new health networks to achieve the minimum Medi-Cal enrollment requirements. (Motion carried 10-0-0; Members Edwards, Jensen, Kahn, Ross and Ruggio absent.)***

CEO AND MANAGEMENT REPORTS

Chief Financial Officer Update

Chet Uma, Chief Financial Officer, presented CalOptima's Financial Summary for April 2016, which included FY 2015-16 Consolidated Enrollment, Revenues, Medical Expenses, and Administrative Expenses and Change In Net Assets . Mr. Uma noted that the FY 2015-16 Consolidated Enrollment is up by 0.5% for the month and by 1% on a year-to-date basis with enrollment tracking as budgeted. Medi-Cal Expansion continued to grow with an increase of 11.7% higher than budgeted in April. Mr. Uma noted that the actual Medical Loss Ratio is tracking well with the budget; Positive Net Assets are attributable to the savings in the Administrative Loss Ratio . Mr. Uma also reviewed the Health Network enrollment summary by health network as requested by the PAC. He reminded the PAC that the current Medi-Cal Expansion rates (MCE Rates) would expire on June 30, 2016.

Chief Medical Officer Update

Dr. Richard Helmer, Chief Medical Officer, provided an update regarding four initiatives currently in progress in Medical Affairs. They include the California Children Services, Whole Person Care, Health Homes and the Long-Term Care Initiative recently approved by CMS and the DHCS. Dr. Helmer also updated the PAC members on the Pay for Value program. After a lengthy discussion, the PAC concurred with two Information System initiatives: real-time tracking of members who present to the emergency department and/or admitted, and a robust CalOptima provider portal that would provide bi-directional information for utilization, care and quality management.

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Chief Operating Officer Update
Ladan Khamseh, Chief Operating Officer, provided an update on the SB 75 transition of children to full scope Medi-Cal. Ms. Khamseh noted that although CalOptima was prepared to receive 9,800 children from this program, only 6,566 members transferred on June 1, 2016. An additional 641 children had already been transitioned prior to June 1. The Department of Health Care Services has indicated that there may have been issues with the transition of aid codes that prevented the entire population from transitioning and that the other County Organized Health Systems (COHS) were experiencing the same problems. The DHCS expects the remaining members to transition to CalOptima, but a timeframe has yet to be determined.

INFORMATION ITEMS

Federal and State Budget Update
Phil Tsunoda, Executive Director, Public Affairs, reviewed the unofficial election results from the June 7, 2016 Primary with the PAC members.

Behavioral Health Request for Proposal (RFP)
Edwin Poon, Ph.D., Director of Behavioral Health, gave a presentation on the upcoming CalOptima Managed Behavioral Healthcare Organization Request for Proposal (RFP). Dr. Poon suggested that a PAC member be appointed to the RFP review panel. Member Dr. Edwards, Orange County Health Care Agency Representative has agreed to represent the PAC as a member of this panel. The PAC members also expressed concerns about the adequate assessment of the behavioral health network during the RFP process.

Group Needs Assessment
Pshyra Jones, Director, Health Education and Disease Management, presented information on the Groups Needs Assessment (GNA), which is required by Department of Health Care Services to be completed at least once every five years. Currently, the GNA is scheduled to be conducted during 3rd Quarter, 2016 and the results will be shared with PAC when available.

PAC Member Comments
Acting Chair Miranti reviewed the reappointments and new appointments to the PAC that were approved at the Board meeting on June 2, 2016. Outgoing members Fitzpatrick, Petterson and Ruggio were thanked for their service on the PAC and asked to return to the August meeting to be honored. Ms. Miranti reminded the PAC members that there would be no meeting in July.

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ADJOURNMENT

There being no further business before the Committee, the Acting PAC Chair adjourned the meeting at 9:35 a.m.

/s/ Cheryl Simmons
Cheryl Simmons
Staff to the PAC

Approved: August 11, 2016

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

3. Consider Authorization of Contract with a Managed Behavioral Health Organization (MBHO) Effective January 1, 2017 and Contract with Consultant to Assist with MBHO Contract Implementation; Consider Authorization of Extension of Current Behavioral Health Contracts with College Health Independent Practice Association and Windstone Behavioral Health

Contact

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

Recommended Actions

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

Background

Like many managed care plans, CalOptima has used Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of behavioral health benefits. Behavioral Health is a covered benefit for CalOptima's Medi-Cal and managed Medicare beneficiaries. CalOptima also provides Behavioral Health Treatment (BHT) services to Medi-Cal beneficiaries under the age of 21 under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. CalOptima currently contracts with CHIPA for the provision of Medi-Cal Managed Care Plan covered behavioral health and BHT services. This contract commenced January 1, 2014, was amended September 15, 2014 to include BHT services, and currently expires on December 31, 2016.

In addition, CalOptima contracts with Windstone to provide behavioral health services for members enrolled in CalOptima's OneCare and OneCare Connect programs. The OneCare contract with Windstone commenced January 1, 2007 and has been extended four times (January 1, 2010, January 1, 2013, January 1, 2014, and January 1, 2015). On May 7, 2015, the CalOptima Board of Directors authorized a contract with Windstone for the OneCare Connect program for the period July 1, 2015 through June 30, 2016, and extension of the Windstone OneCare contract through December 31, 2016. In addition, the CalOptima Board recommended a RFP process for future coverage, to ensure that the best available behavioral health services are obtained for CalOptima members in a most cost effective manner.

All CalOptima behavioral health contracts have been aligned to have the same expiration date. This change was made in part to minimize the possibility of confusion for members new to OneCare

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Connect. On February 4, 2016, the CalOptima Board approved the extension of the OneCare Connect contract through December 31, 2016, thereby aligning all behavioral health contracts termination dates. The Board also authorized the use of a consultant to assist with required activities related to the issuance, scoring and awarding of the RFP for MBHO services.

Discussion

On April 1, 2016, CalOptima contracted with Health Management Associates (HMA) to help conduct a thorough search of potential Behavioral Health vendors and assist in the evaluation process to select the a vendor to provide best practice treatment to members. HMA's scope of work for MBHO RFP included providing assistance in the development of the proposal, creation of the proposal scoring tool, assessment of proposals, and selection of vendor.

On June 1, 2016, CalOptima released the Behavioral Health Request for Proposal (RFP) via BidSync. The CalOptima Procurement Department also contacted identified MBHOs nationwide notifying them about the RFP. Vendors had six weeks to submit their proposals. They also had two opportunities to submit questions to CalOptima about the RFP.

The responses to the RFP were reviewed by an evaluation team consisting of the Executive Director of Clinical Operations, Director of Behavioral Health Services, Behavioral Health Medical Director, and members of the Provider Advisory and Member Advisory Committees. Staff representatives from Claims, Information Services, and Finance scored sections related to their respective technical areas. The evaluation team also met with Subject Matter Experts (SMEs), including Customer Service, Quality Improvement, Grievances and Appeals, Compliance, Case Management, Utilization Management, and Behavioral Health, to discuss the strengths and weaknesses of each proposal.

Selection criteria used for scoring the proposals included:

- Experience in managed care
- Accreditation with the National Committee for Quality Assurance (NCQA)
- Corporate capabilities
- Information processing system
- Financial management
- Proposed staffing and project organization
- Ownership
- Outsourced services
- Provider network management
- Operations
- Utilization management
- Claim processing
- Grievances and Appeals
- Care management
- Cultural competency
- Quality improvement
- Information technology, data management
- Business intelligence

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- Compliance program
- Implementation plan
- Innovation program and services

Based on the evaluation team's scoring, the results for the RFP were as follows:

Vendor	Score
Magellan	4.41
Envolve	4.00
CHIPA	3.54
Optum	3.28
Windstone	2.80

As the table indicates, Magellan finished with the highest score at 4.41 out of 5.

As part of the final review, the evaluation team invited the top two finalists, Magellan and Envolve, to an on-site presentation/interview. In the on-site portion of the evaluation, Magellan finished first with a score of 4.36. Envolve received a score of 2.67 for the on-site portion.

Based on the review of each vendor's capabilities, references, contract requirements and financial costs, the evaluation team is recommending that the Board authorize the CEO to contract with Magellan as the new MBHO. However, in the event that final contract terms cannot be reached within 30 days, staff plans to return to the Board with further recommendations.

Assuming contract terms are reached, the implementation phase will begin as soon as agreement with Magellan has been reached; implementation is calendared to be completed by December 31, 2016. However, if it is identified that additional time is needed for thorough implementation, the team is requesting authorization to extend the existing CHIPA and Windstone proposed to ensure no gap in coverage of behavioral health services. This process includes the winding down of current contracts with CHIPA and Windstone and the transition to the Magellan. Staff also recommends that the Board also authorize a contract with a consultant(s) in an amount not to exceed $50,000 to facilitate this implementation process.

Both CHIPA and Windstone have indicated that they are willing to extend their current contracts in the event that the implementation of the new MBHO contract is not fully completed within the aggressive timeline that is outlined.

Fiscal Impact

Management has included expenses for behavioral health benefits in the CalOptima Fiscal Year (FY) 2016-17 Operating Budget, which is sufficient to fund the projected costs of the new MBHO contract for the period of January 1, 2017, through June 30, 2017. Based on projected enrollment and the proposed rates, Staff estimates the total annual cost of the new MBHO contract will be approximately $41 million.

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In the event CalOptima will need to extend the CHIPA and Windstone contracts, Management will execute an amendment to extend the termination date of the existing contract. No additional expenses will be incurred due to the contract extensions, since there will not be an overlap in dates for when the CHIPA and Windstone contracts expire and the effective date of the new MBHO contract.

The recommended action to authorize the CEO to contract with a consultant to assist with the implementation of the Behavioral Health MBHO contract is unbudgeted and will not exceed $50,000 through June 30, 2017. An allocation of $50,000 from existing reserves will fund this action.

Rationale for Recommendation

CalOptima staff believes contracting with the selected MBHO will allow CalOptima to continue to provide a comprehensive provider network and Behavioral Health and Autism Spectrum Disorder services for CalOptima's Medi-Cal and Duals programs. The evaluation team reviewed qualified MBHO responses and identified the candidate believed to best meet CalOptima's needs for integration of care, regulatory compliance, operational efficiency, administrative simplification, best practices, as well as overall reasonableness of price. The recommended MBHO is expected to be able to provide all delegated functions related to Behavioral Health Benefits including, but not limited to, customer service, care management, utilization management, credentialing, quality improvement, claims processing and payment, and provider dispute resolution. Moreover, the recommended MBHO will help CalOptima organize care around the needs of our members to achieve efficient and effective assessment, diagnosis, care planning, strength based and person centered treatment implementation, support services and outcomes evaluation.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. Board Actions referenced:
    a. Board Action dated December 5, 2013, Contract with College Health Independent Practice Association for the Provision of Medi-Cal Outpatient Mental Health Services Beginning on January 1, 2014
    b. Board Actions dated October 2, 2014:
        i. Amendments to the Primary Agreement between DHCS and CalOptima to Implement Behavioral Health Therapy Benefit
        ii. Amend CalOptima's Contract with College Health Independent Association to Include Behavioral Health Therapy Services to meet DHCS Requirements
    c. Board Action dated May 7, 2015 Authorizing Contract for Behavioral Health Services with Windstone Behavioral Health
    d. Board Action dated February 4, 2016 Authorizing the Extension of the Contract with Windstone Behavioral Health for Behavioral Health Services
2. Behavioral Health Services PowerPoint Presentation

/s/ Michael Schrader — *8/25/2016*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken December 5, 2013
Regular Meeting of the CalOptima Board of Directors

Consent Calendar

V. F. Authorize the Chief Executive Officer (CEO) to Contract with College Health Independent Practice Association (CHIPA) for the Provision of Medi-Cal Outpatient Mental Health Services Beginning on January 1, 2014

Contact

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

Recommended Action

Authorize the CEO, with the assistance of legal counsel, to enter into a contract with CHIPA for the provision of Medi-Cal outpatient mental health services, as defined by the Department of Health Care Services (DHCS), effective January 1, 2014 for a one year term with two one year extension options, exercisable at CalOptima's discretion.

Background

At its September 5, 2013 meeting, the CalOptima Board of Directors authorized the CEO to contract with Beacon Health Strategies, LLC (Beacon) to provide outpatient mental health services effective January 1, 2014 based legislative changes requiring Medi-Cal managed care plans to provide these services. Excluded from this arrangement are benefits provided by county mental health plans under the Specialty Mental Health Services Waiver, which CalOptima administers under a separate contract with the Orange County Health Care Agency (OCHCA), and also contracts with Beacon for the provision of administrative services organization (ASO) services under the CalOptima contract with the OCHCA. Separately, CHIPA has a Master Service Agreement with Beacon.

Discussion

As CalOptima prepares to provide all Medi-Cal members with mental health benefits beginning on January 1, 2014, it has been determined that Beacon is neither Knox-Keene licensed in CalOptima's service area nor a professional corporation. Consequently, Beacon cannot be fully delegated for the medical management of the program. Instead, under CalOptima's National Committee Quality Improvement (NCQA) accreditation for the Medi-Cal program, the contract for the medical management of the mental health program must be directly with the delegated entity performing the utilization management for the program. Although Beacon can function as the Management Services Organization (MSO), it cannot perform the full delegation required by CalOptima. As a result, staff recommends that CalOptima instead contract directly with CHIPA, which in turn, has an existing management services agreement with Beacon.

Operational

By contracting with CHIPA, CalOptima will be positioned to continue to leverage Beacon's expertise, experience with the Medi-Cal program, and substantial provider network, as well as meet the NCQA delegation requirements. Additionally, based on CalOptima's experience with Beacon staff co-located at CalOptima's facility for the last three years, CHIPA and Beacon are integrated into CalOptima's operational processes. This is particularly important given the aggressive timeline for implementation of the new benefit.

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Member Experience
With the implementation of the new benefit, CalOptima's goal is to ensure that members' continue to have a seamless experience of care. CalOptima's relationship with Beacon through CHIPA will allow staff to leverage the existing services and processes that Beacon has in place.

In summary, staff proposes contracting with CHIPA for the provision of the new Medi-Cal managed care mental health benefit. Having a contract in place with CHIPA prior to the implementation date of the new benefit will allow CalOptima staff to respond quickly to the requirements associated with implementing this mandatory new benefit. Staff believes that this recommendation will result in optimal member care and allow CalOptima to leverage existing resources and operational processes to the fullest extent.

Fiscal Impact
The recommended action to provide Medi-Cal mental health services will result in revenue neutrality for CalOptima. Management believes that DHCS will apply an adjustment to Medi-Cal capitation rates through a forthcoming contract amendment in an amount equivalent to the benefit expense plus an administrative load. Management will operate the program within the confines of this revenue allocation.

Rationale for Recommendation
A contract with CHIPA for the delivery of this new Medi-Cal mental health benefit will allow CalOptima to maintain the NCQA standards for delegation and leverage existing Beacon resources and operational processes to the fullest extent. Additionally, CalOptima must be prepared to provide this benefit to all Medi-Cal members beginning January 1, 2014.

Concurrence
Gary Crockett, Chief Counsel

Attachment
None

/s/ Michael Schrader — *11/27/2013*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item
VII. A. Authorize and Direct the Chairman of the Board of Directors to Execute Amendments to the Primary Agreement between the California Department of Health Care Services (DHCS) and CalOptima to Implement the Behavioral Health Therapy (BHT) Benefit

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

Recommended Action
Authorize and direct the Chairman of the Board of Directors to execute Amendments to the Primary Agreement between the California DHCS and CalOptima (Primary Agreement) to implement the Behavioral Health Therapy (BHT) Benefit.

Background
As a County Organized Health System (COHS), CalOptima contracts with DHCS to provide health care services to Medi-Cal beneficiaries in Orange County. In January 2009, CalOptima entered into a new agreement with DHCS. The agreement contains, among other terms and conditions, the payment rates CalOptima receives from DHCS to provide health care services.

Discussion
On August 29, 2014, DHCS notified Medi-Cal Managed Care Plans (Plans) that effective September 15, 2014, Plans' responsibility for the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services will extend to coverage of Behavioral Health Therapy (BHT). Through the same notification, DHCS provided draft interim policy guidance regarding BHT services to include Applied Behavioral Analysis (ABA).

On September 15, 2014, DHCS released the final interim policy guidance pertaining to BHT services in Medi-Cal managed care for children and adolescents 0 to 21 years of age diagnosed with Autism Spectrum Disorder (ASD). The final interim guidance includes information regarding recipient criteria, covered services and limitations.

DHCS is beginning the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with health plans and stakeholders. DHCS committed to Plans to develop rates, which will be retroactive to September 15, 2014. DHCS will also engage stakeholders to further define eligibility criteria, provider participation criteria, utilization controls, and the delivery system for ABA services.

At this time, CalOptima staff requests your approval of amendments necessary with DHCS to implement the BHT benefit, subject to the terms being consistent with the requirements of the benefit and the rates being satisfactory to provide the services. While the State has not yet provided any amendments to CalOptima for execution, management understands that the State will present them in

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the near future and require prompt execution. There is a separate staff report and recommended action for your Board's consideration related to the administration of the BHT benefit by College Health Independent Practice Association (CHIPA)

Fiscal Impact
At this time, the fiscal impact of the BHT benefit is unknown.

Rationale for Recommendation
The approval of amendments will make language changes consistent with EPSDT requirements and ensure CalOptima will receive funding for the benefit.

Concurrence
Gary Crockett, Chief Counsel

Attachment
Appendix summary of amendments to Primary Agreement with DHCS

/s/ Michael Schrader — *9/26/2014*
Authorized Signature — **Date**

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APPENDIX TO AGENDA ITEM VII. A.

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

Amendments to Primary Agreement	Board Approval
A-01 provided language changes related to Indian Health Services, home and community-based services, and addition of aid codes effective January 1, 2009.	October 26, 2009
A-02 provided rate changes that reflected implementation of the gross premiums tax authorized by AB 1422 (2009) for the period January 1, 2009, through June 30, 2009.	October 26, 2009
A-03 provided revised capitation rates for the period July 1, 2009, through June 30, 2010; and rate increases to reflect the gross premiums tax authorized by AB 1422 (2009) for the period July 1, 2009, through June 30, 2010.	January 7, 2010
A-04 included the necessary contract language to conform to AB X3 (2009), to eliminate nine (9) Medi-Cal optional benefits.	July 8, 2010
A-05 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, including rate increases to reflect the gross premium tax authorized by AB 1422 (2009), the hospital quality assurance fee (QAF) authorized by AB 1653 (2010), and adjustments for maximum allowable cost pharmacy pricing.	November 4, 2010
A-06 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding for legislatively mandated rate adjustments to Long Term Care facilities effective August 1, 2010; and rate increases to reflect the gross premiums tax on the adjusted revenues for the period July 1, 2010, through June 30, 2011.	September 1, 2011
A-07 included a rate adjustment that reflected the extension of the supplemental funding to hospitals authorized in AB 1653 (2010), as well as an Intergovernmental Transfer (IGT) program for Non-Designated Public Hospitals (NDPHs) and Designated Public Hospitals (DPHs).	November 3, 2011
A-08 provided revised capitation rates for the period July 1, 2010, through June 30, 2011, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine.	March 3, 2011
A-09 included contract language and supplemental capitation rates related to the addition of the Community Based Adult Services (CBAS) benefit in managed care plans.	June 7, 2012
A-10 included contract language and capitation rates related to the transition of Healthy Families Program (HFP) subscribers into CalOptima's Medi-Cal program	December 6, 2012
A-11 provided capitation rates related to the transition of HFP subscribers into CalOptima's Medi-Cal program.	April 4, 2013

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Amendments to Primary Agreement	Board Approval
A-12 provided capitation rates for the period July 1, 2011 to June 30, 2012.	April 4, 2013
A-13 provided capitation rates for the period July 1, 2012 to June 30, 2013	June 6, 2013
A-14 extended the Primary Agreement until December 31, 2014	June 6, 2013
A-15 included contract language related to the mandatory enrollment of seniors and persons with disabilities, requirements related to the Balanced Budget Amendment of 1997 (BBA) and Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule	October 3, 2013
A-16 provided revised capitation rates for the period July 1, 2012, through June 30, 2013 and revised capitation rates for the period January 1, 2013, through June 30, 2014 for Phases 1, 2 and 3 transition of Healthy Families Program (HFP) children to the Medi-Cal program	November 7, 2013
A-17 included contract language related to implementation of the Affordable Care Act, expansion of Medi-Cal, the integration of the managed care mental health and substance use benefits and revised capitation rates for the period July 1, 2013 through June 30, 2014.	December 5, 2013
A-18 provided revised capitation rates for the period July 1, 2013, through June 30, 2014.	June 5, 2014
A-19 extended the Primary Agreement until December 31, 2014 and included language that incorporates provisions related to Medicare Improvements for Patients and Providers Act (MIPPA)-compliant contracts and eligibility criteria for Dual Eligible Special Needs Plans (D-SNPs)	August 7, 2014
A-20 provided revised capitation rates for the period July 1, 2012, through June 30, 2013, for funding related to the Intergovernmental Transfer (IGT) Agreement between CalOptima and the University of California, Irvine and Optional Targeted Low-Income Child Members	September 4, 2014

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken October 2, 2014
Regular Meeting of the CalOptima Board of Directors

Report Item

VII. B. Ratify Amendment of CalOptima's Contract with College Health Independent Practice Association (CHIPA) to Include Behavioral Health Therapy (BHT) Services, Including Applied Behavioral Analysis (ABA) Services, to Meet Department of Health Care Services (DHCS) Requirements; Authorize the Development of Policies and Procedures as Necessary to Implement the BHT Benefit

Contact

Donald Sharps, M.D., Medical Director, (714) 246-8400

Recommended Actions

1. Ratify amendment of CalOptima's contract with College Health Independent Practice Association (CHIPA) to implement the Behavioral Health Therapy (BHT), including ABA services, effective September 15, 2014 for Medi-Cal beneficiaries aged 0 to 21 years diagnosed with Autism Spectrum Disorder (ASD); and
2. Authorize the Chief Executive Officer (CEO) to develop and implement required policies and procedures as required to implement the BHT benefit as required by the Department of Health Care Services (DHCS).

Background

Behavioral Health Treatment Benefit for Autism
On August 29, 2014, the Department of Health Care Services (DHCS) released a draft All Plan Letter (APL) to provide interim policy guidance for Medi-Cal Managed Care Plans' (Plans) coverage of Behavioral Health Treatment (BHT) for children diagnosed with Autism Spectrum Disorder (ASD).

CalOptima was informed at that time of DHCS's intent to provide BHT services as a covered Medi-Cal benefit for individuals 0 to 21 years of age with ASD to the extent required by the federal government under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. DHCS is currently seeking federal approval to provide BHT as it is defined by Section 1374.73 of the California Health and Safety Code. DHCS has begun the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT in Medi-Cal, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with health plans and stakeholders. DHCS released a subsequent APL on this topic dated September 15, 2014. Based on this guidance:

- Effective September 15, 2014, Plans' responsibility for the provision of EPSDT services for beneficiaries 0 to 21 years of age were further defined to include medically necessary BHT services such as ABA and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD. Plans (including CalOptima) are obligated to ensure that appropriate EPSDT services are initiated in accordance with timely access standards; and

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- Continuity of Care under the following circumstances:
  - Plan members 0 to 21 years diagnosed with ASD who, as of September 14, 2014 were receiving BHT services including ABA services through a Regional Center will continue to receive these services through the Regional Center until such time that the department and the Department of Developmental Services develop a plan for transition.
  - For a Plan's Medi-Cal members receiving BHT services outside of the Plan's network for Medi-Cal services, the Plan is obligated to ensure continuity of care for up to 12 months in accordance with existing contract requirements.
    - DHCS also detailed the requirements for out-of-network providers
  - Plans shall not discontinue BHT services during a continuity of care evaluation.

- Rates:
  - Per the APL, DHCS has committed to working with Plans to develop capitation rates for the costs associated with the provision of ABA services. Any rate adjustments will be retroactively applied to September 15, 2014.
  - On and after September 15, 2014, beneficiaries must receive ABA services from the Plan unless they are receiving their ABA services from a Regional Center.

- DHCS has also provided:
  - Recipient Criteria For ABA-Based Therapy Services
  - Defined Covered Services under Welfare & Institutions Code section 14059.5.
  - Limitations for services to include discontinuation when treatment goals and objectives are achieved or are no longer appropriate

CalOptima's Behavoral Health Intergration unit has been working with our contracted Medi-Cal Behavioral Health Vendor CHIPA/Beacon to gain a better understanding of the population of CalOptima members who may ultimately access ABA services. CalOptima has approximately 314,000 members age 18 and under, with an estimated incidence of autism at approximately 1.0 percent, or roughly 3,140 children. From that group, it is estimated, based on experience with similar populations they service, that approximately 20 percent may use ABA services, or 628 members. Beacon projects approximately half of those children will continue to receive ABA services through the Regional Center of Orange County, which is allowed until the state develops its transition plan. It is anticipated that CalOptima will serve approximately 314 members under this new benefit. However these figures may vary depending on a number of factors, including whether members' parent or guardian wish to continue receiving these services through the Regional Center.

Discussion

CalOptima is currently contracted with CHIPA for the medical management of the Medi-Cal mental health program, which in turn, has an existing management services agreement with Beacon.

Operational
By amending the current contract with CHIPA, CalOptima will be positioned to continue to leverage Beacon's experience with the mental health benefit included in the Medi-Cal program and also meet both DHCS regulatory and National Committee for Quality Assurance (NCQA) accreditation requirements.

Member Experience
With the implementation of the new benefit, CalOptima's goal is to ensure that members continue to have a seamless experience of care. CalOptima's relationship with Beacon through CHIPA allows staff to leverage the existing services and processes that Beacon currently has in place.

Clinical Expertise
Autism Service Group (ASG) has been fully integrated with CHIPA/Beacon for the last four years. Beacon ASG administers autism benefits on behalf of a number of health plans. Services that Beacon ASG provides include Network Management, ASD diagnosis validation, a comprehensive assessment and intake process, Care Management, Claims, and Reporting.
CalOptima and other Plans can expect that DHCS:

- Will require them to undergo a readiness review with DHCS. In the coming weeks, both the DHCS and the Department of Managed Health Care (DMHC) will issue a readiness review checklist. This checklist is expected to include submission timelines which will mirror each other when both Departments are collecting the same information. Both Departments are also working to draft template Evidence of Coverage (EOC) language. This language is expected to be shared with Plans in the near future.

- Will update APL 13-023, *Continuity of Care for Medi-Cal Beneficiaries who Transition from Fee-For-Service Medi-Cal into Medi-Cal Managed Care*, to include the new benefit. These new requirements are expected to include:
    - New noticing requirements when continuity of care: 1) are approved, and 2) approvals are 30 days from ending;
    - Retroactive coverage in certain situations;
    - Utilization management requirements for qualified providers; and
    - Timelines for approving requests when more immediate attention is needed and when there is a risk of harm.

In summary, management requests ratification of an amendment to the current CalOptima-CHIPA contract to include the provision of BHT services related to ASD as required by DHCS.

Fiscal Impact
As proposed, Beacon will be paid via capitation, at a rate of $0.14 per member per month (PMPM) for the period prior to the Regional Center of Orange County transition (September 15, 2014), and $0.25 PMPM for the period after the transition. Based on the projected total costs of ABA services, these rates result in administrative loads of 7.1% and 6.4% respectively for Beacon. As indicated, based on

APL 14-011, management anticipates that the DHCS will work with Plans including CalOptima to ensure that the new capitation rates are sufficient to cover the cost of providing this enhanced benefit.

Rationale for recommendation
The proposed changes are intended to ensure that, within the parameters delineated by the DHCS, CalOptima Medi-Cal beneficiaries have access to this newly added Medi-Cal mental health benefit.

Concurrence
Gary Crockett, Chief Counsel

Attachment
DHCS All Plan Letter 14-011

/s/ Michael Schrader — *9/26/2014*
Authorized Signature — **Date**

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

TOBY DOUGLAS
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

DATE: September 15, 2014

All Plan Letter 14-011

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: INTERIM POLICY FOR THE PROVISION OF BEHAVIORAL HEALTH TREATMENT COVERAGE FOR CHILDREN DIAGNOSED WITH AUTISM SPECTRUM DISORDER

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with interim policy guidance for providing Behavioral Health Therapy (BHT) services to Medi-Cal children and adolescent beneficiaries 0 to 21 years of age diagnosed with Autism Spectrum Disorder (ASD).

BACKGROUND:
ASD is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that previously were diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called ASD[1]. Currently, the Centers for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD.

On July 7, 2014, the Centers for Medicare and Medicaid Services (CMS) released guidance regarding the coverage of BHT services pursuant to section 1905(a)(4)(B) of the Social Security Act (the Act) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to provide coverage to individuals eligible for the EPSDT benefit for any Medicaid covered service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to ensure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and

[1] See Diagnostic and Statistical Manual (DSM) V.

treated as early as possible. When medically necessary, States may not impose limits on EPSDT services and must cover services listed in section 1905(a) of the Act regardless of whether or not they have been approved under a State Plan Amendment.

All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. When a screening examination indicates the need for further evaluation of a child's health, the child must be appropriately referred for medically necessary diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to ensure children receive the health care they need, when they need it.

The Department of Health Care Services (DHCS) intends to include BHT services, including Applied Behavioral Analysis (ABA) and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD, as a covered Medi-Cal benefit for individuals 0 to 21 years of age with ASD to the extent required by the federal government. DHCS will seek federal approval to provide BHT as it is defined by Section 1374.73 of the Health and Safety (H&S) Code.

Pursuant to Section 14132.56 of the Welfare & Institutions Code (WIC), DHCS is beginning the process to obtain all necessary federal approvals to secure federal funds for the provision of BHT as defined by H&S code section 1374.73, to seek statutory authority to implement this benefit in Medi-Cal, to seek an appropriation that would provide the necessary state funding, and to consult with stakeholders. In consultation with stakeholders, DHCS will further develop and define eligibility criteria, provider participation criteria, utilization controls, and the delivery system for BHT services, subject to the limitations allowed under federal law, and provide final policy guidance to MCPs upon federal approval.

PROGRAM DESCRIPTION AND PURPOSE:
BHT means professional services and treatment programs, including but not limited to ABA and other evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with ASD. BHT is the design, implementation, and evaluation of environmental modification using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the direct observation, measurement, and functional analysis of the relations between environment and behavior. BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services are services based on reliable evidence and are not experimental.

INTERIM POLICY:
In accordance with existing contracts, MCPs are responsible for the provision of EPSDT services for members 0 to 21 years of age, including those who have special health care needs. MCPs shall: (1) inform members that EPSDT services are available for beneficiaries 0 to 21 years of age, (2) provide comprehensive screening and prevention

services, (including, but not limited to, a health and developmental history, a comprehensive physical examination, appropriate immunizations, lab tests, lead toxicity screening, etc.), and (3) provide diagnosis and treatment for all medically necessary services, including but not limited to, BHT.

Effective September 15, 2014, the MCP responsibility for the provision of EPSDT services for beneficiaries 0 to 21 years of age includes medically necessary BHT services such as ABA and other evidence-based behavioral intervention services that develop or restore, to the maximum extent practicable, the functioning of a beneficiary with ASD. MCPs shall ensure that appropriate EPSDT services are initiated in accordance with timely access standards as set forth in the MCP's contracts.

CONTINUITY OF CARE:
MCP beneficiaries 0 to 21 years diagnosed with ASD who are receiving BHT services through a Regional Center on September 14, 2014, will automatically continue to receive all BHT services through the Regional Center until such time that DHCS and the Department of Developmental Services (DDS) develop a plan for transition. Until DHCS and DDS develop a plan for transition and communicate this transition plan to Regional Centers and to MCPs (through a forthcoming APL), Regional Centers will continue to provide BHT services for Medi-Cal beneficiaries and reimburse providers for BHT services provided in accordance with existing federal approvals, unless the parent or guardian requests that the MCP provide BHT services to the beneficiary prior to the development and/or implementation of the transition plan. Beneficiaries presenting for BHT services at a Regional Center on or after September 15, 2014, should be referred to the MCP for services.

For Medi-Cal beneficiaries receiving BHT services outside of a Regional Center or the MCPs' network, upon parental or guardian request, the MCPs shall ensure continuity of care for up to 12 months in accordance with existing contract requirements and All Plan Letter (APL) 13-023, unless the parent or guardian requests that the MCP change the service provider to an MCP BHT in-network provider prior to the end of the 12 month period.

BHT services will not be discontinued during a continuity of care evaluation. Pursuant to Health & Safety Code section 1373.96, BHT services must continue until MCPs have established a treatment plan.

An MCP shall offer continuity of care with an out-of-network provider to beneficiaries if all of the following circumstances exist:

- The beneficiary has an existing relationship with a qualified autism service provider. An existing relationship means a beneficiary has seen an out-of-network provider at least twice during the 12 months prior to September 15, 2014;

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- The provider is willing to accept payment from the MCP based on the current Medi-Cal fee schedule; and

- The MCP does not have any documented quality of care concerns that would cause it to exclude the provider from its network.

HEALTH PLAN READINESS:
DHCS and the Department of Managed Health Care (DMHC) will coordinate efforts to conduct readiness reviews of MCPs for purposes of ensuring that MCPs are providing timely medically necessary BHT services. DHCS and DMHC will engage in joint decision making processes when considering the content of any licensing filing submitted to either department. The departments will work together to issue template language to MCPs, as needed.

Guidance pertaining to MCPs' readiness review requirements will be provided to MCPs separate from this APL.

DELEGATION OVERSIGHT:
MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations and other contract requirements, as well as DHCS guidance, including APLs.

REIMBURSEMENT:
DHCS will engage in discussions with the MCPs in order to develop capitation rates for the costs associated with the provision of BHT services as soon as possible. Any rate adjustments for BHT services will be retroactively applied to September 15, 2014, subject to federal approval.

To the extent Medi-Cal beneficiaries received BHT services from licensed providers between July 7, 2014, and up to and including September 14, 2014, and incurred out-of-pocket expenditures for such services, these expenditures shall be submitted to the Fiscal Intermediary for reimbursement of expenditures through the existing *Medi-Cal Out-of-Pocket Expense Reimbursement (Conlan)* process (http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-Cal_Conlan.aspx). On and after September 15, 2014, Medi-Cal beneficiaries that are not receiving BHT services from a Regional Center or an out-of-network provider must receive all BHT services from a MCP.

CRITERIA FOR BHT SERVICES:
In order to be eligible for BHT services, a Medi-Cal beneficiary must meet all of the following coverage criteria. The recipient must:

1. Be 0 to 21 years of age and have a diagnosis of ASD;
2. Exhibit the presence of excesses and/or deficits of behaviors that significantly interfere with home or community activities (examples include, but are not limited to, aggression, self-injury, elopement, and/or social interaction, independent living, play and/or communication skills, etc.);

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3. Be medically stable and without a need for 24-hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for persons with intellectual disabilities (ICF/ID);
4. Have a comprehensive diagnostic evaluation[2] that indicates evidence-based BHT services are medically necessary and recognized as therapeutically appropriate; and
5. Have a prescription for BHT services ordered by a licensed physician or surgeon or developed by a licensed psychologist.

COVERED SERVICES AND LIMITATIONS:
Medi-Cal covered BHT services must be:

1. Medically necessary as defined by Welfare & Institutions Code Section 14132(v).
2. Prior authorized by the MCP or its designee; and
3. Delivered in accordance with the beneficiary's MCP approved treatment plan.

Services must be provided and supervised under an MCP approved treatment plan developed by a contracted and MCP-credentialed "qualified autism service provider" as defined by Health & Safety Code Section 1374.73(c)(3). Treatment services may be administered by one of the following:

1. A qualified autism service provider as defined by H&S Code section 1374.73(c)(3).
2. A qualified autism service professional as defined by H&S Code section 1374.73(c)(4) who is supervised and employed by the qualified autism services provider.
3. A qualified autism service paraprofessional as defined by H&S Code section 1374.73(c)(5) who is supervised and employed by a qualified autism service provider.

BHT services must be based upon a treatment plan that is reviewed no less than every six months by a qualified autism service provider and prior authorized by the MCP for a time period not to exceed 180 days. Services provided without prior authorization shall not be considered for payment or reimbursement except in the case of retroactive Medi-Cal eligibility.

BHT services shall be rendered in accordance with the beneficiary's treatment plan. The treatment plan shall:

1. Be person-centered and based upon individualized goals over a specific timeline;
2. Be developed by a qualified autism service provider for the specific beneficiary being treated;
3. Delineate both the frequency of baseline behaviors and the treatment planned to address the behaviors;

[2] MCPs shall obtain a diagnostic evaluation of no more than four hours in duration that includes:

- A clinical history with informed parent/guardian, inclusive of developmental and psychosocial history;
- Direct observation;
- Review of available records; and
- Standardized measures including ASD core features, general psychopathology, cognitive abilities, and adaptive functioning using published instruments administered by qualified members of a diagnostic team.

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4. Identify long, intermediate, and short-term goals and objectives that are specific, behaviorally defined, measurable, and based upon clinical observation;
5. Include outcome measurement assessment criteria that will be used to measure achievement of behavior objectives;
6. Utilize evidence-based practices with demonstrated clinical efficacy in treating ASD, and are tailored to the beneficiary;
7. Ensure that interventions are consistent with evidenced-based BHT techniques.
8. Clearly identify the service type, number of hours of direct service and supervision, and parent or guardian participation needed to achieve the plan's goals and objectives, the frequency at which the beneficiary's progress is reported, and identifies the individual providers responsible for delivering the services;
9. Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
10. Include parent/caregiver training, support, and participation.

BHT Service Limitations:

1. Services must give consideration to the child's age, school attendance requirements, and other daily activities as documented in the treatment plan.
2. Services must be delivered in a home or community-based settings, including clinics.
3. BHT services shall be discontinued when the treatment goals and objectives are achieved or are no longer medically necessary.
4. MCPs will comply with current contract requirements relating to coordination of care with Local Education Agencies to ensure the delivery of medically necessary BHT services.

The following services do not meet medical necessity criteria, nor qualify as Medi-Cal covered BHT services for reimbursement:

1. Therapy services rendered when continued clinical benefit is not expected;
2. Services that are primarily respite, daycare or educational in nature and are used to reimburse a parent for participating in the treatment program;
3. Treatment whose purpose is vocationally or recreationally-based;
4. Custodial care
   a. for purposes of BHT services, custodial care:
      i. shall be defined as care that is provided primarily to assist in the activities of daily living (ADLs), such as bathing, dressing, eating, and maintaining personal hygiene and safety;
      ii. is provided primarily for maintaining the recipient's or anyone else's safety; and
      iii. could be provided by persons without professional skills or training.
5. Services, supplies, or procedures performed in a non-conventional setting including, but not limited to:
   a. resorts;
   b. spas; and
   c. camps.

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6. Services rendered by a parent, legal guardian, or legally responsible person.

For questions about this APL, contact your Medi-Cal Managed Care Division Contract Manager.

Sincerely,

Original Signed by Sarah C. Brooks

Sarah C. Brooks
Program Monitoring and Medical Policy Branch Chief
Medi-Cal Managed Care Division
Department of Health Care Services

Attachments

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What to Expect if You Suspect or You Have Been Told Your Child has Autism Spectrum Disorder

If you have a concern about how your child is communicating, interacting or behaving, or your child has been diagnosed with autism spectrum disorder (ASD) but you have been unable to access services to treat your child, you are likely wondering what to expect now that Behavioral Health Treatment services to treat children with ASD are available in Medi-Cal.

The following guidance is provided to share information about obtaining an evaluation of your child's development and treatment options, if needed, and the approximate amount of time it will take to obtain evaluations and medically necessary treatment.

1. If you have concerns about your child's development or your child has been diagnosed with ASD, call your Health Plan's Call Center and/or make an appointment to see your child's doctor. Your child's doctor should offer you an appointment within 10 business days. The evaluation and approval processes for your child to receive Behavioral Health Treatment services could take approximately 60 to 90 days to complete.

2. At the appointment with your child's doctor, share your concerns about your child, noting how your child is different from other children the same age, or provide any documents you may have from a health care provider that state your child has been diagnosed with autism spectrum disorder.

3. Your child's doctor will listen to your concerns, review documents that you share, examine your child, and may conduct a developmental screening. The doctor may ask you questions or talk or play with your child during the examination to see how your child learns, speaks, behaves, and moves. This screening provides useful information to identify if your child is developing differently from other children.

4. As a result of this visit with the doctor, your child may be referred to a specialist who will meet with you and your child, conduct further tests/exams of your child, and then prepare a report. The specialist should offer you an appointment within 15 business days after your appointment with your child's doctor.

5. The specialist will submit his/her report to your child's Health Plan for review and approval of medically necessary services, if deemed necessary.

6. Your child's Health Plan will notify you of its determination whether or not to provide Behavioral Health Treatment services to your child in accordance with the recommendations of the specialist.

7. If the Health Plan determines that Behavioral Health Treatment services are medically necessary, your child will be referred to a qualified autism service provider who will meet with you and your child and develop a treatment plan. The qualified autism service provider should offer to meet with you within 15 business days after your Health Plan makes its determination.

8. The proposed treatment plan will be submitted by the qualified autism service provider to the Health Plan and reviewed by your Health Plan to determine whether or not the Behavioral Health Treatment services recommended by the qualified autism service provider are medically necessary.

9. Your child's Health Plan will notify you of its determination whether or not to provide Behavioral Health Treatment services to your child in accordance with the treatment plan developed by the qualified autism service provider.

10. If the Health Plan determines that Behavioral Health Treatment services recommended by the qualified autism service provider are medically necessary, your child will be referred back to the qualified autism service provider who will meet with you and your child in your home or another community setting, such as a community clinic, to describe the treatment plan and specific services your child will receive. The qualified autism provider should offer you an appointment within 15 days after your Health Plan makes its determination.

11. You have the right to make complaints about your child's covered services or care. This includes the right to:

    a) File a complaint or grievance or appeal certain decisions made by the Health Plan or health plan provider. For more information on filing a complaint, grievance, or appeal, contact your Health Plan.

    b) Ask for an Independent Medical Review (IMR) of the medical necessity of Medi-Cal Services or terms that are medical in nature from the California Department of Managed Health Care (DMHC). For more information on asking for an IMR, contact DMHC's Help Center at 1-888-466-2219 or (TDD) 1-877-688-9891 or online at http://www.dmhc.ca.gov/FileaComplaint/ConsumerIndependentMedicalReviewComplaint.aspx

c) Ask for a State Fair Hearing (SFH) from the California Department of Social Services (DSS). You can request a SFH over the phone by contacting DSS at 1-800-952-5253 or (TDD) 1-800-952-8349, by faxing DSS at 916-651-5210 or 916-651-2789, or by sending a letter to DSS. Additional information on the SFH process can be accessed at: http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx

12. The qualified autism service provider will meet with you and your child and describe the behavioral health treatment service type, the number of hours of direct service and the supervision of the service provider, parent or guardian participation needed, the frequency of reporting progress, and identify the individual providers responsible for delivering services to your child. Services will be scheduled at the location and in the frequency approved by the Health Plan.

13. The qualified autism service provider will provide a description of care coordination involving parents, guardians or caregivers, school, state disability programs, and others. The provider will also describe parent, guardian or caregiver training, support and participation that will be required.

14. The effectiveness of Behavioral Health Treatment is dramatically improved when parents or guardians receive training and are actively participating in their child's treatment. Your participation will ensure the best long term outcomes from the treatments your child is receiving.

15. If you have any questions or concerns about obtaining services for your child at any point in the process, call your Health Plan's Call Center or your child's doctor for assistance.

16. If you are concerned about what you can do when your child is not receiving services, the federal government and the Association for Children and Families has put together a guide to help parents facilitate development every day. This guide can be found at www.acf.hhs.gov/ecd/ASD. Themes include:

    a. Engaging your child in play through joint attention
    b. Using your child's interests in activities
    c. Using a shared agenda in daily routines
    d. Using visual cues
    e. Sharing objects and books
    f. Teaching your children to play with each other
    g. Using predictable routines and predictable spaces for your child.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

CMCS Informational Bulletin

DATE: July 7, 2014

FROM: Cindy Mann, Director
Center for Medicaid and CHIP Services

SUBJECT: **Clarification of Medicaid Coverage of Services to Children with Autism**

In response to increased interest and activity with respect to services available to children with autism spectrum disorder (ASD), CMS is providing information on approaches available under the federal Medicaid program for providing services to eligible individuals with ASD.

Background

Autism spectrum disorder is a developmental disability that can cause significant social, communication and behavioral challenges. A diagnosis of ASD now includes several conditions that used to be diagnosed separately: autistic disorder, pervasive developmental disorder not otherwise specified (PDD-NOS), and Asperger syndrome. These conditions are now all called autism spectrum disorder. Currently, the Center for Disease Control and Prevention (CDC) estimates that approximately 1 in 68 children has been identified with ASD. [1]

Treatments for children with ASD can improve physical and mental development. Generally these treatments can be categorized in four categories: 1) behavioral and communication approaches; 2) dietary approaches; 3) medications; and 4) complementary and alternative medicine. [2] While much of the current national discussion focuses on one particular treatment modality called Applied Behavioral Analysis (ABA), there are other recognized and emerging treatment modalities for children with ASD, including those described in the ASD Services, Final Report on Environmental Scan (see link below)[3]. This bulletin provides information related to services available to individuals with ASD through the federal Medicaid program.

The federal Medicaid program may reimburse for services to address ASD through a variety of authorities. Services can be reimbursed through section 1905(a) of the Social Security Act (the Act), section 1915(i) state plan Home and Community-Based Services, section 1915(c) Home

[1] http://www.cdc.gov/ncbddd/autism/facts.html
[2] http://www.cdc.gov/ncbddd/autism/treatment.html
[3] http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Downloads/Autism-Spectrum-Disorders.pdf

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and Community-Based Services (HCBS) waiver programs and section 1115 research and demonstration programs.

State Plan Authorities

Under the Medicaid state plan, services to address ASD may be covered under several different section 1905(a) benefit categories. Those categories include: section 1905(a)(6) - services of other licensed practitioners; section 1905(a)(13)(c) - preventive services; and section 1905(a)(10) - therapy services. States electing these services may need to update the Medicaid state plan in order to ensure federal financial participation (FFP) is available for expenditures for these services. In addition, for children, as discussed below, states must cover services that could otherwise be covered at state option under these categories consistent with the provisions at 1905(a)(4)(B) for Early and Periodic Screening, Diagnostic and Treatment services (EPSDT). Below is information on these coverage categories for services to address ASD. Under these section 1905(a) benefit categories all other state Medicaid plan requirements such state-wideness and comparability must also be met.

Other Licensed Practitioner Services

Other Licensed Practitioner services (OLP) services, defined at 42 CFR 440.60, are "medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice as defined under State law." If a state licenses practitioners who furnish services to address ASD, the state may elect to cover those providers under this section of their state plan even if the providers are not covered under other sections of the plan (e.g., physical therapist, occupational therapist, etc.). A state would need to submit a state plan amendment (SPA) to add the new licensed provider to their Medicaid plan. The SPA must describe the provider's qualifications and include a reimbursement methodology for paying the provider.

In addition, services that are furnished by non-licensed practitioners under the supervision of a licensed practitioner could be covered under the OLP benefit if the criteria below are met:

- Services are furnished directly by non-licensed practitioners who work under the supervision of the licensed practitioners;
- The licensed provider is able to furnish the service being provided;
- The state's Scope of Practice Act for the licensed practitioners specifically allows the licensed practitioners to supervise the non-licensed practitioners who furnish the service;
- The state's Scope of Practice Act also requires the licensed practitioners to assume professional responsibility for the patient and the service furnished by the unlicensed practitioner under their supervision; and
- The licensed practitioners bill for the service;

Preventive Services

Preventive Services, defined at 42 CFR 440.130(c) are "services recommended by a physician or other licensed practitioner of the healing arts within the scope of his practice under state law to—

(1) Prevent disease, disability, and other health conditions or their progression;
(2) Prolong life; and
(3) Promote physical and mental health and efficiency"

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A regulatory change that took effect January 1, 2014, permits coverage of preventive services furnished by non-licensed practitioners who meet the qualifications set by the state, to furnish services under this state plan benefit as long at the services are recommended by a physician or other licensed practitioner. Under the preventive services benefit, in the state plan, the state must 1) list the services to be provided to ensure that services meet the definition of preventive services as stated in section 4385 of the State Medicaid Manual (including the requirement for the service to involve direct patient care); 2) identify the type(s) of non-licensed practitioners who may furnish the services; and 3) include a summary of the state's provider qualifications that make these practitioners qualified to furnish the services, including any required education, training, experience, credentialing, supervision, oversight and/ or registration.

Therapy Services

Physical therapy, occupational therapy and services for individuals with speech, hearing and language disorders, may be covered under the Medicaid therapies benefit at 42 CFR 440.110. Physical and occupational therapy must be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his/her practice under state law and provided to a beneficiary by or under the direction of a qualified therapist. Services for individuals with speech, hearing and language disorders mean diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law.

States would need to include an assurance in the state plan that the state furnishes the therapy in accordance with 42 CFR 440.110. States would also need to describe the supervisory arrangements if a practitioner is furnishing the therapy under the direction of a qualified therapist. Finally, for audiology services, the state plan must reflect the supervision requirements as set forth at 42 CFR 440.110(c)(3).

Section 1915(i) of the Social Security Act

States can offer a variety of services under a section 1915(i) state plan Home and Community-Based Services (HCBS) benefit. The benefit may be targeted to one or more specific populations including individuals with ASD and can provide services and supports above and beyond those included in section 1905(a). Participants must meet state-defined criteria based on need and typically receive a combination of acute-care medical services (like dental services, skilled nursing services) and other long-term services such as respite care, supported employment, habilitative supports, and environmental modifications.

Other Medicaid Authorities

There are several other Medicaid authorities that may be used to provide services to address ASD. Below is a discussion of each of those authorities:

Section 1915 (c) of the Social Security Act

The section 1915(c) Home and Community-Based Services waiver program allows states to provide a combination of medical services and long-term services and supports. Services include

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but are not limited to adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community. Participants must meet an institutional level of care but are served in the community. Section 1915(c) waiver programs also require that services be furnished in home and community-based settings. For individuals under the age of 21 who are eligible for EPSDT services, an HCBS waiver could provide services and supports for ASD that are above and beyond services listed in section 1905(a), such as respite care. Additionally, for individuals who are receiving state plan benefits as part of EPSDT that are not available to adults under the state plan, waiver services may be used to help these individuals transition into adulthood and not lose valuable necessary services and supports.

Section 1115 Research and Demonstration Waiver

Section 1115 of the Act provides the Secretary of the Department of Health and Human Services broad authority to authorize experimental, pilot, or demonstration programs that promote the objectives of the Medicaid program. Flexibility under section 1115 is sufficiently broad to allow States to test substantially new ideas, including benefit design or delivery system reform, of policy merit. The Secretary can approve an 1115 demonstration for up to five years, and states may submit extension requests to continue the program for additional periods of time. Demonstrations must be "budget neutral" over the life of the program, meaning they cannot be expected to cost the Federal government more than it would cost without the demonstration.

EPSDT Benefit Requirements

Section 1905(r) of the Act defines the EPSDT benefit to include a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21. States are required to arrange for and cover for individuals eligible for the EPSDT benefit any Medicaid coverable service listed in section 1905(a) of the Act that is determined to be medically necessary to correct or ameliorate any physical or behavioral conditions. The EPSDT benefit is more robust than the Medicaid benefit package required for adults and is designed to assure that children receive early detection and preventive care, in addition to medically necessary treatment services, so that health problems are averted or diagnosed and treated as early as possible. All children, including children with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible. Good clinical practice requires ruling out any additional medical issues and not assuming that a behavioral manifestation is always attributable to the ASD. EPSDT also requires medically necessary diagnostic and treatment services. When a screening examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnosis and treatment without delay. Ultimately, the goal of EPSDT is to assure that children get the health care they need, when they need it – the right care to the right child at the right time in the right setting.

The role of states is to make sure all covered services are available as well as to assure that families of enrolled children, including children with ASD, are aware of and have access to a broad range of services to meet the individual child's needs; that is, all services that can be covered under section 1905(a), including licensed practitioners' services; speech, occupational,

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and physical therapies; physician services; private duty nursing; personal care services; home health, medical equipment and supplies; rehabilitative services; and vision, hearing, and dental services.

If a service, supply or equipment that has been determined to be medically necessary for a child is not listed as covered (for adults) in a state's Medicaid State Plan, the state will nonetheless need to arrange for and cover it for the child as long as the service or supply is included within the categories of mandatory and optional services listed in section 1905(a) of the Social Security Act. This longstanding coverage design is intended to ensure a comprehensive, high-quality health care benefit for eligible individuals under age 21, including for those with ASD, based on individual determinations of medical necessity.

Implications for Existing Section 1915(c), Section 1915 (i) and Section 1115 Programs

In states with existing 1915(c) waivers that provide services to address ASD, this 1905(a) policy clarification may impact on an individual's eligibility for the waiver. Waiver services are separated into two categories: waiver services and extended state plan services. Extended state plan services related to section 1905(a) services are not available to individuals under the age of 21 (individuals eligible for EPSDT) because of the expectation that EPSDT will meet the individual's needs. There are therefore a limited number of services that can be provided to this age group under 1915 (c) waivers, primarily respite, and/or environmental/vehicle modifications.

For states that currently provide waiver services to individuals under age 21 to address ASD, the ability to provide services under the 1905(a) state plan may have the effect of making these individuals ineligible for the waiver unless another waiver service is provided. This implication is especially important for individuals with ASD who may not otherwise be eligible for Medicaid absent the (c) waiver. States need to ensure that these individuals are receiving a waiver service, not coverable under section 1905(a), to ensure that they do not lose access to all Medicaid services by losing waiver eligibility. Individuals age 21 and older may continue to receive services to address ASD through the waiver if a state does not elect to provide these services to adults under its Medicaid state plan.

The same issues arise for children under the 1915(i) authority, which allows for services above and beyond section 1905(a) to be provided under the state plan. CMS is available to provide technical assistance to states that currently have approved waivers or state plans that may be impacted by this clarification. Similarly, states with existing 1115 demonstrations authorizing reimbursement for services provided to children with autism should contact CMS to ensure that EPSDT requirements are met.

We hope this information is helpful. If you have questions please send them to AutismServicesQuestions@cms.hhs.gov.

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item
VIII. C. Authorize Contract for Behavioral Health Services with Windstone Behavioral Health for Cal MediConnect/OneCare Connect, and Extend the Current OneCare Contract

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

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

1. Enter into a contract with Windstone Behavioral Health (Windstone) for the Cal MediConnect/OneCare Connect program for the period July 1, 2015 through ~~December 31~~, June 30, 2016. ~~with the option to renew for one additional year at CalOptima's sole discretion.~~ Revised 5/7/15
2. Amend the OneCare contract to extend it for one additional year (through calendar 2016), with the option to renew for one additional year at CalOptima's sole discretion. The current OneCare contract expires December 31, 2015.

Background and Discussion
Behavioral Health is a Medicare covered benefit for OneCare and OneCare Connect members. CalOptima currently contracts with Windstone to provide Medicare covered behavioral health services for the OneCare program. Windstone has been contracted with OneCare for behavioral health since January 1, 2007. The current contract is set to expire December 31, 2015, based on the previous contract extensions.

CalOptima's medical management and behavioral health staff have reviewed the utilization performance of this provider and also evaluated the access needs of CalOptima members, and determined that Windstone adequately meets CalOptima's requirements for the current OneCare program and future OneCare Connect program. At its January 2013 meeting, the CalOptima Board authorized the CEO to leverage the OneCare provider network as the basis for the Duals Delivery system. Therefore, staff recommends initiating a new contract for the OneCare Connect program, and renewing the current OneCare contract as indicated above.

Renewal of the OneCare contract will support the stability of CalOptima's contracted provider network should CalOptima decide to renew the OneCare program for 2016. The new contract for OneCare Connect will initiate a stable network with an already established provider. Contract language does not guarantee any particular volume and allows for CalOptima and the provider to terminate the contracts with or without cause.

Fiscal Impact
Based on forecasted OneCare and OneCare Connect enrollment for the extended contract periods, the fiscal impact of the recommended action is approximately $650,000 for OneCare and $2 million for OneCare Connect. Funding for the recommended actions will be included in the upcoming Fiscal Year 2015-16 CalOptima Consolidated Operating Budget.

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Rationale for Recommendation

CalOptima staff recommends authorizing an extension to OneCare's contract with Windstone to ensure that OneCare members continue to have access to covered services, and extending a new contract for the OneCare Connect program so that these members will also receive the same quality level of service.

Concurrence

Gary Crockett, Chief Counsel

Attachments

None

/s/ Michael Schrader — *5/1/2015*

Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken February 4, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

7. Authorize Extension of the Cal MediConnect/OneCare Connect Contract with Windstone Behavioral Health for Behavioral Health Services; Authorize Contract for Consulting Services Related to Request for Proposal (RFP) Development and Delivery Model Optimization for the Behavioral Health Benefit

Contact

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

Recommended Action

1. Authorize the Chief Executive Officer (CEO), with the assistance of legal counsel, to:
    a. Extend the CalOptima-Windstone Behavioral Health Cal MediConnect/OneCare Connect contract for a six month period, through December 31, 2016, with the option to renew for one additional year (or two consecutive six month periods) exercisable at CalOptima's sole discretion; and
    b. Contract for up to $150,000 to hire a consultant through a Request for Proposal (RFP) process to determine the delivery model optimization for the behavioral health benefit and for the development of an RFP for contracted services, as appropriate.
2. Authorize budget allocation of $150,000 from the Medical Management department to the Behavioral Health Integration department.

Background/Discussion

Behavioral Health is a Medicare covered benefit for both OneCare and OneCare Connect members. In actions taken on May 7, 2015, the CalOptima Board of Directors authorized CalOptima staff to:

1. Enter into a contract with Windstone Behavioral Health (Windstone) for the Cal MediConnect/OneCare Connect program for the period July 1, 2015, through June 30, 2016, with direction that CalOptima staff would conduct a Request for Proposal (RFP) process by March 2016, to ensure that the best services are obtained for our members in a cost efficient manner; and
2. Extend the contract with CalOptima-OneCare Windstone for remaining OneCare members through December 31, 2016, with the option to renew for one additional year at CalOptima's sole discretion.

During the process of developing the RFP's Scope of Work for a Managed Care Behavioral Health Organization (MBHO), staff noted that the separate timing for implementation and transition of two MBHO contracts would potentially increase disruption of services for CalOptima OneCare and OneCare Connect members. Additionally, since the CalOptima Medi-Cal contract with CHIPA / Beacon Health Strategies expires on December 31, 2016, there is an opportunity to issue a single MBHO RFP that would potentially allow a single vendor to respond for OneCare, OneCare Connect, and Medi-Cal.

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In order to minimize disrupting services with multiple MBHO implementations and transitions for OneCare and OneCare Connect members, Staff recommends that the Board authorize extending the current OneCare Connect contract with Windstone through December 31, 2016 (a six month extension) to align with the OneCare and Medi-Cal contracts. Aligning these contract expiration dates would allow time to include the Medi-Cal MBHO in the RFP. In addition, Staff believes that it would be prudent to have the option of renewing the Windstone OneCare Connect contract for one additional year (or two consecutive six month periods) at CalOptima's sole discretion, should additional time be required to complete the selection process.

Extending the current contract will support the stability of CalOptima's contracted provider network and ensure continued services without disruption to OneCare Connect members until the RFP process has been completed. Contract language does not guarantee any particular volume and allows for CalOptima and the provider to terminate the contract with or without cause.

To assist in developing an RFP and determining how best to administer the behavioral health benefit, management proposes to engage a consultant. The consultant, to be selected consistent with CalOptima's Board-approved procurement policy, will help with the development of the RFP and to assist staff in evaluating the advisability and feasibility of building internal capacity to perform some or all of the behavioral health benefit functions. Activities in which the consultant would assist staff include, but are not limited to:

- Development/ refinement of an RFP
- Identifying organizations with the capacity to respond to the RFP
- Developing proposed scoring tool(s)
- Assessing proposals, panel review management
- Assisting in the selection process for a vendor
- Make recommendations on activities that should (or should not) be delegated to the proposed vendor(s)
- Provide support in the contract negotiation process

As future plans for the OneCare and OneCare Connect programs are finalized, staff will return to the Board to request authority to enter into future contracts/contract extensions for behavioral health and or consulting services as appropriate.

Fiscal Impact

Staff assumes the capitation rate included in the OneCare Connect Contract with Windstone Behavioral Health will remain unchanged under the contract extension, and will therefore be budget neutral to CalOptima. Funding for the recommended action will be included in the forthcoming Fiscal Year 2016-17 CalOptima Consolidated Operating Budget.

The recommended action to hire a consultant through an RFP process to determine the delivery model optimization for the behavioral health benefit and for the development an RFP for contracted services, as appropriate, is an unbudgeted item, and will be funded in an amount not to exceed

$150,000 of budgeted funds from the Medical Management department to the Behavioral Health Integration department.

Rationale for Recommendation

CalOptima staff recommends authorizing an extension to the OneCare Connect contract with Windstone to ensure that OneCare Connect members continue to have access to covered services, and to authorize contracting with a consultant to assist in optimizing the administration of the behavioral health benefit.

Concurrence

Gary Crockett, Chief Counsel

Attachments

Previous Board action dated May 7, 2015

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

01/29/2016 — **Date**

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Attachment to:
February 4, 2016
Agenda Item 7

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken May 7, 2015
Regular Meeting of the CalOptima Board of Directors

Report Item

VIII. C. Authorize Contract for Behavioral Health Services with Windstone Behavioral Health for Cal MediConnect/OneCare Connect, and Extend the Current OneCare Contract

Contact

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

Recommended Actions

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

1. Enter into a contract with Windstone Behavioral Health (Windstone) for the Cal MediConnect/OneCare Connect program for the period July 1, 2015 through ~~December 31~~, June 30, 2016. ~~with the option to renew for one additional year at CalOptima's sole discretion.~~ Revised 5/7/15
2. Amend the OneCare contract to extend it for one additional year (through calendar 2016), with the option to renew for one additional year at CalOptima's sole discretion. The current OneCare contract expires December 31, 2015.

Background and Discussion

Behavioral Health is a Medicare covered benefit for OneCare and OneCare Connect members. CalOptima currently contracts with Windstone to provide Medicare covered behavioral health services for the OneCare program. Windstone has been contracted with OneCare for behavioral health since January 1, 2007. The current contract is set to expire December 31, 2015, based on the previous contract extensions.

CalOptima's medical management and behavioral health staff have reviewed the utilization performance of this provider and also evaluated the access needs of CalOptima members, and determined that Windstone adequately meets CalOptima's requirements for the current OneCare program and future OneCare Connect program. At its January 2013 meeting, the CalOptima Board authorized the CEO to leverage the OneCare provider network as the basis for the Duals Delivery system. Therefore, staff recommends initiating a new contract for the OneCare Connect program, and renewing the current OneCare contract as indicated above.

Renewal of the OneCare contract will support the stability of CalOptima's contracted provider network should CalOptima decide to renew the OneCare program for 2016. The new contract for OneCare Connect will initiate a stable network with an already established provider. Contract language does not guarantee any particular volume and allows for CalOptima and the provider to terminate the contracts with or without cause.

Fiscal Impact

Based on forecasted OneCare and OneCare Connect enrollment for the extended contract periods, the fiscal impact of the recommended action is approximately $650,000 for OneCare and $2 million for OneCare Connect. Funding for the recommended actions will be included in the upcoming Fiscal Year 2015-16 CalOptima Consolidated Operating Budget.

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Rationale for Recommendation
CalOptima staff recommends authorizing an extension to OneCare's contract with Windstone to ensure that OneCare members continue to have access to covered services, and extending a new contract for the OneCare Connect program so that these members will also receive the same quality level of service.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *5/1/2015*
Authorized Signature — **Date**

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Behavioral Health Integration - Managed Behavioral Healthcare Organization (MBHO) Vendor Selection

Board of Directors Meeting

September 1, 2016

Richard Helmer, M.D., Chief Medical Officer

Donald Sharps, M.D., Medical Director

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Today's Agenda

- Behavioral Health Services at CalOptima
- MBHO Functions
- BH Request for Proposal
- Evaluation Team
- Selection Criteria
- Evaluation Process
- Evaluation Result
- Next Step

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Behavioral Health Services at CalOptima

- OneCare (Medicare Duals Special Needs)
  - Benefits began on January 1, 2007
- Medi-Cal Managed Care Plan
  - Behavioral health benefits began on January 1, 2014
  - Autism Spectrum Disorder Behavioral Health Treatment benefit began on September 15, 2014
- OneCare Connect (Duals Demonstration Project)
  - Benefit began on July 1, 2015

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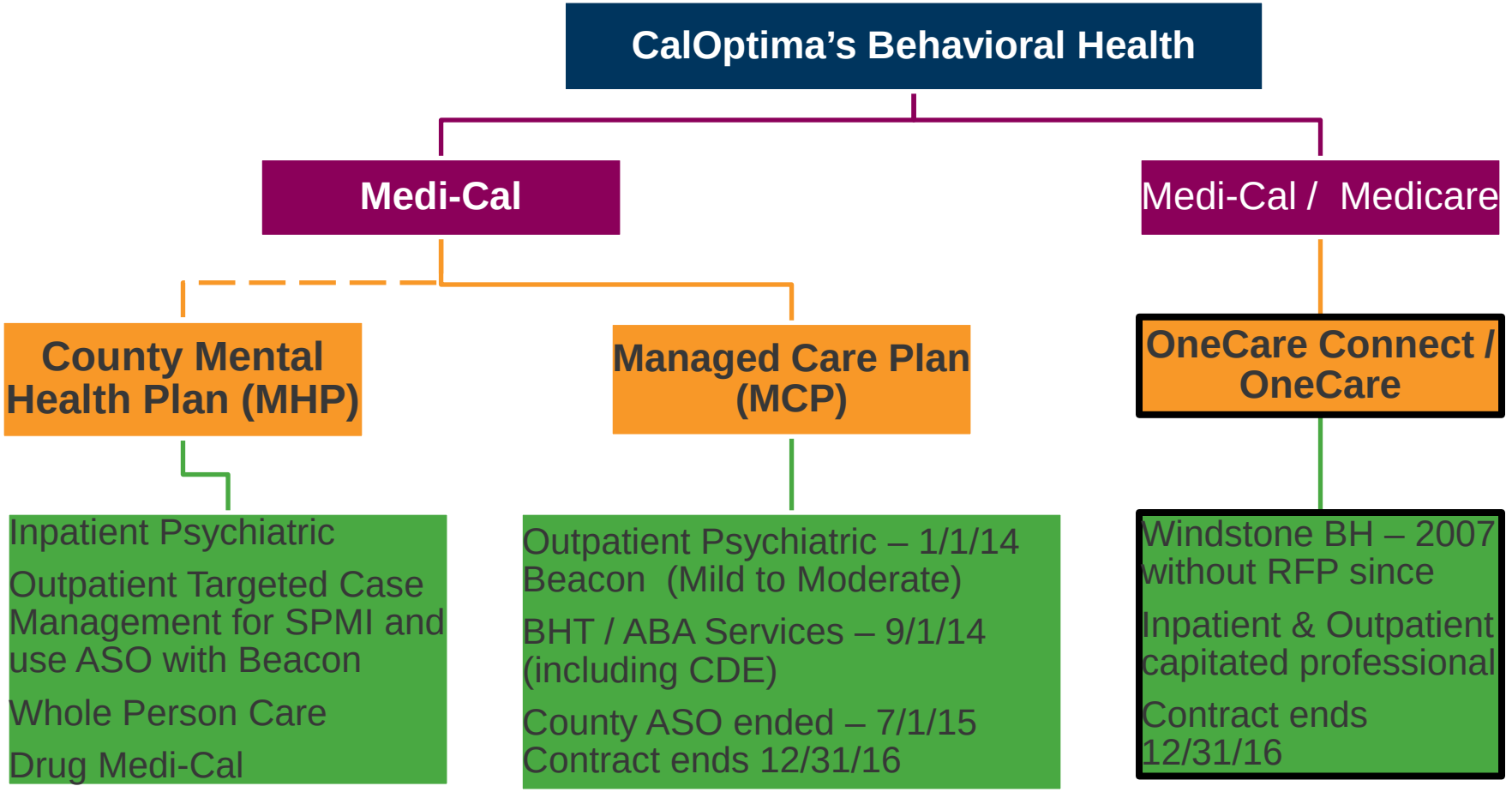
Behavioral Health Services at CalOptima



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Behavioral Health Services at CalOptima

- Behavioral Health (BH) services include services to address both mental health and substance use disorder conditions

- CalOptima is responsible for behavioral health services for all of its lines of business

- CalOptima has an opportunity to enhance the overall health of its members through the effective management of its behavioral health benefits

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Behavioral Health Services at CalOptima

- Like many managed care plans, CalOptima has used Managed Behavioral Health Organizations (MBHOs) to provide expertise and specialization in the management of BH benefits

Line of Business	Current Vendor
OneCare	Windstone Behavioral Health
OneCare Connect	Windstone Behavioral Health
Medi-Cal	CHIPA

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MBHO Functions

- MBHOs can support managed care plans by providing efficiency and subject matter expertise with:
  - BH Provider Network and Provider Relations
  - BH specific Credentialing
  - Call Center management
  - Eligibility verification
  - Level of care determinations
  - Claims payment and processing
  - Utilization management
  - Care management
  - Quality Improvement
  - Value based payment management

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BH Request for Proposal Timeline

Date	Key Steps
06/01/16	RFP released
06/29/16	Questions submitted from bidders*
07/15/16	Five bidders submitted proposal by deadline
07/20/16	RFP evaluation team met with CalOptima SME's
08/04/16	Completed scoring of written proposals
08/10/16	Bidder presentations to RFP evaluation team

* "CalOptima is requesting an at-risk (i.e. capitated) pricing model for each line of business"

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MBHO RFP Status - Evaluation Team

Proposals were evaluated by a collaborative team including CalOptima staff and HMA:

- Executive Director of Clinical Operations
- Behavioral Health Medical Director
- Director of Behavioral Health Services
- MAC member
- MAC OCC member
- PAC member

Additionally, only CalOptima staff scored specific sections of technical nature

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MBHO Selection Criteria – 21 Elements

- Experience in managed care
- Accreditation
- Corporate capabilities
- Information processing system*
- Financial management*
- Proposed staffing and project organization
- Ownership
- Outsourced services
- Provider network management and credentialing
- Operations
- Utilization management
- Claim processing*
- Grievances and appeals
- Care management
- Cultural competency
- Quality improvement
- Information technology, data management*
- Business intelligence*
- Compliance program
- Implementation plan
- Innovative program and services

* Technical Sections scored only by CalOptima staff

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MBHO Selection Process – Written Proposal

- The scoring tool contained 171 questions in 21 sections
  - Each question is scored on a scale of 1 to 5
- CalOptima Subject Matter Experts (SMEs) provided the evaluation team qualitative feedback
- CalOptima Staff also provided the evaluation team quantitative scores for the technical sections
- Weighted average score was calculated for each proposal

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MBHO Written Proposal Scores

Bidder Final Score Summary	Magellan	Envolve	CHIPA	Optum	Windstone
TOTAL Weighted	4.41	4.00	3.54	3.28	2.80
1.0 Experience and References	4.5	4.2	3.7	4.1	3.8
2.0 Accreditation	4.3	3.8	4.1	3.7	2.0
3.0 Corporate Capabilities	4.2	3.8	3.6	3.1	3.5
4.0 Information Processing System*	5.0	4.0	3.0	2.0	1.0
5.0 Financial Management*	4.0	4.0	3.0	4.0	2.0
6.0 Proposed Staffing and Project Organization	4.4	4.0	3.7	3.9	2.5
7.0 Ownership	3.7	3.1	2.9	3.7	3.0
8.0 Outsourced Services	N/A	N/A	3.5	2.3	N/A
9.0 Provider Network Management / Credentialing	4.6	4.7	3.8	3.5	3.6
10.0 Operations	4.2	4.0	3.0	2.7	2.7
11.0 Utilization Management	5.1	4.6	3.5	3.5	3.6
12.0 Claims Processing*	3.4	3.5	3.0	3.3	3.0
13.0 Grievances and Appeals	4.0	3.3	2.9	2.5	2.8
14.0 Care Management / Coordination	4.5	4.4	3.4	3.2	3.4
15.0 Cultural Competency	4.2	4.6	3.7	3.2	3.3
16.0 Quality Improvement	5.1	4.6	3.7	3.3	3.3
17.0 IT, Data Management, Electronic Data Exchange, and Health Information Exchange*	5.1	4.5	3.7	2.8	1.2
18.0 Business Intelligence*	4.6	4.4	4.4	4.4	1.3
19.0 Compliance Program	3.6	2.0	3.9	3.1	2.8
20.0 Implementation Plan	4.7	4.0	4.0	3.2	2.8
21.0 Innovative Programs & Services	4.7	4.5	4.2	3.4	4.4

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* Technical Sections scored only by CalOptima staff

MBHO Selection Process – Presentation

- The two bidders with highest written proposal scores, also
  1) Submitted bids for both Medi-Cal and Duals
  2) Had reasonableness of price
  3) Submitted bids with an at-risk (i.e. capitated) pricing model for each line of business
- Additional questions were submitted to these two bidders by the evaluation team and asked to present in person on 8/10/16

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MBHO Presentation Scores

Additional areas with follow-up questions from Evaluation Team	Magellan	ENVOLVE
1. Accreditation	3.71	1.00
2. Provider Network	4.14	3.33
3. Operations	4.71	3.50
4. Utilization Management	4.29	3.33
5. Grievances and Appeals	4.29	2.17
6. Care Management / Coordination	4.43	3.17
7. Quality Improvement	4.14	2.50
8. Reporting	5.00	2.20
9. Claims	4.57	2.83
Overall Average Score	4.36	2.67

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MBHO Selection Process – Additional Steps

- **Contract Language**
  - ➢Proposed changes reviewed
- **References**
  - ➢Reference checks completed and support the RFP scoring
- **Financial Review**
  - ➢Magellan and Envolve proposals were reviewed with Finance and determined to have a reasonable pricing model

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Rationale for Recommendation

- The evaluation team reviewed qualified MBHO responses and identified the candidate believed to best meet CalOptima's needs for:
  - Integration of care, regulatory compliance, operational efficiency, administrative simplification, best practices, as well as overall reasonableness of price
  - All delegated functions related to the Behavioral Health benefits: Customer Service, Care Management, Utilization Management, Credentialing, Quality Improvement, Claims Processing and Payment, Provider Dispute Resolution, Compliance and first level Provider Appeals

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Rationale for Recommendation

- CalOptima staff believes contracting with Magellan will meet CalOptima's goal of continuing to provide a comprehensive provider network and Behavioral Health and ASD services for CalOptima's Medi-Cal and Duals programs with:
  - Efficient and effective assessment, diagnosis, integrated care planning, strength based and person centered treatment implementation, support services and outcomes evaluation
  - Cultural responsiveness to our diverse membership, to develop a full picture of the various needs of the person and support goals and strategies to help members achieve and maintain recovery

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Next Steps

- Authorize the CEO to:
  - Enter into contract within 30 days with Magellan Health Inc.
  - Contract with a consultant(s) for up to $50,000 to assist with implementation
  - Extend the current CHIPA and Windstone contracts for up to six months, if necessary, to ensure no gap in coverage during the transition
- Direct CEO to return to the Board with further recommendations if contract is not finalized with Magellan within 30 days.

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CalOptima's Mission

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

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

Recommended Action
Authorize the Chief Executive Officer, with the assistance of legal counsel, to enter into an agreement with American Specialty Health (ASH) to serve as CalOptima's Gym Benefit Vendor for OneCare Connect and OneCare members effective January 1, 2017. The contract is for a two (2) year term with three additional one-year extension options, each exercisable at CalOptima's sole discretion.

Background
The CalOptima Board of Directors approved the addition of gym benefit to the OneCare Bid and OneCare Connect Plan Benefit Package submission to CMS on August 4, 2016. The gym benefit was not included in the CalOptima Fiscal Year (FY) 2016-17 Operating Budget approved by the Board on June 2, 2016.

Supplemental gym benefits were included in the OneCare line of business from 2008 – 2015 contracted through American Specialty Health (ASH). The benefit was not included in 2016 for OneCare due to budget constraints.

Staff issued a Request for Proposal (RFP) for gym services on June 15, 2016, for the contract period commencing January 1, 2017. Following CalOptima's standard RFP process, two responses from vendors were received.

Discussion
The responses to the RFP were reviewed by CalOptima's evaluation team consisting of Program Management, Customer Service, Communications, Disease Management, Clinical, Regulatory Affairs and Procurement. Based on the final weighted score for the two responses submitted, on August 10, 2016, the evaluation team selected American Specialty Health (ASH) for the contract. Through ASH, OneCare Connect and OneCare members would have access to over 100 gyms located throughout Orange County, approximately including the following:

- 35 24 Hour Fitness locations
- 15 LA Fitness locations
- 10 Curves locations
- 2 Gold's Gym locations
- 2 YMCA locations
- 2 Nifty at Fifty locations
- And potentially others.

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Fiscal Impact
Under the terms of the proposed contract with ASH, gym benefit expenses would cover approximately 20,000 OneCare and OneCare Connect members. Based on the projected enrollment, the total fiscal impact for the recommended action for the period of January 1, 2017, through June 30, 2017 is $322,149. Management proposes to apply a combination of surplus OneCare rebate dollars ($16,279) and a portion of the projected FY 2016-17 OneCare Connect budget surplus ($305,870) to fund the proposed gym membership benefit.

Management will include expenses for the period of July 1, 2017, through December 31, 2019, related to the proposed contract in the CalOptima FY 2017-18 and FY 2018-19 Operating Budgets.

Rationale for Recommendation
Contracting with American Specialty Health (ASH) will assist CalOptima in meeting the goal of ensuring that CalOptima members have access to a variety of fitness services.

Concurrence
Gary Crockett, Chief Counsel

Attachments
None

/s/ Michael Schrader — *8/25/2016*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

Contact
Len Rosignoli, Chief Information Officer, (714) 246-8400
Ladan Khamseh, Chief Operating Officer, (714) 246-8400

Recommended Actions
Authorize the Chief Executive Officer (CEO) to:

1. Extend the contracts with the following vendors as listed below through the dates indicated in the attached Tables 1, 2, and 3:
    a. Burgess-Burgess Reimbursement System (Medicare/Medi-Cal Fee Schedules and Claims Pricing)
    b. Medecision (Provider Portal (CalOptima Link)
    c. Edifeces-XEngine (Claims Electronic transaction standardization tool)
    d. Microstrategy (Enterprise Business Analytics and Intelligence)
    e. Office Ally (Claims Clearinghouse)
    f. Change Healthcare (Claims Clearinghouse)
    g. HMS (Medi-Cal Cost Containment)
    h. SCIO Health Analytics-My Socrates (Third Party Liability and Subrogation Recovery Services)
    i. OptumInsight (Credit Balance Recovery Services)
    j. MCG-CareWebQI (Evidence-based Clinical Guidelines
    k. Intelli-Flex (Telephone system and supporting Customer Service applications)
    l. TW Telcom/Level III(CalOptima's carrier for telecommunications as well as Internet connectivity); and

2. Authorize payment of maintenance and support fees to these vendors through the dates and up to the amounts indicated in the attached Tables 1, 2, and 3.

Background
CalOptima contracts with many vendors that provide a variety of software solutions to support the overall business model. Two Core Systems are central to this infrastructure while many other supporting solutions surround the Core.

Within the managed care industry, this is standard practice, as no commercially-available single solution is able to meet the demands of the industry for all functions. The trend over the past ten years or more has been to utilize this approach by using the Core for what those systems handle best, and to use specialty solutions to surround the Core. CalOptima, as well as the other 15 Local Health Plans of California, and virtually all health plans, use this approach.

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At the center and in the Core for CalOptima are two systems:

- TriZetto Facets – This solution handles the key functions of enrollment of members, health benefit configuration, claims processing and adjudication, and customer service.
- Altruista Guiding Care – This solution handles the key functions of Care Management, including Case Management, Utilization Management, Authorizations/Referrals, Disease Management, and Appeals & Grievances.

Supporting Systems include:

a. Burgess Reimbursement System – This solution provides two key functions. It enables continuous monitoring of the hundreds of claims reimbursement Medicare fee schedules maintained by the Federal Centers for Medicare and Medicaid Services (CMS) ensuring that CalOptima's Medicare fee schedules are up-to-date as soon as Medicare makes a change. It also uses sophisticated algorithms to calculate the reimbursement pricing for all CalOptima Medicare related claims. In the future, this solution will be expanded to perform the same functions for the Medi-Cal fee schedules and claims pricing.
b. Medecision - Aerial Care Coordination - This solution is the current CalOptima provider portal – more commonly known to the CalOptima provider partners as CalOptima Link. This portal enables the over 5,000 provider users to verify eligibility, review claims status, view patient rosters, and submit service authorization requests.
c. Edifecs – XEngine – This tool supports quality for the CalOptima Facets Claims process. XEngine is a tool that helps to validate compliance with regulatory transaction standards and streamline operational efficiency.
d. Microstrategy – This is the current CalOptima Business Intelligence and Analytics solution. Many routine analytics processes developed within Microstrategy have become part of the standard operations of CalOptima, providing data analytics to support all business functions.
e. and f. Office Ally and Change Healthcare – These vendor solutions are known as Claims Clearinghouses. Essentially, providers in the community interact with their systems to submit claims for payment to a variety of health plans/payers. The Office Ally Clearinghouse services the vast majority of California providers. Office Ally also provides Claims Submission, Electronic Health Record, and Practice Management solutions at no cost to provider offices, including hundreds of CalOptima provider offices. Change Healthcare (formerly known as Emdeon) is the largest claims Clearinghouse in the Country. In 2015, Change Healthcare handled over 8.5 billion transactions, covering $1.7 trillion in claims.
g. Health Management Systems (HMS) – HMS is a cost containment service vendor. For CalOptima, as well as the California Department of Health Care Services (DHCS), HMS is contracted to identify, audit and recover improper Medi-Cal payments. HMS' mission is to help protect the integrity of government-sponsored health and human services programs. HMS provides similar services to 23 states including 41 state Medicaid programs.
h. SCIO Health Analytics - My Socrates – My Socrates is a subrogation service solution used to support CalOptima's Medicare Claims processing. This service handles and identifies third-party liability, for example, subrogation with motor vehicle accidents, often a contributor to total claims cost. SCIO's services reach more than 400 million medical claims and 1.3 billion prescription claims nationwide.
i. OptumInsight – For CalOptima, OptumInsight provides Credit Balance Recovery services. There is a Medicare regulation dictating that providers may not retain any overpayments. An overpayment is where a health insurer reimburses a provider in excess of what should be

reimbursed, most often caused by billing or processing errors. There are a variety of significant penalties that can be assessed if overpayments are not identified and handled appropriately. This service helps CalOptima recover overpayments and its provider partners to identify procedural and system issues that create credit balances to identify opportunities to prevent future overpayments.

j. MCG, part of the Hearst Health Network – CareWebQI – This solution is embedded and tightly integrated within the Altruista Guiding Care solution for Care Management. CareWebQI provides electronic, automated access to evidence-based best practices and clinical criteria for the support and documentation of care management decisions.

The next two solutions support the overall Information Technology Infrastructure:

k. Intelliflex – This is the vendor that provides CalOptima's Avaya telephone System. The Avaya equipment is used for all employees. In addition, Avaya Contact Center and TelStrat Call Recording services are tightly embedded into CalOptima's Customer Service Operation, helping maintain regulatory compliance and policy adherence.

l. TW Telecom / Level 3 – This is CalOptima's carrier for telecommunications as well as Internet connectivity. This vendor supports this particular area of the County.

Discussion

The vendors listed in the attached table represent the solutions described above with contracts expiring over the next six months.

Many of these solutions are tightly embedded/integrated into either Facets and/or Altruista (the Core Systems) – see Table 1. Unless Facets or Altruista were to be replaced, replacing these tightly integrated solutions is infeasible without substantial investment and significant disruption to operations. Some also represent the most viable solution considering CalOptima's operating environment. See Table 2. Those falling into this category will not enter the competitive bidding process at this time.

Other solutions are less tightly integrated, less costly, less complex to replace, and are handled by competing vendors within the marketplace. For these vendors, a competitive bidding process is planned, and the approximate date to issue the RFI or RFP is listed in Table 3.

Fiscal Impact

The CalOptima Fiscal Year 2016-17 Operating Budget includes the annual fees for the listed contracted vendors related to CalOptima's core and supporting systems through June 30, 2017. Management will include expenses for the recommended contract extension periods on or after July 1, 2017, in future CalOptima Operating Budgets.

Rationale for Recommendation

Extension of the contracts for these systems that support the Core Systems will ensure there is no disruption to the services provided by each of the solutions and allow continuity of operations throughout the organization and with CalOptima's member and provider community.

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Concurrence
Gary Crockett, Chief Counsel
Chet Uma, Chief Financial Officer

Attachment
Proposed Contract Extensions

/s/ Michael Schrader — *8/25/2016*
Authorized Signature — **Date**

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Attachment - Proposed Contract Extensions

Table 1 – Solutions tightly integrated with Facets and/or Altruista

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
a. Burgess – Burgess Reimbursement System	Medicare/Medi-Cal Fee Schedules and Claims Pricing	1/1/2008	12/31/2016	12/31/2019	N/A	$811,700
b. Medecision – Aerial Care Coordination	Provider Portal (Calopima Link)	3/23/2011	9/1/2016	12/31/2019	N/A	$1,531,935
c. Edifecs – XEngine	Claims Electronic transaction standardization tool	3/9/2011	3/30/2017	12/31/2019	N/A	$93,702
d. Microstrategy	Enterprise Business Analytics and Intelligence	9/13/2011	9/19/2016	9/19/2019	N/A	$155,000

Table 2 – Solutions defined as “most viable” based on market standards, lack of competition, or related to State consistency

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
e. Office Ally	Claims Clearinghouse	7/1/2004	12/31/2016	12/31/2020	N/A	$474,579
f. Change Healthcare	Claims Clearinghouse	10/12/2000	10/18/2016	12/31/2020	N/A	$94,916
g. HMS	Medi-Cal Cost Containment	5/15/2008	5/14/2017	5/14/2020	N/A	$398,646
k. Intelli-Flex	Telephone system and supporting Customer Service applications.	12/7/2009	1/1/2017	12/31/2019	N/A	$306,936

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Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
l. TW Telecom / Level III	CalOptima's carrier for telecommunications as well as Internet connectivity.	2/15/2012	1/1/2017	12/31/2021	N/A	$720,000

Table 3 – Solutions with sufficient market competition with approximate RFP issue years listed

Number from List, Vendor, Solution Name (if applicable)	Description of Service	Original Contract Start Date	Current Contract Expires	Recommend Contract Extension Through:	Competitive Bid Initiation (approximate):	Annual Cost Based on Fiscal Year 2016-17 Budget
h. SCIO Health Analytics - My Socrates	Third Party Liability and Subrogation Recovery Services. (No cost, only contingency fee on percentage of recoveries).	2/19/2010	12/31/2016	12/31/2018	2017	Recovered in FY 2015-2016: $219,258.00 Fee (25%): $54,814.50 Net Recovery: $164,443.50
i. OptumInsight	Credit Balance Recovery Services. (No cost, only contingency fee on percentage of recoveries).	11/1/2011	12/31/2016	12/31/2018	2017	Recovered in FY 2015-2016: $44,834.00 Fee (12%): $5,380.08 Net Recovery: $39,453.92
j. MCG – CareWebQI	Evidence-based Clinical Guidelines	4/1/2008	3/31/2017	3/31/2021	2019	$641,300

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

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

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer (CEO), with the assistance of Legal Counsel, to execute a lease of up to 66 months for up to 20,000 square feet of office space with City Plaza located at 1 City Boulevard West, Orange, CA, in an amount not to exceed an average cost per square foot of $2.55 per month for base rent over the 66 month term;
2. Authorize additional expenditures of up to $.10 per square foot to account for projected increases to property taxes, insurance and Common Area Maintenance; and
3. Authorize additional expenditures of up to $95,000 for unreserved parking spaces.

Background

At the April 2, 2015, CalOptima Board of Directors meeting, Staff presented space planning options on the CalOptima Facilities strategy to accommodate the employee growth that is anticipated over the next five years. Along with expansion of the Telework program, the two options presented were:

- Option 1 – Lease longer term for term of five years or more; or
- Option 2 – Sub lease space that is already furnished for a shorter term of two to three years and purchase or build additional space.

At that meeting, the Board directed staff to evaluate leases for a term of three to five years, and conduct an evaluation of space needs near the end of the lease term. Staff was to evaluate lease alternatives, and return to the Board with a lease recommendation for 40,000 square feet at a cost of no more than $2.75 per square foot for a length of five years.

At the March 3, 2016, meeting, the Board authorized the CEO, with assistance of legal counsel, to negotiate and execute a lease for up to 66 months for up to 20,000 square feet of office space at a price per square foot not to exceed $2.55 per month with City Plaza located at 1 City Boulevard West, Orange, California, and authorized a supplemental budget of up to $2.8 million for expenditures for associated furnishings. The total cost for a 66 month lease agreement with City Plaza at $2.55 per square foot per month was approximately $3,240,700.

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Discussion

At the March 3, 2016 meeting, the Board authorized a lease at City Plaza at a price per square foot not to exceed $2.55 per square foot per month. However, following the Board meeting and during negotiations with the landlord of City Plaza, specific terms and conditions were negotiated, which resulted in the price per square foot per month to exceed the $2.55 level for a number of months during the lease term. However, if seven months of proposed rent abatement and one month of reduced rent over the 66 month base term are factored in, the net average base rent would equate to approximately $2.55 per square foot. The following table provides a summary of the proposed lease schedule and an updated total base rent cost for the lease term of $3,239,173.

Period	Annual	Months	Average Price per Square Foot
1	NA	• 7 months of rent abatement • 1 month of reduced rent	NA
	$242,624	4.75	$2.65
2	$631,333	12	$2.73
3	$650,273	12	$2.81
4	$669,782	12	$2.90
5	$689,875	12	$2.98
6	$355,286	6	$3.07
Total	**$3,239,173**	**66**	**$2.55**

As indicated, the proposed lease schedule includes seven months of rent abatement and one month of reduced rent. During the 66 month base lease term, monthly base rent will range from $1.99 to $3.07 per square foot. As the table above summarizes, this results in an effective average base rent of $2.55 per square foot for the 66 month base lease agreement. Following the base lease term, CalOptima will have two (fair market value) five year lease extension options.

In addition to base rent, the 66 month base lease term does not include projected average increases to property taxes, insurance, and Common Area Maintenance, estimated at $0.10 per square foot, adding an estimated expense of $127,215.

The proposed lease includes 5 unreserved parking spaces per 1,000 square feet of rental space, resulting in an allocation of 97 unreserved parking spaces. Staff projects that there will be 132 employees that will require parking at City Plaza. The cost for an additional 35 unreserved parking spaces over 66 months is approximately $95,000.

Fiscal Impact

The effective average base rent of $2.55 per square foot, the projected increases to property taxes, insurance and Common Area Maintenance estimated at $0.10 per square foot for City Plaza, and up to $95,000 for unreserved parking spaces are budgeted items under the CalOptima Fiscal Year 2016-17 Operating Budget approved by the Board on June 2, 2016.

Rationale for Recommendation

Management anticipates that CalOptima's space needs will continue to grow in the near term. To accommodate this growth, management recommends that the Board authorize the CEO to execute the

lease for City Plaza based on the cost and terms discussed above to ensure that CalOptima's space needs are adequately met.

Concurrence
Gary Crockett, Chief Counsel

Attachment
CalOptima Board Action dated March 3, 2016, Authorize Staff to Negotiate a Lease Agreement for Office Space, Expend Funds on Furnishings, and Evaluate and Pursue Other Space Planning Options

/s/ Michael Schrader — *8/25/2016*
Authorized Signature — **Date**

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action To Be Taken March 3, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

13. Authorize Staff to Negotiate a Lease Agreement for Office Space, Expend Funds on Furnishings and Evaluate and Pursue Other Space Planning Options

Contact

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

Recommended Actions

1. Authorize the Chief Executive Officer, with the assistance of legal counsel, to negotiate and execute a lease of up to 66 months for up to 20,000 square feet of office space at a price per square foot not to exceed $2.55 per month with City Plaza located at 1 City Boulevard West, Orange, California; and
2. Authorize a supplemental budget of up to $2.8 million for expenditures for associated furnishings.

Background

At the April 2, 2015, CalOptima Board of Directors meeting, staff presented space planning options on the CalOptima Facilities strategy to accommodate the employee growth that is anticipated over the next five years. Along with expansion of the Telework program, the two options for additional office space presented were:

- Option 1 – Lease longer term for term of five years or more; or
- Option 2 – Sublease space that is already furnished for a shorter term of two to three years and purchase or build additional space.

At that meeting, the Board directed staff to evaluate leases for a term of three to five years, and conduct an evaluation of space needs near the end of the lease term. Staff was to evaluate lease alternatives, and return to the Board with a lease recommendation for 40,000 square feet at a cost of no more than $2.75 per square foot for a length of five years.

In addition, CalOptima recently received an extension of the development agreement with the City of Orange that allows for the development of a parking structure and an addition office building on the 505 City Parkway site. The agreement currently expires on October 28, 2019. And while the agreement could potentially be extended further, no such commitment has been requested or received at this time.

Discussion

Current usable space at CalOptima's offices at 505 City Parkway West is 144,150 square feet which accommodates approximately 853 work stations, including cubicles and offices. As of December 2015, CalOptima has 1,007 employees, with 220 teleworkers and 49 temporary staff. CalOptima expects to have 1,209 full time equivalents (FTEs) by June 30, 2016, with the building's capacity growing from 853 to 1,042 work spaces as the build out of the second and third floors (recently vacated by a former tenant) is completed. This space should be ready to be occupied in May 2016.

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CalOptima has been experiencing unprecedented growth during the past two years. Management projects the employee growth rate to flatten in the coming months for Medi-Cal and within the next two years for Medicare. Even with that stabilization, Management anticipates an annual employee growth rate of approximately 3% through 2018.

In addition, CalOptima is engaged in a healthcare environment where the state and federal governments are moving existing fee-for-service programs into managed care and increasing regulatory requirements as new programs are introduced. CalOptima has seen, and will continue to see, continued growth in our Medical Management area due to the administration of the Model of Care, utilization and case management of our CalOptima Community Network, execution of our Long Term Care strategy and other drivers. CalOptima's budget and budget assumptions do not include the impact of the implementation of the 1115 waiver programs, the integration of California Children Services (CCS) program, the implementation of Health Homes and other programs that will have a significant impact on CalOptima and our staffing.

While the current capacity of the 505 building, including space that will be gained from departing tenants, of 1,042 will be close to the capacity needed at the end of Fiscal Year 2015-16, staff assumes CalOptima will be able to use all of the 30% of total headcount allocation for telework. However, this may not be realistic considering some of the work may not be suited for telework. As such, the work may require staff to be on site.

Lastly, an important item to consider is the lease environment in Orange County. The price per square foot has increased by as much as 13.5% from 2014 to 2015 in certain portions of Orange County. In addition, the demand for space remains relatively strong as space continues to be leased and vacancy rates decline. In Central Orange County, vacancy rates are now under 10% and there has been over 600,000 square feet of space taken during the first six (6) months of calendar year 2015.

Based on these factors, staff has engaged in an RFP process to identify potential additional leased space. Based on this process, management recommends pursuing a lease agreement for one floor at the 1 City Boulevard West building.

The proposed lease does not include an opt-out or early termination provision. In fact, none of the four finalists provided that option without significant cost increases in the lease. In order to mitigate the risk of not having an opt-out clause, in the event that the space was no longer needed by CalOptima, staff would pursue, with Board approval, a sub-lease arrangement to offset the cost of any unused space. The proposed lease structure would include an extension option of two additional terms of sixty (60) months.

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Fiscal Impact

The total lease cost for recommended action for a 66 month lease agreement with City Plaza at $2.55 per square foot per month is approximately $3,240,700. The recommended action upon approval will be included in the CalOptima FY 2016-17 Operating Budget.

The recommended action to authorize expenditures for furnishing costs to one floor of leased space is an unbudgeted item. Staff estimates the recommended action would increase the CalOptima FY 2015-16 Capital Budget by $2,732,049 in order to furnish and establish Information Services connectivity.

In total, the recommended actions would cost $5,972,749 over a period of 66 months. This estimate excludes increases to reflect property taxes, insurance, and Common Area Maintenance estimated at $0.10 per square foot or approximately $127,215 over 66 months. Cost estimates are based on the un-negotiated proposal received from City Plaza.

Rationale for Recommendation

Conservative estimates have CalOptima outgrowing our building capacity by the end of FY 2015-2016 with no room for growth beyond that. This does not include any of the programs that could significantly impact CalOptima staffing. Examples include the 1115 waiver, the implementation of Health Homes, Behavioral Health, Long Term Care, Whole Person Care and the integration of CCS. The increasing intensity of government programs, growth in our CalOptima Community Network, and implementation and growth of OneCare Connect are the main short term drivers. Relative to timing, the lease environment is becoming more competitive with a shortage of available space and prices increasing as a result. Specifically, large blocks of space are down to a minimum. If we do not act now, there is a likelihood that needed space will not be available in close proximity to the 505 building, and we will have to look in South County to accommodate our growth needs at rates that will be much higher than the current proposal.

Concurrence

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

Attachments

None

/s/ Michael Schrader — *02/26/2016*
Authorized Signature — **Date**

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CalOptima
A Public Agency
Better. Together.

Space Planning

Board of Directors Meeting
March 3, 2016

Chet Uma, Chief Financial Officer
Ken Wong, Director, Budget and Procurement

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Background

- 4/2/15 Board meeting: Staff presentation on space planning options
  - Option 1: Lease longer term for 5 years or more
  - Option 2: Sub lease space for 2 to 3 years and purchase or build additional space
  - CalOptima's development agreement with City of Orange expires 10/28/19
- Board action
  - Evaluate leases for term of 3 to 5 years
  - Conduct evaluation of space needs at end of lease term
  - Return with recommendation for 40,000 square feet at a cost of no more than $2.75 per square foot for a term of 5 years

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Current Staffing Levels

Staff FTEs (excluding PACE)	Actual (Jan 2016)	Budget (FY 2015-16)
On site		
Filled Seat	692.0	820.6
Temporary Help	49.0	40.0
Subtotal	**741.0**	**860.6**
Off site		
Teleworker	222.0	330.0
Community Worker	19.0	19.0
Shared Space	24.0	--
Total	**1,006.0**	**1,209.6**

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Available Space

- 505 City Parkway West: 144,150 square feet (853 work stations)

	Actual (Jan 2016)	Budget (FY 2015-16)
Total Space Available	**853.0**	**853.0**
Total Occupied Space		
Filled Seats and Temporary Help	(741.0)	(860.6)
Additional Space Needs		
Pending Request to Fills	(110.0)	--
Subtotal	**(851.0)**	**(860.6)**
Total Space Surplus (Shortfall)	**2.0**	**(7.6)**
New Construction: 2nd & 3rd Floors	189.0	189.0
New Space: City Plaza	126.0	126.0
Net Space Surplus (Shortfall)	**317.0**	**307.4**
Expected Employee Count for New Programs	(165)	(165)
Net Space Surplus (Shortfall)	**152**	**142.4**

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Why Do We Need Additional Space?

- Assumptions
  - 3% annual employee growth rate through 2018
  - Allocation of 30% of total headcount for telework
  - Continued shift from fee-for-service to managed care
  - Increased regulatory requirements
  - Growth in Medical Management (i.e., Model of Care, Community Network)

New Programs	Date	Expected Employee Count
Long Term Care	Now	20
Behavioral Health Treatment	July 2016	45
California Children's Services (CCS)	July 2017	100
Health Homes	July 2017	TBD
Section 1115 Waiver: Whole Person Care Pilot	May 2016: Applications due	TBD
Total		**165**

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Why Do We Need Additional Space? (cont.)

- Orange County Lease Environment
  - As much as 13.5% increase in price per square foot from 2014 to 2016
  - Strong demand for leased space
  - <10% vacancy rates in Central Orange County
  - >600,000 square feet of space leased during January through June 2015
- Staff performed RFP to identify potential additional space
  - Resulted in today's recommendation to pursue lease agreement for one floor at City Plaza
  - If space is no longer needed, Staff will pursue, with Board approval, a sub-lease arrangement to offset the cost of any unused space

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Recommended Actions

- 66 month lease agreement with City Plaza
  - Up to 20,000 square feet of leased space to create capacity for additional 126 FTEs
  - Propose extension option of two additional terms of 60 months**
  - Tentative start date: July 2016
    - Date available: April 2016
  - Annual Cost: $612,360

	Total Cost	Monthly Cost
City Plaza: 66 month lease agreement ($2.55 per square foot)	$3,240,700	$49,102
Common area maintenance, insurance, property taxes, utilities	$127,215	$1,928
Total ($2.65 per square foot)	**$3,367,915**	**$51,030**

•Costs are based on the un-negotiated proposal received from City Plaza
•**City Plaza proposal included 1 additional term of 60 months

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Recommended Actions (cont.)

- Furnishing costs to leased space:

Category	Total Cost	% of Total
Information Technology	$1,468,372	54%
Furniture	$748,000	27%
Network Cabling	$112,000	4%
Moving Expenses	$55,000	2%
Project Management	$35,000	1%
Security	$30,000	1%
Audio Visual	$22,500	1%
Shelving, Copiers, Signage	$15,750	1%
Incidentals	$31,200	1%
Contingency	$214,227	8%
Total	**$2,732,049**	**100%**

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Recap and Conclusion

- Board authorized Management to procure leased space
  - Up to 40,000 square feet at a cost of no more than $2.75 per square foot
- 2/18/16 meeting: FAC approved recommended actions

	333 City Tower	City Plaza*
Lease cost	$6,621,867	$3,240,700
Furnishing costs	$5,464,099	$2,732,049
Common area maintenance, insurance, property taxes, utilities, parking costs	$432,123	$127,215
Total	**$12,518,089**	**$6,099,964**
Total square feet	41,480	19,275
Lease cost per square foot	$2.58	$2.65
Lease duration	66 months	66 months
Board meeting presentation	8/6/15	3/3/16

* City Plaza's un-negotiated proposal

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

Action to Be Taken September 1, 2016
Regular Meeting of the CalOptima Board of Directors

Report Item

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

Contact

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

Recommended Actions

1. Authorize an expenditure of $10,000 from existing reserves to support of the development of an Orange County Strategic Plan for Aging (OCSPA) in partnership with Alzheimer's Orange County, the County of Orange Health Care Agency, Orange County United Way and other community partners;
2. Make a finding that such expenditure is for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the planning and development of the OCSPA.

Background

The Orange County Strategic Plan for Aging (OCSPA) will focus on preparing Orange County for the growing number of seniors and older adults, including CalOptima members, and the issues they encounter. The plan will be based on qualified data and assessments and the review and analysis of existing data on the state of seniors. The data collection and analysis will focus on where older adults are most vulnerable and in need. The plan will include recommended steps to address those needs over time. Data elements that may be considered for the OCSPA include health care, housing needs, food insecurity, caregiver burden and veterans issues, to name a few. The final plan will include strategies to address identified gaps in the community.

Alzheimer's Orange County (AOC, formerly the Alzheimer's Association Orange County Chapter) will provide support, act as the fiscal agent, as well as provide in-kind management for the development of the OCSPA. AOC is a non-profit, community-based organization that provides and coordinates resources and support related to Alzheimer Disease in Orange County.

Several public and community agencies are participants on the project's Leadership Council as well as providing financial support for the project, including:

- County of Orange Health Care Agency
- County of Orange Office on Aging
- Orange County United Way
- Orange County Community Foundation
- Alzheimer's Orange County
- Council on Aging – Orange County
- SeniorServ
- AgeWell Senior Services

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A recent grand jury report on the Orange County Office on Aging states that the "65 and over segment of the Orange County population is the only age group increasing in numbers, according to the 2015 Orange County Community Indicators report. The demand for senior services will surge accordingly, while the demand for services for those over 75 years old, along with frail elderly, will rise at an even faster rate." The needs of older adults in Orange County have long been a low priority. The last comprehensive county report on the condition of older adults was conducted back in 2003.

Discussion

Staff recommends the authorization of the expenditure in support of the development of the Orange County Strategic Plan for Aging. This is an opportunity for CalOptima and community partners, who serve seniors and older adults in our community to engage in efforts to address the gaps of the rapidly changing community including the health care environment; in addition to the needs of the growing older adult and vulnerable populations. CalOptima will also participate on the project's Leadership Council and project workgroups.

CalOptima currently manages care for 17.5% (72,297 as of August 10, 2016) of Orange County's senior and older adult 65 and older population (412,071 persons 65 and older in Orange County per the US Census Bureau). The senior and older adult members participate not only in the Medi-Cal program, but also are OneCare and OneCare Connect members as well as participants in CalOptima's Program for All-Inclusive Care for the Elderly (PACE).

CalOptima has participated in other similar planning and reporting activities such as the Orange County Healthier Together plan with the Orange County Health Care Agency, the Orange County Community Indicators Report and the Condition of Children report with the Children and Families Commission of Orange County. The planning and development process for the Strategic Plan for Aging will include the recruitment of additional partners and funders, identifying the best strategic model for Orange County, data review and analysis, drafting of the strategic plan, publication of the final plan and development of a timeline for implementation of the plan.

Twenty years ago, CalOptima was created by our community, governed by our community and accountable to our community and continues to serve the Orange County Medi-Cal population. As a public and community health plan that serves low-income Medi-Cal beneficiaries, CalOptima establishes partnerships and works with community-based organizations, social service providers and government agencies to make a greater impact in the community. Community initiatives, such as the development of the OCSPA, serves to strengthen, develop and sustain positive relationships among community-based organizations, health care providers, policy makers and other community health organizations serving the community.

The collaborative efforts of the Leadership Council for the OCSPA, the identified workgroup members and several other community partners who work together, are committed to effectively identify and address the needs and issues impacting our aging community through ongoing coordination.

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CalOptima staff conducted a review of the request and attended the initial Leadership Council meeting. Staff recommends that CalOptima be an active council and workgroup member, participate and support the planning and development process where information regarding our membership and the community we serve may be used to identify significant challenges and ways to address the challenges our members encounter. Staff also recommends that the Board making a finding that the proposed partnership and expenditure is in the public interest and in furtherance of CalOptima's statutory purpose.

Fiscal Impact

The recommended action to support the development of an Orange County Strategic Plan for Aging in partnership with the Alzheimer's Orange County, the County of Orange Health Care Agency, Orange County United Way and other community partners through June 30, 2017, is an unbudgeted item. As proposed, the item will involve an allocation of $10,000 from existing reserves to fund this action.

Rationale for Recommendation

As part of CalOptima's vision in working better together, staff believes providing financial support to the development of an Orange County Strategic Plan for Aging will help CalOptima to stay focused on changes in the environment of community health as well as strengthening efficiencies and coordination. Staff recommends approval of the recommended action to support a process where information regarding overall community health improvement and access will potentially be used to identify and address significant challenges that our community encounters. CalOptima's participation in the planning process and support of the development of an OCSPA supports CalOptima's mission and encourages collaboration among our community and health care partners for the benefit of Medi-Cal members. The opportunity is most appropriate that CalOptima participate, given its strategy and activity regarding our programs and other health initiatives that impact CalOptima's senior and older adult members.

Concurrence

Gary Crockett, Chief Counsel

Attachment

July 26, 2016 Article by the Orange County Community Foundation ConnectOC

/s/ Michael Schrader — *8/25/2016*

Authorized Signature — **Date**

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print

ConnectOC Blog

Creating an OC Strategic Plan for Aging

Did you like this article?
Please share it!

Posted by: Orange County Community Foundation on 7/26/2016

Orange County's senior population is growing exponentially while other age demographics are shrinking, exposing at least a third of our neighbors to problems we've never faced as a community. Although residents age 65 and above make up 12.4 of Orange County's population this year, this figure will double by 2045. By then, nearly 5 percent of residents will be older than 85, an especially fragile demographic. The "silvering" of our population has wide-ranging implications on our local economy and increases the need for health services, housing, transportation and social services for older people. And while most residents plan to remain in Orange County through retirement, they're concerned with how they'll manage health care and whether they'll have access to transportation services. The community leaders behind the about-to-launch Orange County Strategic Plan for Aging (OCSPA) are hoping to address these concerns and prepare us for the growing numbers of seniors in Orange County and the issues they face.

"Many nonprofit and county agencies that have been serving older adults are feeling the impact

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of funding that is either staying the same or decreasing, while there are more individuals entering into the 60 and over category and living longer than ever before," explained Alzheimer's Orange County President and CEO Jim McAleer, who launched the concept of the OCSPA, and who serves as Co-Chair of the Orange County Aging Services Collaborative. "Since the landscape continues to change, it is important for all of us to recognize that we need to strategically utilize resources to better serve this population."

In 2010, there were 496,404 people over the age of 60 living in Orange County. By 2030, Orange County will be home to more than 870,500 seniors. This 75 percent increase over 20 years is just one of the factors spurring the development of the plan.

The OCSPA is the first attempt since 1999 to gather and coalesce qualified data and assessments on the state of Orange County seniors, identify their areas of greatest need and put into place ways to address those needs over time. The building blocks for the plan were constructed by Alzheimer's Orange County and introduced to the Orange County Aging Services Collaborative (OCASC). Seeing the potential of the project to impact seniors and the County, OCASC realized it was time to take the next step in elevating senior issues and adopted the project as a core program.

In October 2015, the Orange County Aging Services Collaborative, United Way, and Orange County Community Foundation introduced the vision for the OCSPA to a group of local leaders. Area experts on housing, health care, transportation and nutrition presented their perspectives on the greatest risks seniors face in Orange County during this event. . The plan is guided by a leadership Council comprised of a County Supervisor, local non profit leaders, city officials and non profit executives. It will be operationally managed by a planning group of content experts. When completed in 2017, the final plan will be presented to the County of Orange and multiple local government and nonprofit agencies for adoption, making this truly the first Strategic Plan for Aging incorporating funders, providers of service and government

Although the group believes they have a grasp of the big issues facing seniors – including housing, food insecurity, transportation options, isolation, access to quality long-term services and support – McAleer said OCSPA is "hoping to better frame the top needs and make an actionable plan. Different leaders hold different pieces of the puzzle, so it is possible that there is something that will be an 'Aha!' moment during the planning process."

To kick-start planning, OCSPA will convene the first meeting of a leadership council Aug. 4 with representatives from the Orange County Board of Supervisors, CalOptima, Alzheimer's Orange County, SeniorServ, Age Well Senior Services, Council on Aging Orange County, OC Health Care Agency, Office on Aging, Orange County, OC Transit Authority, Jamboree Housing and OC United Way and the Orange County Community Foundation.

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“Based on the Leadership Council’s direction and the findings from our work groups, a three-year plan will be developed,” McAleer explained. “There are multiple directions that the Leadership Council could take, hand picking three-to-four pillars with actionable items within each pillar or working within an age-friendly community planning framework such AARP or the World Health Organization.”

Although there are pros and cons with each option, “our plan is to get everyone around the table to talk about aging on a regular basis,” he said. “Through this process, we are hoping to analyze the top areas identified by the Leadership Council and make a decision on where we can focus our efforts to move the needle. We want to make sure that this plan is making a measurable impact in the lives of older adults in Orange County and will help build capacity for future generations.”

To get involved with OCASC’s efforts or explore how OCCF is championing efforts to define how Orange County will support our aging population, contact Todd Hanson, vice president of OCCF’s Center for Engaged Philanthropy.

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3 Comments

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Email
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06a59

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Report|Reply

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

Report Item

8. Consider Authorization of 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 $1,000 and staff participation at the12th Annual NAMIWalks Orange County on Saturday, October 1, 2016 in Irvine;
    b. Up to $1,000 and staff participation at the 4th Orange County Women's Health Summit on Friday, October 21, 2016 at Cal State University, Fullerton;
    c. Up to $1,000 and staff participation at the 2016 California Association for Adult Day Services (CAADS) Fall Conference and Annual Meeting on Wednesday November 16th through Friday, November 18, 2016 in Garden Grove;
2. Make a finding that such expenditure is for a public purpose and in furtherance of CalOptima's mission and statutory purpose; and
3. Authorize the Chief Executive Officer to execute agreements as necessary for the 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 following community events to provide outreach and education for CalOptima's programs and services, an opportunity to highlight CalOptima's behavioral health benefits available to our members, and strengthen collaboration with community-based adult services organizations. Participation in these events will increase CalOptima's

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visibility in the community, while providing opportunities for collaboration to strengthen our relationship with our community partners.

a. For the 12th Annual National Alliance on Mental Illness Orange County (NAMI-OC) NAMIWalks Orange County event in Irvine, a $1,000 financial commitment includes a 1/4 page ad in the event program, CalOptima logo display on the event banner, event brochure and website and a resource table at the Health and Wellness event. Employee time will be used to participate in this event. Staff from our Behavioral Health Integration department will be available to highlight mental health services available to our members, potentially increasing use of this heavily under-utilized service available to our members. Staff will be available to answer questions regarding access and mental health benefits for attendees, which will include members, potential members, providers and advocates for mental health. Over 2,000 individuals are expected to attend the event.

b. For the 4th Orange County Women's Health Summit at Cal State University, Fullerton, a $1,000 financial commitment includes registration and seating for two staff at the Summit, CalOptima logo display on the Health Summit marketing materials, event brochure and a resource table. This year the Orange County Women's Health Project has partnered with three Orange County universities, including Chapman University, Cal State University, Fullerton, and University of California, Irvine to include students as well as healthcare, nonprofit, government, academic and other professionals dedicated to women's health issues in Orange County. Employee time will be used to participate in this event. Workshops will be offered to address Breast and Cervical Cancer, Health and Domestic Violence and Emerging Issues in Women's Health. Staff will be available to provide information and education for all CalOptima programs and services with members, potential members, students, professionals and advocates for women's health. Past events drew approximately 150 attendees; however greater attendance is anticipated with the new partnership with the local universities and increased awareness of the Orange County Women's Health Project. In addition, the event will potentially provide an opportunity for increased enrollment, outreach and education to students, who may be members or potential members through the Medi-Cal expansion.

c. For the 2016 California Association for Adult Day Services (CAADS) Fall Conference and Annual Meeting in Garden Grove, a $1,000 financial commitment includes one day registration for the event, CalOptima display on event signage and refreshment signage and CalOptima name on the attendee list. Employee time will be used to participate in this event. Participants for the event will include CAADS members, state personnel and provider and managed care organizations, including adult day programs, adult day health care/community-based adult services, Alzheimer's resource centers, Medi-Cal managed care plans, and health care professionals who serve our members, including nurses, social workers, therapists and others. Staff will be available to provide information and education to service providers, advocates and professionals regarding Community-Based Adult Services available to our members. CalOptima's participation in this event will strengthen our existing relationship with CAADS and the service providers serving our members.

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CalOptima staff has reviewed each request and all three meet the considerations for participation including the following:

1. The number of people the activity/event will reach;
2. The marketing benefits accrued to CalOptima and the potential to create positive visibility for CalOptima;
3. The strength of the partnership or level of involvement with the requesting entity;
4. Past participation;
5. Staff availability; and
6. Available budget.

CalOptima's involvement in community events is coordinated by the Community Relations department. The Community Relations department will take the lead to coordinate staff schedules, resources, and appropriate materials for the event.

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

Fiscal Impact

Funding for the recommended actions of up to $3,000 is included as part of the Community Events budget under the CalOptima Fiscal Year 2016-17 Operating Budget approved by the CalOptima Board of Directors on June 2, 2016.

Rationale for Recommendation

Staff recommends approval of the recommended actions in order to support community and provider activities that offer opportunities that reflect CalOptima's mission, encourage broader participation in CalOptima's programs and services, promote health and wellness as well as highlight mental health and community-based adult services available to our members.

Concurrence

Gary Crockett, Chief Counsel

Attachments

1. 12th Annual NAMIWalks Orange County Registration Materials
2. 4th Orange County Women's Health Summit Information and Registration Materials
3. 2016 CAADS Fall Conference & Annual Meeting Registration Materials

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

8/25/2016 — **Date**

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NAMI Orange County

National Alliance on Mental Illness

Help fund quality mental health care educational programs offered at no cost to families throughout Orange County!

IN KIND

Any type of donations are always accepted!

Elite ($15,000)

All in previous level plus:

- *Promotion for all future walks for 5 years*

KILOMETER ($250)

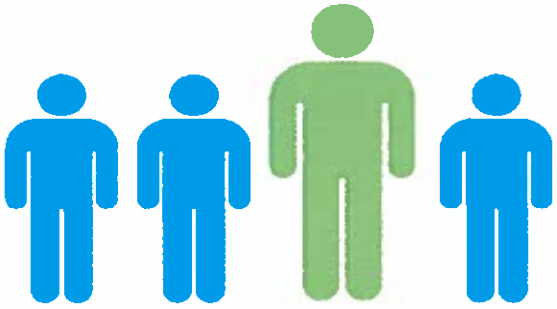
Sponsorship name & logo on:

- Route Sign
- Listing on WALK website
- Table at WALK
- WALK t-shirt

Saturday, October 1, 2016

WALK

SPONSORSHIP OPPORTUNITIES



PREMIER ($10,000)

All in previous level plus:

- Business logo/photo on all printed material
- Onstage banner

SUPPORTER ($500)

All in previous level plus:

- Brochure name listing
- 1/4 page ad in program brochure

PLATINUM ($7,500)

All in previous level plus:

- Reserved parking on day of event
- Signage in middle of WALK event

BRONZE ($1,000)

All in previous level plus:

- Banner
- Table at Health and Wellness event and WALK

1 in 4 ...

William R Mason Park

18712 University Drive, Irvine, CA

GOLD ($5,000)

All in previous level plus:

- Full page ad and placement on covers
- Signage at kickoff meeting

SILVER ($2,500)

All in previous level plus:

- 1/2 page ad in program brochure
- Media/press release
- Premier spots for tables
- Event promotion posters

Start/Finish ($1,500)

All in previous level plus:

- *Signage at start/finish line*

Call: 714.544.8488 | Email: adurham@namioc.org | www.namiwalks.org/orangecounty

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NAMI Orange County

2016 W lk Sponsors

Sally Segerstrom, Segerstrom Foundation Premier Sponsor
Beacon Health Systems, Collaborative Neuroscience Network, Silver Sponsor
Hittelman Law Group Start/Finish

SPONSORSHIP CONFIRMATION FORM

☑ Yes! We are proud to support the 2016 Orange County NAMIWalk. We authorize NAMI to include our name and/or logo on all the materials printed for the event consistent with our sponsorship selection below.

☐ Elite Sponsor	$15,000	☐ Start/Finish Line Sponsor	$1,500
☐ Premier Sponsor	$10,000	☐ Bronze Sponsor	$1,000
☐ Platinum Sponsor	$7,500	☐ Supporter Sponsor	$500
☐ Gold Sponsor	$5,000	☐ Kilometer Sponsor	$250
☐ Silver Sponsor	$2,500		

Company Name: _____

Contact Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Website: _____

E-mail Address: _____

For guaranteed inclusion of name/logo on printed materials, return form by September 5, 2016.

- ☐ Check enclosed (please make payable to NAMI Orange County)
- ☐ Credit card payment (accepted online at www.namiwalks.org/OrangeCounty)
- ☐ Please send an invoice
- ☐ Please reserve an exhibit booth space
- ☐ Please reserve an exhibit table and two chairs
- ☐ We will not be using our included exhibit space

For your records, our Tax ID# is #95-372369. Please forward logo and any questions to:
Amy Durham, Development Manager, at adurham@namioc.org or (714) 544 8488.

PLEASE MAIL SPONSORSHIP CHECKS TO: NAMI-Orange County, 1810 E 17th St, Santa Ana, CA 92705

1 4 ...

Orange County
WOMEN'S HEALTH PROJECT

July 8, 2016

Tiffany Kaaiakamanu
Community Relations Manager
CalOptima

Via E-Mail: tkaaiakamanu@caloptima.org

Tiffany! Thank you very much for your support! Allyn

RE: Sponsorship Request for the 4th Orange County Women's Health Summit on 10/21/16

Dear Tiffany:

I am pleased to invite CalOptima to sponsor the 4th Orange County Women's Health Summit, which will be held on Friday, Oct. 21, 2016 at California State University, Fullerton.

The Orange County Women's Health Summit is the premier gathering for healthcare, nonprofit, government, academic, and other professionals dedicated to women's health issues in Orange County. Past Summits, which attract approximately 150 attendees, reviewed the state of women's health in the county, explained the Affordable Care Act and its impact on women, trained attendees on advocacy and presented policy recommendations to improve breast cancer, cervical cancer, domestic violence, andreproductive health disparities affecting local women.

This year, the Orange County Women's Health Project is partnering with three OC universities:

Chapman University - Crean College of Health & Behavioral Sciences
California State University, Fullerton - Health Promotion Research Institute
University of California, Irvine - Initiative to End Family Violence

Together, we will feature – for the first-time ever – innovative women's health research and pilot projects happening here in the county. A brief description of scheduled presentations is enclosed.

The Summit, the only women's health conference for professionals in the region, is uniquely positioned to reach a diverse audience of practitioners, researchers, and policymakers. If you are interested in sponsoring this important event, please submit the enclosed sponsorship form by Sept. 16, 2016 to be recognized in our printed materials.

If you have any questions, please contact me at (949) 246-6404 or Susan Winterhoff at Charitable Ventures of Orange County at (714) 597-6630 x105. Otherwise, thank you for your support;we look forward to seeing you on Oct. 21.

Sincerely yours,

Allyson W. Sonenshine, JD
Project Director, Orange County Women's Health Project

Orange County
WOMEN'S HEALTH PROJECT

SCHEDULED PRESENTATIONS*
4th ORANGE COUNTY WOMEN'S HEALTH SUMMIT

SESSION 1 – BREAST & CERVICAL CANCER

- Assessing risk for breast cancer among low-income women of color under 40 in OC
  Karen Herold, DNP, FNP-BC, WHCNP-BC – Hoag Memorial Hospital Presbyterian
- Developing HPV vaccination narratives for ethnically diverse patients
  Suellen Hopfer, PhD, CGC – UC Irvine
- Increasing PAP testing among Pacific Islanders in Orange County
  Sora Park Tanjasiri, DrPH, MPH – CSU Fullerton
- Improving adherence to adjuvant aromatase inhibitor hormonal therapy
  Souhiela Fawaz, PhD – Chapman University

SESSION 2 – HEALTH & DOMESTIC VIOLENCE

- Intimate Partner Violence (IPV) screening for pregnant patients in OC healthcare setting
  Liza Eshilian-Oates, MD – Kaiser Permanente Orange County
- Identifying and assessing IPV by Nurse-Family Partnership® home visitors in OC
  Marcia Salomon, RN, MSW, MPH – Orange County Health Care Agency
- Understanding dating violence among Orange County youth
  Michelle Miller-Day, PhD, MFA – Chapman University
- Addressing mental health & substance use/abuse needs of DV survivors in OC
  Allyson Sonenshine, JD – Orange County Women's Health Project

SESSION 3 – EMERGING ISSUES IN WOMEN'S HEALTH

- Tracking e-cigarette and tobacco use among adolescent girls in Orange County
  Georgiana Bostean, PhD – Chapman University
- Identifying transgender women health disparities in Orange County
  Tony Viramontes – LGBT Center of Orange County
- Understanding breastfeeding gaps between different ethnic groups in hospitals
  Jennifer Hahn-Holbrook, PhD – Chapman University
- Preventing excessive gestational weight gain among WIC clients in Orange County
  Maria Koleilat, DrPH, MPH – CSU Fullerton

* Some presentation titles have been abbreviated.

1505 E. 17th Street, Ste. 101 • Santa Ana, CA • 92705 • (714) 619-8419 Phone • (714) 647-0901 Fax • www.ocwomenshealth.org

Orange County
WOMEN'S HEALTH PROJECT

SPONSORSHIP FORM – 2016 ORANGE COUNTY WOMEN'S HEALTH SUMMIT

Deadline for Publication in the Health Summit Program is Sept. 16, 2016

Name: _____ Title: _____

Organization: _____

Address: _____

Phone: _____ Email: _____

How Do You Wish To Be Recognized: _____

PLEASE SELECT SPONSORSHIP LEVEL:

☐ **Women's Health Champion - $10,000**
- Registration and reserved seating for 12 guests
- Logo on Health Summit marketing materials and program
- Exhibit table and opportunity to distribute literature to participants

☐ **Women's Health Guardian - $5,000**
- Registration and reserved seating for 6 guests
- Logo on Health Summit marketing materials and program
- Exhibit table and opportunity to distribute literature to participants

☐ **Women's Health Advocate - $2,500**
- Registration and reserved seating for 4 guests
- Logo on Health Summit marketing materials and program
- Exhibit table and opportunity to distribute literature to participants

☐ **Women's Health Activist - $1,000**
- Registration and reserved seating for 2 guests
- Logo on Health Summit marketing materials and program
- Exhibit table and opportunity to distribute literature to participants

AND/OR simply make a DONATION in this amount: _____

Please make check payable to "Charitable Ventures of Orange County – OCWHP" and mail to:

Orange County Women's Health Project
c/o Charitable Ventures of Orange County
Attn: Susan Winterhoff
1505 E. 17th Street, Ste 101
Santa Ana, CA 92705
(714) 597-6630 Phone (x105)
(714) 647-0901 Fax
Susan.Winterhoff@CharitableVenturesOC.org

Questions:
Allyson Sonenshine, Project Director, OCWHP
(949) 246-6404 / sonenshine@ocwomenshealth.org

Sydney Minchin, Project Assistant, OCWHP
(714) 619-8419 / minchin@ocwomenshealth.org

Good morning Debra and Cathy:

I am writing to let you know about our upcoming Southern California Fall Conference and Annual Meeting to be held **Nov. 16-18 at the Marriott Suites Hotel in Anaheim**. Our theme for the year is "**The Quality Imperative.**" We expect record attendance including our faithful CAADS members and MCO partners, potential new providers, exhibitors, and state personnel.

We have greatly appreciated your past financial support in bringing excellent educational content to the provider and managed care communities, and invite you to be a sponsor for this Fall conference.

Attached is the **sponsorship flyer** with the various levels of sponsorship recognition and benefits.

We are excited about the exceptional line up of speakers and relevant topics such as motivational interviewing, non-pharmaceutical approaches to pain, person-centered care, dementia and mindfulness, Department of Aging updates, keynote presenter **Dr. Tsai with the LA County** Substance Abuse Prevention and Control (SAPC) program, and training on CBAS documentation.

The **deadline** to be featured as a sponsor in the conference brochure is **September 9th.** If a decision cannot be made until a later time, we would still be able to include CalOptima as a sponsor in our email reminders, in the final brochure, and at the conference itself if we receive the signed sponsor form on or before September 9.

We value the partnership that CalOptima continues to nurture with our CBAS sites and with us here at CAADS and ALE. We look forward to seeing you soon!

All my best,
Lydia

Lydia Missaelides, MHA ~ Executive Director
California Association for Adult Day Services
Alliance for Leadership and Education
1107 9th Street, Suite 701 ~ Sacramento, CA 95814
Tel: 916.552.7400 FAX: 866.725.3123 www.caads.org
Adult Day Services: Where Care & Community Meet

Save-the Dates! **| NOV 16-18, 2016 ~ CAADS Fall Conference and Annual Meeting ~** ***THE QUALITY IMPERATIVE*** **| Mariott Suites Hotel, Anaheim**

Back to Agenda

Sponsorship Opportunities

A Great Way to Support Adult Day Services!

2016 CAADS FALL CONFERENCE & ANNUAL MEETING

THE QUALITY IMPERATIVE

November 16-18, 2016
Anaheim Marriott Suites
Garden Grove, CA

Pledge your support by **September 9, 2016,** to be listed in Conference marketing materials and/or by **October 28, 2016,** to be listed in on-site program. Questions? Call CAADS: **(916) 552-7400.**

☐ **BRONZE*** (General Support) ..... $ 300

- Listing in on-site program
- Attendee list with names & addresses

☐ **SILVER*** (Education Course) ..... $ 500

- Listing on Education Course signage
- Listing in on-site program
- Attendee list with names & addresses

☐ **GOLD*** (Refreshments) ..... $ 1,000

- ☐ Thursday Continental Breakfast
- ☐ Thursday PM Break
- ☐ Friday Continental Breakfast
- ☐ Friday PM Break

- **One-Day COMP Registration** for Nov 17 or 18, for **one (1) person**, including meal functions
- Listing with logo on Refreshment signage
- Listing with logo in on-site program
- Attendee list with names & addresses

☒ **PLATINUM*** (Special Event) ..... $ 2,000

- ☐ Wednesday *Members Only* Luncheon
- ☐ Thursday Conference Luncheon
- ☐ Thursday Exhibits Reception
- ☐ Friday Conference Luncheon
- ☐ Conference Badge Holders & Lanyards

- **Two-Day COMP Registration** for Nov 17 & 18, for **one (1) person**, including meal functions
- **Your Company's Giveaway Item** *(optional)*
- Listing with logo on Special Event signage
- Listing with logo in on-site program
- Attendee list with names & addresses

☐ **DIAMOND*** (Keynote Speaker) ..... $ 4,000

Diamond Deadline: September 26, 2016

- **Two-Day COMP Exhibit Table** (Nov 16 & 17), for **one (1) person**, including meal functions
- **Two- or Three-Day COMP Registration** for **one (1) person**, including meal functions *(Member: Nov 16, 17, 18; Non-member: Nov 17 & 18)*
- **Conference Tote Bags with Company Logo**
- Listing with logo on Keynote Session signage
- Listing with logo in on-site program
- Attendee list with names & addresses

Please check the box next to your sponsorship preference, and complete the contact and payment information.

**As a participating sponsor, we hereby agree to assume financial responsibility as indicated. It is further acknowledged that the person signing below has authority to do so on behalf of the participating organization.*
Sponsorships confirmed based on date and time payment and form are received by CAADS.

DEADLINES

September 9, 2016
to be listed in Conference marketing materials

September 26, 2016
Diamond Sponsors
(for time to order Tote Bags)

October 28, 2016
to be listed in Conference program

Organization's name (as you want it to appear in print)

Street Address

City, State, Zip — Web Address

Tel — Fax — Email

Print Name & Title — Signature

Make check payable to CAADS, or complete the credit card information below:

☐ Visa ☐ MasterCard ☐ Discover
(Sorry, we do **NOT** accept American Express)

Total Amount Enclosed: $_____

Credit Card Number — Expiration Date

Name as it appears on the card

Cardholder's Billing Address — Zip Code

Signature — Date

Submit completed form and payment to CAADS by Mail, Email or Fax:

CAADS
1107 9th Street, Suite 701
Sacramento, CA 95814-3610

Tel: **916-552-7400**
Fax: **866-725-3123**
Email: **caads@caads.org**

C A A D S
California Association for Adult Day Services

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2016 CAADS Fall Conference & Annual Meeting

Target Your Sales to Nearly 200 Decision Makers!

- Adult Day Programs (non-medical model) | Adult Day Health Care / Community Based Adult Services (medical model) Alzheimer's Day Care Resource Centers (medical and non-medical models) | Medi-Cal Managed Care Plans
- Owners, Executive Directors, Administrators, Finance Staff, Program Directors, Nurses, Social Workers, Therapists, and Others
- Experienced, New and Pre-Licensed Providers
- For-Profit and Non-Profit Providers serving adults with Alzheimer's and related dementia, chronic illnesses, frail elders, persons with developmental disabilities and individuals with mental health challenges.

Exhibit with CAADS in Southern California!

- Market Your Products / Services
- Meet Decision Makers
- Reinforce Customer Loyalty
- Establish New Markets
- Support Local Dealers / Distributors
- Introduce New Products/Services

Great Value and Benefits!

- CAADS Members: **$625/$525*** per table-top
- Non-members: **$975/$875*** per table-top

** Return signed contract and full payment by 5:00 PM, September 9, 2016, and get a $100 discount PLUS additional marketing exposure!*

Table-Top Space Selection: Approximately 30 days prior to event, exhibitors will receive the layout of exhibit tables. Table assignments will be confirmed based on the date signed contract with full payment was received by CAADS. ***CAADS management reserves the right to change space designations as deemed in the best interest of the event.***

Exhibit Space Rental Fee Includes:

- **One 6' x 18" (schoolroom size, not 6' x 30") skirted table-top** and **two chairs**
- **Thursday Reception** — The perfect opportunity to be in the center of it all while attendees mingle and network among the exhibits and vie for gift baskets to be raffled.
- **One free "Exhibitor Registration" per table**, to attend Wednesday and Thursday all day including the Exhibit Reception & Gift Basket Raffles. Note: Non-Member exhibitors will not be able to attend *Members Only* portion on Wednesday. *(Each additional exhibit representative is required to pay a $185 "Exhibitor Registration" fee)*
- **Free Listing in Conference marketing pieces** IF signed contract & full payment received by September 9, 2016
- **Free Listing in Program distributed on-site**, IF signed contract & full payment received by October 28, 2016
- **Free List of Pre-Registrants prior to event** (name, title, company, address, email, telephone)
- **Free Labels and List of ALL REGISTRANTS** after event (name, title, company, address, email, telephone)

Space Selection Based on Date Contract with Full Payment is Received

Complete the enclosed contract and send it with payment by check or credit card to:

California Association for Adult Day Services (CAADS)
1107 9th Street, Suite 701 | Sacramento, CA 95814
OR FAX to (866) 725-3123

Questions/Assistance: Please contact CAADS at **(916) 552-7400** or email **caads@caads.org**

Exhibit Dates: Wednesday & Thursday, November 16 & 17, 2016
ANAHEIM MARRIOTT SUITES | 12015 HARBOR BOULEVARD | GARDEN GROVE, CA 92840-4001

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CALOPTIMA BOARD ACTION AGENDA REFERRAL

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

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

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

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

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

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

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

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

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

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

Fiscal Impact

The fiscal impact of this recommended action is budget neutral. Unspent budgeted funds for salaries and benefits approved in the CalOptima FY 2016-17 Operating Budget on June 2, 2016, will fund the total cost of $9,032.11. This estimate includes market adjustments effective on or after the pay period beginning September 4, 2016. The annual impact of the recommended action is estimated at $11,182.61.

Market Adjustments

Staff recommends salary adjustments for two (2) positions effective on or after the pay period beginning September 4, 2016. This impacts employees in the following departments: one (1) in Encounters; and one (1) in PACE. The recommended increase is to attract and retain well qualified staff. Pursuant to the Compensation Administration Guidelines adopted as part of CalOptima Policy GA. 8057: Compensation Program, approval by the Board of Directors is required as part of the process for market adjustments, which are not part of the regular merit process. Recommendations are made based on extensive review by CalOptima's Resources Workgroup consistent with the market adjustment process to ensure that CalOptima remains competitive with market trends and meets its ongoing obligation to provide structure and clarity on employment matters, consistent with applicable federal, state, and local laws and regulations.

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Concurrence
Gary Crockett, Chief Counsel

Attachments
1. Resolution No. 16-0901, Approve Updated Human Resources Policies
2. Revised CalOptima Policy GA.8058: Salary Schedule (redlined and clean versions) – with revised Attachment
3. Summary of Changes to the Salary Schedule, Market Adjustments and Executive Salary

/s/ Michael Schrader — *8/25/2016*
Authorized Signature — **Date**

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RESOLUTION NO. 16-0901

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

APPROVE UPDATED HUMAN RESOURCES POLICY

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

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

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

NOW, THEREFORE, BE IT RESOLVED:

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

APPROVED AND ADOPTED by the Board of Directors of the Orange County Health Authority, d.b.a., CalOptima this 1st day of September, 2016.

AYES:
NOES:
ABSENT:
ABSTAIN:

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

Attest:

/s/_____
Suzanne Turf, Clerk of the Board

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Policy #:	GA.8058
Title:	**Salary Schedule**
Department:	Human Resources
Section:	Not Applicable
CEO Approval:	Michael Schrader
Effective Date:	05/01/14
Last Review Date:	0~~8~~9/01~~4~~/16
Last Revised Date:	09~~8~~/01~~4~~/16

~~*Board Approved Policy*~~

I. PURPOSE

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

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

II. POLICY

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

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

2. Identification of position titles for every employee position;

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

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

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

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

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

and

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

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

III. PROCEDURE

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

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

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

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

IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of 098/014/16)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

Not Applicable

VII. BOARD ACTIONS

A. 09/01/16: Regular Meeting of the CalOptima Board of Directors
~~A.~~B. 08/04/16: Regular Meeting of the CalOptima Board of Directors
~~B.~~C. 06/02/16: Regular Meeting of the CalOptima Board of Directors
~~C.~~D. 03/03/16: Regular Meeting of the CalOptima Board of Directors
~~D.~~E. 12/03/15: Regular Meeting of the CalOptima Board of Directors
~~E.~~F. 10/01/15: Regular Meeting of the CalOptima Board of Directors
~~F.~~G. 06/04/15: Regular Meeting of the CalOptima Board of Directors

VIII. REVIEW/REVISION HISTORY

Version	Date	Policy Number	Policy Title
Effective	05/01/2014	GA.8057	Compensation Program and Salary Schedule
Revised	08/07/2014	GA.8057	Compensation Program and Salary Schedule

Version	Date	Policy Number	Policy Title
Revised	11/06/2014	GA.8057	Compensation Program and Salary Schedule
Revised	12/04/2014	GA.8057	Compensation Program and Salary Schedule
Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule
Revised	06/04/2015	GA.8058	Salary Schedule
Revised	10/01/2015	GA.8058	Salary Schedule
Revised	12/03/2015	GA.8058	Salary Schedule
Revised	03/03/2016	GA.8058	Salary Schedule
Revised	06/02/2016	GA.8058	Salary Schedule
Revised	08/04/2016	GA.8058	Salary Schedule
Revised	09/01/2016	GA.8058	Salary Schedule

IX. GLOSSARY

Not Applicable

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

I. PURPOSE

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

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

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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.

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IV. ATTACHMENTS

A. CalOptima - Salary Schedule (Revised as of 09/01/16)

V. REFERENCES

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

VI. REGULATORY AGENCY APPROVALS

Not Applicable

VII. BOARD ACTIONS

A. 09/01/16: Regular Meeting of the CalOptima Board of Directors
B. 08/04/16: Regular Meeting of the CalOptima Board of Directors
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Revised	03/05/2015	GA.8057	Compensation Program and Salary Schedule
Revised	06/04/2015	GA.8058	Salary Schedule
Revised	10/01/2015	GA.8058	Salary Schedule
Revised	12/03/2015	GA.8058	Salary Schedule
Revised	03/03/2016	GA.8058	Salary Schedule
Revised	06/02/2016	GA.8058	Salary Schedule
Revised	08/04/2016	GA.8058	Salary Schedule
Revised	09/01/2016	GA.8058	Salary Schedule

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IX. GLOSSARY

Not Applicable

CalOptima - Annual Base Salary Schedule - Revised September 1, 2016
Effective as of May 1, 2014

	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Accountant	K	39	$47,112	$61,360	$75,504	
	Accountant Int	L	TBD	$54,288	$70,512	$86,736	New Position
	Accountant Sr	M	68	$62,400	$81,120	$99,840	
	Accounting Clerk	I	334	$37,128	$46,384	$55,640	
	Actuarial Analyst	L	558	$54,288	$70,512	$86,736	
	Actuarial Analyst Sr	M	559	$62,400	$81,120	$99,840	
	Actuary	O	357	$82,576	$107,328	$131,976	
	Administrative Assistant	H	19	$33,696	$42,224	$50,648	
	Analyst	K	562	$47,112	$61,360	$75,504	
	Analyst Int	L	563	$54,288	$70,512	$86,736	
	Analyst Sr	M	564	$62,400	$81,120	$99,840	
	Applications Analyst	K	232	$47,112	$61,360	$75,504	
	Applications Analyst Int	L	233	$54,288	$70,512	$86,736	
	Applications Analyst Sr	M	298	$62,400	$81,120	$99,840	
	Associate Director Customer Service	O	593	$82,576	$107,328	$131,976	
	Associate Director Information Services	Q	557	$114,400	$154,440	$194,480	
	Auditor	K	565	$47,112	$61,360	$75,504	
	Auditor Sr	L	566	$54,288	$70,512	$86,736	
	Behavioral Health Manager	N	383	$71,760	$93,184	$114,712	
	Biostatistics Manager	N	418	$71,760	$93,184	$114,712	
	Board Services Specialist	J	435	$40,976	$53,352	$65,624	
	Business Analyst	J	40	$40,976	$53,352	$65,624	
	Business Analyst Sr	M	611	$62,400	$81,120	$99,840	
	Business Systems Analyst Sr	M	69	$62,400	$81,120	$99,840	
	Buyer	J	29	$40,976	$53,352	$65,624	
	Buyer Int	K	49	$47,112	$61,360	$75,504	
	Buyer Sr	L	67	$54,288	$70,512	$86,736	
	Care Transition Intervention Coach (RN)	N	417	$71,760	$93,184	$114,712	
	Certified Coder	K	399	$47,112	$61,360	$75,504	
	Change Control Administrator	L	499	$54,288	$70,512	$86,736	
	Change Control Administrator Int	M	500	$62,400	$81,120	$99,840	
	Change Management Analyst Sr	N	465	$71,760	$93,184	$114,712	
**	Chief Counsel	T	132	$197,704	$266,968	$336,024	
**	Chief Executive Officer	V	138	$319,740	$431,600	$543,600	
**	Chief Financial Officer	U	134	$237,224	$320,216	$403,312	
**	Chief Information Officer	T	131	$197,704	$266,968	$336,024	
**	Chief Medical Officer	U	137	$237,224	$320,216	$403,312	
**	Chief Operating Officer	U	136	$237,224	$320,216	$403,312	
	Claims - Lead	J	574	$40,976	$53,352	$65,624	
	Claims Examiner	H	9	$33,696	$42,224	$50,648	
	Claims Examiner - Lead	J	236	$40,976	$53,352	$65,624	
	Claims Examiner Sr	I	20	$37,128	$46,384	$55,640	
	Claims QA Analyst	I	28	$37,128	$46,384	$55,640	
	Claims QA Analyst Sr.	J	540	$40,976	$53,352	$65,624	

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	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Claims Recovery Specialist	I	283	$37,128	$46,384	$55,640	
	Claims Resolution Specialist	I	262	$37,128	$46,384	$55,640	
	Clerk of the Board	O	59	$82,576	$107,328	$131,976	
	Clinical Auditor	M	567	$62,400	$81,120	$99,840	
	Clinical Auditor Sr	N	568	$71,760	$93,184	$114,712	
	Clinical Pharmacist	P	297	$95,264	$128,752	$162,032	
	Clinical Systems Administrator	M	607	$62,400	$81,120	$99,840	
	Clinician (Behavioral Health)	M	513	$62,400	$81,120	$99,840	
	Communications Specialist	J	188	$40,976	$53,352	$65,624	
	Community Partner	K	575	$47,112	$61,360	$75,504	
	Community Partner Sr	L	612	$54,288	$70,512	$86,736	
	Community Relations Specialist	J	288	$40,976	$53,352	$65,624	
	Compliance Claims Auditor	K	222	$47,112	$61,360	$75,504	
	Compliance Claims Auditor Sr	L	279	$54,288	$70,512	$86,736	
	Contract Administrator	M	385	$62,400	$81,120	$99,840	
	Contracts Manager	N	207	$71,760	$93,184	$114,712	
	Contracts Specialist	K	257	$47,112	$61,360	$75,504	
	Contracts Specialist Int	L	469	$54,288	$70,512	$86,736	
	Contracts Specialist Sr	M	331	$62,400	$81,120	$99,840	
*	Controller	Q	464	$114,400	$154,440	$194,480	
	Credentialing Coordinator	J	41	$40,976	$53,352	$65,624	
	Credentialing Coordinator - Lead	J	510	$40,976	$53,352	$65,624	
	Customer Service Coordinator	J	182	$40,976	$53,352	$65,624	
	Customer Service Rep	H	5	$33,696	$42,224	$50,648	
	Customer Service Rep - Lead	J	482	$40,976	$53,352	$65,624	
	Customer Service Rep Sr	I	481	$37,128	$46,384	$55,640	
	Data Analyst	K	337	$47,112	$61,360	$75,504	
	Data Analyst Int	L	341	$54,288	$70,512	$86,736	
	Data Analyst Sr	M	342	$62,400	$81,120	$99,840	
	Data and Reporting Analyst - Lead	O	TBD	$82,576	$107,328	$131,976	
	Data Entry Tech	F	3	$27,872	$34,840	$41,808	
	Data Warehouse Architect	O	363	$82,576	$107,328	$131,976	
	Data Warehouse Programmer/Analyst	O	364	$82,576	$107,328	$131,976	
	Data Warehouse Project Manager	O	362	$82,576	$107,328	$131,976	
	Data Warehouse Reporting Analyst	N	412	$71,760	$93,184	$114,712	
	Data Warehouse Reporting Analyst Sr	O	522	$82,576	$107,328	$131,976	
	Database Administrator	M	90	$62,400	$81,120	$99,840	
	Database Administrator Sr	O	179	$82,576	$107,328	$131,976	
**	Deputy Chief Counsel	S	160	$164,736	$222,352	$280,072	
**	Deputy Chief Medical Officer	T	561	$197,704	$266,968	$336,024	
*	Director Accounting	P	122	$95,264	$128,752	$162,032	
*	Director Applications Management	R	170	$137,280	$185,328	$233,376	
*	Director Audit & Oversight	Q	546	$114,400	$154,440	$194,480	
*	Director Behavioral Health Services	P	392	$95,264	$128,752	$162,032	

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* Director Budget and Procurement	Q	527	$114,400	$154,440	$194,480	
* Director Business Development	P	351	$95,264	$128,752	$162,032	
* Director Business Integration	Q	543	$114,400	$154,440	$194,480	
* Director Case Management	Q	318	$114,400	$154,440	$194,480	
* Director Claims Administration	P	112	$95,264	$128,752	$162,032	
* Director Clinical Outcomes	Q	602	$114,400	$154,440	$194,480	
* Director Clinical Pharmacy	R	129	$137,280	$185,328	$233,376	
* Director Coding Initiatives	P	375	$95,264	$128,752	$162,032	
* Director Communications	P	361	$95,264	$128,752	$162,032	
* Director Community Relations	P	292	$95,264	$128,752	$162,032	
* Director Configuration & Coding	Q	596	$114,400	$154,440	$194,480	
* Director Contracting	P	184	$95,264	$128,752	$162,032	
* Director COREC	Q	369	$114,400	$154,440	$194,480	
* Director Customer Service	P	118	$95,264	$128,752	$162,032	
* Director Electronic Business	P	358	$95,264	$128,752	$162,032	
* Director Enterprise Analytics	Q	520	$114,400	$154,440	$194,480	
* Director Facilities	P	428	$95,264	$128,752	$162,032	
* Director Finance & Procurement	P	157	$95,264	$128,752	$162,032	
* Director Financial Analysis	R	374	$137,280	$185,328	$233,376	
* Director Financial Compliance	P	460	$95,264	$128,752	$162,032	
* Director Fraud Waste & Abuse and Privacy	Q	581	$114,400	$154,440	$194,480	
* Director Government Affairs	P	277	$95,264	$128,752	$162,032	
* Director Grievance & Appeals	P	528	$95,264	$128,752	$162,032	
* Director Health Education & Disease Management	Q	150	$114,400	$154,440	$194,480	
* Director Health Services	Q	328	$114,400	$154,440	$194,480	
* Director Human Resources	Q	322	$114,400	$154,440	$194,480	
* Director Information Services	R	547	$137,280	$185,328	$233,376	
* Director Long Term Support Services	Q	128	$114,400	$154,440	$194,480	
* Director Medi-Cal Plan Operations	P	370	$95,264	$128,752	$162,032	
* Director Network Management	P	125	$95,264	$128,752	$162,032	
* Director OneCare Operations	P	425	$95,264	$128,752	$162,032	
* Director Organizational Training & Education	P	579	$95,264	$128,752	$162,032	
* Director PACE Program	Q	449	$114,400	$154,440	$194,480	
* Director Process Excellence	Q	447	$114,400	$154,440	$194,480	
* Director Program Implementation	Q	489	$114,400	$154,440	$194,480	
* Director Project Management	Q	447	$114,400	$154,440	$194,480	
* Director Provider Data Quality	Q	TBD	$114,400	$154,440	$194,480	
* Director Provider Services	P	597	$95,264	$128,752	$162,032	
* Director Public Policy	P	459	$95,264	$128,752	$162,032	
* Director Quality (LTSS)	Q	613	$114,400	$154,440	$194,480	
* Director Quality Analytics	Q	591	$114,400	$154,440	$194,480	
* Director Quality Improvement	Q	172	$114,400	$154,440	$194,480	
* Director Regulatory Affairs and Compliance	Q	625	$114,400	$154,440	$194,480	
* Director Strategic Development	P	121	$95,264	$128,752	$162,032	

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*	Director Systems Development	R	169	$137,280	$185,328	$233,376	
*	Director Utilization Management	Q	265	$114,400	$154,440	$194,480	
	Disease Management Coordinator	M	70	$62,400	$81,120	$99,840	
	Disease Management Coordinator - Lead	M	472	$62,400	$81,120	$99,840	
	EDI Project Manager	O	403	$82,576	$107,328	$131,976	
	Enrollment Coordinator (PACE)	K	441	$47,112	$61,360	$75,504	
	Enterprise Analytics Manager	P	582	$95,264	$128,752	$162,032	
	Executive Assistant	K	339	$47,112	$61,360	$75,504	
	Executive Assistant to CEO	L	261	$54,288	$70,512	$86,736	
**	Executive Director, Behavioral Health Integration	S	614	$164,736	$222,352	$280,072	
**	Executive Director Clinical Operations	S	501	$164,736	$222,352	$280,072	
**	Executive Director Compliance	S	493	$164,736	$222,352	$280,072	
**	Executive Director Human Resources	S	494	$164,736	$222,352	$280,072	
**	Executive Director Network Operations	S	632	$164,736	$222,352	$280,072	
**	Executive Director Operations	S	276	$164,736	$222,352	$280,072	
**	Executive Director Program Implementation	S	490	$164,736	$222,352	$280,072	
**	Executive Director Public Affairs	S	290	$164,736	$222,352	$280,072	
**	Executive Director Quality Analytics	S	601	$164,736	$222,352	$280,072	
	Facilities & Support Services Coord - Lead	J	631	$40,976	$53,352	$65,624	
	Facilities & Support Services Coordinator	J	10	$40,976	$53,352	$65,624	
	Facilities Coordinator	J	438	$40,976	$53,352	$65,624	
	Financial Analyst	L	51	$54,288	$70,512	$86,736	
	Financial Analyst Sr	M	84	$62,400	$81,120	$99,840	
	Financial Reporting Analyst	L	475	$54,288	$70,512	$86,736	
	Gerontology Resource Coordinator	M	204	$62,400	$81,120	$99,840	
	Graphic Designer	M	387	$62,400	$81,120	$99,840	
	Grievance & Appeals Nurse Specialist	N	226	$71,760	$93,184	$114,712	
	Grievance Resolution Specialist	J	42	$40,976	$53,352	$65,624	
	Grievance Resolution Specialist - Lead	L	590	$54,288	$70,512	$86,736	
	Grievance Resolution Specialist Sr	K	589	$47,112	$61,360	$75,504	
	HCC Coding Specialist	K	405	$47,112	$61,360	$75,504	
	HCC Coding Specialist Sr	L	615	$54,288	$70,512	$86,736	
	Health Coach	M	556	$62,400	$81,120	$99,840	
	Health Educator	K	47	$47,112	$61,360	$75,504	
	Health Educator Sr	L	355	$54,288	$70,512	$86,736	
	Health Network Liaison Specialist (RN)	N	524	$71,760	$93,184	$114,712	
	Health Network Oversight Specialist	M	323	$62,400	$81,120	$99,840	
	HEDIS Case Manager	N	443	$71,760	$93,184	$114,712	
	HEDIS Case Manager (LVN)	M	552	$62,400	$81,120	$99,840	
	Help Desk Technician	J	571	$40,976	$53,352	$65,624	
	Help Desk Technician Sr	K	573	$47,112	$61,360	$75,504	
	HR Assistant	I	181	$37,128	$46,384	$55,640	
	HR Business Partner	M	584	$62,400	$81,120	$99,840	
	HR Coordinator	J	316	$40,976	$53,352	$65,624	

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HR Representative	L	278	$54,288	$70,512	$86,736	
HR Representative Sr	M	350	$62,400	$81,120	$99,840	
HR Specialist	K	505	$47,112	$61,360	$75,504	
HR Specialist Sr	L	608	$54,288	$70,512	$86,736	
HRIS Analyst Sr	M	468	$62,400	$81,120	$99,840	
ICD-10 Project Manager	O	411	$82,576	$107,328	$131,976	
Infrastructure Systems Administrator	J	541	$40,976	$53,352	$65,624	
Infrastructure Systems Administrator Int	K	542	$47,112	$61,360	$75,504	
Intern	E	237	$25,272	$31,720	$37,960	
Investigator Sr	L	553	$54,288	$70,512	$86,736	
IS Coordinator	J	365	$40,976	$53,352	$65,624	
IS Project Manager	O	424	$82,576	$107,328	$131,976	
IS Project Manager Sr	P	509	$95,264	$128,752	$162,032	
IS Project Specialist	M	549	$62,400	$81,120	$99,840	
IS Project Specialist Sr	N	550	$71,760	$93,184	$114,712	
Kitchen Assistant	E	585	$25,272	$31,720	$37,960	
Legislative Program Manager	N	330	$71,760	$93,184	$114,712	
Licensed Clinical Social Worker	L	598	$54,288	$70,512	$86,736	
Litigation Support Specialist	M	588	$62,400	$81,120	$99,840	
LVN (PACE)	M	533	$62,400	$81,120	$99,840	
Mailroom Clerk	E	1	$25,272	$31,720	$37,960	
Manager Accounting	N	98	$71,760	$93,184	$114,712	
Manager Actuary	P	453	$95,264	$128,752	$162,032	
Manager Applications Management	P	271	$95,264	$128,752	$162,032	
Manager Audit & Oversight	O	539	$82,576	$107,328	$131,976	
Manager Behavioral Health	O	633	$82,576	$107,328	$131,976	
Manager Business Integration	O	544	$82,576	$107,328	$131,976	
Manager Case Management	O	270	$82,576	$107,328	$131,976	
Manager Claims	N	92	$71,760	$93,184	$114,712	
Manager Clinic Operations	O	551	$82,576	$107,328	$131,976	
Manager Clinical Pharmacist	Q	296	$114,400	$154,440	$194,480	
Manager Coding Quality	N	382	$71,760	$93,184	$114,712	
Manager Communications	N	398	$71,760	$93,184	$114,712	
Manager Community Relations	M	384	$62,400	$81,120	$99,840	
Manager Concurrent Review	O	320	$82,576	$107,328	$131,976	
Manager Contracting	O	329	$82,576	$107,328	$131,976	
Manager Creative Branding	N	430	$71,760	$93,184	$114,712	
Manager Cultural & Linguistic	N	349	$71,760	$93,184	$114,712	
Manager Customer Service	N	94	$71,760	$93,184	$114,712	
Manager Decision Support	O	454	$82,576	$107,328	$131,976	
Manager Disease Management	O	372	$82,576	$107,328	$131,976	
Manager Electronic Business	O	422	$82,576	$107,328	$131,976	
Manager Employment Services	N	420	$71,760	$93,184	$114,712	
Manager Encounters	N	516	$71,760	$93,184	$114,712	

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Manager Environmental Health & Safety	N	495	$71,760	$93,184	$114,712	
Manager Facilities	N	209	$71,760	$93,184	$114,712	
Manager Finance	N	148	$71,760	$93,184	$114,712	
Manager Financial Analysis	O	356	$82,576	$107,328	$131,976	
Manager Government Affairs	N	437	$71,760	$93,184	$114,712	
Manager Grievance & Appeals	N	426	$71,760	$93,184	$114,712	
Manager Health Education	N	173	$71,760	$93,184	$114,712	
Manager HEDIS	O	427	$82,576	$107,328	$131,976	
Manager Human Resources	O	526	$82,576	$107,328	$131,976	
Manager Information Services	P	560	$95,264	$128,752	$162,032	
Manager Information Technology	P	110	$95,264	$128,752	$162,032	
Manager Integration Government Liaison	N	455	$71,760	$93,184	$114,712	
Manager Long Term Support Services	O	200	$82,576	$107,328	$131,976	
Manager Marketing & Enrollment (PACE)	O	414	$82,576	$107,328	$131,976	
Manager Medical Data Management	O	519	$82,576	$107,328	$131,976	
Manager Medi-Cal Program Operations	N	483	$71,760	$93,184	$114,712	
Manager Member Liaison Program	N	354	$71,760	$93,184	$114,712	
Manager Member Outreach & Education	N	616	$71,760	$93,184	$114,712	
Manager Member Outreach Education & Provider Relations	O	576	$82,576	$107,328	$131,976	
Manager MSSP	O	393	$82,576	$107,328	$131,976	
Manager OneCare Clinical	O	359	$82,576	$107,328	$131,976	
Manager OneCare Customer Service	N	429	$71,760	$93,184	$114,712	
Manager OneCare Regulatory	N	197	$71,760	$93,184	$114,712	
Manager OneCare Sales	O	248	$82,576	$107,328	$131,976	
Manager Outreach & Enrollment	N	477	$71,760	$93,184	$114,712	
Manager PACE Center	O	432	$82,576	$107,328	$131,976	
Manager Payroll & Benefits	N	144	$71,760	$93,184	$114,712	
Manager Pharmacy Operations	N	396	$71,760	$93,184	$114,712	
Manager Prior Authorizations	O	269	$82,576	$107,328	$131,976	
Manager Process Excellence	O	622	$82,576	$107,328	$131,976	
Manager Program Implementation	O	488	$82,576	$107,328	$131,976	
Manager Project Management	O	532	$82,576	$107,328	$131,976	
Manager Provider Data Management Services	N	TBD	$71,760	$93,184	$114,712	
Manager Provider Network	O	191	$82,576	$107,328	$131,976	
Manager Provider Relations	N	171	$71,760	$93,184	$114,712	
Manager Provider Services	O	TBD	$82,576	$107,328	$131,976	
Manager Purchasing	N	275	$71,760	$93,184	$114,712	
Manager QI Initiatives	N	433	$71,760	$93,184	$114,712	
Manager Quality Analytics	O	617	$82,576	$107,328	$131,976	
Manager Quality Improvement	O	104	$82,576	$107,328	$131,976	
Manager Regulatory Affairs and Compliance	O	626	$82,576	$107,328	$131,976	
Manager Reporting & Financial Compliance	O	572	$82,576	$107,328	$131,976	
Manager Strategic Development	O	603	$82,576	$107,328	$131,976	
Manager Strategic Operations	N	446	$71,760	$93,184	$114,712	

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	Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
	Manager Systems Development	P	515	$95,264	$128,752	$162,032	
	Manager Utilization Management	O	250	$82,576	$107,328	$131,976	
	Marketing and Outreach Specialist	J	496	$40,976	$53,352	$65,624	
	Medical Assistant	H	535	$33,696	$42,224	$50,648	
	Medical Authorization Asst	H	11	$33,696	$42,224	$50,648	
	Medical Case Manager	N	72	$71,760	$93,184	$114,712	
	Medical Case Manager (LVN)	L	444	$54,288	$70,512	$86,736	
*	Medical Director	S	306	$164,736	$222,352	$280,072	
	Medical Records & Health Plan Assistant	G	548	$30,576	$38,272	$45,968	
	Medical Records Clerk	E	523	$25,272	$31,720	$37,960	
	Medical Services Case Manager	K	54	$47,112	$61,360	$75,504	
	Member Liaison Specialist	I	353	$37,128	$46,384	$55,640	
	MMS Program Coordinator	K	360	$47,112	$61,360	$75,504	
	Nurse Practitioner (PACE)	P	TBD	$95,264	$128,752	$162,032	New Position
	Occupational Therapist	N	531	$71,760	$93,184	$114,712	
	Occupational Therapist Assistant	M	623	$62,400	$81,120	$99,840	
	Office Clerk	C	335	$21,008	$26,208	$31,408	
	OneCare Operations Manager	O	461	$82,576	$107,328	$131,976	
	OneCare Partner - Sales	K	230	$47,112	$61,360	$75,504	
	OneCare Partner - Sales (Lead)	K	537	$47,112	$61,360	$75,504	
	OneCare Partner - Service	I	231	$37,128	$46,384	$55,640	
	OneCare Partner (Inside Sales)	J	371	$40,976	$53,352	$65,624	
	Outreach Specialist	I	218	$37,128	$46,384	$55,640	
	Paralegal/Legal Secretary	K	376	$47,112	$61,360	$75,504	
	Payroll Specialist	J	554	$40,976	$53,352	$65,624	
	~~Payroll/HRIS Analyst~~	~~K~~	~~286~~	~~$47,112~~	~~$61,360~~	~~$75,504~~	Remove position
	Performance Analyst	L	538	$54,288	$70,512	$86,736	
	Personal Care Attendant	C	485	$21,008	$26,208	$31,408	
	Personal Care Attendant - Lead	E	498	$25,272	$31,720	$37,960	
	Personal Care Coordinator	I	525	$37,128	$46,384	$55,640	
	Pharmacy Resident	K	379	$47,112	$61,360	$75,504	
	Pharmacy Services Specialist	I	23	$37,128	$46,384	$55,640	
	Pharmacy Services Specialist Int	J	35	$40,976	$53,352	$65,624	
	Pharmacy Services Specialist Sr	K	507	$47,112	$61,360	$75,504	
	Physical Therapist	N	530	$71,760	$93,184	$114,712	
	Physical Therapist Assistant	M	624	$62,400	$81,120	$99,840	
	Policy Advisor Sr	O	580	$82,576	$107,328	$131,976	
	Privacy Manager	N	536	$71,760	$93,184	$114,712	
	Process Excellence Manager	O	529	$82,576	$107,328	$131,976	
	Program Assistant	I	24	$37,128	$46,384	$55,640	
	Program Coordinator	I	284	$37,128	$46,384	$55,640	
	Program Development Analyst Sr	M	492	$62,400	$81,120	$99,840	
	Program Manager	M	421	$62,400	$81,120	$99,840	
	Program Manager Sr	O	594	$82,576	$107,328	$131,976	

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	Program Specialist	J	36	$40,976	$53,352	$65,624	
	Program Specialist Int	K	61	$47,112	$61,360	$75,504	
	Program Specialist Sr	L	508	$54,288	$70,512	$86,736	
	Program/Policy Analyst	K	56	$47,112	$61,360	$75,504	
	Program/Policy Analyst Sr	M	85	$62,400	$81,120	$99,840	
	Programmer	L	43	$54,288	$70,512	$86,736	
	Programmer Int	N	74	$71,760	$93,184	$114,712	
	Programmer Sr	O	80	$82,576	$107,328	$131,976	
	Project Manager	M	81	$62,400	$81,120	$99,840	
	Project Manager - Lead	M	467	$62,400	$81,120	$99,840	
	Project Manager Sr	O	105	$82,576	$107,328	$131,976	
	Project Specialist	K	291	$47,112	$61,360	$75,504	
	Project Specialist Sr	L	503	$54,288	$70,512	$86,736	
	Projects Analyst	K	254	$47,112	$61,360	$75,504	
	Provider Enrollment Data Coordinator	I	12	$37,128	$46,384	$55,640	
	Provider Enrollment Data Coordinator Sr	J	586	$40,976	$53,352	$65,624	
	Provider Enrollment Manager	K	190	$47,112	$61,360	$75,504	
	Provider Network Rep Sr	L	391	$54,288	$70,512	$86,736	
	Provider Network Specialist	K	44	$47,112	$61,360	$75,504	
	Provider Network Specialist Sr	L	595	$54,288	$70,512	$86,736	
	Provider Office Education Manager	L	300	$54,288	$70,512	$86,736	
	Provider Relations Rep	K	205	$47,112	$61,360	$75,504	
	Provider Relations Rep Sr	L	285	$54,288	$70,512	$86,736	
	Publications Coordinator	J	293	$40,976	$53,352	$65,624	
	QA Analyst	L	486	$54,288	$70,512	$86,736	
	QA Analyst Sr	N	380	$71,760	$93,184	$114,712	
	QI Nurse Specialist	N	82	$71,760	$93,184	$114,712	
	QI Nurse Specialist (LVN)	M	445	$62,400	$81,120	$99,840	
	Receptionist	F	140	$27,872	$34,840	$41,808	
	Recreational Therapist	L	487	$54,288	$70,512	$86,736	
	Recruiter	L	406	$54,288	$70,512	$86,736	
	Recruiter Sr	M	497	$62,400	$81,120	$99,840	
	Registered Dietitian	L	57	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Analyst	K	628	$47,112	$61,360	$75,504	
	Regulatory Affairs and Compliance Analyst Sr	L	629	$54,288	$70,512	$86,736	
	Regulatory Affairs and Compliance Lead	M	630	$62,400	$81,120	$99,840	
	RN (PACE)	N	480	$71,760	$93,184	$114,712	
	Security Analyst Int	N	534	$71,760	$93,184	$114,712	
	Security Analyst Sr	O	474	$82,576	$107,328	$131,976	
	Security Officer	F	311	$27,872	$34,840	$41,808	
	SharePoint Developer/Administrator Sr	O	397	$82,576	$107,328	$131,976	
	Social Worker	K	463	$47,112	$61,360	$75,504	
*	Special Counsel	R	317	$137,280	$185,328	$233,376	
	Sr Manager Government Affairs	O	451	$82,576	$107,328	$131,976	

CalOptima - Annual Base Salary Schedule - Revised September 1, 2016
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Staff Attorney	P	195	$95,264	$128,752	$162,032	
Supervisor Accounting	M	434	$62,400	$81,120	$99,840	
Supervisor Audit and Oversight	N	618	$71,760	$93,184	$114,712	
Supervisor Budgeting	M	466	$62,400	$81,120	$99,840	
Supervisor Case Management	N	86	$71,760	$93,184	$114,712	
Supervisor Claims	K	219	$47,112	$61,360	$75,504	
Supervisor Coding Initiatives	M	502	$62,400	$81,120	$99,840	
Supervisor Customer Service	K	34	$47,112	$61,360	$75,504	
Supervisor Data Entry	K	192	$47,112	$61,360	$75,504	
Supervisor Day Center (PACE)	K	619	$47,112	$61,360	$75,504	
Supervisor Encounters	L	253	$54,288	$70,512	$86,736	
Supervisor Facilities	L	162	$54,288	$70,512	$86,736	
Supervisor Finance	N	419	$71,760	$93,184	$114,712	
Supervisor Grievance and Appeals	M	620	$62,400	$81,120	$99,840	
Supervisor Health Education	M	381	$62,400	$81,120	$99,840	
Supervisor Health Services	N	506	$71,760	$93,184	$114,712	
Supervisor Information Services	N	457	$71,760	$93,184	$114,712	
Supervisor Long Term Support Services	N	587	$71,760	$93,184	$114,712	
Supervisor Member Outreach and Education	L	592	$54,288	$70,512	$86,736	
Supervisor MSSP	N	348	$71,760	$93,184	$114,712	
Supervisor OneCare Customer Service	K	408	$47,112	$61,360	$75,504	
Supervisor Payroll	M	517	$62,400	$81,120	$99,840	
Supervisor Pharmacy Services	K	146	$47,112	$61,360	$75,504	
Supervisor Pharmacist	P	610	$95,264	$128,752	$162,032	
Supervisor Provider Enrollment	K	439	$47,112	$61,360	$75,504	
Supervisor Regulatory Affairs and Compliance	N	627	$71,760	$93,184	$114,712	
Supervisor Social Work (PACE)	L	TBD	$54,288	$70,512	$86,736	
Supervisor Systems Development	O	456	$82,576	$107,328	$131,976	
Supervisor Therapy Services (PACE)	N	TBD	$71,760	$93,184	$114,712	
Supervisor Quality Analytics	M	609	$62,400	$81,120	$99,840	
Supervisor Quality Improvement	N	600	$71,760	$93,184	$114,712	
Systems Manager	N	512	$71,760	$93,184	$114,712	
Systems Network Administrator Int	M	63	$62,400	$81,120	$99,840	
Systems Network Administrator Sr	N	89	$71,760	$93,184	$114,712	
Systems Operations Analyst	J	32	$40,976	$53,352	$65,624	
Systems Operations Analyst Int	K	45	$47,112	$61,360	$75,504	
Technical Analyst Int	L	64	$54,288	$70,512	$86,736	
Technical Analyst Sr	M	75	$62,400	$81,120	$99,840	
Technical Writer	L	247	$54,288	$70,512	$86,736	
Technical Writer Sr	M	470	$62,400	$81,120	$99,840	
Therapy Aide	J	521	$40,976	$53,352	$65,624	
Training Administrator	L	621	$54,288	$70,512	$86,736	
Training Program Coordinator	K	471	$47,112	$61,360	$75,504	

CalOptima - Annual Base Salary Schedule - Revised September 1, 2016
Effective as of May 1, 2014

Job Title	Pay Grade	Job Code	Min	Mid	Max	For Approval
Translation Specialist	G	241	$30,576	$38,272	$45,968	
Web Architect	O	366	$82,576	$107,328	$131,976	

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

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

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

Summary of Changes to Salary Schedule

For September 2016 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Payroll/HRIS Analyst	K	N/A	Remove title from salary schedule. Position is being eliminated.	N/A	September 2016
Accountant Int	N/A- new position	TBD / L	This new position will be responsible for accounting activities which support the preparation, record-keeping, and reconciliation of accounting/business transactions.	N/A	September 2016
Nurse Practitioner (PACE)	N/A- new position	TBD / P	This new position will be responsible for Primary health care to CalOptima PACE program participants focusing on disease prevention and/or stabilization, and management of chronic and episodic illness in collaboration with the program's primary care physician.	N/A	September 2016

Summary of Market Adjustment Changes

For September 2016 Board Meeting:

Title	Old Wage Grade	New Job Code / Wage Grade	Notes / Reason	Salary Adjustment (% Increase)	Month Added/Changed
Data Analyst Int.	L	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties, responsibilities and performance expectations.	1 Data Analyst Int. will receive a 14.24% adjustment. The total impact for the current fiscal year is $6,544.56 or $8,102.78 annualized.	September 2016
Program Specialist	K	N/A	Market competitive pay; adjusting to pay range target for position based on proficiency in aspects of job duties, responsibilities and performance expectations.	1 Program Specialist will receive a 6.17% adjustment. The total impact for the current fiscal year is $2,487.56 or $3,079.83 annualized.	September 2016

Summary of Executive Salary Changes

For September 2016 Board Meeting:

Pursuant to the Compensation Administration Guidelines adopted as part of CalOptima Policy GA. 8057: Compensation Program, the Board will be informed of all Chief and Executive Director compensation changes. The below change reflects a temporary assignment of an existing employee into an interim executive position.

Title	Salary Adjustment - Fiscal Impact (% Increase)	Effective on Pay Date
Executive Director Clinical Operations (Interim)	The total impact for the current fiscal year is $21,494.83. (17.3%)	August 7, 2016

Board of Directors Meeting
September 1, 2016

Member Advisory Committee Update

The Member Advisory Committee (MAC) did not have a meeting scheduled in August, as the committee meets bi-monthly. The next scheduled MAC meeting is September 8, 2016 and MAC will provide an update at the October 6, 2016 Board meeting.

The recruitment for the vacant Recipients of CalWORKs seat ended on August 1, 2016. Recruitment efforts included outreach to community stakeholders and agencies that work with this population, notification to the CalOptima Board and placement of vacancy notices on the CalOptima website. CalOptima received four applications from interested candidates. Upon MAC's consideration of the candidates, the MAC will forward a recommendation to the Board for consideration.

The MAC appreciates the opportunity to provide the CalOptima Board with input and updates on the MAC's activities.

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Board of Directors Meeting
September 1, 2016

Provider Advisory Committee (PAC) Update

August 11, 2016 PAC Meeting

Nine (9) PAC members were in attendance for the August PAC meeting.

PAC members received three presentations. Liberty Dental presented an overview of the dental benefits administered to CalOptima's OneCare Connect members. The SCAN Foundation shared with members of the PAC their Findings from Waves 1-3 of the Rapid Cycle Polling Project: a survey on California's Coordinated Care Initiative (CCI) which evaluated and tracked beneficiary transitions into Cal MediConnect over time. PAC members also heard from the Illumination Foundation on the safety net system for Orange County's chronically homeless population.

Dr. Richard Bock, Deputy Chief Medical Officer provided an update on current Medical Affairs initiatives. This update included information on the progress after six months of the new Pharmacy Benefits Manager (PBM), information on a supplemental survey that is being completed with help from the PAC CAHPS Ad Hoc Committee and an update on how physicians are being educated about combating the current opioid epidemic.

PAC received a HEDIS update on the Medi-Cal quality improvement performance measures and scores for both pediatric and adult care utilizing CalOptima's contracted health networks.

PAC received the following updates from CalOptima executive staff at the June 9, 2016 PAC meeting: CFO Financial Update covering June financials, COO Update and a Federal and State Budget update.

PAC has opened nominations for the Chair and Vice Chair positions and will make candidate recommendations to the Board in conjunction with the MAC and OCC MAC in the upcoming months.

Once again, the PAC appreciates and thanks the CalOptima Board for the opportunity to present input and updates on the PAC's activities.

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Board of Directors Meeting
September 1, 2016

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

A quorum was not reached at the July 28, 2016 OneCare Connect Member Advisory Committee (OCC MAC) meeting.

At a previous OCC MAC meeting, committee members learned about two programs managed by the Social Services Agency (SSA), including Operation Santa Claus and Senior Santa & Friends. Operation Santa Claus distributes gifts to children and teens during the holidays. Senior Santa & Friends provides critical supplies and items that make life easier and more comfortable for frail seniors and disabled adults during the holiday season and as needed throughout the year. After hearing about these programs, OCC MAC members expressed interest in performing a service project during the fiscal year. OCC MAC will consider service project opportunities at a future meeting.

The OCC MAC appreciates the opportunity to provide the CalOptima Board with input and updates on the OCC MAC activities.

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Financial Summary

July 2016

Board of Directors Meeting

September 1, 2016

Chet Uma

Chief Financial Officer

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FY 2016-17: Consolidated Enrollment

- July 2016 MTD:
  - Overall enrollment was 799,083 member months
    - Actual higher than budget by 588 or 0.1%
      - Medi-Cal: favorable variance of 4,041 members
        - Medi-Cal Expansion (MCE) growth higher than budget
        - SPD enrollment higher than budget due to less than anticipated dual eligible members transferring to OneCare Connect
        - Offset by lower than budget TANF enrollment
      - OneCare Connect: unfavorable variance of 3,384 members
    - 1.0% decrease from prior month
      - OneCare Connect: decrease of 10,514 due to YTD true-up in June
      - Medi-Cal: increase of 2,120 from June 2016
    - 5.6% or 42,271 increase in enrollment from prior year

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FY 2016-17: Consolidated Revenues

- July 2016 MTD:
  - ➢ Actual lower than budget by $1.5 million or 0.5%
    - Medi-Cal: favorable to budget by $7.7 million
      - Favorable price variance of $6.5 million due to higher enrollment and IHSS estimated revenue $4.1 million higher than budget
      - Favorable volume variance of $1.2 million
    - OneCare Connect: unfavorable variance of $9.7 million
      - Unfavorable price variance of $2.7 million due to cohort mix
      - Unfavorable volume variance of $7.0 million due to enrollment variance
    - OneCare: favorable to budget by $0.5 million

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FY 2016-17: Consolidated Medical Expenses

- July 2016 MTD:
  - Actual lower than budget by $0.3 million or 0.1%
    - Medi-Cal: unfavorable variance of $9.8 million
      - Price variance of ($8.6) million due to IHSS estimated expenses $4.1 million higher than budget
      - Volume variance of ($1.2) million
    - OneCare Connect: favorable variance of $10.1 million
      - Price variance of $3.6 million mainly in Rx category
      - Volume variance of $6.6 million
- Medical Loss Ratio (MLR):
  - July 2016 MTD: Actual: 96.3% Budget: 95.9%

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FY 2016-17: Consolidated Administrative Expenses

- July 2016 MTD:
  - Actual lower than budget by $3.4 million or 27.6%
    - Salaries and Benefits: favorable variance of $1.8 million driven by lower than budgeted FTE of 91
    - Other categories: favorable variance of $1.7 million

- Administrative Loss Ratio (ALR):
  - July 2016 MTD: Actual: 3.2% Budget: 4.5%

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FY 2016-17: Change in Net Assets

- July 2016 MTD:
  - $1.7 million surplus
  - $2.6 million favorable to budget
    - Attributable to:
      - Lower administrative expenses of $3.4 million
      - Savings in medical expenses of $0.2 million
      - Higher investment income of $0.3 million
      - Offset by lower than budgeted revenue of $1.5 million

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Enrollment Summary: July 2016

	Month-to-Date			
Enrollment (By Aid Category)	Actual	Budget	Variance	%
Aged	56,934	54,758	2,176	4.0%
BCCTP	635	675	(40)	(5.9%)
Disabled	48,453	47,539	914	1.9%
TANF Child	335,030	337,897	(2,867)	
MCE	230,537	221,527	9,010	4.1%
TANF Adult	104,008	109,730	(5,722)	(5.2%)
LTC	3,236	2,669	567	21.2%
Medi-Cal	**778,833**	**774,792**	**4,041**	**0.5%**
OneCare Connect	**18,902**	**22,286**	**(3,384)**	**(15.2%)**
PACE	**177**	**165**	**12**	**7.3%**
OneCare	**1,171**	**1,252**	**(81)**	**(6.5%)**
CalOptima Total	**799,083**	**798,495**	**588**	**0.1%**

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Financial Highlights: July 2016

	Month-to-Date			
	Actual	Budget	$ Variance	% Variance
Member Months	799,083	798,495	588	0.1%
Revenues	279,561,710	281,047,454	(1,485,744)	(0.5%)
Medical Expenses	269,283,475	269,536,193	252,718	0.1%
Administrative Expenses	9,068,157	12,517,994	3,449,837	27.6%
Operating Margin	**1,210,078**	**(1,006,734)**	**2,216,812**	**(220.2%)**
Non Operating Income (Loss)	513,913	143,250	370,663	258.8%
Change in Net Assets	**1,723,991**	**(863,484)**	**2,587,475**	**(299.7%)**
Medical Loss Ratio	96.3%	95.9%	(0.4%)	
Administrative Loss Ratio	3.2%	4.5%	1.2%	
Operating Margin Ratio	0.4%	(0.4%)	0.8%	
Total Operating	100.0%	100.0%	0.0%	

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Consolidated Performance Actual vs. Budget: July 2016 (in millions)

	MONTH-TO-DATE		
	Actual	Budget	Variance
Medi-Cal	0.1	(0.7)	0.9
OneCare	0.2	0.0	0.2
OCC	1.0	0.0	1.0
PACE	(0.1)	(0.3)	0.2
Operating	**1.2**	**(1.0)**	**2.2**
Inv./Rental Inc, MCO tax	0.5	0.1	0.4
Non-Operating	**0.5**	**0.1**	**0.4**
TOTAL	**1.7**	**(0.9)**	**2.6**

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Consolidated Revenue & Expense: July 2016 MTD

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	548,296	230,537	$ 778,833	1,171	18,902	177	799,083
REVENUES							
Capitation Revenue	135,855,683	104,512,152	$ 240,367,835	$ 1,909,332	$ 36,216,029	$ 1,068,515	$ 279,561,710
Other Income	-		-	-	-	-	-
Total Operating Revenues	135,855,683	104,512,152	240,367,835	1,909,332	36,216,029	1,068,515	279,561,710
MEDICAL EXPENSES							
Provider Capitation	32,531,374	42,062,700	74,594,073	372,155	8,173,122	113	83,139,464
Facilitities	26,736,302	34,828,873	61,565,175	605,024	9,385,123	325,487	71,880,809
Ancillary				36,727	524,096	-	560,824
Skilled Nursing				42,814	5,054,277	-	5,097,091
Professional Claims	12,706,695	4,304,271	17,010,966	-	-	214,223	17,225,188
Prescription Drugs	16,769,736	15,993,602	32,763,338	487,704	8,401,395	96,410	41,748,847
Quality Incentives					378,780		378,780
Long-term Care Facility Payments	38,010,650	6,032,845	44,043,496	-	-	5,601	44,049,097
Contingencies	-	-	-	-	-	-	-
Medical Management	3,061,704	-	3,061,704	28,089	972,124	353,698	4,415,616
Reinsurance & Other	(378,657)	972,456	593,799	5,209	107,004	81,748	787,759
Total Medical Expenses	129,437,804	104,194,747	233,632,551	1,577,722	32,995,922	1,077,280	269,283,475
Medical Loss Ratio	**95.3%**	**99.7%**	**97.2%**	**82.6%**	**91.1%**	**100.8%**	**96.3%**
GROSS MARGIN	6,417,879	317,404	**6,735,283**	**331,610**	**3,220,107**	**(8,766)**	**10,278,235**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			5,307,828	17,843	1,093,502	89,921	6,509,095
Professional Fees			185,211	22,000	103,950	4,938	316,099
Purchased Services			591,820	20,280	116,934	0	729,034
Printing and Postage			122,064	2,385	14,418	222	139,089
Depreciation and Amortization			264,591			2,014	266,605
Other Expenses			726,221	714	1,492	9,037	737,463
Indirect Cost Allocation, Occupancy Expense			(598,659)	29,494	937,491	2,446	370,771
Total Administrative Expenses			6,599,076	92,716	2,267,787	108,578	9,068,157
Admin Loss Ratio			**2.7%**	**4.9%**	**6.3%**	**10.2%**	**3.2%**
INCOME (LOSS) FROM OPERATIONS			136,207	238,894	952,320	(117,344)	1,210,078
INVESTMENT INCOME			-	-	-	-	510,861
NET RENTAL INCOME			-	-	-	-	2,800
OTHER INCOME			252	-	-	-	252
CHANGE IN NET ASSETS			**$ 136,459**	**$ 238,894**	**$ 952,320**	**$ (117,344)**	**$ 1,723,991**
BUDGETED CHANGE IN ASSETS			(713,688)	29,395	(29,527)	(292,914)	(863,484)
VARIANCE TO BUDGET - FAV (UNFAV)			850,147	209,499	981,847	175,570	2,587,475

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CalOptima A Public Agency Better. Together.

Balance Sheet: As of July 2016

ASSETS		
Current Assets		
	Operating Cash	$475,725,744
	Catastrophic Reserves	11,633,210
	Investments	1,134,227,219
	Capitation receivable	234,516,162
	Receivables - Other	20,291,900
	Prepaid Expenses	11,935,241
	Total Current Assets	**1,888,329,476**
Capital Assets	Furniture and equipment	28,851,790
	Leasehold improvements	11,762,557
	505 City Parkway West	46,707,144
		87,321,491
	Less: accumulated depreciation	(32,262,681)
	Capital assets, net	**55,058,810**
Other Assets	Restricted deposit & Other	279,518
	Board-designated assets	
	Cash and cash equivalents	3,104,519
	Long term investments	472,836,571
	Total Board-designated Assets	475,941,090
	Total Other Assets	**476,220,608**
	Deferred outflows of Resources - Pension contributions	**3,787,544**
	Deferred outflows of Resources - Difference in Experience	**1,215,473**
TOTAL ASSETS & OUTFLOWS		**2,424,611,911**

LIABILITIES & FUND BALANCES		
Current Liabilities		
	Accounts payable	$14,887,899
	Medical claims liability	613,681,231
	Accrued payroll liabilities	8,867,872
	Deferred revenue	673,243,791
	Deferred revenue - CMS	0
	Deferred lease obligations	267,070
	Capitation and withholds	414,314,900
	Total Current Liabilities	**1,725,262,764**
	Other (than pensions) post employment benefits liability	27,594,452
	Net Pension Liabilities	8,158,985
	Long Term Liabilities	150,000
	TOTAL LIABILITIES	**1,761,166,201**
	Deferred inflows of Resources - Excess Earnings	**502,900**
	Deferred inflows of Resources - changes in Assumptions	**1,651,640**
	Tangible net equity (TNE)	89,012,314
	Funds in excess of TNE	572,278,856
Net Assets		**661,291,170**
TOTAL LIABILITIES, INFLOWS & FUND BALANCES		**2,424,611,911**

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CalOptima A Public Agency Better. Together.

Board Designated Reserve and TNE Analysis As of July 2016

CalOptima
Board Designated Reserve and TNE Analysis
as of July 31, 2016

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	135,383,499				
	Tier 1 - Logan Circle	125,385,604				
	Tier 1 - Wells Capital	125,378,616				
Board-designated Reserve						
		386,147,719	286,467,328	447,387,174	99,680,391	(61,239,455)
TNE Requirement	Tier 2 - Logan Circle	89,793,371	89,012,314	89,012,314	781,057	781,057
	Consolidated:	**475,941,090**	**375,479,642**	**536,399,488**	**100,461,449**	**(60,458,398)**
	Current reserve level	*1.77*	*1.40*	*2.00*		

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UNAUDITED FINANCIAL STATEMENTS

July 2016

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CalOptima - Consolidated
Financial Highlights
For the One Month Ended July 31, 2016

	Month-to-Date			
	Actual	Budget	$ Variance	% Variance
Member Months	799,083	798,495	588	0.1%
Revenues	279,561,710	281,047,454	(1,485,744)	(0.5%)
Medical Expenses	269,283,475	269,536,193	252,718	0.1%
Administrative Expenses	9,068,157	12,517,994	3,449,837	27.6%
Operating Margin	**1,210,078**	**(1,006,734)**	**2,216,812**	**(220.2%)**
Non Operating Income (Loss)	513,913	143,250	370,663	258.8%
Change in Net Assets	**1,723,991**	**(863,484)**	**2,587,475**	**(299.7%)**
Medical Loss Ratio	96.3%	95.9%	(0.4%)	
Administrative Loss Ratio	3.2%	4.5%	1.2%	
Operating Margin Ratio	0.4%	(0.4%)	0.8%	
Total Operating	100.0%	100.0%	0.0%	

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CalOptima
Financial Dashboard
For the One Month Ended July 31, 2016

MONTH

Enrollment	Actual	Budget	Fav / (Unfav)	
Medi-Cal	778,833	774,792	4,041	0.5%
OneCare	1,171	1,252	(81)	(6.5%)
OneCare Connect	18,902	22,286	(3,384)	(15.2%)
PACE	177	165	12	7.3%
Total	799,083	798,495	588	0.1%

Change in Net Assets ($000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal (w/ MSSP)	$ 136	$ (714)	$ 850	119.1%
OneCare	239	29	209	712.7%
OneCare Connect	952	(30)	982	3325.2%
PACE	(117)	(293)	176	59.9%
505 Bldg.	3	(65)	68	104.3%
Investment Income & Other	511	208	303	145.3%
Total	$ 1,724	$ (863)	$ 2,588	299.7%

MLR	Actual	Budget	% Point Var
Medi-Cal (w/ MSSP)	97.2%	96.2%	(1.0)
OneCare	82.6%	91.3%	8.7
OneCare Connect	91.1%	93.9%	2.8

Administrative Cost ($000)	Actual	Budget	Fav / (Unfav)	
Medi-Cal (w/ MSSP)	$ 6,599	$ 9,474	$ 2,875	30.3%
OneCare	93	96	3	3.4%
OneCare Connect	2,268	2,829	561	19.8%
PACE	109	119	10	8.5%
Total	$ 9,068	$ 12,518	$ 3,450	27.6%

Total FTE's Month	Actual	Budget	Fav / (Unfav)
Medi-Cal (w/ MSSP)	793	886	92
OneCare	7	3	(4)
OneCare Connect	248	240	(8)
PACE	38	57	18
Total	1,087	1,185	98

MM per FTE	Actual	Budget	Fav / (Unfav)
Medi-Cal (w/ MSSP)	982	875	107
OneCare	164	417	(254)
OneCare Connect	76	93	(17)
PACE	5	3	2
Total	1,226	1,388	(162)

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CalOptima - Consolidated
Statement of Revenue and Expenses
For the One Month Ended July 31, 2016

	Actual		Month Budget		Variance	
	$	PMPM*	$	PMPM*	$	PMPM
Member Months**	799,083		798,495		588	
Revenues						
Medi-Cal	$ 240,367,835	$ 308.63	$ 232,618,271	$ 300.23	$ 7,749,564	$ 8.39
OneCare	1,909,332	1,630.51	1,443,251	1,152.76	466,081	477.76
OneCare Connect	36,216,029	1,915.99	45,941,706	2,061.46	(9,725,677)	(145.47)
PACE	1,068,515	6,036.81	1,044,226	6,328.64	24,288	(291.84)
Total Operating Revenue	279,561,710	349.85	281,047,454	351.97	(1,485,744)	(2.12)
Medical Expenses						
Medi-Cal	233,632,551	299.98	223,857,585	288.93	(9,774,966)	(11.05)
OneCare	1,577,722	1,347.33	1,317,865	1,052.61	(259,857)	(294.72)
OneCare Connect	32,995,922	1,745.63	43,142,302	1,935.85	10,146,380	190.22
PACE	1,077,280	6,086.33	1,218,441	7,384.49	141,161	1,298.16
Total Medical Expenses	269,283,475	336.99	269,536,193	337.56	252,718	0.56
Gross Margin	10,278,235	12.86	11,511,260	14.42	(1,233,026)	(1.55)
Administrative Expenses						
Salaries and benefits	6,509,095	8.15	8,267,086	10.35	1,757,991	2.21
Professional fees	316,099	0.40	337,898	0.42	21,799	0.03
Purchased services	729,034	0.91	956,717	1.20	227,683	0.29
Printing and Postage	139,089	0.17	458,772	0.57	319,683	0.40
Depreciation and amortization	266,605	0.33	385,117	0.48	118,512	0.15
Other	737,463	0.92	1,684,234	2.11	946,770	1.19
Indirect Cost Allocation, Occupancy Expense	370,771	0.46	428,170	0.54	57,399	0.07
Total Administrative Expenses	9,068,157	11.35	12,517,994	15.68	3,449,837	4.33
Income (Loss) From Operations	1,210,078	1.51	(1,006,734)	(1.26)	2,216,812	2.78
Investment income						
Interest income	735,703	0.92	208,333	0.26	527,369	0.66
Realized gain/(loss) on investments	54,735	0.07	-	-	54,735	0.07
Unrealized gain/(loss) on investments	(279,576)	(0.35)	-	-	(279,576)	(0.35)
Total Investment Income	510,861	0.64	208,333	0.26	302,528	0.38
Net Rental Income	2,800	0.00	(65,083)	(0.08)	67,884	0.09
Total Net Operating Tax	-	-	-	-	-	-
Total Net Grant Income	-	-	-	-	-	-
QAF/IGT	-	-	-	-	-	-
Other Income	252	0.00	-	-	252	0.00
Change In Net Assets	**1,723,991**	**2.16**	**(863,484)**	**(1.08)**	**2,587,475**	**3.24**
Medical Loss Ratio	**96.3%**		**95.9%**		**(0.4%)**	
Administrative Loss Ratio	**3.2%**		**4.5%**		**1.2%**	

* PMPMs for Revenues and Medical Expenses are calculated using line of business enrollment
** Includes MSSP

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CalOptima - Consolidated - Month to Date
Statement of Revenues and Expenses by LOB
For the One Month Ended July 31, 2016

	Medi-Cal Classic	Medi-Cal Expansion	Total Medi-Cal	OneCare	OneCare Connect	PACE	Consolidated
Member Months	548,296	230,537	$ 778,833	1,171	18,902	177	799,083
REVENUES							
Capitation Revenue	135,855,683	104,512,152	$ 240,367,835	$ 1,909,332	$ 36,216,029	$ 1,068,515	$ 279,561,710
Other Income	-		-	-	-	-	-
Total Operating Revenues	135,855,683	104,512,152	240,367,835	1,909,332	36,216,029	1,068,515	279,561,710
MEDICAL EXPENSES							
Provider Capitation	32,531,374	42,062,700	74,594,073	372,155	8,173,122	113	83,139,464
Facilitities	26,736,302	34,828,873	61,565,175	605,024	9,385,123	325,487	71,880,809
Ancillary				36,727	524,096	-	560,824
Skilled Nursing				42,814	5,054,277	-	5,097,091
Professional Claims	12,706,695	4,304,271	17,010,966	-	-	214,223	17,225,188
Prescription Drugs	16,769,736	15,993,602	32,763,338	487,704	8,401,395	96,410	41,748,847
Quality Incentives					378,780		378,780
Long-term Care Facility Payments	38,010,650	6,032,845	44,043,496	-	-	5,601	44,049,097
Contingencies	-	-	-	-	-	-	-
Medical Management	3,061,704	-	3,061,704	28,089	972,124	353,698	4,415,616
Reinsurance & Other	(378,657)	972,456	593,799	5,209	107,004	81,748	787,759
Total Medical Expenses	129,437,804	104,194,747	233,632,551	1,577,722	32,995,922	1,077,280	269,283,475
Medical Loss Ratio	**95.3%**	**99.7%**	**97.2%**	**82.6%**	**91.1%**	**100.8%**	**96.3%**
GROSS MARGIN	6,417,879	317,404	**6,735,283**	**331,610**	**3,220,107**	**(8,766)**	**10,278,235**
ADMINISTRATIVE EXPENSES							
Salaries, Wages & Employee Benefits			5,307,828	17,843	1,093,502	89,921	6,509,095
Professional Fees			185,211	22,000	103,950	4,938	316,099
Purchased Services			591,820	20,280	116,934	0	729,034
Printing and Postage			122,064	2,385	14,418	222	139,089
Depreciation and Amortization			264,591			2,014	266,605
Other Expenses			726,221	714	1,492	9,037	737,463
Indirect Cost Allocation, Occupancy Expense			(598,659)	29,494	937,491	2,446	370,771
Total Administrative Expenses			6,599,076	92,716	2,267,787	108,578	9,068,157
Admin Loss Ratio			**2.7%**	**4.9%**	**6.3%**	**10.2%**	**3.2%**
INCOME (LOSS) FROM OPERATIONS			136,207	238,894	952,320	(117,344)	1,210,078
INVESTMENT INCOME			-	-	-	-	510,861
NET RENTAL INCOME			-	-	-	-	2,800
NET OPERATING TAX			-	-	-	-	0
NET GRANT INCOME			-	-	-	-	0
QAF/IGT			-	-	-	-	0
OTHER INCOME			252	-	-	-	252
CHANGE IN NET ASSETS			**$ 136,459**	**$ 238,894**	**$ 952,320**	**$ (117,344)**	**$ 1,723,991**
BUDGETED CHANGE IN ASSETS			(713,688)	29,395	(29,527)	(292,914)	(863,484)
VARIANCE TO BUDGET - FAV (UNFAV)			850,147	209,499	981,847	175,570	2,587,475

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SUMMARY

MONTHLY RESULTS:

- Change in Net Assets is $1.7 million, $2.6 million favorable to budget
- Operating surplus is $1.2 million with a surplus in non-operating of $0.5 million

Change in Net Assets by LOB ($millions)

	MONTH-TO-DATE		
	Actual	Budget	Variance
Medi-Cal	0.1	(0.7)	0.9
OneCare	0.2	0.0	0.2
OCC	1.0	0.0	1.0
PACE	(0.1)	(0.3)	0.2
Operating	**1.2**	**(1.0)**	**2.2**
Inv./Rental Inc, MCO tax	0.5	0.1	0.4
Non-Operating	**0.5**	**0.1**	**0.4**
TOTAL	**1.7**	**(0.9)**	**2.6**

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CalOptima

Enrollment Summary

For the One Month Ended July 31, 2016

Month-to-Date					Month-to-Date			
Actual	**Budget**	**Variance**	**%**	**Enrollment (By Aid Category)**	**Actual**	**Budget**	**Variance**	**%**
56,934	54,758	2,176	4.0%	Aged	56,934	54,758	2,176	4.0%
635	675	(40)	(5.9%)	BCCTP	635	675	(40)	(5.9%)
48,453	47,539	914	1.9%	Disabled	48,453	47,539	914	1.9%
335,030	337,897	(2,867)		TANF Child	335,030	337,897	(2,867)	
230,537	221,527	9,010	4.1%	MCE	230,537	221,527	9,010	4.1%
104,008	109,730	(5,722)	(5.2%)	TANF Adult	104,008	109,730	(5,722)	(5.2%)
3,236	2,669	567	21.2%	LTC	3,236	2,669	567	21.2%
778,833	**774,792**	**4,041**	**0.5%**	**Medi-Cal**	**778,833**	**774,792**	**4,041**	**0.5%**
18,902	**22,286**	**(3,384)**	**(15.2%)**	**OneCare Connect**	**18,902**	**22,286**	**(3,384)**	**(15.2%)**
177	**165**	**12**	**7.3%**	**PACE**	**177**	**165**	**12**	**7.3%**
1,171	**1,252**	**(81)**	**(6.5%)**	**OneCare**	**1,171**	**1,252**	**(81)**	**(6.5%)**
799,083	**798,495**	**588**	**0.1%**	**CalOptima Total**	**799,083**	**798,495**	**588**	**0.1%**
				Enrollment (By Network)				
47,280	46,631	649	1.4%	HMO	47,280	46,631	649	1.4%
232,018	233,539	(1,521)	(0.7%)	PHC	232,018	233,539	(1,521)	(0.7%)
345,323	341,925	3,398	1.0%	Shared Risk Group	345,323	341,925	3,398	1.0%
154,212	152,700	1,512	1.0%	Fee for Service	154,212	152,700	1,512	1.0%
778,833	**774,792**	**4,038**	**0.5%**	**Medi-Cal**	**778,833**	**774,792**	**4,038**	**0.5%**
18,902	**22,286**	**(3,384)**	**(15.2%)**	**OneCare Connect**	**18,902**	**22,286**	**(3,384)**	**(15.2%)**
177	**165**	**12**	**7.3%**	**PACE**	**177**	**165**	**12**	**7.3%**
1,171	**1,252**	**(81)**	**(6.5%)**	**OneCare**	**1,171**	**1,252**	**(81)**	**(6.5%)**
799,083	**798,495**	**588**	**0.1%**	**CalOptima Total**	**799,083**	**798,495**	**588**	**0.1%**

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CalOptima
Enrollment Trend by Network Type
Fiscal Year 2017

Network Type	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	MMs
HMO													
Aged	351	-	-	-	-	-	-	-	-	-	-	-	351
BCCTP	1	-	-	-	-	-	-	-	-	-	-	-	1
Disabled	1,799	-	-	-	-	-	-	-	-	-	-	-	1,799
TANF Child	24,211	-	-	-	-	-	-	-	-	-	-	-	24,211
MCE	12,989	-	-	-	-	-	-	-	-	-	-	-	12,989
TANF Adult	7,929	-	-	-	-	-	-	-	-	-	-	-	7,929
	47,280	-	-	-	-	-	-	-	-	-	-	-	47,280
PHC													
Aged	1,495	-	-	-	-	-	-	-	-	-	-	-	1,495
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	7,903	-	-	-	-	-	-	-	-	-	-	-	7,903
TANF Child	169,358	-	-	-	-	-	-	-	-	-	-	-	169,358
MCE	38,002	-	-	-	-	-	-	-	-	-	-	-	38,002
TANF Adult	15,260	-	-	-	-	-	-	-	-	-	-	-	15,260
	232,018	-	-	-	-	-	-	-	-	-	-	-	232,018
Shared Risk Group													
Aged	7,658	-	-	-	-	-	-	-	-	-	-	-	7,658
BCCTP	-	-	-	-	-	-	-	-	-	-	-	-	-
Disabled	14,428	-	-	-	-	-	-	-	-	-	-	-	14,428
TANF Child	118,748	-	-	-	-	-	-	-	-	-	-	-	118,748
MCE	140,640	-	-	-	-	-	-	-	-	-	-	-	140,640
TANF Adult	63,849	-	-	-	-	-	-	-	-	-	-	-	63,849
	345,323	-	-	-	-	-	-	-	-	-	-	-	345,323
Fee for Service (Dual)													
Aged	43,684	-	-	-	-	-	-	-	-	-	-	-	43,684
BCCTP	27	-	-	-	-	-	-	-	-	-	-	-	27
Disabled	19,790	-	-	-	-	-	-	-	-	-	-	-	19,790
TANF Child	3	-	-	-	-	-	-	-	-	-	-	-	3
MCE	2,960	-	-	-	-	-	-	-	-	-	-	-	2,960
TANF Adult	1,179	-	-	-	-	-	-	-	-	-	-	-	1,179
LTC	2,868	-	-	-	-	-	-	-	-	-	-	-	2,868
	70,511	-	-	-	-	-	-	-	-	-	-	-	70,511
Fee for Service (Non-Dual)													
Aged	3,746	-	-	-	-	-	-	-	-	-	-	-	3,746
BCCTP	607	-	-	-	-	-	-	-	-	-	-	-	607
Disabled	4,533	-	-	-	-	-	-	-	-	-	-	-	4,533
TANF Child	22,710	-	-	-	-	-	-	-	-	-	-	-	22,710
MCE	35,946	-	-	-	-	-	-	-	-	-	-	-	35,946
TANF Adult	15,791	-	-	-	-	-	-	-	-	-	-	-	15,791
LTC	368	-	-	-	-	-	-	-	-	-	-	-	368
	83,701	-	-	-	-	-	-	-	-	-	-	-	83,701
MEDI-CAL TOTAL													
Aged	56,934	-	-	-	-	-	-	-	-	-	-	-	56,934
BCCTP	635	-	-	-	-	-	-	-	-	-	-	-	635
Disabled	48,453	-	-	-	-	-	-	-	-	-	-	-	48,453
TANF Child	335,030	-	-	-	-	-	-	-	-	-	-	-	335,030
MCE	230,537												230,537
TANF Adult	104,008	-	-	-	-	-	-	-	-	-	-	-	104,008
LTC	3,236	-	-	-	-	-	-	-	-	-	-	-	3,236
	778,833	-	-	-	-	-	-	-	-	-	-	-	778,833
PACE	177	-	-	-	-	-	-	-	-	-	-	-	177
OneCare	1,171	-	-	-	-	-	-	-	-	-	-	-	1,171
OneCare Connect	18,902	-	-	-	-	-	-	-	-	-	-	-	18,902
TOTAL	799,083	-	-	-	-	-	-	-	-	-	-	-	799,083

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ENROLLMENT:

Overall MTD enrollment was 799,083

- Favorable to budget by 588
- Decreased 8,388 or 1.0% from prior month
- Increased 42,271 or 5.6% from prior year (July 2015)

Medi-Cal enrollment was 778,833

- Favorable to budget by 4,041 primarily driven by:
    - 0 Medi-Cal Expansion favorable by 9,010 and SPD by 3,616
    - 0 Offset by TANF unfavorable by 8,587

- Increased 2,120 from prior month

OneCare enrollment was 1,171

- Unfavorable to budget by 81
- Decreased 3 from prior month

OneCare Connect enrollment was 18,902

- Unfavorable to budget by 3,384
- Decreased 10,514 from prior month (YTD true-up done in June)

PACE enrollment at 177

- Favorable to budget by 12
- Increased 9 from prior month

CalOptima - MediCal Total
Statement of Revenues and Expenses
For the One Month Ended July 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
778,833	774,792	4,041	0.5%	Member Months	778,833	774,792	4,041	0.5%
				Revenues				
240,367,835	232,618,271	7,749,564	3.3%	Capitation revenue	240,367,835	232,618,271	7,749,564	3.3%
240,367,835	232,618,271	7,749,564	3.3%	Total Operating Revenues	240,367,835	232,618,271	7,749,564	3.3%
				Medical Expenses				
74,594,073	74,846,297	252,224	0.3%	Provider capitation	74,594,073	74,846,297	252,224	0.3%
61,565,175	56,311,770	(5,253,406)	(9.3%)	Facilities	61,565,175	56,311,770	(5,253,406)	(9.3%)
17,010,966	16,471,521	(539,445)	(3.3%)	Professional Claims	17,010,966	16,471,521	(539,445)	(3.3%)
32,763,338	34,361,134	1,597,796	4.7%	Prescription drugs	32,763,338	34,361,134	1,597,796	4.7%
44,043,496	37,218,911	(6,824,585)	(18.3%)	Long-term care facility payments	44,043,496	37,218,911	(6,824,585)	(18.3%)
3,061,704	4,601,286	1,539,582	33.5%	Medical Management	3,061,704	4,601,286	1,539,582	33.5%
593,799	46,667	(547,132)	(1172.4%)	Reinsurance & other	593,799	46,667	(547,132)	(1172.4%)
233,632,551	223,857,585	(9,774,966)	(4.4%)	Total Medical Expenses	233,632,551	223,857,585	(9,774,966)	(4.4%)
6,735,283	8,760,686	(2,025,402)	(23.1%)	Gross Margin	6,735,283	8,760,686	(2,025,402)	(23.1%)
				Administrative Expenses				
5,307,828	7,149,604	1,841,776	25.8%	Salaries, wages & employee benefits	5,307,828	7,149,604	1,841,776	25.8%
185,211	279,427	94,216	33.7%	Professional fees	185,211	279,427	94,216	33.7%
591,820	707,003	115,183	16.3%	Purchased services	591,820	707,003	115,183	16.3%
122,064	314,582	192,519	61.2%	Printing and postage	122,064	314,582	192,519	61.2%
264,591	383,061	118,470	30.9%	Depreciation & amortization	264,591	383,061	118,470	30.9%
726,221	1,180,533	454,312	38.5%	Other operating expenses	726,221	1,180,533	454,312	38.5%
(598,659)	(539,837)	58,822	10.9%	Indirect cost allocation	(598,659)	(539,837)	58,822	10.9%
6,599,076	9,474,374	2,875,298	30.3%	Total Administrative Expenses	6,599,076	9,474,374	2,875,298	30.3%
				Operating Tax				
10,319,388	8,789,850	(1,529,539)	(17.4%)	Tax Revenue	10,319,388	8,789,850	(1,529,539)	(17.4%)
10,281,461	0	(10,281,461)	0.0%	Premium tax expense	10,281,461	0	(10,281,461)	0.0%
37,927	8,789,850	8,751,923	99.6%	Sales tax expense	37,927	8,789,850	8,751,923	99.6%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
				Grant Income				
0	287,500	(287,500)	(100.0%)	Grant Revenue	0	287,500	(287,500)	(100.0%)
0	250,000	250,000	100.0%	Grant expense - Service Partner	0	250,000	250,000	100.0%
0	37,500	37,500	100.0%	Grant expense - Adminsitrative	0	37,500	37,500	100.0%
0	0	0	0.0%	Total Net Grant Income	0	0	0	0.0%
252	0	252	0.0%	Other income	252	0	252	0.0%
136,459	(713,688)	850,147	119.1%	Change in Net Assets	136,459	(713,688)	850,147	119.1%
97.2%	96.2%	(1.0%)	(1.0%)	Medical Loss Ratio	97.2%	96.2%	(1.0%)	(1.0%)
2.7%	4.1%	1.3%	32.6%	Admin Loss Ratio	2.7%	4.1%	1.3%	32.6%

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MEDI-CAL INCOME STATEMENT – JULY MONTH:

REVENUES of $240.4 million are favorable to budget by $7.7 million, driven by:

- Price related variance of: $6.5 million due to IHSS and aid code mix variances
- Volume related variance of: $1.2 million due to the higher enrollment

MEDICAL EXPENSES: Overall $233.6 million, unfavorable to budget by $9.8 million due to:

- **Facility claim payments** are unfavorable to budget $5.3 million due to:
  - 0 Price related unfavorable variance of: $5.0 million related to claims actuarial experience
  - 0 Volume related unfavorable variance of: $0.3 million
- **Long term care claim payments** are unfavorable to budget $6.8 million due to:
  - 0 Price related unfavorable variance of: $6.6 million related to actuarial experience and County IHSS expense reporting
  - 0 Volume related unfavorable variance of: $0.2 million

ADMINISTRATION EXPENSES are $6.6 million, favorable to budget $2.9 million, driven by:

- Salary & Benefits: $1.8 million favorable to budget
- Non-Salary: $1.0 million favorable to budget across all categories

CHANGE IN NET ASSETS is $0.1 million for the month, favorable to budget by $0.9 million

CalOptima - OneCare Connect
Statement of Revenues and Expenses
For the One Month Ended July 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
18,902	22,286	(3,384)	(15.2%)	Member Months	18,902	22,286	(3,384)	(15.2%)
				Revenues				
36,216,029	45,941,706	(9,725,677)	(21.2%)	Capitation revenue	36,216,029	45,941,706	(9,725,677)	(21.2%)
36,216,029	45,941,706	(9,725,677)	(21.2%)	Total Operating Revenue	36,216,029	45,941,706	(9,725,677)	(21.2%)
				Medical Expenses				
8,173,122	9,723,130	1,550,008	15.9%	Provider capitation	8,173,122	9,723,130	1,550,008	15.9%
9,385,123	11,648,615	2,263,492	19.4%	Facilities	9,385,123	11,648,615	2,263,492	19.4%
524,096	630,460	106,363	16.9%	Ancillary	524,096	630,460	106,363	16.9%
5,054,277	10,526,741	5,472,464	52.0%	Skilled nursing facilities	5,054,277	10,526,741	5,472,464	52.0%
8,401,395	8,217,757	(183,638)	(2.2%)	Prescription drugs	8,401,395	8,217,757	(183,638)	(2.2%)
378,780	459,915	81,135	17.6%	Quality incentives	378,780	459,915	81,135	17.6%
972,124	1,293,879	321,755	24.9%	Medical management	972,124	1,293,879	321,755	24.9%
107,004	641,806	534,802	83.3%	Other medical expenses	107,004	641,806	534,802	83.3%
32,995,922	43,142,302	10,146,380	23.5%	Total Medical Expenses	32,995,922	43,142,302	10,146,380	23.5%
3,220,107	2,799,404	420,703	15.0%	Gross Margin	3,220,107	2,799,404	420,703	15.0%
				Administrative Expenses				
1,093,502	996,673	(96,829)	(9.7%)	Salaries, wages & employee benefits	1,093,502	996,673	(96,829)	(9.7%)
103,950	41,804	(62,146)	(148.7%)	Professional fees	103,950	41,804	(62,146)	(148.7%)
116,934	229,333	112,399	49.0%	Purchased services	116,934	229,333	112,399	49.0%
14,418	131,444	117,026	89.0%	Printing and postage	14,418	131,444	117,026	89.0%
1,492	492,187	490,694	99.7%	Other operating expenses	1,492	492,187	490,694	99.7%
937,491	937,491	0	0.0%	Indirect cost allocation, Occupancy Expense	937,491	937,491	0	0.0%
2,267,787	2,828,931	561,144	19.8%	Total Administrative Expenses	2,267,787	2,828,931	561,144	19.8%
				Operating Tax				
756,071	0	756,071	0.0%	Tax Revenue	756,071	0	756,071	0.0%
757,560	0	(757,560)	0.0%	Premium tax expense	757,560	0	(757,560)	0.0%
(1,489)	0	1,489	0.0%	Sales tax expense	(1,489)	0	1,489	0.0%
0	0	0	0.0%	Total Net Operating Tax	0	0	0	0.0%
952,320	(29,527)	981,847	3325.2%	Change in Net Assets	952,320	(29,527)	981,847	3325.2%
91.1%	93.9%	2.8%	3.0%	Medical Loss Ratio	91.1%	93.9%	2.8%	3.0%
6.3%	6.2%	(0.1%)	(1.7%)	Admin Loss Ratio	6.3%	6.2%	(0.1%)	(1.7%)

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ONECARE CONNECT INCOME STATEMENT – JULY MONTH:

REVENUES of $36.2 million are unfavorable to budget by $9.7 million driven by:

- Price related variance of: $2.7 million due to cohort experience
- Volume related variance of: $7.0 million due to the higher enrollment

MEDICAL EXPENSES are favorable to budget $10.1 million due to:

- Corresponding to revenue, along with higher prescription drug experience

ADMINISTRATIVE EXPENSES are favorable to budget by $0.6 million

CHANGE IN NET ASSETS is $1.0 million, favorable to budget by $1.0 million

CalOptima - OneCare
Statement of Revenues and Expenses
For the One Month Ended July 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
1,171	1,252	(81)	(6.5%)	Member Months	1,171	1,252	(81)	(6.5%)
				Revenues				
1,909,332	1,443,251	466,081	32.3%	Capitation revenue	1,909,332	1,443,251	466,081	32.3%
1,909,332	1,443,251	466,081	32.3%	Total Operating Revenue	1,909,332	1,443,251	466,081	32.3%
				Medical Expenses				
372,155	393,478	21,323	5.4%	Provider capitation	372,155	393,478	21,323	5.4%
605,024	322,709	(282,315)	(87.5%)	Inpatient	605,024	322,709	(282,315)	(87.5%)
36,727	49,175	12,448	25.3%	Ancillary	36,727	49,175	12,448	25.3%
42,814	23,817	(18,997)	(79.8%)	Skilled nursing facilities	42,814	23,817	(18,997)	(79.8%)
487,704	478,471	(9,233)	(1.9%)	Prescription drugs	487,704	478,471	(9,233)	(1.9%)
28,089	18,500	(9,589)	(51.8%)	Medical management	28,089	18,500	(9,589)	(51.8%)
5,209	31,715	26,507	83.6%	Other medical expenses	5,209	31,715	26,507	83.6%
1,577,722	1,317,865	(259,857)	(19.7%)	Total Medical Expenses	1,577,722	1,317,865	(259,857)	(19.7%)
331,610	125,386	206,224	164.5%	Gross Margin	331,610	125,386	206,224	164.5%
				Administrative Expenses				
17,843	22,668	4,825	21.3%	Salaries, wages & employee benefits	17,843	22,668	4,825	21.3%
22,000	13,333	(8,667)	(65.0%)	Professional fees	22,000	13,333	(8,667)	(65.0%)
20,280	19,382	(898)	(4.6%)	Purchased services	20,280	19,382	(898)	(4.6%)
2,385	11,025	8,640	78.4%	Printing and postage	2,385	11,025	8,640	78.4%
714	89	(625)	(705.6%)	Other operating expenses	714	89	(625)	(705.6%)
29,494	29,494	0	0.0%	Indirect cost allocation, Occupancy Expense	29,494	29,494	0	0.0%
92,716	95,991	3,275	3.4%	Total Administrative Expenses	92,716	95,991	3,275	3.4%
238,894	29,395	209,499	712.7%	Change in Net Assets	238,894	29,395	209,499	712.7%
82.6%	91.3%	8.7%	9.5%	Medical Loss Ratio	82.6%	91.3%	8.7%	9.5%
4.9%	6.7%	1.8%	27.0%	Admin Loss Ratio	4.9%	6.7%	1.8%	27.0%

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CalOptima - PACE
Statement of Revenues and Expenses
For the One Month Ended July 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
177	165	12	7.3%	Member Months	177	165	12	7.3%
				Revenues				
779,409	737,856	41,553	5.6%	Medi-Cal capitation revenue	779,409	737,856	41,553	5.6%
289,106	306,370	(17,265)	(5.6%)	MediCare Part D Revenue	289,106	306,370	(17,265)	(5.6%)
1,068,515	1,044,226	24,288	2.3%	Total Operating Revenues	1,068,515	1,044,226	24,288	2.3%
				Medical Expenses				
245,211	417,027	171,816	41.2%	Clinical salaries & benefits	245,211	417,027	171,816	41.2%
0	0	0	0.0%	Pace Center Support salaries & benefits	0	0	0	0.0%
113	0	(113)	0.0%	Provider capitation	113	0	(113)	0.0%
325,487	214,807	(110,679)	(51.5%)	Claims payments to hospitals	325,487	214,807	(110,679)	(51.5%)
214,223	225,589	11,366	5.0%	Professional Claims	214,223	225,589	11,366	5.0%
96,410	122,748	26,338	21.5%	Prescription drugs	96,410	122,748	26,338	21.5%
5,601	22,000	16,399	74.5%	Long-term care facility payments	5,601	22,000	16,399	74.5%
55,435	68,291	12,856	18.8%	Patient Transportation	55,435	68,291	12,856	18.8%
48,342	49,349	1,007	2.0%	Depreciation & amortization	48,342	49,349	1,007	2.0%
37,655	37,214	(441)	(1.2%)	Occupancy expenses	37,655	37,214	(441)	(1.2%)
22,340	13,833	(8,507)	(61.5%)	Utilities & Facilities Expense	22,340	13,833	(8,507)	(61.5%)
150	250	100	40.0%	Purchased Services	150	250	100	40.0%
21,040	24,547	3,507	14.3%	Indirect Allocation	21,040	24,547	3,507	14.3%
5,273	22,785	17,512	76.9%	Other Expenses	5,273	22,785	17,512	76.9%
1,077,280	1,218,441	141,161	11.6%	Total Medical Expenses	1,077,280	1,218,441	141,161	11.6%
(8,766)	(174,215)	165,449	95.0%	Gross Margin	(8,766)	(174,215)	165,449	95.0%
				Administrative Expenses				
89,921	98,141	8,219	8.4%	Salaries, wages & employee benefits	89,921	98,141	8,219	8.4%
4,938	3,333	(1,605)	(48.1%)	Professional fees	4,938	3,333	(1,605)	(48.1%)
0	1,000	1,000	100.0%	Purchased services	0	1,000	1,000	100.0%
222	1,720	1,498	87.1%	Printing and postage	222	1,720	1,498	87.1%
2,014	2,056	42	2.0%	Depreciation & amortization	2,014	2,056	42	2.0%
9,037	11,426	2,389	20.9%	Other operating expenses	9,037	11,426	2,389	20.9%
2,446	1,023	(1,423)	(139.1%)	Indirect cost allocation, Occupancy Expense	2,446	1,023	(1,423)	(139.1%)
108,578	118,699	10,121	8.5%	Total Administrative Expenses	108,578	118,699	10,121	8.5%
(117,344)	(292,914)	175,570	59.9%	Change in Net Assets	(117,344)	(292,914)	175,570	59.9%
100.8%	116.7%	15.9%	13.6%	Medical Loss Ratio	100.8%	116.7%	15.9%	13.6%
10.2%	11.4%	1.2%	10.6%	Admin Loss Ratio	10.2%	11.4%	1.2%	10.6%

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CalOptima - Building 505 City Parkway
Statement of Revenues and Expenses
For the One Month Ended July 31, 2016

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
24,056	21,285	2,772	13.0%	Rental income	24,056	21,285	2,772	13.0%
24,056	21,285	2,772	13.0%	Total Operating Revenue	24,056	21,285	2,772	13.0%
				Administrative Expenses				
1,235	2,085	850	40.8%	Professional fees	1,235	2,085	850	40.8%
36,665	22,405	(14,261)	(63.6%)	Purchase services	36,665	22,405	(14,261)	(63.6%)
144,226	210,141	65,914	31.4%	Depreciation & amortization	144,226	210,141	65,914	31.4%
16,000	14,300	(1,700)	(11.9%)	Insurance expense	16,000	14,300	(1,700)	(11.9%)
123,855	189,537	65,682	34.7%	Repair and maintenance	123,855	189,537	65,682	34.7%
65,105	0	(65,105)	0.0%	Other Operating Expense	65,105	0	(65,105)	0.0%
(365,830)	(352,100)	13,730	3.9%	Indirect allocation, Occupancy Expense	(365,830)	(352,100)	13,730	3.9%
21,256	86,368	65,112	75.4%	Total Administrative Expenses	21,256	86,368	65,112	75.4%
2,800	(65,083)	67,884	104.3%	Change in Net Assets	2,800	(65,083)	67,884	104.3%

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OTHER STATEMENTS – JULY MONTH:

ONECARE INCOME STATEMENT

REVENUES of $1.9 million are favorable to budget by $0.5 million due to Part D experience

CHANGE IN NET ASSETS is $0.2 million, $0.2 million favorable to budget

PACE INCOME STATEMENT

- **Change in Net Assets** for the month is ($117.3) thousand, which is operating favorable to budget by $175.6 thousand

505 CITY PARKWAY BUILDING INCOME STATEMENT

- **Change in Net Assets** for the month is $2.8 thousand which is favorable to budget $67.9 thousand

CalOptima
BALANCE SHEET
July 31, 2016

ASSETS			**LIABILITIES & FUND BALANCES**		
Current Assets			Current Liabilities		
	Operating Cash	$475,725,744		Accounts payable	$14,887,899
	Catastrophic Reserves	11,633,210		Medical claims liability	613,681,231
	Investments	1,134,227,219		Accrued payroll liabilities	8,867,872
	Capitation receivable	234,516,162		Deferred revenue	673,243,791
	Receivables - Other	20,291,900		Deferred revenue - CMS	0
	Prepaid Expenses	11,935,241		Deferred lease obligations	267,070
				Capitation and withholds	414,314,900
	Total Current Assets	**1,888,329,476**		**Total Current Liabilities**	**1,725,262,764**
Capital Assets	Furniture and equipment	28,851,790			
	Leasehold improvements	11,762,557			
	505 City Parkway West	46,707,144		Other (than pensions) post employment benefits liability	27,594,452
		87,321,491		Net Pension Liabilities	8,158,985
	Less: accumulated depreciation	(32,262,681)		Long Term Liabilities	150,000
	Capital assets, net	**55,058,810**		**TOTAL LIABILITIES**	**1,761,166,201**
Other Assets	Restricted deposit & Other	279,518			
				Deferred inflows of Resources - Excess Earnings	**502,900**
	Board-designated assets			Deferred inflows of Resources - changes in Assumptions	**1,651,640**
	Cash and cash equivalents	3,104,519			
	Long term investments	472,836,571		Tangible net equity (TNE)	89,012,314
	Total Board-designated Assets	475,941,090		Funds in excess of TNE	572,278,856
	Total Other Assets	**476,220,608**		**Net Assets**	**661,291,170**
	Deferred outflows of Resources - Pension contributions	**3,787,544**			
	Deferred outflows of Resources - Difference in Experience	**1,215,473**			
TOTAL ASSETS & OUTFLOWS		**2,424,611,911**	**TOTAL LIABILITIES, INFLOWS & FUND BALANCES**		**2,424,611,911**

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CalOptima
Board Designated Reserve and TNE Analysis
as of July 31, 2016

Type	Reserve Name	Market Value	Benchmark		Variance	
			Low	High	Mkt - Low	Mkt - High
	Tier 1 - Payden & Rygel	135,383,499				
	Tier 1 - Logan Circle	125,385,604				
	Tier 1 - Wells Capital	125,378,616				
Board-designated Reserve		386,147,719	286,467,328	447,387,174	99,680,391	(61,239,455)
TNE Requirement	Tier 2 - Logan Circle	89,793,371	89,012,314	89,012,314	781,057	781,057
	Consolidated:	**475,941,090**	**375,479,642**	**536,399,488**	**100,461,449**	**(60,458,398)**
	Current reserve level	*1.77*	*1.40*	*2.00*		

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CalOptima
Statement of Cash Flows
July 31, 2016

	Month Ended	Year-To-Date
CASH FLOWS FROM OPERATING ACTIVITIES:		
Change in net assets	1,723,991	1,723,991
Adjustments to reconcile change in net assets to net cash provided by operating activities		
Depreciation and amortization	410,832	410,832
Changes in assets and liabilities:		
Prepaid expenses and other	(5,150,994)	(5,150,994)
Catastrophic reserves		
Capitation receivable	231,942,945	231,942,945
Medical claims liability	14,986,373	14,986,373
Deferred revenue	82,541,150	82,541,150
Payable to providers	12,488,598	12,488,598
Accounts payable	6,508,702	6,508,702
Other accrued liabilities	1,477,871	1,477,871
Net cash provided by/(used in) operating activities	346,929,468	346,929,468
GASB 68 CalPERS Adjustments	-	-
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of Investments	(114,962,586)	(114,962,586)
Purchase of property and equipment	(474,077)	(474,077)
Change in Board designated reserves	(85,243)	(85,243)
Net cash provided by/(used in) investing activities	(115,521,907)	(115,521,906)
NET INCREASE/(DECREASE) IN CASH & CASH EQUIVALENTS	231,407,562	231,407,562
CASH AND CASH EQUIVALENTS, beginning of period	$255,951,393	255,951,393
CASH AND CASH EQUIVALENTS, end of period	**$ 487,358,954**	**$ 487,358,954**

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BALANCE SHEET:

ASSETS Increased $119.7 million from June

- **Cash and Cash Equivalents** increased by $231.2 million from June based upon timing of state checks received, month-end cut-off and cash funding requirements
- **Net Capitation Receivables** decreased $230.6 million based upon receipt timing and receivables
- **Investments** increased $115.0 million due to month-end cut-off and cash funding requirements

LIABILITIES increased $118.0 million from June

- **Deferred Revenue** increased by $82.5 million from June due to:
    - Payment differentials for Medi-Cal Expansion and aged and disabled members
- **Medical Claim Liability** increased by $15.0 million from June based upon payment timing and actuarial estimates
- **Incentives and Risk Pool** increased $18.1 million based upon timing of pool estimates, recalculations and payouts

NET ASSETS are $661.3 million

CalOptima Foundation
Statement of Revenues and Expenses
For the One Month Ended July 31, 2016
Consolidated

Month					Year - To - Date			
Actual	Budget	$ Variance	% Variance		Actual	Budget	$ Variance	% Variance
				Revenues				
19,384	2,264	17,120	756.0%	Income - Grant	19,384	2,264	17,120	756.0%
32,050	0	32,050	100.0%	In Kind Revenue - HITEC Grant	32,050	0	32,050	100.0%
51,434	2,264	49,169	2171.4%	Total Operating Revenue	51,434	2,264	49,169	2171.4%
				Operating Expenditures				
21,166	6,184	(14,982)	(242.3%)	Personnel	21,166	6,184	(14,982)	(242.3%)
10,793	2,985	(7,809)	(261.6%)	Taxes and Benefits	10,793	2,985	(7,809)	(261.6%)
(3)	0	3	100.0%	Travel	(3)	0	3	100.0%
90	10,000	9,910	99.1%	Supplies	90	10,000	9,910	99.1%
19,387	17,174	(2,213)	(12.9%)	Contractual	19,387	17,174	(2,213)	(12.9%)
0	232,065	232,065	100.0%	Other	0	232,065	232,065	100.0%
51,434	268,408	216,974	80.8%	Total Operating Expenditures	51,434	268,408	216,974	80.8%
0	0	0	0.0%	Investment Income	0	0	0	0.0%
0	(266,144)	(266,144)	100.0%	Program Income	0	(266,144)	(266,144)	100.0%

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CalOptima Foundation
Balance Sheet
July 31, 2016

ASSETS		LIABILITIES & NET ASSETS	
Operating cash	2,870,525	Accounts payable-Current	29,386
Grants receivable	54,743	Deferred Revenue	0
Prepaid expenses	0	Payable to CalOptima	0
Total Current Assets	**2,925,269**	Grants-Foundation	1,037
		Total Current Liabilities	**30,423**
		Total Liabilities	**30,423**
		Net Assets	**2,894,845**
TOTAL ASSETS	**2,925,269**	**TOTAL LIABILITIES & NET ASSETS**	**2,925,269**

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CALOPTIMA FOUNDATION

INCOME STATEMENT:

Revenues

- Revenues from Health Information Technology for Economics and Clinical Health (HITEC) and in-kind contributions from CalOptima
- The Foundation recognized $51.4 thousand for July, 2016
    - HITEC Grant revenue totaled $19.4 thousand, which leaves $7.8 thousand remaining in HITEC Grant funding as of July 2016
    - CalOptima in-kind contribution totaled $32.0 thousand
- Revenue budget variances attributed to:
    - Grant funding originally allocated July-September 2016 for original extension, later ONC extended it through October 2016
    - CalOptima in-kind revenue was not included in FY17 budget

Expenses

- $51.4 thousand for grant related activities incurred in July, 2016
- Expense categories include staff services, travel and miscellaneous supplies
    - $217.0 thousand favorable to budget
    - FY17 budget was based on remaining fund balance in Foundation total assets
    - Actual expenses were much lower than anticipated for CalOptima support activities

BALANCE SHEET:

Assets

- Cash of $2.9 million remains from the FY14 $3.0 million transfer from CalOptima for grants and programs in support of providers and community
- $55.0 thousand current month grant receivable for ONC draw down of HITEC grant

Liabilities

- $29.4 thousand current month provider payable for HITEC grant services

Budget Allocation Changes
Reporting changes for July 2016

Transfer Month	Line of Business	From	To	Amount	Expense Description	Fiscal Year
July	OneCare Connect	Office of Compliance - Professional Fees (Consultant for Annual CPE Audit & CMS Mock Audit)	Office of Compliance - Professional Fees - Consultant for DMHC Mock Audit	$69,000	Re-purpose $53,631 from Professional Fees (Consultant for Annual CPE Audit) and $15,369 from Professional Fees (Consultant for CMS Mock Audit) to pay for consultant for DMHC Mock Audit	2017
July	COREC	REC - Other	REC - Comp Supply/Minor Equip	$10,000	Re-allocate funds to cover costs for computer equipment upgrade which is approved ONC grant managers	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$63,810	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for FY17 Ceridian Software Maintenance	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$15,010	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for FY17 Talentova Learning Management System	2017
July	Medi-Cal	IS-Application Development - Software Maintenance - Corporate Software Maintenance	IS-Application Development - Software Maintenance - Human Resources Corporate Application Software Maintenance	$23,900	Re-purpose funds within Software Maintenance (from Corporate Software Maintenance to Human Resources Corporate Application Software Maintenance) to pay for Silk Road	2017
July	Medi-Cal	Claims Administration - Purchased Services - Integration of Claim Editing Software	Claims Administration - Purchased Services - LTC Rate Adjustments	$98,000	Re-purpose funds from within Purchased Services (Integration of Claim Editing Software) to pay for LTC Adjustments (TriZetto Robot Process)	2017
July	Medi-Cal	Human Resources - Advertising, Travel, Comp Supply/Minor Equip, Subscriptions, Courier/Delivery	Human Resources - Professional Fees (Salary & Compensation Research), Public Activities, Office Supplies, Food Service Supplies, Professional Dues, Training & Seminars, Cert./Cont. Education	$84,491	Re-allocate HR FY17 Budget based on HR dept's past spending trends to better meet department's need	2017
July	Medi-Cal	IS-Infrastructure - Telephone - General Telecommunication and Network Connectivity	IS-Infrastructure - Purchased Services - Disaster Recovery Services	$35,575	Re-allocate funds from Telephone (General Telecommunication and Network Connectivity) to Purchased Services to pay for Disaster Recovery Services	2017

This report summarizes budget transfers between general ledger classes that are greater than $10,000 and less than $100,000.
This is the result of Board Resolution No. 12-0301-01 which permits the CEO to make budget allocation changes within certain parameters.

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Board of Directors Meeting
September 1, 2016

Monthly Compliance Report

The purpose of this report is to provide compliance updates to CalOptima's Board of Directors, including but may not be limited to, updates on internal and external audits conducted by CalOptima's Audit & Oversight department, regulatory audits, privacy updates, fraud, waste, and abuse (FWA) updates, and any notices of non-compliance or enforcement action issued by a regulator.

A. Updates on Regulatory Audits

1. OneCare Connect

- One Care Connect CMS Mock Audit: CalOptima anticipates that CMS will select its OneCare Connect program for a full-scope program audit some time in CY 2016. As such, CalOptima has engaged a consultant to conduct a mock audit on its OneCare Connect program using the 2016 CMS audit protocols. Mock audit activities, began the week of June 6, 2016, and will continue through November 2016.

- OneCare Connect DMHC Mock Audit: CalOptima anticipates that the Department of Managed Health Care (DMHC) will begin an audit of Medicaid-based services in OneCare Connect beginning on September 26, 2016. In preparation, CalOptima has engaged a consultant to conduct a mock audit on its OneCare Connect program using the DMHC Cal MediConnect Technical Assistance Guides (TAG) tools. Mock audit activities began the week of June 16, 2016. Associated efforts, including remediation of mock audit findings, continue through August 2016.

2. PACE

- 2016 Annual PACE Audit: On June 30, 2016, CMS issued an engagement letter to CalOptima PACE for the annual audit scheduled to occur from August 29 - September 1, 2016. Pre-audit file submissions were submitted to CMS by the July 29, 2016 deadline.

- 2016 PACE Level of Care (LOC) Audit: On August 2, 2016, DHCS issued an engagement notice to CalOptima PACE for the level of care (LOC) audit scheduled to occur on October 26, 2016. The purpose of the audit is to ensure the information submitted on the initial LOC documents is consistent with the assessments documented by the Interdisciplinary Care Team.

3. Medi-Cal

- 2015 Medi-Cal Audit: The Department of Health Care Services (DHCS) conducted an onsite audit of CalOptima's Medi-Cal program from February 8 – 19, 2016. The review

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period was from February 1, 2015 - November 30, 2015. The DHCS Medi-Cal audit consisted of an evaluation of CalOptima's compliance with its contract and regulations in the areas of utilization management, case management and care coordination, access and availability, member rights and responsibilities, quality improvement system, organization and administration of CalOptima, facility site reviews, and medical records review. On July 13, 2016, DHCS issued the final audit report, which identified findings in the following three (3) areas --- case management and care coordination, member's rights, and administrative and organizational capacity. Specifically, the findings were as follows:

- Case Management and Care Coordination:
  - Medical record documentation for the completion of an Initial Health Assessment requirement is inadequate.
  - The Plan's methodology to monitor compliance with the Initial Health Assessment requirement is inadequate.
- Member's Rights: The Plan did not submit the completed report of investigation to all required DHCS personnel.
- Administrative and Organizational Capacity: The Plan did not report a suspected fraud and abuse case to the DHCS within the required timeframe.

- CalOptima submitted its corrective action plans (CAPs) to the DHCS by the August 15, 2016 deadline. CalOptima is pending acceptance of the CAPs and closure of the audit by the DHCS.

4. Other

- 2016 DMHC Routine Examination: The DMHC began the routine examination of CalOptima's financial and administrative affairs on August 15, 2016. The audit will primarily focus on CalOptima's Healthy Families Program in place during the review period, and on CalOptima's organization-wide finances and administration.

B. Regulatory Compliance Notices

1. On 8/1/16, CMS issued a notice to CalOptima that it did not successfully submit Medication Therapy Management (MTM) program data for calendar year 2015 for its OneCare program; and therefore, no data were available for independent validation. As a result, CalOptima failed the data validation for its OneCare MTM program. No further action is required by CMS. However, the expectation is for CalOptima to ensure that it successfully submits MTM program data in a timely manner moving forward.

C. Updates on Internal /External Audits

1. Internal Audits: Medi-Cal

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

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness for Routine	Timeliness for Denials	Clinical Decision Making (CDM) for Denials	Letter Score for Denials	Timeliness for Extended
March 2016	27%	NA	N/A	3%	75%	88%	93%	25%
April 2016	67%	100%	85%	0%	94%	88%	88%	18%
May 2016	7%	NA	NA	23%	88%	89%	87%	38%

- The lower scores for timeliness for urgent PA requests were due to the following reasons:
  - Failure to meet decision timeframe (72 hours)

- The lower scores for timeliness for routine PA requests were due to the following reasons:
  - Failure to meet decision timeframe (5 business days)
  - Failure to meet provider initial notification timeframe (24 hours)

- The lower scores for timeliness for denials were due to the following reasons:
  - Failure to meet decision timeframe (5 business days)
  - Failure to meet provider initial notification timeframe (24 hours) and written notification timeframe (2 business days)

- The lower scores for timeliness for extended PA requests were due to the following reasons:
  - Failure to meet extended decision timeframe (14 calendar days)
  - Failure to meet provider initial notification timeframe (24 hours)
  - Failure to meet member written notification timeframe (2 business days)

- The lower scores for clinical decision making (CDM) for denials were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision
  - Failure to obtain adequate clinical information for decision

- The lower letter scores for denials were due to the following reasons:

- Failure to use lay language for services description
- Failure to describe reason the request did not meet criteria in lay language
- Failure to provide alternative direction

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2016	100%	100%	100%	100%
April 2016	93%	97%	100%	100%
May 2016	90%	100%	100%	97%

- The lower review score for denied claims accuracy in May 2016 was due to the following reason:
  - Claim was denied incorrectly for authorization

- The compliance rate for denied claims timeliness has been consistent at 100% from March to May 2016.

- The lower review score for paid claims timeliness in May 2016 was due to a failure to meet the claims processing timeframe (45 business days/60 calendar days).

- The compliance rate for paid claims accuracy has increased from 97% to 100% from April to May 2016.

2. Internal Audits: OneCare

- OneCare Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
March 2016	100%
April 2016	100%
May 2016	100%

- Monitoring scores for coverage determination timeliness remain consistent at 100% from March to May 2016.

- OneCare Pharmacy: Coverage determinations for protected classes of drugs are reviewed weekly to ensure that they are processed in accordance with the regulatory requirements and the appropriate timeframe.

Month	Protected Drug Cases Reviewed	Protected Drug Cases Failed	Overall Compliance
March 2016	4	0	100%
April 2016	1	0	100%
May 2016	3	0	100%

- The compliance rate for protected classes of drugs remains consistent at 100% from March to May 2016.

- OneCare Pharmacy: Coverage determinations for unprotected classes of drugs are reviewed weekly to ensure that they are processed in accordance with the regulatory requirements and appropriate timeframe.

Month	Unprotected Drug Cases Reviewed	Unprotected Drug Cases Failed	Overall Compliance
March 2016	23	0	100%
April 2016	20	2	90%
May 2016	29	2	93%

- The compliance rate for unprotected classes of drugs has increased from 90% to 93% at or above 90% from April to May 2016.

- OneCare Pharmacy: Direct member reimbursement (DMR) requests are reviewed on a monthly basis to ensure that they are processed in accordance with the regulatory requirements and appropriate timeframe.

Month	% of DMR Cases Compliant
March 2016	100%
April 2016	No DMR Requests
May 2016	100%

- For March and May 2016, 100% of DMR cases were compliant.

- There were no DMR requests for April 2016.

- OneCare Utilization Management (UM):

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials
March 2016	Nothing to Report	Nothing to Report	Nothing to Report	100%	67%	Nothing to Report	Nothing to Report	Nothing to Report
April 2016	Nothing to Report	Nothing to Report	Nothing to Report	100%	78%	Nothing to Report	Nothing to Report	Nothing to Report
May 2016	Nothing to Report	Nothing to Report	Nothing to Report	100%	67%	Nothing to Report	Nothing to Report	Nothing to Report

  - The lower letter scores for SOD were due to the following reasons:
    - Failure to use approved CMS letter templates
    - Failure to use lay language

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2016	100%	87%	100%	100%
April 2016	90%	100%	100%	83%
May 2016	100%	100%	100%	100%

  - The monitoring scores for denied claims timeliness have remained consistent at 100% from March to May 2016.
  - The monitoring scores for paid claims accuracy have remained consistent at 100% from April to May 2016.
  - The compliance rate for paid claims timeliness and denied claims accuracy increased to 100% for May 2016.

3. Internal Audits: OneCare Connect

- OneCare Connect Pharmacy: Coverage determination timeliness is reviewed on a daily basis to ensure that they are processed in the appropriate timeframe.

Month	% Compliant with Timeliness
March 2016	100%
April 2016	100%
May 2016	100%

- Timeliness for coverage determinations remained consistent at 100% from March to May 2016.

- OneCare Connect Pharmacy: Coverage determinations for protected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements and in the appropriate timeframe.

Month	Protected Drug Cases Reviewed	Protected Drug Cases Failed	Overall Compliance
March 2016	15	0	100%
April 2016	10	0	100%
May 2016	29	0	100%

- The monitoring scores for coverage determinations for protected drug cases remain consistent at 100% from March to May 2016.

- OneCare Connect Pharmacy: Coverage determinations for unprotected classes of drugs are reviewed weekly to ensure that they are processed in accordance with regulatory requirements and in the appropriate timeframe.

Month	Unprotected Drug Cases Reviewed	Unprotected Drug Cases Failed	Overall Compliance
March 2016	105	8	92.4%
April 2016	110	7	93.6%
May 2016	121	7	94.2%

- The monitoring scores for coverage determinations for unprotected classes of drugs range from 92% to 94% from March to May 2016.

- OneCare Connect Pharmacy: Direct member reimbursement (DMR) requests are reviewed on a monthly basis to ensure that they are processed in accordance with regulatory requirements and in the appropriate timeframe.

Month	DMR Cases Reviewed	DMR Cases Failed	Overall Compliance
March 2016	12	1	91.7%
April 2016	13	0	100%
May 2016	8	0	100%

- The compliance rate for direct member reimbursements is consistent at 100% for April and May 2016.

- The lower score for March 2016 was due to check payment information that was not made available for the review period.

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

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
March 2016	85%	NA	52%	23%	3%	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report	Nothing to Report
April 2016	0%	100%	94%	25%	50%	67%	100%	89%	Nothing to Report	Nothing to Report	Nothing to Report
May 2016	57%	NA	71%	91%	78%	75%	92%	100%	Nothing to Report	Nothing to Report	Nothing to Report

- The lower scores for timelines for urgent PA requests were due to the following reasons:
  - Failure to meet decision timeframe (72 hours)
  - Failure to provide initial notification within timeframe (24 hours) and written notification within timeframe (2 business days)

- The lower letter scores for urgents PA requests were due to the following reasons:
  - Failure to use lay language
  - Failure to issue member letter in the member's preferred language

- The lower scores for timelines for routine PA requests were due to the following reasons:
  - Failure to meet decision timeframe (5 business days)
  - Failure to meet initial provider notification timeframe (24 hours)

- The lower letter scores for routine PA requests were due to the following reasons:
  - Failure to use lay language
  - Failure to issue member letter in the member's preferred language

- The lower scores for timelines for denied PA requests were due to the following reasons:
  - Failure to meet decision timeframe (5 business days)

- The lower score for clinical decision making for denied PA requests was due to the following reason:
  - Failure to cite specific criteria utilized to make the decision

- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2016	97%	87%	100%	100%
April 2016	88%	88%	100%	100%
May 2016	77%	87%	100%	100%

- The monitoring scores for paid claims timeliness decreased from April to May 2016 due to a failure to meet claims processing timeframes (non-contracted provider, clean claims must be processed within 30 calendar days).

- The monitoring scores for paid claims accuracy has remained consistent between 87%-88% due to the following reasons:
  - Payment made for non-payable charges
  - Claim developed in error
  - Incorrect authorization used
  - Incorrect interest payment

- The monitoring scores for denied claims timeliness and accuracy have remained at 100% from March to May 2016.

4. External Audits: Medi-Cal

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

Month	Timeliness for Urgents	Clinical Decision Making (CDM) for Urgents	Letter Score for Urgents	Timeliness for Routine	Timeliness for Denials	CDM for Denials	Letter Score for Denials	Timeliness for Modifieds	CDM for Modifieds	Letter Score for Modifieds	Timeliness for Deferrals	CDM for Deferrals	Letter Score for Deferrals
March 2016	93%	97%	93%	92%	92%	99%	97%	88%	100%	100%	50%	100%	83%
April 2016	95%	100%	100%	98%	89%	97%	95%	85%	95%	98%	39%	100%	85%
May 2016	80%	100%	100%	77%	76%	89%	95%	91%	93%	97%	50%	67%	77%

- The lower scores for timeliness were due to the following reasons:
  - Failure to meet decision timeframe (Urgent – 72 hours; Routine – 5 business days)
  - Failure to meet timeframe for member notification (Routine – 2 business days)
  - Failure to meet timeframe for initial provider notification (24 hours)

  - Failure to provide proof of successful initial written notification to requesting provider (24 hours)
  - Failure to meet timeframe for delayed notification to provider (Extended – 5 business days)

- The lower scores for clinical decision making (CDM) were due to the following reasons:
  - Failure to cite the criteria utilized to make the decision
  - No indication that the medical reviewer was involved in the denial determination
  - No indication of adequate clinical information obtained to make the decision to deny

- The lower letter scores were due to the following reasons:
  - Provider notification did not include name and contact information for the medical director responsible for the decision to delay
  - Language assistance program (LAP) insert was not provided to member and typographical errors were identified throughout the document
  - Failure to provide letter with description of services in lay language
  - Failure to provide letter in member's primary language
  - Failure to include name and contact information for health care professional responsible for decision to deny
  - Failure to notify member of delayed decision and anticipated decision date
  - Failure to notify provider of delayed decision and anticipated decision date

- Medi-Cal Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
March 2016	97%	100%
April 2016	98%	95%
May 2016	98%	99%

- The compliance rate for misclassified paid and denied claims has remained stable at or above 95% from March to May 2016.

- Medi-Cal Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2016	99%	97%	100%	90%
April 2016	89%	88%	100%	100%
May 2016	93%	98%	98%	95%

  - The compliance rate for denied claims timeliness and accuracy has decreased from April to May 2016 due to untimely and inaccurate processing of claims (45 business days/60 calendar days).

  - The compliance rate for paid claims timeliness and accuracy has increased from April to May 2016.

- Medi-Cal Claims: Misclassified Hospital Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
March 2016	96%	100%
April 2016	100%	77%
May 2016	100%	74%

  - The compliance rate for misclassified denied claims decreased from 77% in April 2016 to 74% in May 2016 as a result of not providing evidence of member denial letter being sent and invalid billing/procedure codes being utilized.

- Medi-Cal Claims: Hospital Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2016	100%	100%	100%	100%
April 2016	100%	100%	100%	100%
May 2016	100%	100%	100%	100%

  - The compliance rate for paid claims timeliness and accuracy as well as denied claims timeliness and accuracy has remained at 100% from March to May 2016.

5. External Audits: OneCare

- OneCare Utilization Management (UM): Prior Authorization (PA) Requests

Month	Timeliness for Expedited Initial Organization Determination (EIOD)	Clinical Decision Making (CDM) for EIOD	Letter Score for EIOD	Timeliness for Standard Organization Determination (SOD)	Letter Score for SOD	Timelines for Denials	Clinical Decision Making (CDM) for Denials	Letter Score for Denials
March 2016	83%	Nothing to Report	79%	89%	83%	67%	67%	67%
April 2016	100%	Nothing to Report	91%	100%	96%	100%	100%	100%
May 2016	100%	Nothing to Report	100%	100%	81%	100%	89%	100%

  - The lower letter scores were due to the following reasons:
    - Failure to use approved CMS letter template
    - Failure to provide letter with description of services in lay language
  - The lower scores for clinical decision making (CDM) were due to the following reasons:
    - Failure to cite the criteria utilized to make the decision

- OneCare Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
March 2016	100%	100%
April 2016	98%	97%
May 2016	100%	100%

  - The compliance rate for misclassified paid and denied claims increased to 100% from April to May 2016.

- OneCare Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2016	97%	97%	99%	84%
April 2016	98%	98%	100%	83%
May 2016	100%	100%	100%	100%

  - The compliance rate for paid claims timeliness, paid claims accuracy, and denied claims accuracy increased to 100% from April to May 2016.

6. External Audits: OneCare Connect

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

Month	Timeliness for Urgents	Clinical Decision Making for Urgents	Letter Score for Urgents	Timeliness For Routine	Letter Score for Routine	Timeliness for Denials	Clinical Decision Making for Denials	Letter Score for Denials	Timeliness for Modifieds	Clinical Decision Making for Modifieds	Letter Score for Modifieds	Timeliness for Deferrals	Clinical Decision Making for Deferrals	Letter Score for Deferrals
March 2016	70%	33%	59%	78%	67%	61%	67%	65%	0%	33%	33%	44%	50%	50%
April 2016	86%	89%	86%	94%	77%	66%	100%	98%	43%	83%	89%	100%	100%	100%
May 2016	92%	100%	78%	87%	83%	51%	92%	85%	33%	100%	90%	100%	100%	100%

  - The lower scores for timeliness were due to the following reasons:
    - Failure to meet decision timeframe (Urgent – 72 hours; Routine – 5 business days)
    - Failure to meet timeframe for initial provider notification (24 hours)
    - Failure to provide proof of successful initial written notification to requesting provider (24 hours)
    - Failure to provide letter with description of services in lay language

  - The lower scores for clinical decision making were due to the following reasons:
    - Failure to cite the criteria utilized to make the decision

  - The lower letter scores were due to the following reasons:
    - Failure to provide letter in member's primary language
    - Failure to outline reason for not meeting the criteria (lay language) in denial letter
    - Failure to include name and contact information for health care professional responsible for decision to deny
    - Failure to provide peer-to-peer discussion of the decision with medical reviewer
    - Failure to provide referral back to primary care physician (PCP) on denial letter

- OneCare Connect Claims: Misclassified Claims

Month	Misclassified Paid Claims	Misclassified Denied Claims
March 2016	99%	99%
April 2016	100%	100%
May 2016	98%	92%

  - The compliance rate for misclassified denied claims accuracy decreased from April to May 2016 due to paid claim being reported on the denial universe.

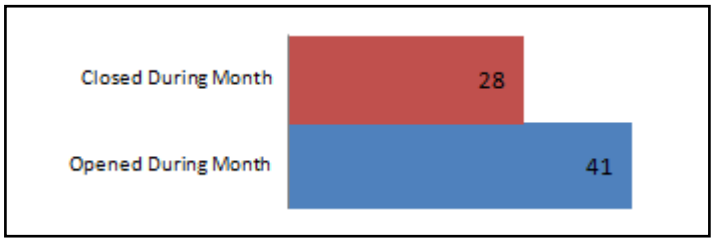
- OneCare Connect Claims: Professional Claims

Month	Paid Claims Timeliness	Paid Claims Accuracy	Denied Claims Timeliness	Denied Claims Accuracy
March 2016	98%	97%	100%	77%
April 2016	99%	93%	100%	85%
May 2016	98%	98%	100%	89%

  - The lower compliance scores were due to the following reasons:
    - Misdirected claims received by CalOptima
    - Failure to add correct interest on billed amount
    - Failure to forward claims to CalOptima in a timely manner

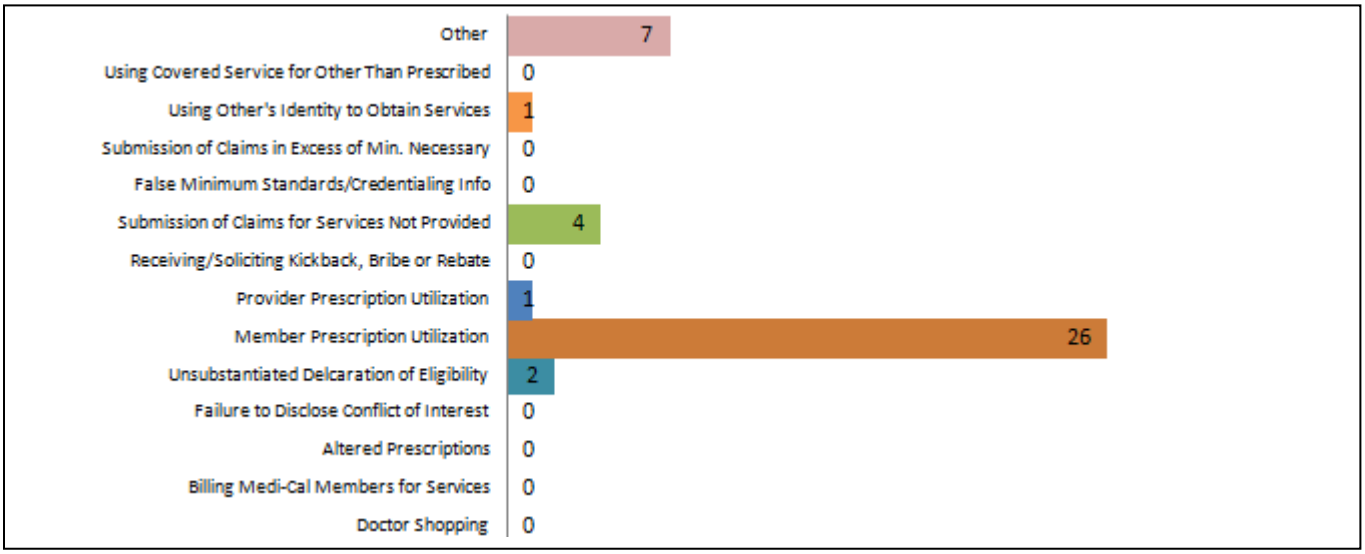
D. Special Investigations Unit (SIU) / Fraud, Waste & Abuse (FWA) Investigations (July 2016)

Case Status
Case status at the end of July 2016

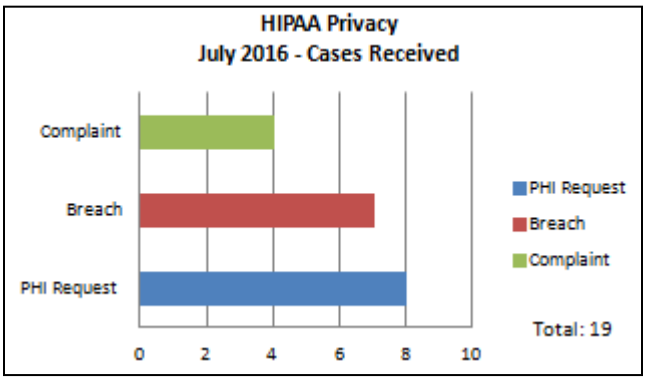


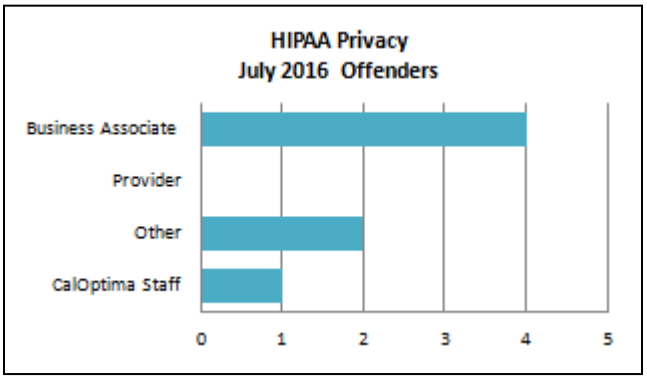
Note: Cases that are referred to DHCS or the MEDIC are not "closed" until CalOptima receives notification of case closure from the applicable government agency.

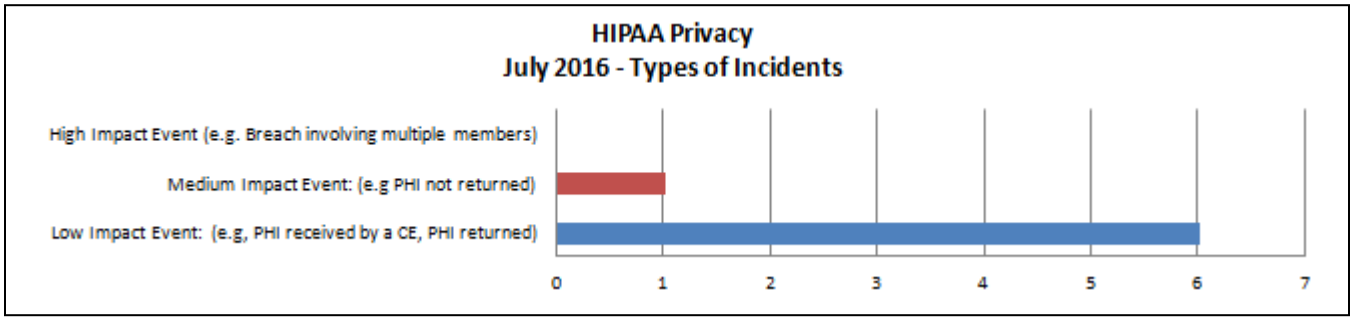
Types of FWA Cases:
(Received in July 2016)



E. Privacy Cases (July 2016)







PRIVACY STATISTICS

Total Number of Breaches Reported to DHCS (State)	7
Total Number of Breaches Reported to Office of Civil Rights (OCR)	0

A Public Agency

CalOptima

Better. Together.

Federal & State Legislative Advocate Reports

Board of Directors Meeting

September 1, 2016

James McConnell / Edelstein Gilbert Robson & Smith

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CalOptima
Washington Report
August 19, 2016

The House and Senate remain in their seven-week summer recess until September 6. This fall, Congress will act on all 12 annual spending bills for the new fiscal year which begins on October 1. This will inevitably be a two-step process—first, in September, a Continuing Resolution (CR) to keep the government open and functioning after the start of the new fiscal year until after the elections, and second—most likely in December—an Omnibus appropriations bill to fund the government for the remainder of the fiscal year.

On July 22, President Obama signed the "Comprehensive Addiction and Recovery Act (CARA) of 2016" (S. 524) into law. The new act addresses the opioid addiction crisis unfolding throughout the country through new Department of Justice (DOJ) and Department of Health and Human Services (HHS) grant programs to prevent and treat addiction, and support those in recovery.

CARA authorizes several new federal grant programs, but does not appropriate any new funding. Congressional Republicans have said that the opioid programs should be funded through the traditional appropriations process. House and Senate appropriators have approved or introduced various opioid spending provisions for Fiscal Year 2017, including: between $103-132 million within the Commerce-Justice-Science FY 2017 Appropriations bills for DOJ enforcement, prevention and treatment programs and between $261-581 million within the Labor-HHS-Education FY 2017 Appropriations bills for HHS opioid programs.

The Administration issued a statement on President Obama signing CARA into law, stating that "[t]his legislation includes some modest steps to address the opioid epidemic. Given the scope of this crisis, some action is better than none."

On August 5, the Government Accountability Office (GAO) issued a report on the "innovation" waivers that states can seek under the Affordable Care Act (ACA) starting in 2017 which are designed to bring health coverage to more residents in vulnerable groups. The report suggests that states which seek to roll back Medicaid expansion will have a difficult time doing so under the "superwaiver" process that is distinct from the 1115 "demonstration" waiver. That process has been used by several states to make adjustments to the program.

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Under the ACA, states can use 1332 Medicaid waivers starting in 2017 to tinker with some of the law's core provisions, including the individual mandate, employer penalties, rules governing exchanges and covered benefits, as well as premium tax credits. However, the GAO report states that as a practical matter, proposals cannot upend the need for the IRS and the federal exchange, HealthCare.gov, to administer a consistent program across states.

States that are using the federal exchange will have more limits on using the 1332 process than those that have their own exchange. The report states that "Changes to the calculation of premium tax credits, as well as applying state-specific enrollment periods are examples of changes that cannot be accommodated" for states using the federal exchange.

The most high-profile attempt to change Medicaid expansion is occurring in Kentucky, where Governor Matt Bevin has proposed an 1115 waiver to make several changes to the program. He has said the current Medicaid expansion, which is credited with insuring 450,000 people and bringing the uninsured rate down from above 20 percent to 7.5 percent, is not sustainable. Under the ACA, states will start paying up to 10 percent of the costs of expansion in 2017.

The GAO report states that the 1332 waivers must achieve four goals: (1) they must cover "at least a comparable" number of people, (2) benefits must be on par with a qualified health plan, (3) coverage and out-of-pocket spending cannot be more expensive than they were without the waiver, and (4) the wavier cannot increase the federal deficit.

Also, the report notes, states seeking waivers must show how they will affect those with low incomes, the elderly, and the chronically ill. The effect on vulnerable populations is key: "Even if a state can demonstrate that a waiver meets the criteria for its overall population, if the waiver reduces coverage, comprehensiveness, or affordability for any of these subgroups, the waiver would fail to meet the criteria," the report states.

GAO found that the Departments of HHS and the Treasury do not plan to let states develop their own numbers; rather, they must use federal population, growth, and cost trend information. An actuary must certify that benefit levels and how many people will be covered. The report also states that deficit neutrality tests will mean that waivers cannot shift costs to other federal programs, including traditional Medicaid.

HHS and Treasury are developing tools to accommodate an expected wave of applications, taking a "collaborative" approach that calls for states to work actively with the Centers for Medicare and Medicaid Services (CMS) even before a formal plan is submitted. According to the report, HHS believes 1332 waivers must stand on their own, apart from other waivers that might be pending.

Congress will return to Washington on September for a busy month of appropriations activity, and then go into recess for the fall election campaign.

EDELSTEIN GILBERT ROBSON & SMITH LLC

Donald B. Gilbert Michael R. Robson Trent E. Smith Alan L. Edelstein OF COUNSEL

CalOptima Legislative Report

August 19, 2016
By Don Gilbert and Trent Smith

The Legislature adjourns for the year at midnight on August 31. The last few weeks of the Legislative Session are always the most hectic. It is the time of year when deals on big policy objectives are either finalized or abandoned.

In the case of SB 586, authored by Senator Hernandez, a deal appears to be within sight. SB 586 is the California Children's Services (CCS) program reform bill, which proposes placing CCS enrollees into managed care settings only in County Organized Health Systems (COHS).

Our firm has been very involved in SB 586 negotiations. Earlier this year, we helped organized discussions between CalOptima staff and key legislative staff. These discussions were very beneficial and helped shape the current version of the bill.

The latest amendments to SB 586 address one of the biggest policy obstacles remaining in the bill. For the better part of two years, negotiations have focused on how to transition county public health nurses under the purview of COHS plans. These county nurses provide eligibility review and case management services for CCS families. The recent amendments allow COHS and counties to negotiate Memorandums of Understanding (MOU) so that solutions can be developed to best meet local needs. The Department of Health Care Services (DHCS) could interject and impose changes to the MOU if they determine costs to exceed current state payments.

Another of the latest amendments made to SB 586 limits continuity of care requirements for doctors and other health care providers to one year. The previous version allowed a new CCS enrollee that begins receiving care under the COHS model to keep their current doctor up to three years without the doctor entering into a contract with the COHS. DHCS pushed to limit continuity of care to one year, which is consistent with current continuity of care law for other health care programs. DHCS argued that health care providers could continue serving patients for three years without any incentive to contract with the health plan. Without contracting with the plan, these providers would not be part of the plan network and, therefore, would not be available to serve other CCS enrollees.

As we previously reported, it is important to understand that the Governor and DHCS maintained the most leverage in the CCS negotiations. The current CCS carve out from managed care expires at the end of the year. If SB 586 does not become law, DHCS can put CCS under managed care without any of the statutory guidelines included in the bill and supported by patient advocates, providers, and labor unions. Therefore, there was incentive for these groups to draft SB 586 in a form that is acceptable to the

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Governor. We expect that SB 586 will ultimately pass both houses of the Legislature and will be signed into law by the Governor.

Other pending bills that are of interest to CalOptima include AB 2394 by Assemblywoman Garcia. This measure proposes adding nonmedical transportation to the schedule of benefits covered under Medi-Cal. Utilization controls and permissible time and distance standards would be applicable. AB 2394 recently passed out of the Senate Appropriations Committee on a bipartisan vote. It appears that this bill will likely pass to the Governor. However, the Governor's position on the bill is uncertain. Traditionally, the Governor has opposed bills that could add cost to the Medi-Cal program.

AB 2077 by Assemblywoman Burke establishes procedures to ensure that eligible recipients of insurance affordability programs move between the Medi-Cal program and other insurance affordability programs without any breaks in coverage. The bill would require an individual's case to be run through the California Healthcare Eligibility, Enrollment, and Retention System (CalHEERS). Furthermore, the bill would generally prohibit Medi-Cal benefits from being terminated until at least 30 days after the county sends the notice of action terminating Medi-Cal eligibility. AB 2077 will increase the responsibilities of counties in the administration of the Medi-Cal program. This measure has bipartisan support and appears likely to make it to the Governor's desk.

Another bill we have been monitoring for CalOptima is AB 1831 authored by Assemblyman Low. This bill requires all health plans to allow for early refill of covered topical ophthalmic products at 70 percent of the predicted days of use. The author argues that the special early refill policy proposed in AB 1831 is necessary because eye drop medications are difficult to administer and some portion of the medication is wasted in failed attempts to place drops in the patient's eye. The fate of AB 1831 will ultimately be determined by the Governor.

SB 999 by Senator Pavley is another bill that has a good chance to reach the Governor. This measure would require health plans to authorize pharmacies to dispense a 12-month supply of FDA approved self-administered hormonal contraceptives.

Finally, another bill of interest that appears destined to reach the Governor's desk is SB 1335 by Senator Mitchell. This measure authorizes federally qualified health centers (FQHCs) and rural health clinics (RHCs) to provide Drug Medi-Cal (DMC) services.

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LEGISLATIVE TRACKING MATRIX

Bill No. Author	Bill Summary	Bill Status	CalOptima Position
SB 586 Hernandez	Authorizes the Department of Health Care Services (DHCS) to establish a Whole Child Model program that would transition the California Children's Services (CCS) program from the fee-for-service (FFS) delivery model to Medi-Cal managed care in specified health plans, including CalOptima. Requires CalOptima to provide CCS benefits for 11,810 CCS-eligible children in Orange County.	**08/11/2016** – Passed Assembly Committee on Appropriations, ordered to third reading	Watch
SB 1010 Hernandez	Requires health plans or insurers, including CalOptima, to submit prescription drug rate information to the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI). Requires drug manufacturers to justify their drug prices in these situations.	**08/11/2016** – Removed from Assembly at the request of the author	Watch
SB 1034 Mitchell	Prohibits health plans from denying medically necessary Behavioral Health Treatment (BHT) services for members with Autism Spectrum Disorder (ASD) based on setting, location, time of treatment, or lack of parent/caregiver participation. CalOptima already complies with the current provisions of this bill. Eliminates the sunset date on the health insurance mandate for plans to cover BHT services.	**08/11/2016 –** Held under submission	Watch
SB 1273 Moorlach	Clarifies that Mental Health Services Act (MHSA) funds may be used by county mental health programs to provide outpatient crisis stabilization services (CSS) for eligible individuals. This bill does not directly impact CalOptima, but clarifies that individuals (including CalOptima members) in need of CSS can receive outpatient care funded by MHSA.	**08/19/2016** – Removed at the request of the author	Support
SB 1308 Nguyen	Prohibits County Organized Health Systems (COHS), including CalOptima, from utilizing funds for staff retreats, promotional giveaways, or excessive executive compensation. Prohibits COHS from purchasing media campaigns that feature elected public officials.	**04/06/2016** –Removed from Senate Committee on Health hearing agenda at the request of the author	Oppose
SB 1361 Nielsen	Restores Medi-Cal coverage to provide one pair of eyeglasses every two years to a beneficiary over 21 years old whose vision is equal to or poorer than 20/40. Makes changes to vision benefits for CalOptima members.	**05/27/2016** – Held under submission	Watch

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Bill No. Author	Bill Summary	Bill Status	CalOptima Position
SB 1377 Nguyen	Appropriates $3.3 million from the General Fund to DHCS for allocation to contract with 11 non-profit Caregiver Resource Centers statewide, including one in Orange County. May potentially benefit caregivers that support cognitively impaired CalOptima members.	**05/27/2016** – Held under submission	Watch
SB 1436 Bates	Requires that final action on a local public agency's executive salary, salary schedule, or compensation paid in the form of fringe benefits be made a separate discussion item and not placed on the agency's consent calendar. Makes a procedural change to require an oral summary report of the merit increases for the specified executives before final action is taken.	**08/04/2016** – Passed Assembly, presented to Governor	Watch
AB 1051 Maienschein	Appropriates $200 million from the General Fund to the DHCS for the Denti-Cal program, and requires DHCS to allocate these funds to increase funding for preventative care and case management services. Members who receive Denti-Cal benefits outside of CalOptima may be affected by the potential funding increase for the Denti-Cal program.	**08/11/2016 –** Held under submission	Watch
AB 1696 Holden	Expands tobacco cessation benefits for Medi-Cal managed care plans, including increasing the number of quit attempts, expanding the list of approved medication types, and eliminating the care authorization requirement.	**08/16/2016** – Passed Senate, referred to the Assembly	Watch
AB 1795 Atkins	Increases funding and expands benefits of the Breast and Cervical Cancer Treatment Program (BCCTP) by extending treatment services from 18 to 24 months to the total duration of service needed for the individual, so long as the individual continues to meet eligibility requirements. May affect up to approximately 650 CalOptima members who currently receive BCCTP benefits.	**08/17/2016** – Passed Senate, referred to the Assembly	Watch
AB 2077 Burke Bonilla	Establishes procedures to ensure that beneficiaries who move between Medi-Cal and Covered California do not experience any breaks in coverage, and prohibits Medi-Cal benefits from being terminated until at least 20 days after a Notice of Action (NOA) is sent to the beneficiary from the county social services department. Under current law, NOAs are sent to Medi-Cal beneficiaries to notify them of any changes to their eligibility 10 days prior to the termination of Medi-Cal benefits.	**08/11/2016** – Passed Senate Committee on Appropriations, ordered to third reading	Watch
AB 2084 Wood	Requires comprehensive medication management (CMM) services to be a covered benefit under Medi-Cal, and requires plans that administer CMM services include	**05/27/2016** – Held under submission	Watch

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Bill No. Author	Bill Summary	Bill Status	CalOptima Position
	the development and implementation of a written medication treatment plan.		
AB 2207 Wood	Adds performance measures for the Denti-Cal FFS program and seeks to improve access to care for Denti-Cal beneficiaries by increasing the number of providers. May affect CalOptima members receiving Denti-Cal services.	**08/18/2016** – Passed Senate, referred to the Assembly	Watch
AB 2394 Garcia	Requires Medi-Cal health plans to provide non medical transportation (NMT) services for Medi-Cal beneficiaries. Expands NMT benefits for any form of public or private transportation, as well as mileage reimbursement. Makes changes to transportation benefits for CalOptima members.	**08/11/2016** — Passed Senate, referred to the Assembly	Watch
AB 2507 Gordon	Adds video and telephone communications to the definition of telehealth. Provides that the required consent from beneficiaries for telehealth services may be digital, oral, or written. As currently drafted, this bill will not change CalOptima's services or policies, as these benefits are already provided. However, it may relax restrictions for beneficiaries to approve the use of telemedicine.	**05/27/2016** – Held under submission	Watch
AB 2670 Hernández	Requires DHCS to annually administer the Consumer Assessment of Health Care Providers and Systems (CAHPS) Health Plan survey, which is developed for all Medi-Cal managed care plans. Increases the frequency of the survey, and requires it to be administered in all threshold languages. Requires the survey to show detailed information on how factors such as location, ethnicity, and gender play into quality of health care.	**05/27/2016** – Held under submission	Watch
AB 2752 Nazarian	Requires health plans to notify members if a prescription drug is no longer covered by the plan, or if the plan changes its policy to no longer offer a specific drug. Requires plans to annually update their provider directory with prescription drug information and to inform members through annual renewal materials if a prescription drug is no longer covered by their provider.	**05/27/2016** – Held under submission	Watch
AB 2821 Chiu	Requires the Department of Housing and Community Development (HCD) to coordinate with DHCS to establish a housing program for Medi-Cal beneficiaries and award grants to government agencies participating in a Whole Person Care (WPC) pilot program. Allows HCA to be eligible to receive these grant funds which	**08/11/2016** – Passed Senate Committee on Appropriations, ordered to third reading	Watch

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Bill No. Author	Bill Summary	Bill Status	CalOptima Position
	may affect up to approximately 7,300 homeless CalOptima members.		

The CalOptima Legislative Tracking Matrix includes information regarding legislation that directly impacts CalOptima and our members. These bills are closely followed and analyzed by CalOptima's Government Affairs Department throughout the legislative session. All official "Support" and "Oppose" positions are approved by the CalOptima Board of Directors. Bills with a "Watch" position are monitored by staff to determine the level of impact.

UPCOMING LEGISLATIVE DEADLINES

July Deadlines

July 1: Last day for policy committees to meet and report bills. Summer Recess begins upon adjournment if a Budget Bill has been passed

August Deadlines

Aug. 1: Legislature reconvenes from Summer Recess

Aug. 12: Last day for fiscal committees to meet and report bills

Aug. 15-31: Floor Session only. No committee may meet for any purpose except the Rules Committee

Aug. 19: Last day to amend on the Floor

Aug. 31: Last day for each house to pass bills. Final Recess begins upon adjournment

Final Recess Deadlines

Sept. 30: Last day for Governor to sign or veto bills passed by the Legislature before Sept. 1

Oct. 2: Bills enacted on or before this date take effect Jan. 1, 2017

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Nov. 8: General Election

Nov. 30 Legislature officially adjourns at midnight

Dec. 5: 2017-18 Regular Session convenes for Organizational Session at 12:00 p.m.

2017

Jan. 1: Statutes take effect

* Holiday schedule subject to final approval by Rules Committee

About CalOptima

CalOptima is a county organized health system that administers health insurance programs for low-income children, adults, seniors and people with disabilities in Orange County. Our mission is to provide members with access to quality health care services delivered in a cost-effective and compassionate manner. As one of Orange County's largest health insurers, we provide coverage through four major programs: Medi-Cal, OneCare (HMO SNP) (a Medicare Advantage Special Needs Plan), OneCare Connect Cal MediConnect Plan (Medicare-Medicaid Plan) and PACE (Program of All-Inclusive Care for the Elderly).

If you have any questions regarding the above information, please contact:

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Sources: Legislative Deadlines, California State Assembly: http://assembly.ca.gov/legislativedeadlines

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Board of Directors Meeting
September 1, 2016

CalOptima Community Outreach Summary — August 2016

Background

CalOptima is committed to serving our community by sharing information with current and potential members and strengthening relationships with our community partners. One of the ways CalOptima accomplishes this is through our participation in public events. CalOptima participates in public activities that meet at least one of the following criteria:

- Member interaction/enrollment: The event/activity attracts a significant number of CalOptima members and/or potential members who could enroll in any of CalOptima's programs.
- Branding: The event/activity promotes awareness of CalOptima in the community.
- Partnerships: The event/activity has the potential to create positive visibility for CalOptima and create a long-term collaborative partnership between CalOptima and the requesting entity.

Requests for sponsorship are considered based on several factors including: the number of people the activity/event will reach; the marketing benefits for CalOptima; the strength of the partnership or level of involvement with the requesting entity; past participation; staff availability; and budget availability.

In addition to participating in community events, CalOptima staff actively participates on a number of community meetings including coalitions/collaboratives, committees, and advisory groups focused on community health issues. CalOptima strives to address issues related to improving access to health care, reducing health disparities, strengthening the safety net system and promoting a healthier Orange County.

CalOptima Community Events Update

On Wednesday, September 14, 2016, the Community Relations department and our community partners will host the Community Alliances Forum. The event will take place from 9:00 a.m. to11:00 a.m. at the Delhi Center in Santa Ana. CalOptima's Chief Executive Officer, Michael Schrader will provide opening remarks and updates regarding CalOptima's current initiatives. The topic of the forum will focus on updates and findings from *Orange County's* latest Community Health Assessment. Presenters at the meeting will include David Souleles, Deputy Agency Director with Orange County Health Care Agency and Donna Fleming, Chief of Operations with the Orange County Health Care Agency, who will be providing updates and findings from the latest Community Health Assessment from the Orange County Health Improvement Plan.

Following the presentation, there will be a breakout session to discuss access, responsiveness, accountability, quality of service and coordination of public health. Attendees will have an opportunity to provide feedback and suggestions to create a healthier Orange County as part of the Orange County Health Improvement Plan.

The Community Alliances Forum was established to strengthen, develop and sustain positive relationships with community-based organizations, health care providers, policy makers, and other individuals/organizations that are invested in community health. Participants have an opportunity to network while learning about health care issues that impact our community.

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For additional information or questions, please contact Tiffany Kaaiakamanu, Manager of Community Relations at 657-235-6872 or via email at tkaaiakamanu@caloptima.org.

Summary of Public Activities

CalOptima participated in 39 community events and coalition and committee meetings:

Date	Events/Meetings	Audience Reached
8/01	• Orange County Health Care Agency Mental Health Services Act Steering Committee	Health and Human Service Provider
8/03	• Orange County Aging Services Collaborative	Health and Human Service Provider
	• Anaheim Human Services Network	Health and Human Service Provider
	• Meet and Greet with Supportive Care Services Foundation	Health and Human Service Provider
8/04	• Caring Well Through the End of Life hosted by Alzheimer's Orange County and Orange County Advance Care Planning Partners	Health and Human Service Provider
	• Homeless Provider Forum	Health and Human Service Provider
8/05	• Covered Orange County General Meeting	Health and Human Service Provider
8/08	• Fullerton Collaborative	Health and Human Service Provider
8/09	• San Clemente Wellness & Prevention Collaborative	Health and Human Service Provider
8/10	• Buena Park Collaborative	Health and Human Service Provider
	• Anaheim Homeless Collaborative	Health and Human Service Provider
	• Conversation Cafe: Experiencing End of Life and Grief as a Professional hosted by Alzheimer's Orange County	Health and Human Service Provider
	• Meet and Greet with MOMS Orange County	Health and Human Service Provider
	• Medicare Marketplace Planning Meeting	Health and Human Service Provider
8/11	• Meet and Greet with Santa Ana Community Center	Health and Human Service Provider
	• FOCUS Collaborative	Health and Human Service Provider
	• Orange County Developmental Screening Network	Health and Human Service Provider
	• GEN Silent hosted by Huntington Beach Senior Services	Member/Potential Member
8/16	• Coordinated Entry's Healthcare and Housing Integration Working Group	Health and Human Service Provider
	• Tapping In To Low-Income Services hosted by North Orange County Senior Collaborative	Health and Human Service Provider
	• Meet and Greet with Volunteers of America	Health and Human Service Provider
8/17	• La Habra Collaborative	Health and Human Service Provider
	• Minnie Street Family Resource Center Professional Roundtable	Health and Human Service Provider
	• Orange County Promotoras	Health and Human Service Provider
	• Covered Orange County Steering Committee	Health and Human Service Provider

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8/18	• Orange County Children's Partnership Committee	Health and Human Service Provider
	• Huntington Beach Surf City Senior Providers Network and Lunch	Health and Human Service Provider
8/20	• Super Senior Saturday Resource Fair hosted by the City of Buena Park *($150 registration fee included 2 outreach tables and 4 chairs)*	Member/Potential Member
	• General Meeting and Youth Ministry Convocation and Resource Fair	Member/Potential Member
8/21	• Family Health Fair hosted by Anaheim Marketplace *($270 registration fee included 1 outreach table and 2 chairs)*	Member/Potential Member
	• National Senior Citizens Day hosted by the Office of Congresswoman Loretta Sanchez	Member/Potential Member
8/22	• Stanton Collaborative	Health and Human Service Provider
	• Community Health Research and Exchange	Health and Human Service Provider
8/23	• Orange County Senior Roundtable	Health and Human Service Provider
	• Santa Ana Building Healthy Communities Prevention Workgroup	Health and Human Service Provider
	• Anaheim Religious Council Meeting	Health and Human Service Provider
	• Meet and Greet with RTH Stroke Foundation	Health and Human Service Provider
8/24	• Anaheim Homeless Collaborative Case Management Meetings	Health and Human Service Provider
8/31	• Orange County Human Trafficking Task Force - General Meeting	Health and Human Service Provider

CalOptima organized or convened the following 1 community stakeholder events, meetings and presentations:

Date	Event/Meeting	Audience Reached
8/08	• CalOptima Speakers Bureau Presentation for Fullerton Collaborative — Topic: Medi-Cal Overview	Health and Human Service Provider

CalOptima endorsed the following 2 events during this reporting period (letters of support, program/public activity event with support, or use of name/logo):

1. Use of CalOptima‘s PACE logo on the Orange County Aging Services Collaborative webpage to promote PACE program and services.

2. Use of CalOptima's OneCare Connect logo on Monarch Healthcare new member welcome packet and flier to promote and educate perspective members.

3. Use of CalOptima's Master logo on St. Joseph Heritage Healthcare digital banner and landing page to promote Heritage Medical Groups.

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CalOptima Board of Directors
Community Activities

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

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
September 2016			
Thursday, 9/1 9-11am	++Homeless Provider Forum	**Steering Committee Meeting: Open to Collaborative Members**	1855 Orange Olive Rd. Orange
Thursday, 9/1 9-11am	++Refugee Forum of Orange County	**Steering Committee Meeting: Open to Collaborative Members**	631 S. Brookhurst St. Ste. 107 Anaheim
Friday, 9/2 9-10:30am	++Covered Orange County General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	1575 E. 17th St. Santa Ana
Monday, 9/5 1-4pm	++OCHCA Mental Health Services Act Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	505 E. Central Ave. Santa Ana
Tuesday, 9/6 9:30-11am	++Collaborative to Assist Motel Families	**Steering Committee Meeting: Open to Collaborative Members**	250 E. Center St. Anaheim
Thursday, 9/8 3-5pm	++OC Women's Health Project Advisory Board	**Steering Committee Meeting: Open to Collaborative Members**	1505 E. 17th St. Santa Ana
Saturday, 9/10 9am-2pm	+Huntington Beach Council on Aging 28th Annual Senior Saturday Community Festival	**Health/Resource Fair Open to the Public**	Huntington Beach Pier Plaza Downtown

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Monday, 9/12 2:30-3:30pm	++Fullerton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	353 W. Commonwealth Ave., Fullerton
Monday, 9/12 6:30-7:30pm	++State Council on Developmental Disabilities OC Regional Advisory Committee	**Steering Committee Meeting: Open to Collaborative Members**	2000 E. Fourth St., Ste. 115 Santa Ana
Tuesday, 9/13 11:30am-12:30pm	++Buena Clinton Neighborhood Coalition	**Steering Committee Meeting: Open to Collaborative Members**	12661 Sunswept Ave. Garden Grove
Tuesday, 9/13 2-4pm	++Susan G. Komen OC Unidos Contra el Cancer del Seno Coalition	**Steering Committee Meeting: Open to Collaborative Members**	3191 A Airport Loop Dr. Costa Mesa
Wednesday, 9/14 10-11:30am	++Buena Park Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	7150 La Palma Ave. Buena Park
Wednesday, 9/14 12-1:30pm	++Anaheim Homeless Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	500 W. Broadway Anaheim
Wednesday, 9/14 10am-12pm	+City of Lake Forest 20th Annual Senior Resource Fair	**Health/Resource Fair Open to the Public**	25550 Commercenter Dr. Lake Forest
Thursday, 9/15 8:30-10am	++Orange County Children's Partnership Committee	**Steering Committee Meeting: Open to Collaborative Members**	10 Civic Center Plaza Santa Ana
Thursday, 9/15 10am-1pm	+State Council on Developmental Disabilities and Fairview Developmental Center Community Options Fair	**Health/Resource Fair Open to the Public**	2501 Harbor Blvd. Costa Mesa
Saturday, 9/17 10am-1pm	+ The Office of Assemblyman Tom Day 2nd Annual Anaheim Family and Health Resource Fair	**Health/Resource Fair Open to the Public**	951 S. State College Anaheim

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Saturday, 9/17 3-8pm	+The Vietnamese Cultural Center Mid-Autumn Moon Festival	**Health/Resource Fair Open to the Public**	16801 Euclid St. Fountain Valley
Sunday, 9/18 10am-5pm	+Pacific Islander Health Partnership 9th Annual Pacific Islander Festival	**Health/Resource Fair Open to the Public**	7111 Talbert Ave. Fountain Valley
Tuesday, 9/20 10-11:30am	++Placentia Community Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	849 Bradford Ave. Placentia
Tuesday, 9/20 2-3:30pm	++Coordinated Entry's Healthcare & Housing Integration Workgroup	**Steering Committee Meeting: Open to Collaborative Members**	1505 E. 17th St. Santa Ana
Wednesday, 9/21 9:15-10:45am	++Covered Orange County Steering Committee	**Steering Committee Meeting: Open to Collaborative Members**	18012 Mitchell S. Irvine
Wednesday, 9/21 11am-1pm	++Minnie Street Family Resource Center Professional Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	1300 McFadden Ave. Santa Ana
Wednesday, 9/21 1-4pm	++Orange County Promotoras	**Steering Committee Meeting: Open to Collaborative Members**	Location Varies
Monday, 9/26 12:30-1:30pm	++Stanton Collaborative	**Steering Committee Meeting: Open to Collaborative Members**	7800 Katella Ave. Stanton
Tuesday, 9/27 7:30-9am	++OC Senior Roundtable	**Steering Committee Meeting: Open to Collaborative Members**	170 S. Olive Orange
Tuesday, 9/27 3:30-4:30pm	++Santa Ana Building Health Communities	**Steering Committee Meeting: Open to Collaborative Members**	1902 W. Chestnut Ave. Santa Ana

Day/Date/Time	Name of Activity/Event	Type of Activity/Event	Location
Wednesday, 9/28 9:30am-12pm	++CA Association of Area Agencies on Aging	**Steering Committee Meeting: Open to Collaborative Members**	980 9th St. Sacramento
Wednesday, 9/28 10:30-11:30am	++OC human Trafficking Task Force General Meeting	**Steering Committee Meeting: Open to Collaborative Members**	1221 E. Deyer Rd., Ste. 120 Santa Ana
Friday, 9/30 7:30am-5pm	+UC Irvine Mind and Alzheimer's Orange County 27th Annual So. California Alzheimer's Disease Research Project	**Health/Resource Fair Open to the Public**	1800 Von Karman Ave. Irvine
Friday, 9/30 9am-5pm	+Cal State Fullerton Center for Successful Aging 3rd Annual Conference & Expo	**Health/Resource Fair Open to the Public**	800 N. State College Blvd. Fullerton